

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

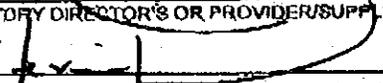
PRINTED: 07/02/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2012
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NAME OF PROVIDER OR SUPPLIER NURSING CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 983 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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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F 000	INITIAL COMMENTS An Abbreviated Survey Investigating KY#00018424 was initiated on 06/19/12 and concluded on 06/20/12. KY#00018424 was substantiated and deficient practice was identified at 483.10 Resident Rights.	F 000	<p>This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.</p> <p>F 167</p> <ol style="list-style-type: none"> The survey book was replaced on the shelf in the dining room by the Executive Director on 6/20/2012. All residents, visitors and vendors have access to the survey book. Residents were educated about the location of the survey book by the Activities Director during the July resident counsel meeting. Staff will be inservice by the Staff Development Coordinator on 7/10/2012. A memo explaining the location of the survey book will be placed in employee paychecks on 7/10/2012 by the Payroll officer. A letter will be mailed to all current resident family members on 7/9/2012 informing them of the location of the survey book. The Executive Director or designee will observe the location of the survey book weekly times four 	
F 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure survey results were available for review without the interested party having to ask a staff person.</p> <p>The findings include: Interview with the Ombudsman, on 06/20/12 at 10:40 AM, revealed she had looked for the survey results about two (2) weeks ago and it was not available. She stated a family member was interested in looking at the book.</p> <p>Upon entrance to the facility, on 06/20/12 at 1:50 PM, observation revealed no survey results were</p>	F 167		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Executive Director	(X6) DATE 6/27/12
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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.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/20/2012
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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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F 167	<p>Continued From page 1 available for review. Continued observation revealed a sign was posted, directing the reader to ask a facility representative for the survey results.</p> <p>Interview with the Administrator, on 06/20/12 at 2:00 PM, revealed the survey book was locked up at the South Wing nurses' station. He stated the book kept disappearing, or parts of the book would be removed, so the facility began looking it up.</p> <p>Interview with the Social Worker, on 06/20/12 at 2:45 PM, revealed the Ombudsman had asked about the book. He stated he directed her to speak to the Director of Nursing (DON).</p> <p>Interview with the DON, on 06/20/12 at 2:48 PM, revealed she had spoken to the Ombudsman by phone about the book. She stated she informed the Ombudsman the book was available. She further stated the sign had been displayed since the prior citation in December, 2010.</p>	F 167	<p>weeks then monthly times three months to ensure compliance with the regulation. Any issues regarding these observations will be brought to the monthly Quality Assurance meeting for review and recommendations as needed.</p> <p>5. Compliance Date: 7/13/2012</p>	
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