

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

PRINTED: 01/09/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  R-C 12/20/2012
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NAME OF PROVIDER OR SUPPLIER  LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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(F 000)	INITIAL COMMENTS  On 12/18/12 through 12/20/12, a revisit to an abbreviated survey (KY #18900, KY #18959, and KY #18984) and recertification survey conducted on 08/20/12 through 09/07/12, was conducted to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S being "D." Deficiencies were recited at F502 and F520.	(F 000)	<u>RESPONSE PREFACE</u>  Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.	
{F 502} SS=D	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's procedure, it was determined the facility failed to ensure one resident (#32), in the selected sample of eleven residents, received laboratory (lab) services in a timely manner.  Findings include:  A review of the Procedure for Monitoring Labs, undated, revealed floor supervisors check the medication records on each of their shifts to ensure there have not been any missed medication and also will follow through on checking any labs that were to be drawn in relation to the medication.  Record review revealed Resident #32 was admitted to the facility on 12/21/00 with diagnoses	{F 502}	Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.  F502 Resident #32's physician ordered on 12/11/12 for a PT/INR to be drawn on 12/14/12. The Administrative Assistant called Gamma Lab on 12/11/12 to inform them that lab needed to be drawn on this date. On 12/15/12 Nurse Supervisor was conducting audits of MAR's as well as any labs ordered related to medications and noted that we had not received the PT/INR results. Nurse Supervisor called Gamma Lab for the results of the PT/INR. The PT/INR was drawn by the lab on 12/15/12. Upon receipt of the specimen on 12/15/12, it	01-10-2013

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Selena Beck NAA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>01-11-2013</i>
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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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{F 502}	<p>Continued From page 1 to include Transient Cerebral Ischemia, Hypertension, Peripheral Vascular Disease, and a Cardiac Pacemaker.</p> <p>Review of the Physician's Order, dated 12/11/12, revealed an order to hold the resident's Coumadin (blood thinner) and perform a Prothrombin Time/International Normalized Ratio (PT/INR) on 12/14/12. A review of the facility's calendar at the nurse's desk, dated 12/14/12, revealed the PT/INR was due for Resident #32. A review of the Medication Administration Record (MAR), dated December 2012, revealed the resident's Coumadin order was scheduled for 5:00 PM daily. The Coumadin was marked "on hold" 12/11/12, 12/12/12, 12/13/12, and 12/14/12; however, the MAR did not indicate any information related to the PT/INR due on 12/14/12. The facility could not provide documentation of the PT/INR results on 12/14/12. A review of the Nurse's Notes, dated 12/15/12 at 10:20 PM, revealed in reviewing the resident's MAR, it was discovered the PT/INR was not completed, as ordered.</p> <p>An Interview with the Assistant Director of Nursing (ADON), on 12/20/12 at 4:30 PM, revealed she was the nurse for Resident #32 on 12/14/12 from 2:00 PM to 10:00 PM. She passed medications to the resident and noticed the Coumadin was "on hold." She indicated there was no information given to her in report related to the resident's PT/INR due on 12/14/12. She revealed the lab was written on the calendar at the nurse's desk; however, she did not check the calendar.</p> <p>An interview with Licensed Practical Nurse (LPN) #2, on 12/20/12 at 4:45 PM, revealed he was the</p>	{F 502}	<p>was determined that it was not a sufficient amount for running the lab. The resident's Physician was notified by the Nursing Supervisor on 12/15/12 with a new order to obtain the PT/INR on 12/16/12. The PT/INR was drawn on 12/16/12 by the lab. The physician was made aware of the results by the Nursing Supervisor on 12/16/12 with an order to restart the resident's coumadin. All other labs were reviewed back to 11/20/12 for this resident by the Director of Nursing. All other lab orders were found to have been drawn according to physician orders with physician notification of the results in a timely manner.</p> <p>A 100% lab audit for all lab orders during the time of 11/20/12 to 12/27/12 has been conducted by Director of Nursing and Facility Consultants to ensure that appropriate labs had been drawn per MD order, results received and timely MD notification of lab results. Any concerns were addressed through the QI Committee.</p> <p>All licensed nurses were in-serviced 12/24/12 through 12/31/12 by Director of Nursing that on Friday, Saturday and Holidays that they are responsible to check accordian folders to assure that lab company has drawn labs due for that day. Once verified the nurse must call lab to obtain the results for timely notification of the physician.</p> <p>All licensed nurses were in-serviced 12/27/12 through 01/10/13 by Assistant</p>	
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{F 502}	Continued From page 2 nurse for Resident #32 from 2:00 PM to 10:00 PM, on 12/15/12. He noticed the resident's Coumadin had been "on hold" and requested the Weekend Supervisor to check on the resident's PT/INR results. It was determined that the lab had not been drawn, per the order.  An interview with the Registered Nurse (RN) Weekend Manager, on 12/20/12 at 2:05 PM and 5:50 PM, revealed she worked from 2:00 PM to 10:00 PM on 12/15/12. She was reviewing the resident's MAR at the end of the shift and verified the PT/INR had not been drawn on 12/14/12, per the physician's order. She verified the nurses and supervisors were supposed to check for lab results on the weekend; however, there was no process in place to ensure ordered labs were obtained.  An interview with the Administrative Assistant, on 12/20/12 at 4:00 PM, revealed there was a lab folder at the nurse's desk where lab requisition forms were kept. When the lab work was completed, the lab took the white copy of the form, leaving the yellow copy in the folder. She revealed every morning (Monday through Friday), she checked the lab folder and pulled the yellow copies to ensure lab results were received for each requisition form. The requisition form for Resident #32 was in the lab folder; however, the lab did not "usually" come to draw a PT/INR until "late." She left the facility at 3:30 PM on 12/14/12.  Interview with the Director of Nursing (DON), on 12/20/12 at 6:00 PM; revealed she was notified by the Weekend Manager on 12/15/12 of the missed PT/INR for Resident #32. The lab does not make routine visits to the facility on Friday or	{F 502}	Director of Nursing on the new Laboratory Monitoring Sheet kept in the Lab Communication book to aid the licensed nurses in knowing who has a lab to be drawn that day. Licensed nurses were also in-serviced on these dates to call Gamma Lab if they have not received their results by 7pm. If the lab was omitted from being drawn, licensed nurses are to call the DON or ADON. The DON or ADON will come in and draw lab, and take them to Marshall County Hospital for testing.  A Lab Monitoring Sheet to include Resident #32 has been placed in the lab communication book on each unit so that each licensed nurse has the ability to audit every shift when a lab is to be drawn, that lab was drawn timely and physician notified timely. This sheet is to aid the licensed nurses in the report communication from shift to shift.  The Lab Communication Book will be brought to the Monday Department Head morning meeting where QI team members are present, for review of the lab monitoring sheet. This QI Committee members include the Administrator, DON, ADON, QI Coordinator, MDS, Activities, Social Service Director, Dietary Director, Maintenance Supervisor and Housekeeping/Laundry Supervisor. Upon identification of any potential or actual lab concern the QI Committee will follow up	

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{F 502}	Continued From page 3 Saturday; therefore, a call was placed to the lab on 12/11/12 to make them aware of the order for the PT/INR for 12/14/12. The lab did not show up on 12/14/12 to draw the PT/INR. It was the responsibility of the charge nurse to ensure the lab was drawn on 12/14/12, per the physician's order. The nurse should have checked the lab folder and the calendar to ensure the PT/INR was drawn.  A review of the Lab Audit QI tool, dated 12/10-16/12, revealed a lab was ordered for 12/14/12; however, the lab was not completed. The physician was notified with a new order to obtain the lab 12/15/12. It was completed; however, there was not enough blood for the sample. It was redrawn on 12/16/12 and the physician was made aware of the results and an order was received to restart the resident's Coumadin.	{F 502}	and take action as deemed necessary to ensure that labs are drawn as ordered, results are obtained with timely physician notification of the results.  The results of these weekly reviews will be forwarded by the Administrator or QI Nurse to the Executive QI Committee monthly x 3 months then quarterly for review, follow up as necessary, evaluation of the effectiveness of the plan, and to determine the need for and frequency of continued QI monitoring.		
{F 520} SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.	{F 520}	F520 Identification of the concern of Resident's #32 PT/INR not being drawn as ordered was identified by the Nurse Supervisor on 12/15/12 and reported to her Director of Nursing on 12/15/12. Upon completion of the analysis of the identified lab issue, the results were reviewed with the Medical Director on 12/19/12 during a QI Committee meeting. An Action plan to ensure labs are drawn as ordered and results are obtained with timely physician notification was developed at the time of the meeting on 12/19/12.  All department leaders and administrative nurses were in-serviced on 12/26/12 through	01-10-2013	

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{F 520}	<p>Continued From page 4</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's policy/procedure and Plan of Correction (PoC), it was determined the facility's Quality Assessment and Assurance Program failed to follow their PoC related to the implementation of an appropriate action plan related to the timeliness of laboratory (lab) services for one resident (#32), in the selected sample of eleven residents. Resident #32 received an order for a Prothrombin Time/International Normalized Ratio (PT/INR) on 12/14/12; however, it was not completed until 12/15/12. The Director of Nursing (DON) completed the Lab Audit Quality Improvement (QI) Tool for the week of 12/10/12 through 12/16/12, where it was identified the lab was not drawn as scheduled; however, a corrective action was not implemented at that time. The missed lab was discussed in the QI Committee meeting, on 12/19/12; however there was no plan of action implemented.</p> <p>Refer to (F502)</p> <p>Findings include:</p>	{F 520}	<p>12/27/12 by the Administrator on their role in recognizing concerns, developing a plan of action, training staff members, evaluating the plan, measuring outcomes and recommending changes.</p> <p>On 01/03/13 Administrator in-serviced the QI Coordinator on bringing all action plans to the morning department head meeting every Friday morning to review with each department the current action plans and progress with each.</p> <p>Upon this review weekly, the QI Committee will evaluate the effectiveness of the action plans with revision as appropriate to ensure continued compliance. This QI Committee members include the Administrator, DON, ADON, QI Coordinator, MDS, Social Service Director, Activities, Dietary Director, Maintenance Supervisor and Housekeeping/Laundry Supervisor.</p> <p>The results of these weekly reviews will be forwarded by the Administrator or QI Coordinator to the Executive QI Committee monthly x 3 then quarterly for review, follow up as necessary, evaluation of the effectiveness of the plan, and to determine the need for and frequency of continued QI monitoring.</p>	

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{F 520}	<p>Continued From page 5</p> <p>A review of the Quality Improvement policy/procedure, dated 01/11, revealed through the Quality Improvement Program, the facility would recognize concerns in resident care and develop a plan of action for the resolution of those concerns. Train staff members on the plan, put the plan into effect and evaluate the plan to ensure that the concerns were resolved and do not reoccur.</p> <p>A review of the facility's PoC, dated 11/20/12, revealed the Administrative Assistant would complete a Daily Lab Audit form (5 times weekly) with tracking of labs drawn, results received and appropriate follow up to include physician notification. Any lab results received after hours or on the weekends would be addressed by the nurse assigned to the specific resident. The Lab Audit QI tool would be used to review the Daily Lab Audit form weekly. The Lab Audit QI tool reviewed the number of labs ordered, the number of labs received, timeliness of physician notification, if the physician replied, if there was a new order, and corrective action needed. Results of the Lab Audit QI tool would identify corrective action needed which the DON would be responsible for validating completion of the corrective action. The results of the Daily Lab Audit forms and Lab Audit QI tool would be reviewed weekly in a QI committee meeting with the Administrator and the DON. The compiled results of these audits would be assessed for any trends by the QI committee and actions taken based on these assessments.</p> <p>Review of Resident #32's Physician orders revealed an order on 12/11/12 to hold the</p>	{F 520}		
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{F 520}	<p>Continued From page 6</p> <p>resident's Coumadin and perform a PT/INR on 12/14/12. Interview with the Weekend Manager and record review revealed she discovered the lab was not obtained when reviewing Resident #32's Medication Administration Record at the end of her shift, on 12/15/12 at 10:00 PM.</p> <p>A review of the Lab Audit QI tool, dated 12/10-16/12, revealed a lab was ordered for 12/14/12; however, the lab was not completed. The physician was notified with a new order to obtain the lab 12/15/12. It was completed; however, there was not enough blood for the sample. It was redrawn on 12/16/12 and when the physician was made aware of the results, an order was received to restart the resident's Coumadin. There was no corrective action identified on the Lab Audit QI tool.</p> <p>An interview with the DON, on 12/20/12 at 6:00 PM, revealed she thought their lab system worked, the problem was the contract lab company "did not show up" to draw the PT/INR. She revealed a QI committee meeting occurred on 12/19/12 where the staff talked about the missed PT/INR; however, no new action plan was implemented.</p> <p>An interview with the Facility Consultant, on 12/20/12 at 6:30 PM, revealed the weekend managers would be completing the Lab Audit form on the weekends; however, she could not provide documentation that verified the implementation of the action plan prior to 12/20/12.</p> <p>An interview with the Administrator, on 12/20/12 at 6:50 PM, revealed the missed lab was</p>	{F 520}		
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{F 520}	Continued From page 7 discussed in the QI committee meeting on 12/19/12; however, an action plan had not been implemented.  An interview with the Vice President of Operations, on 12/20/12 at 7:45 PM, revealed he was aware of the concern related to the missed lab; however, he felt it was an issue with the contract lab as they did not show up to draw the PT/INR. He verified there was no corrective action in place.	{F 520}			