

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

PRINTED: 05/07/2013
FORM APPROVED
OMB NO. 0938-039

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/23/2013
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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 An abbreviated survey (KY #20022) was conducted on 04/21/13-04/23/13 to determine the facility's compliance with Federal requirements. KY #20022 was substantiated with deficiencies cited at a scope and severity of a "D". 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy/procedure, it was determined the facility failed to revise the	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. 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. F280 Resident #3 was care planned on 06/03/2011 by MDS Staff for staff to provide one person as needed for guidance and physical assist, resident often will transfer self without asking for assistance. Care guide indicated for staff to assist in transferring with the aid	
F 280 SS=D		F 280		05-12-2013

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Silvia Beck</i>	TITLE <i>Administrator</i>	(X6) DATE <i>05-13-2013</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 280	<p>Continued From page 1</p> <p>comprehensive care plan for one (1) residents (#3), in the selected sample of three (3) residents, related to falls. The facility failed to revise Resident #3's care plan to include interventions for the staff to transfer the resident to a stationary chair during meal times and for the resident to eat at the table next to the nurse's station.</p> <p>The findings include:</p> <p>A review of the facility's policy/procedure, "Fall Risk Protocol", dated 11/2012, revealed the care plan was to include measurable goals and interventions to ensure the resident's safety, should include interventions related to the resident's risk for falls, and should be reviewed and updated as needed related to each resident's fall risk with interventions noted.</p> <p>A record review revealed Resident #3 was admitted to the facility on 03/15/13 with diagnoses to include Schizophrenia, Delusional disorder, Depression, Chronic Airway, Anemia, Osteoporosis, Hypertension, Anxiety, Senile dementia, and Diabetes type II.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/18/13, revealed the facility assessed Resident #3's cognition as moderately impaired. Further review of the MDS assessment revealed Resident #3 was assessed to be at risk for falls related to wandering, balance problems, history of falls, medications, and a trunk restraint used daily.</p> <p>A review of the Comprehensive Care Plan for falls revealed the most recent revision was dated</p>	F 280	<p>of one. The nursing communication tool was updated on 04/02/2013 by QI Nurse to assist resident #3 to regular chair during mealtimes. On 04/23/2013 resident #3 care guide was updated by QI Nurse to reflect transfer resident to regular chair during meal times as well as resident sits at table near nurses desk during meal times. On 05/08/2013 MDS Coordinator reviewed all of care plan and updated falls care plan to reflect transfer resident to regular chair during meal times as well as resident prefers to sit at table near nurses desk during meal times.</p> <p>A 100% audit was conducted starting on 05/08/2013 by QI nurse and MDS nurse of all falls from 04/21/2013 to 01/21/2013 to validate that all interventions have been completed and updated on care plan and care guides appropriately.</p> <p>All licensed nurses were inserviced by Director of Nursing and Staff Faciliator on 04/25/2013 and 05/09/2013 on updating care plans and care guides when initiating an intervention after a fall starting on 04/25/2013 through 05/10/2013.</p> <p>Each fall to include any for resident # 3 will be reviewed during the morning Administrative nursing team meeting with the presence of the QI Nurse and Rehab Director to review falls interventions that were put in place by the nurse to ensure that intervention are appropriate and specific. At this time the care plan and care guide will be reviewed and updated accordingly by MDS Nurse, QI Nurse or Director of Nursing.</p>	

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F 280	<p>Continued From page 2</p> <p>03/11/13 to add the intervention "up in evolution chair with chair alarm".</p> <p>A review of a Fall Investigation, dated 03/30/13, revealed the fall was observed as the resident was self transferring from the wheelchair to a regular chair. The root cause was determined to be the resident's preference to sit in a different chair. It was determined an intervention would be added for the resident to be transferred to a regular chair during mealtimes.</p> <p>A review of the Comprehensive Care Plan, last revised 03/11/13, and the undated Resident Care Guide for Resident #3, used by the nursing assistants, revealed there was no revision to include the interventions for staff to help transfer the resident to a regular chair during mealtimes".</p> <p>A review of the Fall investigation, dated 04/13/13, revealed the fall was unobserved with the resident self transferring from a regular chair to the wheelchair. It was determined an intervention would be added for the resident to eat at the table next to the nurse's station.</p> <p>Further review of the Comprehensive Care Plan, last revised 03/11/13, and the undated Resident Care Guide for Resident #3, used by the nursing assistants, revealed there was no revision to include the interventions for the "resident to eat at the table next to the nurse's station".</p> <p>Observation on 04/22/13 at 12:00 PM, revealed Resident #3 was in the dining room seated in the wheelchair positioned at a half circle table. The resident had a small cup of liquid to drink but no meal on the table. Further observation, on</p>	F 280	<p>The QI nurse will conduct a root cause analysis of each fall upon receiving notice of fall and present to the Administrator and Director of Nursing at morning Administrative meeting for review. Any deficient area will be brought before the QI team upon identification of deficient area for revising action planning and reviewed at each Friday morning Administrative meeting til resolved.</p>	
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F 280	<p>Continued From page 3</p> <p>04/23/13 at 12:15 PM, revealed Resident #3 was sitting in the wheelchair at the table beside the nurses desk with the lunch tray in front of him/her.</p> <p>Interview with Licensed Practical Nursing (LPN) #1, on 04/23/13 at 10:05 AM, revealed the interventions on the comprehensive care plan were on the resident care guide for the SRNAs to know what care to provide. The Quality Improvement nurse or the admitting nurse made the changes to the resident care guide .</p> <p>Interview with State Registered Nurse Aide (SRNA) #4 and #5, on 04/23/13 at 10:30 AM and 10:35 AM, revealed the resource used to tell the SRNA what care to provide was the resident care guide on the closet door.</p> <p>Interview with Registered Nurse (RN) #1, on 04/23/13 at 10:40 AM, revealed the comprehensive care plan interventions were on the resident care guide in each resident's room. The information was moved from the care plan to the care guide by the MDS coordinator, charge nurse, or administrative staff.</p> <p>Interview with the Director of Nursing, on 04/23/13 at 12:00 PM, revealed she would expect the interventions defined on the Falls Investigation to be on the resident care plan and resident care guide.</p>	F 280		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>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</p>	F 323	<p>F323 Resident #3 was care planned on 06/03/2011 by MDS staff for staff to provide one person as needed for guidance and physical assist, resident often will</p>	05-12-201

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F 323	<p>Continued From page 4 prevent accidents.</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 the resident's environment remains as free of accident hazards as possible and the resident receives adequate supervision to prevent accidents for one (1) resident (#3), in the selected sample of three (3) residents. The facility failed to ensure the Comprehensive Care Plan and Resident Care Guide were revised so the staff would know what interventions to put in place to prevent accidents for Resident #3.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Fall Risk Protocol", dated 11/2012, revealed the care plan was to include measurable goals and interventions to ensure the resident's safety, should include interventions related to the resident's risk for falls, and should be reviewed and updated as needed related to each resident's fall risk with interventions noted.</p> <p>A record review revealed Resident #3 was admitted to the facility on 03/15/13 with diagnoses to include Schizophrenia, Delusional disorder, Depression, Chronic Airway, Anemia, Osteoporosis, Hypertension, Anxiety, Senile dementia, and Diabetes type II.</p>	F 323	<p>transfer self without asking for assistance. Care guide indicated for staff to assist in transferring with the aid of one. The nursing communication tool was updated on 04/02/2013 by QI nurse to assist resident #3 to regular chair during mealtimes. On 04/23/2013 resident #3 care guide was updated by QI Nurse to reflect transfer resident to regular chair during meal times as well as resident sits at table near nurses desk during meal times. On 05/08/2013 MDS Coordinator reviewed all of care plan and updated falls care plan to reflect transfer resident to regular chair during meal times as well as resident prefers to sit at table near nurses desk during meal times.</p> <p>Resident #3 was placed in dining room for all meals to increase supervision and aid in transferring from econo chair to stationary chair at meal times on 05/09/2013. Other residents were reviewed on 05/10/2013 by the Director of Nursing for any with non-compliance of transferring at mealtime and any found will be placed in dining room at meal times for increased supervision.</p> <p>A 100% audit was conducted starting on 05/08/2013 by QI nurse and MDS Nurse of all falls from 04/21/2013 to 01/21/2013 to validate that all interventions have been completed and updated on care plan and care guides appropriately.</p> <p>All licensed nurses were inserviced by Director of Nursing and Staff Faciliator on 04/25/2013 and 05/09/2013 on updating care plans and care guides when initiating an</p>	

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F 323	Continued From page 5 A review of the quarterly Minimum Data Set (MDS) assessment, dated 04/18/13, revealed the facility assessed Resident #3's cognition as moderately impaired. Further review of the MDS assessment revealed Resident #3 was assessed to be at risk for falls related to wandering, balance problems, history of falls, medications, and a trunk restraint used daily. A review of the Comprehensive Care Plan for falls revealed the most recent revision was dated 03/11/13 to add the intervention "up in evolution chair with chair alarm". A review of a Fall Investigation, dated 03/30/13, revealed the fall was observed as the resident was self transferring from the wheelchair to a regular chair. The root cause was determined to be the resident's preference to sit in a different chair. It was determined an intervention would be added for the resident to be transferred to a regular chair during mealtimes. A review of the Comprehensive Care Plan, last revised 03/11/13, and the undated Resident Care Guide for Resident #3, used by the nursing assistants, revealed there was no revision to include the interventions for staff to help transfer the resident to a regular chair during mealtimes". A review of the Fall investigation, dated 04/13/13, revealed the fall was unobserved with the resident self transferring from a regular chair to the wheelchair. It was determined an intervention would be added for the resident to eat at the table next to the nurse's station.	F 323	intervention after a fall starting on 04/25/2013 through 05/10/2013. Each fall to include any for resident #3 will be reviewed during the morning Administrative nursing team meeting with the presence of the QI Nurse and Rehab Director to review falls interventions that were put in place by the nurse to ensure that intervention are appropriate and specific. At this time the care plan and care guide will be reviewed and updated by MDS Nurse, QI Nurse or Director of Nursing accordingly. The QI nurse will upon receiving notice of a fall conduct a root cause analysis of each fall and present to the Administrator and Director of Nursing at morning Administrative meeting for review. Any deficient area will be brought before the QI team upon identification of the deficient area for revising action planning and reviewed for compliance each Friday Administrative morning meeting til area is resolved.		

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F 323	<p>Continued From page 6</p> <p>Further review of the Comprehensive Care Plan, last revised 03/11/13, and the undated Resident Care Guide for Resident #3, used by the nursing assistants, revealed there was no revision to include the interventions for the "resident to eat at the table next to the nurse's station".</p> <p>Observation on 04/22/13 at 12:00 PM, revealed Resident #3 was in the dining room seated in the wheelchair positioned at a half circle table. The resident had a small cup of liquid to drink but no meal on the table. Further observation, on 04/23/13 at 12:15 PM, revealed Resident #3 was sitting in the wheelchair at the table beside the nurses desk with the lunch tray in front of him/her.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #1 and #3, on 04/23/13 at 9:37 AM and 10:00 AM, revealed she was not aware of the resident needing to be transferred to a regular chair during meal times or for the resident to eat at the table next to the nurse's station.</p> <p>Interview with SRNA #2, on 04/23/13 at 9:55 AM, revealed her knowledge of Resident #3 included the preference to sit in stationary chair to eat and if staff doesn't transfer him/her to the stationary chair when the tray is delivered he/she will try to transfer from the wheelchair on his/her own.</p> <p>Interview with Licensed Practical Nursing (LPN) #1, on 04/23/13 at 10:05 AM, revealed the interventions on the comprehensive care plan were on the resident care guide for the SRNAs to know what care to provide. The Quality Improvement nurse or the admitting nurse made the changes to the resident care guide .</p>	F 323		
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F 323	<p>Continued From page 7</p> <p>Interview with SRNA #4 and #5, on 04/23/13 at 10:30 AM and 10:35 AM, revealed the resource used to tell the SRNA what care to provide was the resident care guide on the closet door.</p> <p>Interview with Registered Nurse (RN) #1, on 04/23/13 at 10:40 AM, revealed the comprehensive care plan interventions were on the resident care guide in each resident's room. The information was moved from the care plan to the care guide by the MDS coordinator, charge nurse, or administrative staff.</p> <p>Interview with the Director of Nursing, on 04/23/13 at 12:00 PM, revealed she would expect the interventions defined on the Falls Investigation to be on the resident care plan and resident care guide.</p>	F 323		
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