

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/16/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 115337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 248 EAST MAIN STREET SEATTYVILLE, KY 41311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 281 SS=D</p>	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 03/31/15 through 04/02/15. Deficient practice was identified to exist with the highest scope and severity at "D" level.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to assure services were arranged by the facility to meet professional standards of quality for one (1) of twenty (20) sampled residents (Resident #13). The facility failed to assure Resident #13, a newly admitted resident of the facility, received necessary care to assure toenail care was provided.</p> <p>The findings include:</p> <p>Interview with the facility Director of Nursing on 04/02/15 at 6:56 PM revealed the facility does not have a written policy related to developing initial care plans for residents.</p> <p>Observations made on 03/31/15 at 10:08 AM and on 04/02/15 at 6:55 PM revealed Resident #13 to have long untrimmed toenails.</p> <p>Review of Resident #13's medical record revealed the facility admitted the resident on 03/26/15, with diagnoses including</p>	<p>F 000</p> <p>F 281</p> <p>F281 SS D</p>	<p>Lee County Care and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>1. A Licensed Nurse trimmed resident #13's toenails upon notification by the surveyor on 4/2/15. Resident #13 was scheduled an</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 4/29/15

A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 1</p> <p>Cerebrovascular Accident (CVA), Encephalopathy, and Mental Disorder.</p> <p>Further review of the record revealed the admission Minimum Data Set (MDS) assessment was not complete due to the resident's admission date and the MDS was not required to be complete yet. Review of the Nursing Admission Information assessment, dated 03/28/15, revealed Resident #13 required assistance related to personal hygiene. Continued review of the nursing admission assessment under the Foot Care section revealed the facility assessed the resident to have no issues or concerns related to Resident #13's toenails. Further review of the nursing admission assessment revealed no indication of Resident #13 having long untrimmed toenails on the full body skin assessment.</p> <p>Review of Resident #13's Interim Comprehensive Care Plan dated 03/26/15, and Nurse Assistant Care Plan dated March 2015, revealed the facility did not develop a care plan with interventions to address toenail care.</p> <p>Interview with Registered Nurse (RN) #1 on 04/02/15 at 6:35 PM revealed she was the nurse who admitted Resident #13 to the facility and that when admitting residents to the facility she checks skin, fingernails, and toenails on the admission assessment. Continued interview with RN #1 revealed Resident #13 had been admitted to the facility at shift change and she should have made note of his/her long toenails on the admission assessment. RN #1 stated, "I just missed it. I develop the CNA (certified nursing assistant) care plan and should have developed a care plan for nail care."</p>	F 281	<p>appointment with a Podiatrist on 4/14/15.</p> <p>2. All residents have the potential to have long untrimmed toenails upon admission. A 100% observation was completed on 4/3/15 by the DON, ADON, and Unit Managers to ensure all resident's toenails were trimmed. No other issues were identified.</p> <p>The DON, SDC, and Unit Managers will complete a 100% audit of all resident care plans by 4/30/15 to ensure resident care plans meet professional standards with emphasis on toenail care.</p> <p>3. Education will be provided by the SDC, DON or ADON for licensed nursing staff by 4/30/15 regarding completion of the nursing admission assessment, development of a nursing care plan and a development of a nursing assistant care plan to meet professional standards. With emphasis on providing toenail care upon admission.</p>	

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F 281	Continued From page 2 Interview with the Seasons Unit Clinical Coordinator on 04/02/15 at 6:30 PM revealed that an intervention to address Resident #13's toenail care should have been on the Nurse Aide Care Plan. Continued Interview with the Unit Clinical Coordinator revealed the nurse who admitted Resident #13 was responsible for developing the care plan. Further interview with the Unit Clinical Coordinator revealed resident care plans were reviewed in the facility's morning meetings (Quality Assurance) and she made rounds in order to ensure residents were receiving the care required. The Unit Clinical Coordinator revealed nail care was to be provided once a week on all residents. Interview with the facility Director of Nursing (DON) on 04/02/15 at 7:00 PM revealed nail care was to be provided for residents once a week and the admitting nurse was responsible for developing a care plan related to nail care. Continued interview with the DON revealed they go over resident care plans in their morning meeting (Quality Assurance) and had not identified any concerns with Resident #13's care plan. Further interview with the DON revealed she conducted daily rounds to ensure residents were being cared for and she was not aware of the condition of Resident #13's toenails.	F 281	4. The DON, Unit Managers or SDC will complete an audit of new admission resident's toenails daily M-F x4 weeks, weekly x4 weeks then monthly for two months to ensure toenail care has been provided to meet professional standards. The DON, Unit Managers or SDC will complete an audit of new admission resident's assessment to ensure completion of the nursing admission assessment, development of a nursing care plan and a development of a nursing assistant care plan to meet professional standards. Emphasis will be placed on providing toenail care upon admission. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager,		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312			

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F 312	<p>Continued From page 3</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure that one (1) of twenty (20) sampled residents (Resident #13) received the necessary services to maintain good personal hygiene related to long untrimmed toenails. The facility failed to assure Resident #13 received necessary assistance to assure nail care was completed. Observations of Resident #13 made on 03/31/15 at 10:08 AM and 04/02/15 at 6:55 PM revealed Resident #13 to have long untrimmed toenails.</p> <p>The findings include:</p> <p>Review of facility policy titled "Nails-Cleaning and Trimming," dated December 2010 revealed the nursing staff would provide observation and care of nails for all residents daily and as necessary.</p> <p>Observations made on 03/31/15 at 10:08 AM and on 04/02/15 at 6:55 PM revealed Resident #13 to have long untrimmed toenails.</p> <p>Review of Resident #13's medical record revealed the facility admitted the resident on 03/26/15, with diagnoses including Cerebrovascular Accident (CVA), Encephalopathy, and Mental Disorder.</p> <p>Review of the Nursing Admission Information assessment dated 03/26/15 revealed Resident #13 to need assistance related to personal hygiene. Continued review of the nursing admission assessment under the Foot Care section revealed the facility assessed the resident</p>	F 312	<p>Human Resource Director, Maintenance Director, and Quality of Life Director.</p> <p>5. Date of Compliance 4/30/2015</p> <p>F312 SS D</p> <ol style="list-style-type: none"> 1. A Licensed Nurse trimmed resident #13's toenails upon notification by the surveyor on 4/2/15. Resident #13 was scheduled an appointment with a Podiatrist on 4/14/15. 2. All residents have the potential to have long untrimmed toenails upon admission. A 100% observation was completed on 4/3/15 by the DON, ADON, and Unit Managers to ensure all resident's toenails were trimmed. No other issues were identified. The DON, ADON, and Unit Managers will complete a 100% audit of all resident care plans by 4/30/15 to ensure resident care plans meet professional standards with emphasis on toenail care. 3. Education will be provided by the SDC, DON or ADON for licensed nursing staff by 4/30/15 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(R1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 128307	(R2) MULTIPLE CORRECTIONS A. BUILDING _____ B. WING _____	(R3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 248 EAST MAIN STREET BEAUTYVILLE, KY 41301	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(R4) CORRECTIVE DATE
F 312	<p>Continued From page 4</p> <p>to have no issues or concerns related to Resident #13's toenails. Further review of nursing admission assessment revealed no indication of Resident #13 having long untrimmed toenails on the full body skin assessment.</p> <p>Review of Resident #13's Interim Comprehensive Care Plan dated 03/26/15 and Nurse Assistant Care Plan dated March 2015 revealed the facility did not develop a care plan with interventions to address toenail care for Resident #13.</p> <p>Interview with the Seasons Unit Clinical Coordinator on 04/02/15 at 6:30 PM revealed she should have included an intervention on Resident #13's Nurse Aide Care Plan to address toenail care. Continued interview with the Unit Clinical Coordinator revealed the nurse who admitted Resident #13 was responsible for developing the care plan. Further interview with the Unit Clinical Coordinator revealed resident care plans were reviewed in their morning meeting (Quality Assurance) and she made rounds in order to ensure residents were receiving the care required. The Unit Clinical Coordinator revealed nail care was to be provided once a week on all residents.</p> <p>Interview with Registered Nurse (RN) #1 on 04/02/15 at 8:35 PM revealed she was the nurse who admitted Resident #13 to the facility and that when admitting residents to the facility she checks skin, fingernails, and toenails on the admission assessment. Continued interview with RN #1 revealed Resident #13 had been admitted to the facility at shift change and she should have made note of his/her long toenails on the admission assessment. RN #1 stated, "I just missed it. I develop the CNA (certified nursing</p>	F 312	<p>regarding completion of the nursing admission assessment, development of a nursing care plan and a development of a nursing assistant care plan to meet professional standards. With emphasis on providing toenail care upon admission.</p> <p>The DON, Unit Managers or SDC will complete an audit of new admission resident's toenails daily M-F x4 weeks, weekly x4 weeks and then monthly for two months to ensure toenail care has been provided to meet professional standards.</p> <p>4. The DON, Unit Managers or SDC will complete an audit Daily M-F X4 weeks, Weekly X4 weeks, then Monthly X2 months of new admission resident's assessment to ensure completion of the nursing admission assessment, development of a nursing care plan and a development of a nursing assistant care plan to meet professional standards. Emphasis will be placed on providing toenail care upon admission.</p> <p>Findings of the above stated audits will be discussed in the Quality</p>	

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F 312	Continued From page 5 assistant) care plan and should have developed a care plan for nail care." Interview with the facility Director of Nursing (DON) on 04/02/15 at 7:00 PM revealed nail care was to be provided for residents once a week and the admitting nurse was responsible for developing a care plan related to nail care. Continued interview with the DON revealed they go over resident care plans in their morning meeting (Quality Assurance) and had not identified any concerns with Resident #13's care plan. Further interview with the DON revealed she conducted daily rounds to ensure residents were being cared for and she was not aware of the condition of Resident #13's toenails.	F 312	Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director. 5. Date of Compliance 4/30/2015		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review it was determined the facility failed to ensure that residents' environment was free of accident hazards for one (1) of twenty (20) sampled residents (Resident #15). Observations on 03/31/15 revealed the resident was in bed and a Lidoderm patch (medication for pain) was on the bedside table.	F 323	F323 SS D Resident #15 was assessed for pain. No pain was observed. Resident #15 did have a Lidoderm patch that had been placed in the am on 3/31/15, MD/POA notified on 3/31/15 by RN #2. No new orders were obtained. A medication error report was filled out on 3/31/15 by the Unit Manager. RN#2 was re-educated on 3/31/15 by the DON on environment safety as it related to ensuring that resident's environment is free of accident hazards as possible; and each resident receives adequate supervision and assistance devices to prevent accidents, ie: never leave a patch or any medication sitting on a bedside table, related to RN#2 leaving a Lidoderm patch (medication for Pain) on the bedside table. A medication error report was filled out by the Unit		

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F 323	<p>Continued From page 6</p> <p>The facility failed to assure that the medication was properly stored to prevent accidents.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Medication Administration General Guidelines," (dated 2007) revealed that medications were to be administered at the time they are prepared. Further review of the policy revealed medications were to be administered within 60 minutes of the scheduled time.</p> <p>Review of the facility policy titled "Medication Administration-Administering Medications," (dated 12/20/10) revealed medications were never to be left in a resident's room.</p> <p>Review of the medical record for Resident #15 revealed the resident was admitted to the facility on 11/25/14 with diagnoses that included Hypertension, History of Fractured Femur, Herpes Zoster, Difficulty Walking, Lack of Coordination, Muscle Weakness, Senile Dementia, Atrial Fibrillation, Chronic Airway Obstruction, Dysphagia, Dncephalopathy, and Type II Diabetes. Further review of the record revealed a doctors order for Lidocaine 5%, 700 milligram patch, apply one patch topically to the skin on the right hip daily and remove at bedtime for hip pain.</p> <p>Review of the Minimum Data Set (MDS) dated 01/20/15 revealed the Brief Interview for Mental Status (BIMS) score was 99, indicating that the resident was not interviewable.</p> <p>Observation on 3/31/15 at 10:06 AM revealed the resident was lying in bed resting with eyes closed</p>	F 323	<p>Manager on 3/31/15.</p> <p>2. All residents have the potential to be affected by the facility failing to provide necessary care and services to ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>Unit Managers completed an audit on 3/31/15 for all residents requiring the use of a patch of any kind to ensure all patches were in place per MD orders. All patches were in place per MD order.</p> <p>3. Education for RN#2 and RN #3 was completed on 3/31/15 by the DON. The education provide addressed environment safety as it relates to ensuring that resident's environment is free of accident hazards related to RN#2 leaving a Lidoderm patch (medication for Pain) on the bedside table.</p> <p>The DON, ADON and Unit Managers will complete education for all licensed Staff by 4/30/15. The education will address environment safety as it Relates to ensuring that resident's</p>	

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F 323	Continued From page 7 and the Lidoderm patch was on the bedside table. The patch was noted to have a date of 03/30/15 written on it. Interview with Registered Nurse (RN) #2 on 03/31/15 at 4:39 PM revealed she was assigned to care for Resident #15 on 03/30/15. RN #2 stated during medication pass Resident #15 was not in his/her room and RN #2 laid the patch on the bedside table. RN #2 stated she never gave the medication even though she charted it was administered. RN #2 stated she had been in-serviced by the facility on the proper administration of medication. Interview with RN #3 on 04/02/15 at 1:00 PM revealed that during the evening medication pass she did not take off Resident #15's Lidoderm patch. RN #3 stated that Resident #15 usually takes it off him/herself and puts it on the bed or on the floor. RN #3 stated she "thought" she checked to see if the patch was removed and stated she did not observe the patch on the bedside table. RN #3 stated she had been in-serviced at the facility on medication administration and documentation.	F 323	environment is free of accident hazards as possible and each resident receives adequate supervision and assistive devices to prevent accidents; ie: a Lidoderm patch (medication for Pain) being left on the bedside table.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the	F 514	4. The DON, ADONs, and Unit Managers will complete a 100% audit of all residents requiring a patch of any kind daily M-F x4 weeks, weekly x4 weeks, and then monthly x 2 months to ensure patches are in place per MD order. Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director, and Quality of Life Director. 5. Date of compliance 4/30/15.	

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F 514	<p>Continued From page 8</p> <p>resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, record review, and facility policy review it was determined that the facility failed to maintain accurate records for one (1) of twenty (20) sampled residents (Resident #15). Review of the Medication Administration Record (MAR) for Resident #15 revealed documentation that Resident #15 received a Lidoderm patch on 03/30/15. However, observation on 03/31/15 at 10:08 AM revealed the medication was left on the bedside table and not administered as documented.</p> <p>The findings include:</p> <p>Review of the facility policy titled "Medication Administration-Administering Medications," (dated 12/20/10) revealed medications were never to be left in a resident's room. The policy stated drugs were to be returned to the medication cart, and documentation should indicate failure to administer a medication on the administration record and nurse's clinical notes. Review of the policy titled "Medication Administration General Guidelines," (dated 2007) revealed that medications were to be administered at the time they were prepared. Review of the facility policy titled "Medication Administration Transdermal Delivery Systems,"</p>	F 514	<p>F514 SS D</p> <p>1. Resident #15 Lidoderm patch was found by the surveyor at the resident's bedside. An interview was conducted on 3/31/15 by the surveyor with RN #2 whom was working on 3/31/15 and had also worked on 3/30/15. RN #2 did admit to the surveyor that she had left the Lidoderm patch at the bedside the previous day because the resident was not in the room when she went into the resident #15 room to place the Lidoderm patch on her. RN #2 did tell the surveyor that she had been educated by the facility on the proper administration of medication. RN #3 was also interviewed by the surveyor related to removing the Lidoderm patch at bed time. RN#3 stated to the surveyor "she thought she checked to see if the patch was removed and stated she did not observe the patch on the bedside table." RN #3 did tell the surveyor she had been educated by the facility on the proper administration of medication.</p> <p>Resident #15 was assessed for pain. No pain was observed. Resident #15 did have a Lidoderm patch that had been placed in the am on 3/31/15, MD/POA notified on 3/31/15 by RN #2. No new orders were obtained. A medication error report was filled out on 3/31/15 by the Unit Manager.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 248 EAST MAIN STREET BEATTYVILLE, KY 41311	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 9</p> <p>(dated 09/08) revealed if a resident was found without an ordered patch on the body, "The discovering nurse shall investigate and search for the medication patch. Check package insert for instructions for replacing a missing or loose patch. The prescriber shall be notified and further instructions obtained. Recommend notifying the director of nursing to document incident for potential trending if patterns of missing patches occurs."</p> <p>A review of the medical record revealed Resident #15 was admitted on 11/25/14 with diagnoses that included history of a fractured femur, Herpes Zoster, Difficulty Walking, Lack of Coordination, Muscle Weakness, Senile Dementia, Atrial Fibrillation, Chronic Airway Obstruction, Dysphagia, Encephalopathy, and Type II Diabetes. A review of the physician's order dated 03/01/15 to 03/31/15 revealed an order for Lidoderm patch 5% 700 milligram patch and to apply the patch topically to the skin on the right hip daily and remove at bedtime. Review of the MAR revealed the patch was documented as administered on 03/30/15 at 9:00 AM.</p> <p>Observation made on 03/31/15 at 10:06 AM revealed the resident was lying in bed resting with eyes closed and the Lidoderm patch was observed on the bedside table.</p> <p>Interview with Registered Nurse (RN) #2 on 03/31/15 at 4:39 PM revealed she administered medications to Resident #15 on 03/30/15. RN #2 stated she did not administer the patch because the resident was not in his/her room. RN #2 stated she documented that it was given, but forgot to go back and later change the documentation.</p>	F 514	<p>2. All residents have the potential to be affected by the facility failing to maintain clinical records on each resident in accordance with accepted professional standard and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>Unit Managers completed a 100% audit on 3/31/15 for all residents requiring the use of a patch of any kind to ensure all patches were in place per MD orders. All patches were in place per MD order.</p> <p>3. Education for RN#2 and RN #3 was completed on 4/3/15 by the DON. The education provide addressed maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>Medication Administration- Administering Medications policy, Medication Administration General Guidelines and Medication Administration Transdermal Delivery Systems. Emphasis was placed on Medications were never to be left in a resident's room. Medications and or patches were to be returned to the medication cart, documentation should indicate failure to administer a medication on the MAR.</p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/02/2015
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 10 Interview with the Director of Nursing (DON) on 04/02/15 at 7:00 PM revealed that during medication administration, nursing staff is expected to bring new patches into the room, remove old patches, rotate the site, bring the old patch out, and dispose of it properly, and then document administration of medication.	F 514	<p>Re-education was also provided if a resident was found without an ordered patch on the body, "The discovering nurse shall investigate and search for the medication patch and report the missing patch to the DON.</p> <p>Education for RN#2 and RN #3 was completed on 4/3/15 by the DON. The education provide addressed maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Medication Administration- Administering Medications policy, Medication Administration General Guidelines and Medication Administration Transdermal Delivery Systems. Emphasis was placed on Medications were never to be left in a resident's room. Medications and or patches were to be returned to the medication cart, documentation should indicate failure to administer a medication on the MAR.</p> <p>Re-education was also provided if a resident was found without an ordered patch on the body, "The discovering nurse shall investigate and search for the medication patch and report the missing patch to the DON.</p>		

Education will be completed by 4/13/15 by the DON, SDC, or Unit Managers for all licensed staff. The education provided will address maintaining clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. Medication Administration-Administering Medications policy, Medication Administration General Guidelines and Medication Administration Transdermal Delivery Systems. Emphasis was placed on Medications were never to be left in a resident's room. Medications and or patches were to be returned to the medication cart, documentation should indicate failure to administer a medication on the MAR.

Re-education was also provided if a resident was found without an ordered patch on the body, "The discovering nurse shall investigate and search for the medication patch and report the missing patch to the DON.

4. The DON, ADONs, and Unit Managers will complete an audit of all residents requiring a patch of any kind daily M-F x4 weeks, weekly x4 weeks, and then monthly x 2 months to ensure patches are in place per MD order.

Addendum: 4/29/15

The DON, ADON, and Unit Mangers will complete an audit of all residents MARS and orders requiring a patch of any kind daily M-F x 4 weeks, weekly x4 weeks, and then monthly x 2 months to ensure the records are accurate per MD order.

Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director, Maintenance Director and Quality of Life Director.

5. Date of Compliance 4/30/15

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/31/2015
NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1993</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 6</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II natural gas generator.</p> <p>A life safety code survey was initiated and concluded on 03/31/15. The facility was found to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid, Title 42, Code of Federal Regulations, 483.70 (a) et. seq. (Life Safety from Fire).</p> <p>No deficiencies were identified during the survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.