

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42066		
(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 333	<p>Continued From page 32</p> <p>(1) patch was found on a resident, and the process of documenting patches on new admissions. Additionally, RN #2, RN #4, RN#10 and RN #11 were educated on the notification of the Director of Nursing and/or the Assistant Director of Nursing of new orders for Fentanyl patches, the admission process for transdermal patches documentation, placement checking of the patch and to complete a complete body audit if the patch was not where it was supposed to be and conduct an investigation, and the disposal process for the patches which includes two (2) licensed nursing staff to witness and destroy the patch by folding it and placing it in a Sharp's container.</p> <p>Interviews with CNA #1, CNA #2, CNA #3, and CNA #4, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were inserviced on reporting to the Charge Nurse if while performing care to a resident, two (2) patches were found to be present on the resident. They stated they would fill out a "Stop and Watch" form and turn it in to the Charge Nurse.</p> <p>Review of the Transdermal Patch Audits, on 04/08/14 and 04/09/14 revealed all new transdermal patch orders were reported to the DON and/or ADON. The DON and ADON completed audits of residents who were currently on a transdermal patch of any kind with the last audit completed on 04/08/14 and to continue every day for seven (7) days. The facility did not have any new admissions on transdermal patches at this time.</p> <p>On 04/03/14, the Medical Director was notified of the AoC and agreed with the plan with a verified signature. Review of the Quality Assurance</p>	F 333			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 282 W. 5TH ST. LA CENTER, KY 42056		
(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 333	Continued From page 33 meeting notes, dated 01/01/14, revealed the AoC was discussed via a phone call between the Medical Director and the Executive Director. Review of the PI Committee meeting documentation, dated 01/01/14 through 03/19/14 revealed meetings were held weekly to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. Interviews conducted with the ADON, DON, and the Executive Director, on 04/09/14, revealed medication administration was discussed in the PI meetings as stated in the AoC and training was provided to licensed nursing staff as well as the CNAs related to identifying multiple patches on residents or a patch on a resident on initial admission to the facility.		In addition to the prior abatement submitted and accepted on 04/08/2014, the facility also submits the following plan of correction: F 490 Effective Administration/Resident Well Being. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.		
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, review of the Executive Director's (ED) job description, and review of the facility's policy and procedure and Plan of Correction for the 02/11/14 Abbreviated Survey, it	F 490	1. <u>Resident(s) affected by alleged deficient practice:</u> <ul style="list-style-type: none"> Resident was discharged home on 03/15/14 with family and no longer resides at the center. 2. <u>Residents with potential to be affected by alleged deficient practice:</u> <ul style="list-style-type: none"> All new admissions, readmissions and other residents who have a new order for transdermal patches will be reviewed daily during morning meeting. This discussion will include but not be limited to: <ol style="list-style-type: none"> Type of transdermal medication ordered, Compliance to policy regarding the presence of transdermal patch documentation in clinical record and MAR, Any other medication related concerns. 		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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 490	<p>Continued From page 34</p> <p>was determined the facility failed to have an effective system to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of fifteen (15) sampled residents (Resident #15).</p> <p>During an Abbreviated Survey concluded on 02/11/14, Immediate Jeopardy was identified at 483.20 Resident Assessment F-281 Services Meet Professional Standards; and 483.25 Quality of Care, F-333 Free of Significant Medication Error. The facility submitted a Plan of Correction for the 02/11/14 survey; however, additional investigation during the Standard Recertification, Revisit and Abbreviated Survey concluded on 04/09/14 revealed the residents continued to be at risk for significant medication errors. Immediate Jeopardy was identified at 482.20 Resident Assessment, F-281; 485.25 Quality of Care, F-333 Free of Significant Medication Error; and, 483.76 Administration, F-490 Administration and F-520 Quality Assessment and Assurance.</p> <p>The facility failed to have an effective system in place to monitor the placement and removal of medication transdermal patches and failed to identify if transdermal patches were in place on admission to ensure the medication was administered at the right dose for one (1) of fifteen (15) sampled residents (Resident #16). In addition, the facility failed to ensure education provided to licensed staff was effective. Per the facility's Plan of Correction, for the survey dated 02/11/14, all licensed nurses received education on two (2) occasions on the five (5) rights (right resident, right time, right medication, right dose, and right route) of medication administration.</p>	F 490	<p>4. Actions taken to resolve/correct.</p> <ul style="list-style-type: none"> Beginning 4/03/14 times 8 weeks, the Executive Director to notify RDCS and RVP of any non-compliance to transdermal patch policies, medication errors, and corrective actions taken, at the time of finding. <p>3. <u>Systems to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> On 4/08/14, the Executive Director was provided additional education by the RVP, regarding job description, prompt notification to the RVP/RDCS of issues and medication errors, and how to review the entire plan of correction and monitor. Beginning week of 04/12/14, Executive Director to meet with DON weekly to validate all plan of correction education and audits are completed as indicated, medication errors are identified and action taken if indicated. RVP/RDCS and Executive Director to discuss clinical and plan of correction oversight weekly x 8 weeks, beginning week of 04/12/14, then as PI committee recommends. <p>4. <u>Monitoring to ensure alleged deficient practice does not recur:</u></p>	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42060	
(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 490	<p>Continued From page 35</p> <p>However, a licensed nurse failed to remove a Fentanyl patch prior to the application of a new patch to ensure the resident received the right dose of medication for one (1) of fifteen (15) sampled residents (Resident #15).</p> <p>On 01/14/14, Resident #15 was readmitted to the facility with a Fentanyl patch in place and a physician's order for a fifty (50) microgram (mcg) Fentanyl Patch (opiate pain medication) every seventy-two (72) hours. On 01/17/14, the facility applied a Fentanyl patch; however, there was no documented evidence the facility removed the old patch prior to applying the new one. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli. A Fentanyl Patch was removed and the resident was sent to the Emergency Room. Review of hospital documentation revealed a Fentanyl Patch was removed in the Emergency Room also. The resident was administered a dose of Narcan (Opiate drug reversal drug) 0.4 milligrams (mg) via IV piggyback and the resident woke up and stated his/her name to the Emergency Room Nurse. Resident #15 was admitted to the Intensive Care Unit (ICU), on 01/19/14 at 12:03 AM, with a primary diagnosis of Encephalopathy secondary to a Fentanyl Patch and a secondary diagnosis of Accidental Narcotic Overdose.</p> <p>The facility's failure to have an effective system to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/03/14 and was determined to exist on 01/17/14. The facility was notified of the Immediate Jeopardy on 04/03/14.</p>	F 490	<ul style="list-style-type: none"> On 4/03/14 the medical director and resident's attending physician were notified by the Executive Director of jeopardy and action plan. Both were in agreement with action plan. The PI committee met on 04/04/14 to review action plan, validate education completed, and update Medical Director on the additional documentation for new admission on the initial data collection tool and to validate monitoring is in place. The PI committee will continue to meet weekly for 30 days, then 2x monthly for 30 days, then monthly to review all audit findings and make revisions to the action plan as indicated. At least quarterly, the PI committee will review medication errors and actions taken. RDCS/RVP to attend all PI committee meetings either in person or by phone, to identify quality issues which includes medication errors, trends and assist in plan of correction implementation and development of action plans to correct any issue identified. Beginning week of 04/03/14 x 8 weeks, and on-going until PI committee and RVP recommend change in frequency. Executive Director to meet with clinical team 5 x week, x 8 weeks 	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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 490	Continued From page 36 An acceptable Allegation of Compliance was received on 04/08/14, alleging the removal of the Immediate Jeopardy on 04/08/14. The State Survey Agency validated, on 04/09/14, the Immediate Jeopardy was removed on 04/08/14, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.20 Resident Assessment F-281; 42 CFR 483.25 Quality of Care F-333; and, 42 CFR 483.75 Administration, F-490 and F-520 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes. The findings include: Review of the Executive Director's (ED) job description, revised 04/18/13, revealed the Position Summary as follows: "The ED provides leadership and direction for overall facility operations to provide quality resident care in accordance with all laws and regulations." Further review of the Essential Functions revealed "Must ensure the residents receive high quality care." Review of the Administrative General Policies, (no date), revealed "The ED will be responsible for implementing facility policies and formulating departmental policies with advice and counsel from the consultants, medical staff, and departmental staff. The ED will administer and conduct all aspects of the policies and programs within the framework provided." Review of the facility's Plan of Correction (POC), for the survey dated 02/11/14, revealed all licensed staff was educated on the five (5) rights	F 490	beginning week of 04/03/14 to ensure all clinical issues addressed and plan of correction followed. This audit will continue at least 3 x weekly x 3 months, then as recommended by PI Committee. 5. Completion Date: 04/19/2014		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 37</p> <p>of medication administration and a post competency test related to medication administration was given on two (2) occasions. The five (5) rights of medication administration are: 1.) Right Resident, 2.) Right Drug, 3.) Right Dose, 4.) Right Time and, 5.) Right Route. However, the facility failed to have an effective system in place to monitor the placement and removal of medication transdermal patches and identify if transdermal patches were in place on admission to ensure the medication was administered at the right dose.</p> <p>Interview and record review revealed Resident #15 was readmitted to the facility, on 01/14/14, with a Fentanyl patch in place. On 01/17/14, the facility applied a Fentanyl patch; however, there was no documented evidence the facility removed the old patch prior to applying the new one. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli and was diagnosed with Accidental Narcotic Overdose.</p> <p>Interview with the Facility's ED, on 04/03/14 at 10:45 AM, revealed she did not initiate an investigation into the incident with Resident #15 because she did not feel there was a medication error made even after she was made aware of hospital documentation that Resident #15 was admitted to the hospital Intensive Care Unit with a Fentanyl overdose and had a Fentanyl patch on upon arrival at the hospital. The Executive Director stated the facility received ten (10) Fentanyl patches from the pharmacy when Resident #1 was admitted. She revealed one (1) patch was administered and one patch was removed prior to the resident going to the</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 38</p> <p>hospital. She stated there were nine (9) patches left which meant the count was correct so she did not feel they had made a medication error. However, review of the Hospital Discharge Documentation revealed Resident #15 had a Fentanyl patch applied at the hospital prior to being admitted to the facility. Additionally, she stated, the Medication Administration policy revealed two (2) staff was to monitor the removal and destruction of any used Fentanyl patches. However, on 01/17/14, there was no documented evidence the staff witnessed the removal and destruction of Resident #15's Fentanyl patch that the resident received at the hospital.</p> <p>Further interview with the ED, on 05/09/14 at 2:00 PM, revealed audits were conducted related to medication administration and the five (5) rights of medication administration, and continue to be ongoing monthly. She stated there was no failure identified related to the facility's policy, which would have led to a second significant medication administration error, nor was there a failure related to the training provided after the first significant medication error. Therefore, she did not feel there was a second significant medication error made.</p> <p>Further interview with the ED revealed 100% of all staff was inserviced related to the five rights of medication administration. The ED reiterated, based on the facility's policy on medication administration, there were no failures identified related to the Admitting Nurse's assessment of Resident #15 on 01/14/14.</p> <p>A Post Survey interview with the Director of Nursing (DON), on 05/20/14 at 1:45 PM, revealed</p>	F 490			

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

PRINTED: 08/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42066	
(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 490	<p>Continued From page 39</p> <p>the licensed staff should remove the old transdermal patch prior to applying a new patch to ensure the right dose of medication was administered per physician's order.</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 03/15/14, Resident #15 was discharged home with family and no longer resides at the center.</p> <p>The facility initiated an internal investigation at the time the resident was readmitted on 01/23/14 and was identified as having an accidental narcotic overdose. The DON, ADON, SDC, and Regional Director of Clinical Services (RDCS) conducted a medication pass audit which included administration, rotation, and patch presence on 02/01/14 and 02/06/14. No discrepancies were identified and the audits were on-going.</p> <p>On 04/07/14, the DON and RDCS completed a validation to ensure that all nine (9) residents with any type of transdermal patch had the location of the patch on the resident documented on the MAR and that all medications were being administered per physician's orders.</p> <p>On 01/24/14, two (2) additional residents were identified as receiving Fentanyl patches to treat pain. The DON verified the physician's orders for the patches, reviewed the MAR to assure the patches were being administered correctly, and documentation and verification the residents received the patches as ordered.</p> <p>Fentanyl patches were audited by the DON on 01/24/14 for all residents with orders to verify the patch count was accurately reflective of the</p>	F 490		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LACENTER, KY 42066		
(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 490	<p>Continued From page 40 narcotic count sheet.</p> <p>On 04/03/14, the RDCS and the DON reviewed the documentation of the residents with Fentanyl patches (two residents from 01/23-02/06/14, two (2) residents from 02/06-02/07/14, three (3) residents from 02/07/14-present). The Fentanyl patch orders and January to present MARs reflected the resident's patches were applied per physician's orders. The site for the patch was documented and monitoring was documented on the MAR throughout the month.</p> <p>Residents who had an order for a Fentanyl patch were seen by a physician in the center on 04/03/14 with no concerns with dosage or documentation noted.</p> <p>The Pharmacist conducted a review of all current Fentanyl patch orders and counts were correct on 02/04/14. She also reviewed the documentation of the location of the patch on the MARs and verified each shift placement check.</p> <p>On 01/31-02/02/14, all licensed nurses were provided education on medication administration including Fentanyl patches. This education was completed by the DON and the Staff Development Coordinator (SDC) and was provided for 100% of the licensed nurses before midnight on 02/02/14.</p> <p>On 04/03/14, the RDCS completed education for the Executive Director, DON, Assistant Director of Nursing (ADON), SDC, and the Minimum Data Set Coordinator (MDSC) which included:</p> <p>Transdermal patch administration/removal policy and procedure</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 41</p> <p>Required documentation of the Fentanyl patch removal and application, including anatomical location of patch to be on the MAR. Admission documentation in admission assessment/notes to include Fentanyl patches present and the location. Notification of DON or ADON upon receipt of new Fentanyl patch orders received. All licensed nurses received the above training beginning on 04/03/14. Education was completed by the DON, ADON, or MDS Nurse. Education included a quiz which required a score of 100% to validate competency. This education was completed with 100% of licensed staff on 04/04/14. Any licensed nurse who did not receive the above training would not be allowed to work until the training was completed.</p> <p>The DON, ADON, MDS Nurse, and SDC provided education to the Certified Nursing Assistants (CNAs) to include observing for transdermal patches during activity of daily living (ADL) care and to notify the Charge Nurse if more than one (1) patch was identified on the resident. Education was initiated on 04/04/14 and was completed prior to midnight to all staff on duty. Any staff who did not receive the training prior to midnight on 04/04/14 was to receive the training prior to beginning his/her next working shift.</p> <p>Nursing will notify the DON or ADON at the time of all new Fentanyl patch orders received.</p> <p>On 04/03/14, the DON and ADON completed audits of residents' records who were receiving a Fentanyl patch for documentation of placement on the MAR and verified the patch was located on the resident in accordance to the assessed, documented site. The DON, ADON, and RCDS</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066		
(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 490	<p>Continued From page 42</p> <p>reviewed resident records who currently had Fentanyl patches to validate the physician's order matched the MAR.</p> <p>Beginning 04/04/14, the DON, ADON, SDC, Unit Manager, MDS Nurse and/or RDCS will validate the transdermal patches orders are correct, recorded on the MAR, location will be documented on the MAR, and verify the patch is located on the resident in accordance with the assessed, documented site. The process was to occur seven (7) days a week for thirty (30) days, then would be completed four (4) times a week for thirty (30) days. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>The DON, ADON, SDC, or Unit Manager will monitor the next five (5) admissions with a transdermal patch order beginning on 04/05/14, and again on 04/07/14 to ensure transdermal patch orders were recorded on the MAR correctly, the location was documented on the MAR and on the initial data collection tool. They will verify the patch was on the resident as the MAR indicated. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>All audit and monitoring outcomes would be presented to and reviewed by the Performance Improvement (PI) Committee for revision or plan recommendations. Audits would be completed seven (7) days a week, for the next thirty (30) days, then at a rate of four (4) times per week for</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 43</p> <p>thirty (30) days. The PI Committee would meet weekly over the next thirty (30) days, then bi-weekly for thirty (30) days to review results.</p> <p>PI meetings were held on 02/05, 02/06, 02/12, 02/19, 02/26, 03/05, 03/07, 03/09, and 03/19/14. Review of education provided in regard to medication administration as well as full review of completed medication administration audits were conducted at each PI meeting.</p> <p>On 04/03/14, the Medical Director and the resident's attending physician were notified of Immediate Jeopardy and the facility's action plan and both agreed with the action plan.</p> <p>The PI Committee met on 04/04/14 to review the action plan, validate education as completed, and to update the Medical Director on the additional documentation for new admissions on the initial data collection tool and to validate monitoring was in place.</p> <p>The PI Committee consists of the Executive Director, DON, ADON, SDC, MDS Nurse, Social Services, and Activity Director. The PI Committee was to meet weekly for thirty (30) days to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. The PI Committee was to meet two (2) times a month for thirty (30) days, then monthly to review all audit findings and make revisions as needed to the action plan based on audit findings.</p> <p>**The State Survey Agency validated the</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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 490	<p>Continued From page 44 corrective action taken by the facility as follows:</p> <p>Record review revealed Resident #15 was discharged home with family on 03/15/14.</p> <p>Review of Medication Pass Audits, dated 02/01/14 and 02/06/14 revealed the DON, ADON, SDC, and RDCS conducted a medication pass audit and monitored the entire medication pass including the administration of medication patches to include ensuring the rotation of sites for the patches, patches were dated and timed, as well as documented on the MAR for placement and removal of the old patch. Random patch audits were ongoing and continued to be performed three (3) times a week.</p> <p>Review of the MAR audit list, dated 04/07/14, revealed the DON and RCDS completed observations of the nine (9) residents with any type of transdermal patch to ensure the patch was located at the same site as was documented on the MAR. In addition, they reviewed the physician's orders to ensure the staff was following the physician's order for the patch.</p> <p>Review of the Physician's Progress Notes, dated 04/03/14, for Resident #10 and Resident #3 revealed both residents were assessed and received Fentanyl patches with no adverse side effects noted.</p> <p>Review of a Medication Audit form, dated 04/04/14, revealed the pharmacists reviewed the MARs for Resident #3 and Resident #10 for correct documentation for placement, checks, application, removal, and disposal of Fentanyl patches with no concerns noted.</p>	F 490		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 45</p> <p>Review of the Inservice log, dated 01/31/14-02/02/14, revealed 100% of licensed staff was inserviced and a post test was completed to verify competency of transdermal patch administration by the DON and SDC.</p> <p>Review of training, dated 04/03/14, revealed 100% of licensed staff was inserviced on the procedure for Admission/Readmission of residents utilizing Fentanyl patches by the DON, ADON, SDC, and MDS Coordinator. The training included transdermal patch administration and removal policy and procedure; the required documentation of patch removal and application, including location of the patch; the documentation on Admission Assessments and Notes should include if any patches present and the location of the patches; and Notification of the DON and/or ADON upon receipt of new patch orders. A competency exam was given to verify the understanding of the training. 100% of licensed staff was inserviced and new hires will receive the same training.</p> <p>Review of the CNA training log, dated 04/04/14, revealed a phone training was completed by the Regional Nurse Consultant on 04/04/14 which included to observe for patches during care and to utilize a "stop and watch" tool to report areas to the charge nurse.</p> <p>Interviews with RN #2, RN #4, RN #10, RN #11, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #10, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were trained on the disposal process for transdermal patches, documentation of the site of the patch on the resident, physician notification if more than one (1) patch was found on a resident, and the</p>	F 490			

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

PRINTED: 08/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 8TH ST. LA CENTER, KY 42056		
(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 490	<p>Continued From page 46</p> <p>process of documenting patches on new admissions. Additionally, RN #2, RN #4, RN#10 and RN #11 were educated on the notification of the Director of Nursing and/or the Assistant Director of Nursing of new orders for Fentanyl patches, the admission process for transdermal patches documentation, placement checking of the patch and to complete a complete body audit if the patch was not where it was supposed to be and conduct an investigation, and the disposal process for the patches which includes two (2) licensed nursing staff to witness and destroy the patch by folding it and placing it in a Sharp's container.</p> <p>Interviews with CNA #1, CNA #2, CNA #3, and CNA #4, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were inserviced on reporting to the Charge Nurse if while performing care to a resident, two (2) patches were found to be present on the resident. They stated they would fill out a "Stop and Watch" form and turn it in to the Charge Nurse.</p> <p>Review of the Transdermal Patch Audits, on 04/08/14 and 04/09/14 revealed all new transdermal patch orders were reported to the DON and/or ADON. The DON and ADON completed audits of residents who were currently on a transdermal patch of any kind with the last audit completed on 04/08/14 and to continue every day for seven (7) days. The facility did not have any new admissions on transdermal patches at this time.</p> <p>On 04/03/14, the Medical Director was notified of the AoC and agreed with the plan with a verified signature. Review of the Quality Assurance meeting notes, dated 01/01/14, revealed the AoC</p>	F 490			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056	
(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 490	Continued From page 47 was discussed via a phone call between the Medical Director and the Executive Director. Review of the PI Committee meeting documentation, dated 01/01/14 through 03/19/14 revealed meetings were held weekly to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. Interviews conducted with the ADON, DON, and the Executive Director, on 04/09/14, revealed medication administration was discussed in the PI meetings as stated in the AoC and training was provided to licensed nursing staff as well as the CNAs related to identifying multiple patches on residents or a patch on a resident on initial admission to the facility.	F 490	F 520 Committee-Members/ Meet Quarterly/Plans. The 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 staff. 1. <u>Resident(s) affected by alleged deficient practice:</u> <ul style="list-style-type: none"> Resident was discharged home on 03/15/14 with family and no longer resides at the center. 2. <u>Residents with potential to be affected by alleged deficient practice:</u> <ul style="list-style-type: none"> Upon completion of a 100% resident audit, two residents were identified as having orders for fentanyl patches and on 04/03/14, the Regional Director of Clinical Services (RDCS) and Director of Nursing (DON) reviewed their Medication Administration Record (MAR) to verify administration compliance to physician orders, that two (2) licensed nurses are signing the MAR at each time a patch is applied and removed. In addition, they observed the patch location on the residents' body matched the location documented on the MAR. Any issues identified were immediately addressed. On 04/03/14, the two residents with current orders for fentanyl patches 	
F 520 SS=J	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		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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 520	<p>Continued From page 48</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 and procedure and Plan of Correction for the 02/11/14 Abbreviated Survey, it was determined the facility's Quality Assessment and Assurance Committee failed to ensure the education provided to licensed staff on medication administration was effective. Per the facility's Plan of Correction, for the survey dated 02/11/14, all licensed nurses received education on two (2) occasions on the five (5) rights (right resident, right time, right medication, right dose, and right route) of medication administration. However, a licensed nurse failed to remove a Fentanyl patch prior to the application of a new patch to ensure the resident received the right dose of medication for one (1) of fifteen (15) sampled residents (Resident #15).</p> <p>During an Abbreviated Survey concluded on 02/11/14, Immediate Jeopardy was identified at 483.20 Resident Assessment F-281 Services Meet Professional Standards; and 483.25 Quality of Care, F-333 Free of Significant Medication Error. The facility submitted a Plan of Correction for the 02/11/14 survey; however, additional</p>	F 520	<p>were seen by a physician in the center to identify any issues with dosage or documentation of fentanyl. No concerns were noted.</p> <ul style="list-style-type: none"> On 04/04/14, the pharmacist was in the facility and reviewed the two resident's with orders for fentanyl patches to identify that fentanyl patch orders were correct, fentanyl counts were completed and accurate, fentanyl patches were applied correctly and the location was documented and verified each shift with placement check. No issues were identified. On 04/07/14, RDCS and DON completed an 100% resident audit to identify that the nine (9) residents with any type of transdermal patch had location noted on MAR, that location on resident corresponded with documented site, and that all medications were being administered per physician order. No issues were identified. On 04/07/14, all nine (9) current residents with transdermal patches had a care plan reviews completed by the RDCS to verify that their transdermal patch usage had appropriate care plan interventions as indicated. No issues were identified. A nursing assessment was completed by licensed nurse/charge 		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 282 W. 8TH ST. LA CENTER, KY 42056		
(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 520	<p>Continued From page 49</p> <p>investigation during the Standard Recertification, Revisit and Abbreviated Survey concluded on 04/09/14 revealed the residents continued to be at risk for significant medication errors. Immediate Jeopardy was identified at 483.20 Resident Assessment, F-281; 483.25 Quality of Care, F-333 Free of Significant Medication Error; and, 483.75 Administration, F-490 Administration and F-520 Quality Assessment and Assurance.</p> <p>On 01/14/14, Resident #15 was readmitted to the facility with a Fentanyl patch in place and a physician's order for a fifty (50) microgram (mcg) Fentanyl Patch (opiate pain medication) every seventy-two (72) hours. On 01/17/14, the facility applied a new Fentanyl patch; however, there was no documented evidence the old Fentanyl patch was removed. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli. The physician was notified and a fifty (50) microgram (mcg) Fentanyl Patch was removed from the resident's chest at the facility. The resident was sent to the Emergency Room for evaluation. Review of hospital documentation revealed a Fentanyl Patch was also removed in the Emergency Room. The resident was administered a dose of Narcan (Opiate drug reversal drug) 0.4 milligrams (mg) via IV piggyback and the resident woke up and stated his/her name to the Emergency Room Nurse. Resident #15 was admitted to the Intensive Care Unit (ICU), on 01/19/14 at 12:03 AM, with a primary diagnosis of Encephalopathy secondary to a Fentanyl Patch and a secondary diagnosis of Accidental Narcotic Overdose. The licensed staff had failed to remove the previous Fentanyl patch prior to applying a new patch to ensure the resident received the right dose of medication. The facility's Quality Assurance</p>	F 520	<p>nurse on all nine (9) current residents with transdermal patches 04/02/14-04/07/14 to identify any change in condition. No issues were identified.</p> <p>3. <u>Systems to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> • RDCS completed education with ED on 04/01/14 on Performance Improvement process, identification of issues and root cause process that require plan of action and QA process to ensure resident highest practicable level of well-being. • On 4/08/14, the Executive Director was provided additional education by the RVP, regarding job description, prompt notification to the RVP/RDCS of issues and medication errors, and how to review the entire plan of correction and monitor. • Beginning week of 04/12/14, Executive Director to meet with DON weekly to validate all plan of correction education and audits are completed as indicated, medication errors are identified and action taken if indicated. • RVP/RDCS and Executive Director to discuss clinical and plan of correction oversight weekly x 8 weeks, beginning week of 04/12/14, then as PI committee recommends. 		

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

PRINTED: 08/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42066		
(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)	(X6) COMPLETION DATE	
F 520	<p>Continued From page 50</p> <p>failed to identify this error as a significant medication error and failed to put corrective actions in place.</p> <p>The facility's failure to develop and implement appropriate plans of action to correct identified quality deficiencies has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/03/14 and was determined to exist on 01/17/14. The facility was notified of the Immediate Jeopardy on 04/03/14.</p> <p>An acceptable Allegation of Compliance was received on 04/08/14, alleging the removal of the Immediate Jeopardy on 04/08/14. The State Survey Agency validated, on 04/09/14, the Immediate Jeopardy was removed on 04/08/14, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.20 Resident Assessment F-281 and 42 CFR 483.25 Quality of Care F-333; and, 483.75 Administration, F-490 and F-520 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure, "Performance Improvement Plan", revised 11/23/09, revealed, "The facility implements and maintains an ongoing program designed to monitor and evaluate the quality of resident care, pursue methods to improve quality care, and resolve identified problems." The purpose includes, "to establish and provide a system whereby a specific process and the documentation relative to it is maintained to</p>	F 520	<ul style="list-style-type: none"> Additions were made to the MARs of all residents who have orders for transdermal patches to support documentation of patch application, site, removal and monitoring by two licensed nurses. Transdermal patch application, site documentation, observation, removal, destruction and monitoring is now included in orientation of new licensed nurses. Added to the orientation for Certified Nurse Aides is the responsibility to observe for transdermal patches during ADL care and notify nurse if more than one patch is identified as being present on a resident. On 04/01/14 and 04/02/14 the Administrator and DON provided education to all licensed nurses regarding disposal of fentanyl patches, documenting disposal of fentanyl patches and that two (2) licensed nurses are documenting and monitoring disposal. In addition, on 04/02/14, the Assistant Director of Nursing (ADON) continued to educate the licensed nurses regarding administration of transdermal patches. This education included: <ol style="list-style-type: none"> Five (5) rights of medication pass 		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42056	
(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 520	<p>Continued From page 51</p> <p>support evidence of an ongoing Performance Improvement Program, encompassing all aspects of resident care, including safety, infection control, and quality of life applicable to nursing facility residents."</p> <p>Review of the facility's Plan of Correction (POC), for the survey dated 02/11/14, revealed all licensed staff was educated on the five (5) rights of medication administration and a post competency test related to medication administration was given. The five (5) rights of medication administration were: 1.) Right Resident, 2.) Right Drug, 3.) Right Dose, 4.) Right Time and, 5.) Right Route. However, when conducting the Standard Recertification Survey, Revisit Survey, and the Abbreviated Survey it was determined the training was ineffective and the residents remained at risk for significant medication errors. The facility failed to have an effective system in place to ensure staff was knowledgeable in the placement and removal of medication transdermal patches to ensure the medication was administered at the right dose.</p> <p>Further review of the Plan of Correction revealed, "if any nurse does not follow the proper procedures for medication administration, they will be immediately removed from patient care area and re-educated by DON, ADON. However, the facility's Quality Assurance failed to identify the 01/17/14 medication error as a significant medication error and failed to put corrective actions in place.</p> <p>Further review of the Plan of Correction revealed "all residents unless discharged had one or more physician visits between 11/28/13 and 02/05/14, physician visits constituted review of vitals,</p>	F 520	<ol style="list-style-type: none"> 2. Ensure previous transdermal patch removed 3. Disposal of fentanyl patches and documentation of disposal. 4. Monitoring of fentanyl patch placement and documentation. <ul style="list-style-type: none"> • On 04/03/14, the RDCS completed train-the-trainer education for the DON, Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC) and MDS Coordinator to include: <ol style="list-style-type: none"> 1. Transdermal Patch administration/removal policy and procedure. 2. Required documentation of the fentanyl patch removal and application, including anatomical location of patch to be on the MAR. 3. Admission documentation in admission assessment/notes to include existing fentanyl patches present upon admission, their location and removal, when unable to determine date of application and as ordered by physician. 4. Notification of DON/ADON upon receipt of new fentanyl patch orders received. 	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 62</p> <p>assessments and abnormal findings and plan of treatment, if needed; no resident was identified for any change of condition due to a medication error." However, review of Resident #15's medical record revealed there was no documented evidence Resident #15 was assessed by the physician per the Plan of Correction.</p> <p>On 01/14/14 Resident #15 was administered a fifty (50) mcg Fentanyl Patch prior to the resident being discharged to the nursing facility. Review of the facility's Admission Orders, dated 01/14/14, revealed an order for a Fentanyl Patch fifty (50) mcg to be changed every seventy two (72) hours. Review of Resident #15's January 2014 MAR revealed the facility applied a Fentanyl 50 mcg Patch on 01/17/14; however, further review of the MAR and the resident's record revealed there was no documented evidence of the old patch being removed to ensure the resident would receive the right dose of medication. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli. The resident was sent to the Emergency Room for evaluation and was admitted to the Intensive Care Unit (ICU), on 01/19/14 at 12:03 AM, with a primary diagnosis of Encephalopathy secondary to a Fentanyl Patch and a secondary diagnosis of Accidental Narcotic Overdose. The licensed staff had failed to remove the previous Fentanyl patch prior to applying a new patch to ensure the resident received the right dose of medication.</p> <p>Interview with the Staff Development Coordinator (SDC), on 05/09/14 at 10:03 AM, revealed she was present during the QA meeting related to the significant medication error (related to medication given to the wrong resident). She stated</p>	F 520	<ul style="list-style-type: none"> All licensed nurses received the above training beginning on 04/03/14 by DON/SDC/ADON or MDS nurse. Education included quiz with required score of 100% to validate competency. Licensed nurses were not allowed to work until training and competency was verified. This education was complete on 100% of licensed staff prior to midnight 04/04/14. DON, Staff Development Coordinator (SDC) and MDS Nurse provided education to the Certified Nurse Aides to observe for patches during ADL care and notify nurse if more than one patch is identified as being present on a resident. Education was initiated 04/04/14 and completed prior to midnight for any staff on duty. Staff not receiving education prior to midnight 04/04/14 will receive prior to beginning their next scheduled shift. Beginning 04/04/14, licensed nurses are to notify the DON/ADON at the time of receiving a new order for fentanyl to ensure order is correct, documentation of site, and two (2) nurses monitoring application, removal and disposal. On 04/04/14, SDC provided education to all licensed nurses regarding notification of DON of any new order/admission with an 	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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 520	<p>Continued From page 53</p> <p>measures were discussed and interventions were put in place to prevent future medication errors. However, the facility's QA failed to identify the 01/17/14 medication error as another significant medication error.</p> <p>Interview with the Social Services Director (SSD), on 05/09/14 at 9:20 AM, revealed she was a member of the Quality Assurance Committee. She stated the committee did not identify a system's failure related to the QA process which may have led to the second medication error.</p> <p>Interview with the Director of Nursing (DON), on 05/09/14 at 9:51 AM, when asked about the 01/17/14 medication error, she stated, "we did not have a second medication error; therefore, our QA process did not fail." Additionally, she stated there have been changes made to the admission's process to reflect an additional place to document patches on admission. A Post Survey interview with the DON, on 05/20/14 at 1:45 PM, revealed the licensed staff should remove the old transdermal patch prior to applying a new patch to ensure the right dose of medication was administered per physician's order.</p> <p>Interview with the Executive Director (ED), on 05/09/14 at 9:06 AM, revealed in the Quality Assurance (QA) meeting incidents and accidents were reviewed, and if a system's problem was identified, recommendations for a plan were made to correct the problem. Additionally, she stated she did not believe there was a second significant medication error, and the QA measures put in place after the first significant medication error were effective.</p>	F 520	<p>order for fentanyl patch. Also included was additional education of ensuring that patch order is correct, documentation of site, two (2) nurses witnessing removal and destruction and one (1) licensed nurse is monitoring patch placement every shift.</p> <ul style="list-style-type: none"> On 04/04/14, RDCS provided additional education to Certified Nursing Assistants (CNA) regarding documenting and reporting to the licensed nurse if two (2) patches of any kind are found on the resident. On 04/10/14, DON additional education provided to licensed nurses regarding transdermal patches. Content included transdermal patch application and two (2) nurses to apply and remove on MAR and to contact DON/ED immediately if patch is ordered and not present. On 04/15/14, RDCS additional education was provided to licensed nurses regarding what information is to be documented on MAR, and what Nurse #2 is validating on the MAR. Nurse #2 is validating application, location, removal and disposal with Nurse #1. On 04/14/14, 04/15/14 and 04/16/14 the RDCS additional education provided to licensed nurses regarding therapeutic interchange; 	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42066	
(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 520	<p>Continued From page 64</p> <p>**The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>On 03/15/14; Resident #15 was discharged home with family and no longer resides at the center.</p> <p>The facility initiated an internal investigation at the time the resident was readmitted on 01/23/14 and was identified as having an accidental narcotic overdose. The DON, ADON, SDC, and Regional Director of Clinical Services (RDCS) conducted a medication pass audit which included administration, rotation, and patch presence on 02/01/14 and 02/06/14. No discrepancies were identified and the audits were on-going.</p> <p>On 04/07/14, the DON and RDCS completed a validation to ensure that all nine (9) residents with any type of transdermal patch had the location of the patch on the resident documented on the MAR and that all medications were being administered per physician's orders.</p> <p>On 01/24/14, two (2) additional residents were identified as receiving Fentanyl patches to treat pain. The DON verified the physician's orders for the patches, reviewed the MAR to assure the patches were being administered correctly, and documentation and verification the residents received the patches as ordered.</p> <p>Fentanyl patches were audited by the DON on 01/24/14 for all residents with orders to verify the patch count was accurately reflective of the narcotic count sheet.</p> <p>On 04/03/14, the RDCS and the DON reviewed the documentation of the residents with Fentanyl</p>	F 520	<p>reading MARs, ensuring orders match MAR; transdermal patch orders, specifically MAR to order, medications administration and the 5 rights of medication administration.</p> <ul style="list-style-type: none"> On 04/17/14, RDCS completed additional education regarding transcribing order as soon as medication order received, new MARs each month must be compared to prior month MAR. <p>4. <u>Monitoring to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> On 4/03/14 the medical director and resident's attending were notified of jeopardy and action plan. Both were in agreement with action plan. The PI committee met on 04/04/14 to review action plan, validate education completed, and update Medical Director on the additional documentation for new admission on the initial data collection tool and to validate monitoring is in place. PI Team to review incident management program beginning week of 04/03/14 x 8 weeks to identify clinical team oversight, trends and ensuring root cause determination by bringing specific information regarding issues related 	

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

PRINTED: 08/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 520	<p>Continued From page 55</p> <p>patches (two residents from 01/23-02/06/14, two (2) residents from 02/06-02/07/14, three (3) residents from 02/07/14-present). The Fentanyl patch orders and January to present MARs reflected the resident's patches were applied per physician's orders. The site for the patch was documented and monitoring was documented on the MAR throughout the month.</p> <p>Residents who had an order for a Fentanyl patch were seen by a physician in the center on 04/03/14 with no concerns with dosage or documentation noted.</p> <p>The Pharmacist conducted a review of all current Fentanyl patch orders and counts were correct on 02/04/14. She also reviewed the documentation of the location of the patch on the MARs and verified each shift placement check.</p> <p>On 01/31-02/02/14, all licensed nurses were provided education on medication administration including Fentanyl patches. This education was completed by the DON and the Staff Development Coordinator (SDC) and was provided for 100% of the licensed nurses before midnight on 02/02/14.</p> <p>On 04/03/14, the RDCS completed education for the Executive Director, DON, Assistant Director of Nursing (ADON), SDC, and the Minimum Data Set Coordinator (MDSC) which included:</p> <p>Transdermal patch administration/removal policy and procedure Required documentation of the Fentanyl patch removal and application, including anatomical location of patch to be on the MAR. Admission documentation in admission</p>	F 520	<p>to resident care, medications and resident outcomes.</p> <ul style="list-style-type: none"> • Executive Director to meet with DON weekly to discuss audit findings, trends in care management, medication related issues and plan of correction beginning week of 04/08/14. • RDCS or RVP to audit PI action plans weekly to ensure all identified issues including medication errors are addressed per PI plan. • RDCS to audit weekly beginning 04/12/14, that PI team members are present, that all issues identified are presented, addressed timely and plans of action are implemented. • The PI committee consists of Executive Director, DON, ADON, SDC, MDS nurse, Social Services, Activities Director, and Medical Director. The PI committee will meet weekly for 30 days to review all audits, review new admissions with transdermal patches and revise this plan to ensure residents individual needs are met and residents are receiving care to meet highest practicable well-being. The PI committee will then meet 2 x monthly for 30 days, then monthly to review all audit findings and make revisions as needed to this plan based on audit findings. 		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42066	
(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)	(X6) COMPLETION DATE
F 520	<p>Continued From page 56 assessment/notes to include Fentanyl patches present and the location. Notification of DON or ADON upon receipt of new Fentanyl patch orders received. All licensed nurses received the above training beginning on 04/03/14. Education was completed by the DON, ADON, or MDS Nurse. Education included a quiz which required a score of 100% to validate competency. This education was completed with 100% of licensed staff on 04/04/14. Any licensed nurse who did not receive the above training would not be allowed to work until the training was completed.</p> <p>The DON, ADON, MDS Nurse, and SDC provided education to the Certified Nursing Assistants (CNAs) to include observing for transdermal patches during activity of daily living (ADL) care and to notify the Charge Nurse if more than one (1) patch was identified on the resident. Education was initiated on 04/04/14 and was completed prior to midnight to all staff on duty. Any staff who did not receive the training prior to midnight on 04/04/14 was to receive the training prior to beginning his/her next working shift.</p> <p>Nursing will notify the DON or ADON at the time of all new Fentanyl patch orders received.</p> <p>On 04/03/14, the DON and ADON completed audits of residents' records who were receiving a Fentanyl patch for documentation of placement on the MAR and verified the patch was located on the resident in accordance to the assessed, documented site. The DON, ADON, and RCDS reviewed resident records who currently had Fentanyl patches to validate the physician's order matched the MAR.</p>	F 520	<ul style="list-style-type: none"> • RDCS/RVP to attend all PI committee meetings either in person or by phone, to identify quality issues which includes medication errors, trends and assist in plan of correction implementation and development of action plans to correct any issue identified. Beginning week of 04/03/14 x 8 weeks, and on-going until PI committee and RVP recommend change in frequency. Any issues will be reported to the Medical Director. • Medical Director to attend PI meetings monthly in person, weekly via phone, to ensure that team is meeting as required, identifying care management issues, making recommendations as assisting with plan of correction implementation. • RDCS and/or RVP to have center oversight at least 2 days/week x 8 weeks then 1x week x 3 weeks beginning 04/04/14 to identify QA issues and ensure highest practicable well-being. <p>5. Completion Date: 04/19/2014</p>	

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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 520	<p>Continued From page 57</p> <p>Beginning 04/04/14, the DON, ADON, SDC, Unit Manager, MDS Nurse and/or RDCS will validate the transdermal patches orders are correct, recorded on the MAR, location will be documented on the MAR, and verify the patch is located on the resident in accordance with the assessed, documented site. The process was to occur seven (7) days a week for thirty (30) days, then would be completed four (4) times a week for thirty (30) days. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>The DON, ADON, SDC, or Unit Manager will monitor the next five (5) admissions with a transdermal patch order beginning on 04/05/14, and again on 04/07/14 to ensure transdermal patch orders were recorded on the MAR correctly, the location was documented on the MAR and on the initial data collection tool. They will verify the patch was on the resident as the MAR indicated. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>All audit and monitoring outcomes would be presented to and reviewed by the Performance Improvement (PI) Committee for revision or plan recommendations. Audits would be completed seven (7) days a week, for the next thirty (30) days, then at a rate of four (4) times per week for thirty (30) days. The PI Committee would meet weekly over the next thirty (30) days, then bi-weekly for thirty (30) days to review results.</p>	F 520		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066	
(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 520	<p>Continued From page 58</p> <p>PI meetings were held on 02/05, 02/06, 02/12, 02/19, 02/26, 03/05, 03/07, 03/09, and 03/19/14. Review of education provided in regard to medication administration as well as full review of completed medication administration audits were conducted at each PI meeting.</p> <p>On 04/03/14, the Medical Director and the resident's attending physician were notified of Immediate Jeopardy and the facility's action plan and both agreed with the action plan.</p> <p>The PI Committee met on 04/04/14 to review the action plan, validate education as completed, and to update the Medical Director on the additional documentation for new admissions on the initial data collection tool and to validate monitoring was in place.</p> <p>The PI Committee consists of the Executive Director, DON, ADON, SDC, MDS Nurse, Social Services, and Activity Director. The PI Committee was to meet weekly for thirty (30) days to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. The PI Committee was to meet two (2) times a month for thirty (30) days, then monthly to review all audit findings and make revisions as needed to the action plan based on audit findings.</p> <p>**The State Survey Agency validated the corrective action taken by the facility as follows:</p> <p>Record review revealed Resident #15 was discharged home with family on 03/15/14.</p>	F 520		

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 520	<p>Continued From page 59</p> <p>Review of Medication Pass Audits, dated 02/01/14 and 02/06/14 revealed the DON, ADON, SDC, and RCDS conducted a medication pass audit and monitored the entire medication pass including the administration of medication patches to include ensuring the rotation of sites for the patches, patches were dated and timed, as well as documented on the MAR for placement and removal of the old patch. Random patch audits were ongoing and continued to be performed three (3) times a week.</p> <p>Review of the MAR audit list, dated 04/07/14, revealed the DON and RCDS completed observations of the nine (9) residents with any type of transdermal patch to ensure the patch was located at the same site as was documented on the MAR. In addition, they reviewed the physician's orders to ensure the staff was following the physician's order for the patch.</p> <p>Review of the Physician's Progress Notes, dated 04/03/14, for Resident #10 and Resident #3 revealed both residents were assessed and received Fentanyl patches with no adverse side effects noted.</p> <p>Review of a Medication Audit form, dated 04/04/14, revealed the pharmacists reviewed the MARs for Resident #3 and Resident #10 for correct documentation for placement, checks, application, removal, and disposal of Fentanyl patches with no concerns noted.</p> <p>Review of the inservice log, dated 01/31/14-02/02/14, revealed 100% of licensed staff was inserviced and a post test was completed to verify competency of transdermal patch administration by the DON and SDC.</p>	F 520			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066		
(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 520	<p>Continued From page 60</p> <p>Review of training, dated 04/03/14, revealed 100% of licensed staff was inserviced on the procedure for Admission/Readmission of residents utilizing Fentanyl patches by the DON, ADON, SDC, and MDS Coordinator. The training included transdermal patch administration and removal policy and procedure; the required documentation of patch removal and application, including location of the patch; the documentation on Admission Assessments and Notes should include if any patches present and the location of the patches; and Notification of the DON and/or ADON upon receipt of new patch orders. A competency exam was given to verify the understanding of the training. 100% of licensed staff was inserviced and new hires will receive the same training.</p> <p>Review of the CNA training log, dated 04/04/14, revealed a phone training was completed by the Regional Nurse Consultant on 04/04/14 which included to observe for patches during care and to utilize a "stop and watch" tool to report areas to the charge nurse.</p> <p>Interviews with RN #2, RN #4, RN #10, RN #11, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #10, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were trained on the disposal process for transdermal patches, documentation of the site of the patch on the resident, physician notification if more than one (1) patch was found on a resident, and the process of documenting patches on new admissions. Additionally, RN #2, RN #4, RN#10 and RN #11 were educated on the notification of the Director of Nursing and/or the Assistant Director of Nursing of new orders for Fentanyl</p>	F 520			

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

PRINTED: 06/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066		
(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)	(X6) COMPLETION DATE	
F 520	<p>Continued From page 61</p> <p>patches, the admission process for transdermal patches documentation, placement checking of the patch and to complete a complete body audit if the patch was not where it was supposed to be and conduct an investigation, and the disposal process for the patches which includes two (2) licensed nursing staff to witness and destroy the patch by folding it and placing it in a Sharp's container.</p> <p>Interviews with CNA #1, CNA #2, CNA #3, and CNA #4, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were inserviced on reporting to the Charge Nurse if while performing care to a resident, two (2) patches were found to be present on the resident. They stated they would fill out a "Stop and Watch" form and turn it in to the Charge Nurse.</p> <p>Review of the Transdermal Patch Audits, on 04/08/14 and 04/09/14 revealed all new transdermal patch orders were reported to the DON and/or ADON. The DON and ADON completed audits of residents who were currently on a transdermal patch of any kind with the last audit completed on 04/08/14 and to continue every day for seven (7) days. The facility did not have any new admissions on transdermal patches at this time.</p> <p>On 04/03/14, the Medical Director was notified of the AoC and agreed with the plan with a verified signature. Review of the Quality Assurance meeting notes, dated 01/01/14, revealed the AoC was discussed via a phone call between the Medical Director and the Executive Director.</p> <p>Review of the PI Committee meeting documentation, dated 01/01/14 through 03/19/14</p>	F 520			

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

PRINTED: 08/02/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/09/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 520	Continued From page 62 revealed meetings were held weekly to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. Interviews conducted with the ADON, DON, and the Executive Director, on 04/09/14, revealed medication administration was discussed in the PI meetings as stated in the AoC and training was provided to licensed nursing staff as well as the CNAs related to identifying multiple patches on residents or a patch on a resident on initial admission to the facility.	F 520			

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

PRINTED: 04/23/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/27/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056	
(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: 1967.</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (211).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1967, with 24 smoke detectors and 6 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1967.</p> <p>GENERATOR: Type II generator installed in 2006. Fuel source is Diesel.</p> <p>A Standard Life Safety Code survey was conducted on 03/20/14. The facility was found in compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for seventy (70) beds with a census of sixty-three (63) on the day of 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.