

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

PRINTED: 12/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185227	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2013
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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY 42001
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY20932 was conducted on 11/14/13 through 11/15/13 and was substantiated with deficiencies cited.</p>	F 000		
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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.

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER # 185227	MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	DATE SURVEY COMPLETE: 11/15/2013
NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY		
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 164	<p>483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate consent was obtained prior to the release of medical records for one (1) of five (5) sampled residents (Resident #1).</p> <p>The findings include:</p> <p>Review of the Resident Referral policy, undated, revealed the facility would send a resident referral to another facility only after approval was obtained from the resident or his/her Power of Attorney (POA)/responsible party.</p> <p>Record review revealed Resident #1 was admitted to the facility on 11/12/10. Review of the annual Minimum Data Set assessment, dated 08/14/13, revealed the facility assessed the resident as moderately cognitively impaired. The resident's spouse was listed as his/her responsible party.</p> <p>Interview with the Social Services Director, on 11/15/13 at 1:30 PM and 2:35 PM, revealed she held a care plan meeting for Resident #1, on 07/01/13. The resident's POA was unable to attend; however, she gave permission for her son's to attend the meeting. Due to the resident's increased behaviors, it was discussed with the son's the possibility of the resident's transfer to another facility. The son's gave permission to send referrals; however, it was not discussed with the resident's POA. Referrals were sent to two different facilities.</p> <p>Interview with the Administrator, on 11/15/13 at 2:30 PM, revealed she would expect prior consent by the POA before sending a resident referral to another facility.</p>		

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

The above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER SUPERIOR CARE HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 3100 CLAY STREET PADUCAH, KY	
ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES		
F 164	Continued From Page 1		



Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2013
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NAME OF PROVIDER OR SUPPLIER
SUPERIOR CARE HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**3100 CLAY STREET
PADUCAH, KY 42001**

(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) COMPLETE DATE
N 000	INITIAL COMMENTS A Complaint Survey investigating KY20932 was conducted on 11/14/13 through 11/15/13 and was substantiated with deficiencies cited.	N 000	<p>Preparation and execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies. This Plan of Correction is prepared and executed solely because it is required by federal and state laws. The facility reserves the right to revise/improve corrective actions as determined to be warranted.</p> <p><u>N038</u></p> <p>1) Correction completion date: 11/18/13</p> <p>2) Social Services have been inserviced on the policy on releasing medical record information to outside entities without proper POA/responsible party consent.</p> <p>3) Audits will be performed thru the QA process to ensure POA's are informed and involved in all referral processes.</p>	
N 038	902 KAR 20:300-3(5) Section 3. Resident Rights (5) Privacy and confidentiality of personal and clinical records. The resident shall have the right to personal privacy and confidentiality of his personal and clinical records. This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate consent was obtained prior to the release of medical records for one (1) of five (5) sampled residents (Resident #1). The findings include: Review of the Resident Referral policy, undated, revealed the facility would send a resident referral to another facility only after approval was obtained from the resident or his/her Power of Attorney (POA)/responsible party. Record review revealed Resident #1 was admitted to the facility on 11/12/10. Review of the annual Minimum Data Set assessment, dated 08/14/13, revealed the facility assessed the resident as moderately cognitively impaired. The resident's spouse was listed as his/her responsible party. Interview with the Social Services Director, on 11/15/13 at 1:30 PM and 2:35 PM, revealed she held a care plan meeting for Resident #1, on 07/01/13. The resident's POA was unable to	N 038		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Helen Jane

TITLE

Administrator

(X6) DATE

11/19/13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100312	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/15/2013
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N 038	<p>Continued From page 1</p> <p>attend; however, she gave permission for her son's to attend the meeting. Due to the resident's increased behaviors, it was discussed with the son's the possibility of the resident's transfer to another facility. The son's gave permission to send referrals; however, it was not discussed with the resident's POA. Referrals were sent to two different facilities.</p> <p>Interview with the Administrator, on 11/15/13 at 2:30 PM, revealed she would expect prior consent by the POA before sending a resident referral to another facility.</p>	N 038		