

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

PRINTED: 03/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 8 ASHLAND, KY 41102
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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)	(X6) COMPLETION DATE
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F 000	<p>INITIAL COMMENTS</p> <p>AMENDED 03/01/12 A Recertification/Abbreviated/Partial Extended Survey Investigating KY#00017641 and KY#00017597 was initiated on 01/04/12 and concluded 01/14/12. KY#00017641 was substantiated without deficiencies cited. KY#00017597 was substantiated with deficiencies cited.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Abbreviated Survey was reinvestigated from 01/30/12 through 02/03/12. KY#00017597 was reopened for further investigation and KY#00017727 was investigated. KY#00017727 was substantiated with deficient practice cited.</p> <p>Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to implement it's Abuse Policies by failing to report alleged abuse to the Administration and Social Service Manager and failed to protect the other thirty-two (32) cognitively impaired residents on the locked Dementia Unit by failing to deny the perpetrator access to other residents per policy. The facility failed to ensure residents were free from sexual abuse related to the facility's failure to adequately assess and monitor sexual behaviors. On 12/25/11, at approximately 11:30 AM State Registered Nursing Assistant (SRNA) #2 observed Resident #22, who had a known history of sexually inappropriate behaviors, in Resident #1's room, Resident #1's pants and pull-up were</p>	F 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin M...</i>	TITLE ADMINISTRATOR	(X9) DATE 3-13-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 pulled down below his/her knees while the resident was laying across the foot of the bed on his/her stomach and Resident #22 was behind Resident #1 touching Resident #1's perineal area with his/her hands and mouth. SRNA #2 reported the incident to the Nurse who failed to follow the facility's policy of reporting the abuse, implementing interventions and initiating an investigation. Staff interviews revealed no additional supervision was implemented after the 12/25/11, 11:30 AM incident. Approximately four (4) hours later Resident #22 touched and rubbed Resident #2's thigh. At approximately 8:30 PM, the Evening Weekend Supervisor was notified of the incidents and then initiated the investigation. However fifteen (15) minute checks were not initiated until 11:00 PM. The facility's investigation did not identify abuse as having occurred as the facility felt the residents had the right to have sex because those desires do not recede due to their cognition. Physician interview, Guardian interview, and record review, revealed that both Residents #1 (adjudicated legally incompetent) and #22 were incapable of making any decisions for themselves. Thus neither resident could make decisions for themselves nor give consent for sexual relations. The facility's investigation failed to identify that neither resident could give consent thus determined no abuse had occurred. The facility proceeded to discontinue every fifteen (15) minute checks for Resident #22 on 01/03/12. However, on 01/05/12 the Kentucky State Agency Surveyor observed Resident #22 inappropriately touching and kissing Resident #29's arm and attempting to pull the resident backwards in his/her Geri chair. Staff was observed in the area; however, did not intervene until the	F 000			

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F 000	<p>Continued From page 2</p> <p>Kentucky State Agency Surveyor called it to the staff's attention as the facility failed to identify Resident #22's behavior as a risk to the other thirty-two (32) cognitively impaired residents on the locked Dementia Unit. The facility continued to allow Resident #22 continuous access to other residents of the facility. The facility failed to implement interventions to ensure residents' safety and failed to provide adequate supervision to prevent recurrence of sexually inappropriate behaviors towards residents. Additionally, there was no documented evidence that the facility had attempted to identify other incidents of abuse/neglect through assessment of all residents on the unit. Interview with the Social Service Manager (SSM), who was responsible for conducting investigations and assessments, revealed that she had not assessed any other residents on the unit to identify other incidents of abuse.</p> <p>Immediate Jeopardy (IJ) was identified on 01/12/12 and determined to exist on 12/25/11.</p> <p>Deficiencies cited were 42 CFR 483.13 Resident Behavior, F-226 at a Scope and Severity (S/S) of a "K"; 42 CFR 483.15 Quality of Life, F-250 at a S/S of a "K"; 42 CFR 483.20 Resident Assessment, F-279 at a S/S of a "K"; 42 CFR 483.25, Quality of Care, F-323 at a S/S of a "K"; and 42 CFR 483.75 Administration, F-490 and F-520 at a S/S of a "K". Substandard Quality of Care (SQC) was identified at 42 CFR 483.13, 42 CFR 483.15 and 42 CFR 483.25.</p> <p>An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on</p>	F 000		

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F 000	Continued From page 3 01/21/12. The State Agency verified IJ was removed on 01/21/12, prior to exiting on 02/03/12, with remaining non-compliance at 42 CFR 483.13 Resident Behavior, F-226 at a Scope and Severity (S/S) of an "E"; 42 CFR 483.16 Quality of Life, F-250 at a S/S of an "E"; 42 CFR 483.20 Resident Assessment, F-279 at a S/S of an "E"; 42 CFR 483.25, Quality of Care, F-323 at a S/S of an "E"; and 42 CFR 483.75 Administration, F-490 and F-520 at a S/S of an "E" while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented to ensure residents are free from abuse, receive medically related social services, have developed plans of care to address behaviors, are adequately supervised to prevent accidents and the facility's Administration provides oversight to ensure quality of care.	F 000		
F 156 SS=D	483.10(b)(6) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the	F 156	Resident #17 has a current physician order for Do Not Resuscitate (DNR). All resident charts have been audited to verify that the advanced directive for DNR is signed by the resident and/or Power of Attorney (POA) that there is a corresponding physician order for DNR or CPR, that there is a red dot sticker on the chart for DNR or a green dot sticker for CPR, and that the residents care plan reflect their DNR/CPR status correctly. This audit was completed by the admission coordinator	3-13-12

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F 156	<p>Continued From page 4</p> <p>items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (I)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State</p>	F 156	<p>Nursing/Social Services education on DNR/CPR practices to include 1.) signed advanced directives by witnesses, 2.) current corresponding physician order, 3.) corresponding care plan and 4.) corresponding sticker on chart.</p> <p>Admissions office/designee will audit the following daily-new admits, re-admits, changes in code status. Nursing department to complete code status upon admit, obtain physician order and implement care plan and apply red/green sticker to chart.</p> <p>When code status changes are made with the resident/POA. The nursing department will notify social services via the social services notification form. "Reason for notification--code status changed."</p> <p>Social services to audit when code status changes occur.</p> <p>Social services/MDS team to audit all residents charts according to care plan schedule, admit, quarterly, annually and significant change. The audit will check, advance directive, physician order, care plan, face sheet, medical problem list, and the corresponding sticker on the chart.</p>	
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F 158	<p>Continued From page 5</p> <p>ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,</p>	F 158	<p>Stephanie Hicks, RN, Staff Development/Quality Manager provided education to all staff involved in the systemic change which would be QAPI members on 1/27/12 and 2/24/12. The QAPI committee is made up of the following members: Keith Moore (Administrator), Dr. Phil Fioret, MD (Physician, Medical Director), Lisa Queen (Assistant Administrator), Paige Patton (Finance Director), Arlene Massey (Director of Nursing), Pam Bryan, (Assistant Director of Nursing), Stephanie Hicks (Quality Nurse Manager/Staff Development/QAPI Leader), Curtis Metzler (Resident Care Manager), Valerie Gallion (Resident Care Manager), Susan Kempf (Resident Care Manager), Sharon Queen (Resident Care Manager/ Restorative), Randy Payne (Environmental Services), Anthony Crance (Environmental Services), Shawna Shockey (Therapy Manager), Tammy Stephens/Katie Davis (Admissions), Kathy Keelin (Marketing), Chris Elliott/Susan Thornton (Social Services), Erin Littleton (Dietician), Gail Cunningham (Dietary Services),</p>	

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F 156	<p>Continued From page 6</p> <p>and review of the facility's policy, it was determined the facility failed to follow it's 'Social Services, Advanced Directives' policy related to Do Not Resuscitate (DNR) advanced directives to ensure (1) of fifty-nine (59) sampled residents' code status would be promptly carried out in the event of a cardiac/pulmonary emergency. The facility failed to obtain a Physician's order related to Resident #17's DNR preference.</p> <p>The findings include:</p> <p>Review of the facility's policy titled 'Social Services, Advanced Directives', dated December 2002, revealed advanced directives are defined as preferences regarding treatment options and include the preference of Do Not Resuscitate (DNR). Further review of the policy revealed DNR indicated that in case of respiratory or cardiac failure, the resident, legal guardian, healthcare proxy or representative have directed that no cardiopulmonary resuscitation (CPR) or other life-saving methods are to be used.</p> <p>Review of the facility's policy titled 'DNR Status (Do Not Resuscitate)', dated 10/12/09, revealed the executed DNR forms are placed behind the 'Advanced Directive' tab in the resident's medical record. Further review of the policy revealed a DNR order must be obtained from the attending physician.</p> <p>Review of Resident #17's medical record revealed the facility admitted the resident on 09/27/11, with diagnoses which included Organic Brain Syndrome, Congestive Heart Failure, Pulmonary Obstructive Disease, Cerebral Vascular Accident and Diabetes. Review of the</p>	F 156	<p>Jennifer McFarlin (Human Resources), Keith Carter (Risk Management), Rick Stamper (Wound Care Nurse), Sandy Keaton (Activities), Kathy Shaffer (Pharmacy), Adam Rucker (Resident Services Director), Vickie Bailey (Medical Records), Violet Stewart (Nursing Supervisor), Linda Jordan (Finance), Beverly Madden (MDS Coordinator), Jo Ann Davis (MDS Nurse). The QAPI committee meets on a monthly basis. All audits will be discussed and reviewed in the facility QAPI program meeting. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	

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F 156	<p>Continued From page 7</p> <p>Advanced Directive section of Resident #17's medical record revealed the resident's POA had signed two (2) forms titled 'Kentucky Emergency Medical Services Do Not Resuscitate Order' and 'Cardiopulmonary Resuscitation Status', both dated 11/28/11, indicating the POA wished to change Resident #17 from a Full-Code status to a DNR status. Review of a Quarterly Minimum Data Set (MDS) Assessment, dated 12/06/11, revealed Resident #17 was assessed by the facility to be cognitively impaired with impaired verbal communication.</p> <p>Review of physician's orders and nurse's notes from 11/28/11 through 1/13/12 revealed there was no documented evidence a physician's order was obtained related to changing Resident #17's Full Code status to the DNR status as executed by Resident #17's POA.</p> <p>Interview with Social Services (SS) Worker #13, on 01/13/12 at 10:25 AM, revealed when she was notified by nursing of a change in a resident's code status she looked at the Cardiopulmonary Resuscitation form in a resident's chart to see if a resident was Full Code or DNR and then looked to see if there was a red dot on the resident's chart to indicate the resident was DNR. Observation at that time revealed Resident #17's chart had a red dot on the side of the chart. Further interview revealed SS #13 was unaware a physician's order needed to be obtained.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 01/13/12 at 9:20 AM, revealed nursing was responsible for obtaining physician's orders and if she had received the change in DNR status request and forms from Resident #17's POA she</p>	F 156		
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F 156	Continued From page 8 would have documented in the Nurse's Notes the change in the advance directive as well as obtained a physician's order.	F 156		
F 226 SS=K	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure three (3) of fifty-nine (59) sampled residents, Residents #1, #2 and #29, were free from sexual abuse related to the facility's failure to follow it's Abuse Policies to ensure residents' safety through assessment, care planning and monitoring behaviors that lead to conflict; failed to report abuse to the Administration and Social Service Manager; and failed to deny the perpetrator unsupervised access to residents. State Registered Nursing Assistant (SRNA) #2 observed Resident #22 in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth on 12/25/11 at 11:30 AM. Resident #1 had been	F 226	1. Resident #22 was placed on Q15 minute checks on 12-25-11 to 1-3-12. Resident #22 was then placed on Q15 minute checks on 1-5-12 and was sent out later on 1-5-12 for a psychiatric evaluation and hospitalized. Resident #22 returned on 1-16-12 and was immediately placed on 1:1 staff supervision. On 2-5-12 resident #22 was sent out for behavioral health evaluation and was admitted. Resident returned on 2-9-12 and was immediately placed on 1:1 staff supervision. Resident was referred to a long term behavioral health facility for potential placement at this time. On 2-14-12 resident #22 had 1:1 staff supervision discontinued due to a decline in overall health condition. Resident #22 was placed on palliative care at this time. Resident #22 expired on 2-24-12.	3-13-12

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F 226	<p>Continued From page 9</p> <p>adjudicated legally incompetent and incapable of making decisions for him/herself. Facility staff observed Resident #22 later that day, at approximately 4:00 PM, touching and rubbing Resident #2's thigh. On 01/05/12 at 9:50 AM, a Kentucky State Agency Surveyor observed Resident #22 rubbing Resident #29's left hand on his/her upper right thigh in the dining room and was observed rubbing Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 by his/her arm while he/she was sitting in a Geri chair. No staff was monitoring Resident #22's behavior, despite the resident's sexual history beginning 12/26/11; in order to prevent recurrence of sexual abuse. The facility allowed Resident #22 access to thirty-two (32) cognitively impaired residents without establishing an effective behavior management policy and implementing effective supervision of Resident #22 to deny access to the residents of the facility and to prevent further abuse. Furthermore, the facility failed to identify other incidents of abuse/neglect through assessment of all residents of the unit after the 12/26/11 incident.</p> <p>Based on the above findings, it was determined the facility's failure to follow it's abuse policies by failing to assess, implement a care plan and monitor a resident with a known history of sexual behavior since 12/25/11; failing to report sexual abuse immediately to administration; failing to deny the perpetrator access to other residents; and, failing to provide adequate supervision to prevent further abuse recurrence is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) was identified</p>	F 226	<p>Staff received education on 1-18-12 in regards to the 7 components of abuse, abuse definitions, types of abuse, identifying signs and symptoms of abuse that staff should recognize as such, immediate procedures for suspected abuse and a new suspected abuse communication reporting form which has been implemented. Administrative staff and clinical leadership received training on 1-20-12 on the impact of mental capacity and the determination of abuse. All staff completed a competency validation on abuse and neglect and the new "Code Protect" system.</p> <p>A revised social services, resident abuse policy was put in place which addressed the immediate procedures for suspected abuse which includes placing any residents involved in suspected abuse on 1:1 staff supervision. February all staff education includes preventing, recognizing and reporting abuse, via the facility on-line training program.</p>	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102	
(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 226	<p>Continued From page 10 on 01/12/12 and was determined to exist on 12/25/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The State Agency verified Immediate Jeopardy was removed prior to exit on 02/03/12, with remaining non-compliance at 42 CFR 483.13 Resident Behavior at a S/S of a "E", while the facility's Quality Assurance continues to monitor residents' behaviors.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Social Services. Preventing Resident Abuse", dated 12/2001, revealed all alleged allegations will be responded to through an investigation process. The policy detailed the facility would assess, care plan, and monitor residents with behaviors that may lead to conflict in order to assist in resolving behavior issues. The program included assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues. Interview with the Social Service Manager, on 01/14/12 at 12:46 PM, revealed behaviors were discussed in the weekly focus meetings; however, the facility did not track and trend individual resident behaviors</p>	F 226	<p>As well the facility will conduct a monthly training on abuse, overseen by the QI/Staff Development Manager. The nursing staff will notify social services of any behaviors via the social service notification form and implement interventions and follow up as necessary. All staff will be mandated to pass the competency on abuse and neglect and the new "Code Protect" annually as well as in the new employee orientation training. A house wide psychosocial and physical assessment will be conducted when an instance of suspected abuse is noted. All referrals to the facility are screened by the admissions office for any unmanaged high risk behaviors. To monitor performance, the facility will utilize our quarterly QAPI meeting. Audits will be conducted to verify a 1:1 staff supervision was put in place anytime a suspected abuse is reported, and an audit of the entire "code protect" system to ensure that compliance was met</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 11 and there was no specific behavioral management program.</p> <p>Review of the facility's policy titled, "Social Services. Resident Abuse", dated 09/2008, revealed all residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. All abuse allegations ... must be reported immediately to the facility's Administrator and the Social Services Manager. Further review revealed while the investigation was being conducted, accused individuals would be denied unsupervised access to residents.</p> <p>Review of the facility's policy titled, "Social Services. Reporting Abuse to Facility Management", dated 12/01, revealed employees must report any suspected abuse or incidents of abuse to the Director of Nursing and/or Director of Social Services.</p> <p>Review of the facility's policy titled, "Social Services. Resident-to-Resident Abuse", dated 12/2001, revealed the facility was to develop a plan of care that included interventions to prevent the recurrence of such incident.</p> <p>Record review revealed the facility admitted Resident #22 on 09/13/10 with diagnoses which included Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/10/11, revealed the facility assessed the resident as being severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three (3). Interview with Resident #22's Power of Attorney, on 01/13/12 at 9:50 AM, revealed the resident was incapable of making</p>	F 226	<p>by QI/staff development manager and social service director. During this audit the social service director/designee will call family or responsible party within 24 hours of incident to ensure compliance of procedures and practices. Residents #2 and #29 were assessed using the social service psychosocial assessment tool on 1-16-12. All residents in the facility and/or their family members were contacted by the social service department using the social service psychosocial assessment to identify any other residents who may have been affected on 1-16-12. Audits will also be conducted by the social service director on the social service notification form to verify if behavior noted warranted increased staff supervision and that nursing and social services followed up with appropriate specific individualized approaches as needed. These audit findings will be discussed and reported in the quarterly QAPI meeting. The findings from these audits will be reviewed in the facility QAPI meeting.</p>	

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F 226	<p>Continued From page 12</p> <p>decisions. Interview with Physician #1, on 01/13/12 at 11:27 AM, revealed he believed Resident #22 was not capable of making decisions.</p> <p>Interview with SRNA #5, on 01/06/12 at 9:00 AM, revealed she had cared for Resident #22 since 2010 and he/she had always made sexual comments. Interview with Licensed Practical Nurse (LPN) #1, on 01/07/11 at 4:58 PM, revealed she recalled Resident #22 unzipping his/her pants and exposing himself/herself several weeks ago. Interview with SRNA #1, on 01/04/12 at 1:15 PM, revealed when she provided care for Resident #22, he/she was often "touchy feely". Interview with SRNA #3, on 01/04/12 at 1:40 PM, revealed when she cared for Resident #22, he/she made sexual statements and gestures. Interview with LPN #3, on 01/13/12 at 12:15 PM, revealed she had heard Resident #22 making sexual remarks and hand gestures (as though he/she was touching his/her genitals).</p> <p>Review of Nurse's Notes (NN) from Resident #22's clinical record, dated 12/22/11, revealed Physician #2 had been in to check Resident #22 and to review the resident's medications related to increased behaviors. Review of NN, Physician's orders and the resident's Medication Administration Record (MAR), for 12/22/11, revealed Physician #2 had increased Tagamet (antacid, with a side effect of decreased sexual function) from 300 milligrams (mg) to 400 mg daily; increased Seroquel (antipsychotic) from 25 mg to 50 mg every 12 hours; and increased Depakote (anti-seizure medication also used for mood and behavior) from 500 mg to 750 mg every 12 hours, all related to increased behaviors.</p>	F 226	<p>These findings will be reviewed and discussed at a minimum in the facility quarterly QAPI meeting. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time. All potential employees of Kingsbrook Lifecare Center will be screened for a history of abuse, neglect or mistreating residents, this will be completed by obtaining information from previous and/or current employers, and checking with the appropriate licensing boards and registries by the HR manager/designee. The HR manager will report quarterly in QAPI to ensure compliance. Abuse reporting information has been placed in the admission packets so that all resident/families are informed on the process. Daily rounds are being completed by the social services department to monitor any behaviors on the units. The social services department will also track and trend behaviors through the weekly focus meeting. The social service department also has</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 13</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, on 01/06/12 at 9:47 AM, revealed on 12/26/11 at approximately 11:30 AM, she observed Resident #1 (adjudicated incompetent by a court of law) laying across the foot of the bed with his/her pants and pull-up (adult brief) pulled down below his/her knees. SRNA #2 observed Resident #22 behind Resident #1 touching Resident #1's perineal area with his/her mouth and hands. SRNA #2 stated she removed Resident #22 from Resident #1's room, escorted Resident #22 to the nurses' station and told Licensed Practical Nurse (LPN) #2 what she had observed.</p> <p>Interview with LPN #2, on 01/06/12 at 12:37 PM, revealed she did not recall SRNA #2 reporting the incident and therefore did not report the incident to the Administrator as per the facility's policy. She stated she did not initiate any special monitoring or supervision for Resident #22. She stated she did not do any physical assessments of either resident. However, interview with SRNA #6, on 01/05/12 at 10:22 AM, revealed she was at the Nurse's Station and heard SRNA #2 tell LPN #2, at approximately 11:30 AM, that she had observed Resident #22 in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth.</p> <p>Interview with LPN #1, on 01/07/12 at 4:58 PM, revealed LPN #2 had told her nothing in report about the incident with Resident #22 and Resident #1.</p> <p>Further interview with LPN #1 and SRNA #2 revealed they observed Resident #22 touching</p>	F 226	<p>developed a notification form to help ensure that behaviors are being communicated between social service and the nursing department. The facility risk management officer, Keith Carter, tracks and trends all incident reports in monthly safety meetings, and will monitor to ensure compliance. The facility has a behavior management process which identifies, tracks and manages all residents with behaviors through communicating interdepartmentally. An interdisciplinary plan of care with specific interventions will be implemented for each resident.</p>	
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F 226	<p>Continued From page 14</p> <p>and rubbing on Resident #2's thigh between 4:00 PM and 4:30 PM on 12/25/11. At which time LPN #1 separated the residents and SRNA #2 informed LPN #1 of the previous incident that morning involving Resident #22 and #1, LPN #1 stated she instructed SRNA #2 to keep an eye on Resident #1. However, record review revealed no documented evidence LPN #1 reported the abuse to the Administrator, Social Service Manager, or the Director of Nursing as per the facility's policies; no evidence an investigation was initiated; and no evidence Resident #22's supervision was increased to ensure the safety of other residents as per the facility's policies.</p> <p>Further interview with LPN #1 revealed later that evening, on 12/25/11 between 8:00 PM and 8:30 PM, two (2) Nurses told her about Resident #22 and Resident #1's interaction. She stated it wasn't until that time that she called the Evening Weekend Supervisor and reported the incident to her about twenty (20) to thirty (30) minutes later when she came to the unit to do her rounds.</p> <p>Interview with the Evening Weekend Supervisor, on 01/05/12 at 3:24 PM, revealed she was doing her rounds between 10:00 PM and 10:30 PM when she was told about the incident with Resident #22 and Resident #1. She stated she then called the Day Weekend Supervisor because she had received nothing in report from him and he had stated he knew nothing about the incident. Then she called SRNA #2 and asked her what had happened and she stated she found Resident #22 in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth and SRNA #2 told her she separated the residents and told the Nurse. The Evening</p>	F 226		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 15</p> <p>Weekend Supervisor stated she then called LPN #2 who said she had not been told about the incident. She then called the Assistant Director of Nursing (ADON) and then Social Services. She stated they started fifteen (15) minute checks on Resident #22 at 11:00 PM. There was no documented evidence that the facility had taken measures to deny the perpetrator access to other residents of the locked Dementia unit where review of the census report for 12/25/11 revealed a total of thirty-two (32) residents resided on the locked Dementia Unit. Review of the facility's Roster Matrix revealed all thirty-two (32) residents residing on the locked Dementia Unit were assessed as having cognitive impairment.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 01/06/12 at 11:45 AM, revealed the incident was reported to have happened at approximately 11:30 AM on 12/25/11; however, fifteen (15) minute checks were not initiated until 11:00 PM on 12/25/11, approximately twelve hours later.</p> <p>Review of the Care Plan revealed no documented evidence the facility developed a plan of care to address Resident #22's sexual behavior towards other residents after either incident. Continued review revealed the facility did not develop a care plan until 12/27/11 related to sexual behavior. Review of Resident #22's Plan of Care for sexual behaviors, dated 12/27/11, revealed the facility staff would tell the resident calmly and firmly that the behavior was not acceptable whenever it occurred. Staff was to separate Resident #22 from peers if behavior became offensive to them, take Resident #22 to his/her room and provide privacy, and to teach the resident about</p>	F 226		
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F 226	<p>Continued From page 16</p> <p>acceptable behavior. The Care Plan approaches further stated staff would be non-judgmental when confronting negative behavior and establish consistent staff approaches to deal with problem. The care plan did not detail what consistent staff approaches would be provided to deal with the problem. There was no documented evidence of any increased supervision being implemented related to the resident's sexual behaviors towards residents of the locked Dementia unit nor denying Resident #22's access to these residents to prevent the recurrence of sexual abuse.</p> <p>Interview with the Social Services Manager and Director of Nursing (DON), on 01/11/12 at 10:00 AM, revealed the facility's investigation did not determine abuse had occurred; however, did identify that the failure of LPN #2 to report the incident regarding Resident #22 and Resident #1. Further interview revealed it was believed the residents had a right to have sex because those desires did not recede due to their cognition. However, record review revealed Resident #1 had been adjudicated incompetent by a court of law and appointed a guardian. Record review for Resident #22 revealed he/she was assessed and determined to be cognitively impaired. Interview with Resident #22's Physician #1, on 01/13/12 at 9:50 AM, revealed Resident #22 could not make decisions for him/herself and could not act with willful intent. Thus, neither resident per Physician interview, record review, and Guardian interview were capable of making decisions for themselves in order to give consent for sexual relations. However, the facility's investigation did not identify that neither resident could give consent; therefore had a finding that no abuse had occurred. The facility's failure to follow their</p>	F 226		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 226	<p>Continued From page 17</p> <p>abuse policies and failure in identifying that neither resident could give consent for sexual relations prevented the facility from identifying the need to deny Resident #22's access to other residents within the locked unit and furthermore prevented them from developing and implementing a behavior management program per their policy to address behaviors that may lead to conflict. Review of the Nurse's Notes revealed the facility proceeded to discontinue fifteen (15) minute checks for Resident #22 on 01/03/12 with no specific care plan addressing supervision to deny access to other residents related to Resident #22's recent onset of sexual behaviors towards other residents of the facility.</p> <p>On 01/05/12 between 9:43 AM and 9:50 AM, the Kentucky State Agency Surveyor observed Resident #22 rubbing Resident #29's left hand on his/her upper right thigh in the dining room on the locked unit during an activity while female residents were having their nails painted. There was one (1) Activity Aide in the room, sitting about ten (10) feet away, but within direct vision of the incident, with approximately twelve (12) residents. No other staff was observed in the area. Resident #22 was observed rubbing on Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 backwards, by his/her arm while he/she was sitting in a Geri chair. While the Activity Aide was present at the time of the incident, no staff intervened. No staff was supervising/monitoring this resident to ensure no sexual behaviors were forced upon other residents despite the facility's knowledge of the resident's history since 12/25/11 and the facility's policy "Preventing Resident Abuse" which</p>	F 226		
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F.226	<p>Continued From page 18</p> <p>detailed the facility would assess, care plan and monitor resident behaviors that may lead to conflict. Per record review Resident #22 was allowed to have full access to thirty-two (32) cognitively impaired residents without effective supervision to monitor sexual behaviors. While the facility transferred Resident #22 out to a Psychiatric facility per record review on 01/05/12 with the anticipated return to the facility; the facility could provide no evidence that Resident #22's current Care Plan detailed action the facility would take to ensure adequate supervision and resident safety to prevent sexual abuse recurrence. In addition, the facility had not developed policy and procedures for behavior management in order to comply with their Resident Abuse Policy.</p> <p>Additionally, there was no documented evidence that the facility had attempted to identify other incidents of abuse/neglect through assessment of all residents of the unit. Interview with the Social Services Manager, on 01/11/12 at 10:00 AM, who was responsible for conducting investigations and assessments, revealed that she had not assessed any other residents on the unit to identify other incidents of abuse.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the IJ effective on 01/21/12, based on the following:</p> <p>1) The Social Services Manager contacted all Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other</p>	F 226		

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

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F 226	<p>Continued From page 19 knowledge of relevant safety concerns by 01/16/12.</p> <p>2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/16/12.</p> <p>3) All residents and their family members or healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12.</p> <p>4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/16/12. The resident was placed on one (1) to one (1) supervision.</p> <p>5) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p>	F 226		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 226	<p>Continued From page 20</p> <p>8) All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will become an annual requirement.</p> <p>12) All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12.</p> <p>On 02/03/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following;</p> <p>Observations, on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on</p>	F 226		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102
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F 226	<p>Continued From page 21</p> <p>one (1) supervision since returning from the Psychiatric Hospital.</p> <p>Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:55 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:05 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3 on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Assistant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:46 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes; the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed</p>	F 226		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
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OMB NO. 0938-0391

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F 228	<p>Continued From page 22</p> <p>residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety at the facility and the resident stated he/she felt safe.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on one (1) supervision.</p> <p>The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and</p>	F 228		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
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F 226	Continued From page 23	F 226			
F 250 SS=K	<p>483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE</p> <p>The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the Director of Social Services job description, review of the Social Worker job description and review of the facility's policy, it was determined the facility failed to ensure two (2) of fifty-nine (59) sampled residents received social services to attain and/or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The facility failed to identify Resident #22's history of expressing sexual behaviors which prevented Social Services from addressing and implementing interventions related to these sexual behaviors prior to the resident expressing sexual behaviors towards three (3) residents. Interviews with staff revealed Resident #22 had a history of making sexual comments, sexual gestures and exposing his/her genitals to staff. Resident #22 was observed by State Registered Nursing Assistant (SRNA) #2 to be in Resident #1's room touching Resident #1's perineal area with his/her mouth and hands on 12/25/11 at 11:30 AM. Resident #22 was observed later that</p>	F 250	<p>The facility social services department has been re-structured. This includes employees and daily practices. Communication systems have been enhanced. Social Services Department reviewed and revised residents #22, #2, and #29 care plans by 2-24-12. All residents in the facility and/or their family members were contacted by the social service department using the social service psychosocial assessment to identify any other residents who may have been affected on 1-16-12 and none were identified. A new social service communication tool is in place for nursing to notify social services when a resident is exhibiting behaviors of any kind. This form is a triplicate copy. One copy goes to social services manager and another goes to the social service director.</p>	3-13-12	

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

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OMB NO. 0938-0391

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F 250	<p>Continued From page 24</p> <p>day, at approximately 4:00 PM, touching Resident #2's legs above the knees. The facility Social Services staff failed to accurately describe the occurrence to the Guardian of Resident #1 and failed to assess other residents to ensure they were not effected by these sexual behaviors. After the incident the facility's Social Service staff continued to fail to address and intervene related to Resident #22's continued sexually inappropriate behaviors. The facility's system of oversight for Social Services failed to identify these issues as a failure in their system. Resident #22 resided on the locked Dementia Unit, which had a total census of thirty-two (32) cognitively impaired residents, on 12/25/11.</p> <p>Based on the above findings, it was determined the facility's failure to have an effective system in place to identify, assess and implement social services in order to protect residents from abuse is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 01/12/12 and was determined to exist on 12/26/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The State Agency verified IJ was removed prior to exit on 02/03/12,</p>	F 250	<p>The third copy goes to the QAPI/ Staff development manager. The director of social service will audit to verify that the social service employee addressed the behavior and followed up with appropriate specific care planned/behavior management interventions. The QAPI manager will randomly audit for compliance thru the quarterly QAPI meeting.</p> <p>The director of social services will also randomly audit the tracking and trending of behaviors in the weekly focus meeting and the daily round mood/behavior observation forms for identification of residents with repetitive behaviors and to validate social services has intervened with the appropriate behavior management program, including specific individualized care plans.</p> <p>These findings will be reviewed and discussed at a minimum in the facility quarterly QAPI meeting. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 25</p> <p>with remaining non-compliance at 42 CFR 483.15 Quality of Life at a S/S of a "E", while the facility's Quality Assurance continues to monitor medically related social services.</p> <p>The findings include:</p> <p>Review of the job description titled "Director of Social Services", dated 01/05/01, revealed responsibilities included assists direct care staff with behavioral assessments and development of alternative approaches. Responsibilities also included demonstrating assessment skills sufficient to evaluate residents' behavior, to collect data to evaluate psychosocial needs, risk factors for psychosocial needs, risk factors for psychosocial deterioration and residents' responses to interventions. Able to interpret and explain resident behavior to staff in a way that fosters understanding, facilitates treatment and respect for resident rights and minimizes use of chemical and physical restraints.</p> <p>Review of the job description titled "Social Worker", dated 08/01/03, revealed responsibilities which included assessments to identify residents with current needs for social service interventions to improve or maintain functional abilities and those residents at risk of psychosocial deterioration and to communicate residents' concerns and responses to interventions to interdisciplinary team members and direct care staff.</p> <p>Interview with the Administrator, on 01/14/12 at 4:12 PM, revealed it was his understanding the facility monitors behaviors by typically documenting behaviors in the medical record and</p>	F 250	<p>Kingsbrook Lifecare Center has updated policies and procedures to ensure that all medically related social services are being performed as by example of: Social Service Notification Form (This form is used to enhance better communication and monitoring of residents behaviors and managing their care more effectively with nursing and the social services departments.) Social Service Daily Rounds, observing resident mood and behaviors.</p> <p>Review and revision of abuse policies by administration.</p> <p>Review and revision of care plan policies by administration. Review and revision of abuse training by administration.</p> <p>Monthly abuse education overseen by staff development. Tracking and trending of behaviors in weekly focus meetings by social services.</p> <p>Review and revision of "Code Protect" system by administration.</p> <p>Daily stand-up meeting discussion with all departments.</p> <p>Education with interdisciplinary team on behavior management program by the QAPI manager.</p>		

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F 250	<p>Continued From page 26</p> <p>he believed Social Services monitored resident behaviors. Interview with the Director of Social Services, on 02/03/12 at 3:30 PM, revealed he ensured all the Psycho-Social Assessments were completed on all residents. He further stated if there was a reported behavior the Social Services Worker would complete an assessment, document in the chart and ensure there was a Care Plan in place or a revision was made to the Care Plan if needed. Interview with the Social Services Manager, on 01/14/12 at 8:20 AM, revealed behaviors were discussed in the weekly meeting and should be documented on those minutes.</p> <p>Record review revealed the facility admitted Resident #22, on 09/13/10, with diagnoses which included, Dementia, Hypertension, Chronic Heart Failure (CHF), Left Humeral Fracture and a history of a Right Humeral Fracture. Review of the Quarterly Resident Assessment Instrument (RAI), dated 11/10/11, revealed the resident was assessed as being severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of three (3). Review of the Physician orders, dated 11/16/10, revealed an order for Tagamet 300 mg due to the resident being "very sexually aggressive". Interview with Physician #1 (Medical Director), on 01/13/12 at 11:27 AM, revealed Resident #22 had been ordered Tagamet to decrease sexual desires because Tagamet had a side effect of decreasing sexual desires. However, review of the Comprehensive Care Plan revealed no documented evidence the facility addressed Resident #22's behaviors of sexual aggression.</p> <p>Interview with SRNA #5, on 01/06/12 at 9:00 AM,</p>	F 250	<p>To monitor performance, the facility will utilize our quarterly QAPI meeting. Audits will be conducted to verify a 1:1 staff supervision was put in place anytime a suspected abuse is reported.</p> <p>Audits will also be conducted on the social service notification form to verify if behavior noted warranted increased staff supervision and staff compliance with policy and protocol by the social service director and to ensure that proper notification and follow up was completed and in compliance. These audit findings will be discussed and reported in the quarterly QAPI meeting by the social service director.</p>	
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F 250	<p>Continued From page 27</p> <p>revealed she had cared for Resident #22 since 2010 and he/she had always made sexual comments. Interview with Licensed Practical Nurse (LPN) #1, on 01/07/11 at 4:58 PM, revealed she recalled Resident #22 unzipping his/her pants and exposing himself/herself several weeks ago. Interview with SRNA #1, on 01/04/12 at 1:15 PM, revealed when she provided care for Resident #22, he/she was often "touchy feely". Interview with SRNA #3, on 01/04/12 at 1:40 PM, revealed when she cared for Resident #22, he/she made sexual statements and gestures. Interview with LPN #3, on 01/13/12 at 12:16 PM, revealed she had heard Resident #22 making sexual remarks and hand gestures (as though he/she was touching his/her genitals).</p> <p>Review of the Nurse's Notes (NN) from Resident #22's clinical record, Physician's orders and the resident's Medication Administration Record (MAR), for 12/21/11, revealed Physician #1 had increased Tagamet from 300 milligrams (mg) to 400 mg daily; increased Seroquel from 25 mg to 50 mg every twelve (12) hours; and increased Depakote from 500 mg to 750 mg every twelve (12) hours. Review of NN from Resident #22's clinical record, dated 12/22/11, revealed Physician #1 had been in to check on Resident #22 and to review the resident's medications related to increased behaviors. Record review revealed no documented evidence Social Services addressed the increased behaviors.</p> <p>Interview with SRNA #2, on 01/06/12 at 9:47 AM, revealed on 12/26/11 at approximately 11:30 AM she observed Resident #1 laying across the foot of the bed with his/her pants and pull-up (attends) pulled down below his/her knees. Resident #22</p>	F 250	<p>All residents with behavior symptoms will receive an individualized care plan and/or program designed to address behavioral symptoms by the interdisciplinary care plan team. The facility QAPI team will review and discuss all findings in the quarterly meeting. If systems are deemed ineffective the QAPI team will reevaluate the system and implement changes as necessary to ensure systematic approaches are in place to ensure safety, choices, resident rights and quality of care. The QAPI manager will ensure QAPI program is in compliance by conducting random audits and ensuring all departments have completed all audits and any patterns or trends have been identified and plans of action are put in place. Any identified areas of concerns will be followed up with the facility administrator. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	
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F 250	<p>Continued From page 28</p> <p>was observed by SRNA #2 to be behind Resident #1 sitting in his/her wheel chair touching Resident #1's perineal area with his/her hands and mouth. SRNA #2 further stated she removed Resident #22 from Resident #1's room and told Licensed Practical Nurse (LPN) #2 what she had observed. Further Interview revealed later on 12/25/11, Resident #22 touched and rubbed Resident #2's thighs at approximately 4:00 PM and was separated from Resident #2 by LPN #1.</p> <p>Interview with the Social Services Manager, on 01/06/12 at 12:16 PM, revealed she told Resident #1's Guardian he/she was laying in bed with his/her pants down and a resident of the opposite sex was fondling him/her.</p> <p>Interview with Resident #1's Guardian, on 01/12/12 at 6:40 PM, revealed he/she was told by the Social Worker, on 12/28/11, a resident of the opposite sex was in Resident #1's room and Resident #1's pants were undone and the residents were fondling one another. Further interview revealed she was not told Resident #1's pants and pull-up (attends) was pulled down below Resident #1's knees and Resident #1 was laying across the foot of the bed with the resident's stomach down on the bed while Resident #22 was behind Resident #1 touching Resident #1's perineal area with his/her hands and mouth. Further interview revealed had Resident #1 been in his/her right mind this situation would never have taken place and stated she had given no permission for Resident #1 to perform sexual acts. She revealed Resident #1 was incapable of making decisions.</p> <p>Interview with Physician #1, on 01/13/12 at 11:27</p>	F 250	<p>All residents care plans in the facility have been reviewed for accuracy with problem, goal and specific approaches. Any errors/ glitches were removed by the MDS/care plan team.</p> <p>MDS/care plan team will review aloud each care plan in the care plan meeting which is held weekly on Wednesdays and Thursday and any other times as requested per resident/families and it will be audited for accuracy and specificity related to the problem, goal, and resident cognitive ability. A care plan audit form is being completed by the MDS team to also ensure care plans are revised as needed. The MDS nurses or designee will monitor compliance with the revision of care plans and track and report through the QAPI meeting. The MDS nurses will monitor through the QAPI meeting for 1 year and will re-evaluate at that time.</p> <p>This will be reviewed and discussed in the facility quarterly QAPI meetings by the MDS nurse.</p>

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 28</p> <p>AM, revealed the facility had informed him Resident #1's Guardian was okay with the incident with Resident #22 and he did not consider it a problem if family was comfortable. He further stated legally Resident #1 had been determined to be unable to make decisions.</p> <p>Interview with Resident #22's Power of Attorney, on 01/13/12 at 9:50 AM, revealed the facility had informed him of the resident's sexual behaviors and he had never given permission for Resident #22 to perform sexual acts. He continued to state the resident was incapable of making decisions.</p> <p>Interview with the Social Services Manager, on 01/14/12 at 8:20 AM, revealed she did not ask Resident #1's Guardian or Resident #22's Power of Attorney if either resident had permission to perform sexual acts. She continued to state she did not do any tracking or trending of behaviors. She further stated she did not document when she interviewed residents to see if anyone had touched them inappropriately. Additionally, she stated she did not contact any family members/responsible parties except for one (1) whom she interviewed at the facility on the locked unit; however, this interview was not documented. Record review revealed no documented evidence Social Services staff had taken any action after the two (2) incidents involving Resident #22 on 12/25/11.</p> <p>Observation, on 01/05/12 at 9:50 AM, revealed Resident #22, seated in a wheel chair, was touching and rubbing Resident #29's left hand on Resident #22's upper right thigh. Resident #22 was also noted rubbing on Resident #29's left</p>	F 250		

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F 250	Continued From page 30 arm and kissing up and down his/her arm and hand. Resident #22 was then observed to pull Resident #29, who was seated in a gerichaire, by his/her left arm backwards stating come with me. Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she was responsible for reviewing the Social Services Worker's documentation and signing off that she had reviewed the documentation daily. She further indicated she was unaware of Resident #22's sexual behaviors until the investigation into the sexual behaviors expressed with Resident #1. She further stated she shared the same office with the Social Worker so they could communicate what was occurring with residents on a daily basis. Further interview, on 02/03/12 at 3:55 PM, revealed she did rounds on each unit everyday with the Unit Manager. She stated when she or the Social Worker reviewed the residents' charts they would review Nurses Notes, Physician's orders and notes and behavior sheets. On 02/03/12 at 3:15 PM, the Social Services Manager was shown a Nurse's Note, dated 01/17/12, which read an aide had attempted to change the resident's brief and Resident #22 started yelling damn you, exposed his/her genitals and continued to yell damn you. The Social Services Manager was also shown a note which was documented by a one (1) on one (1) sitter on a form titled "Behavior/Mood and Behavior Patterns Sheet", that noted a case in which the resident stated "come here and give me a kiss" on 01/21/12. The Social Services Manager stated she was unaware of either case and this was why it had not been documented in her notes dated 01/21/12, 01/23/12 and 01/30/12. She stated she had not been told of Resident #22	F 250			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F-260	<p>Continued From page 31</p> <p>expressing sexual behaviors towards staff since his/her return from the psychiatric facility and she had not received a communication form from Nursing staff. Continued interview revealed she did not document, assess or make new interventions related to Resident #22's sexual behaviors after returning from the psychiatric facility secondary to Nursing did not inform her of these behaviors. Further interview revealed she had to learn through staff about behavior incidents. She stated if she had been aware of Resident #22 asking the State Registered Nursing Assistant (SRNA) for a kiss she might have contacted the Physician and discussed the incident, she would have discussed the incident with Resident #22 to let him/her know it was inappropriate and she would have noted behavior in her progress notes. When asked why she was unaware of these behaviors secondary to her reading over Physician's orders/notes, Nurse's Notes, and Behavior Sheets she stated she just skimmed through the Nurses Notes.</p> <p>Interview with the Director of Social Services, on 02/02/12 at 11:30 AM, revealed he was responsible for ensuring Social Worker and Social Services Manager's tasks were done. He stated he was not aware of Resident #22's sexual behaviors towards staff until 12/25/11. He indicated when an investigation was completed regarding an incident such as this, whomever was completing the investigation would be responsible for describing the events in detail to the family. He stated when he spoke to the family he would read from the incident report form what actually occurred, he stated he could not state this was how all the Social Services workers completed their investigation. The Social</p>	F 250		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 250	<p>Continued From page 32</p> <p>Services Director was asked to read the Nurse's Note, dated 01/17/12 and the note documented on the "Behavior/Mood and Behavior Patterns Sheet", dated 01/21/12, and in addition a Nurse's Note, dated 01/31/12, revealed Resident #22 was exposing his/her genitals and stating to the one (1) on one (1) sitter and stating "help me with this, will you please help me with this". He then reviewed the Social Services Manager notes, dated 01/21/12, 01/23/12 and 01/30/12. Further interview revealed the Social Services Manager should have gotten more details about what was going on with the resident. He continued to state she should have researched to see what could have been done for behaviors, should have documented interventions and followed up to monitor the resident's response to those interventions. He further stated he was unaware of Resident #22's sexual behaviors towards staff until the facility began investigating the incident which occurred with Resident #1.</p> <p>The facility was unable to provide evidence that Social Services had addressed the resident's sexually inappropriate behaviors through evaluation, assessment and intervention. Additionally there was no evidence the Social Services Director had identified problems with Social Services through his oversight of the social Services Manager and Social Services Worker.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the IJ effective on 01/21/12, based on the following:</p> <p>1) The Social Services Manager contacted all</p>	F 250		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
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F 250	<p>Continued From page 33</p> <p>Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other knowledge of relevant safety concerns by 01/18/12.</p> <p>2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/18/12.</p> <p>3) All residents and their family members or healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12.</p> <p>4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/18/12. The resident was placed on one (1) to one (1) supervision.</p> <p>5) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on</p>	F 250		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 34 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p> <p>8) All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will become an annual requirement.</p> <p>12) All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12.</p> <p>On 02/03/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following:</p> <p>Observations, on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was</p>	F 250		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 250	<p>Continued From page 36</p> <p>receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on one (1) supervision since returning from the Psychiatric Hospital.</p> <p>Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:56 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:06 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3 on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Assistant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:45 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes, the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of</p>	F 250		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 250	<p>Continued From page 36</p> <p>documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety at the facility and the resident stated he/she felt safe.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on one (1) supervision.</p> <p>The facility remained out of compliance at a lower</p>	F 250		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO: 0938-0391

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F 250 F 279 SS=K	<p>Continued From page 37</p> <p>scope and severity of an "E", a pattern deficiency with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented to ensure residents receive medically related social services and while the facility develops and implements the Plan of Correction (POC).</p> <p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was</p>	F 250 F 279	<p>Resident #22 has had care plan revised to include specific appropriate interventions to prevent further sexual behaviors from affecting other residents by the interdisciplinary care plan team by 2-24-12.</p> <p>All residents on the secured unit and house wide received a physical and psychosocial assessment to identify if other instances of potential abuse occurred. Nursing Department completed a head to toe assessment and the social service department completed a psychosocial assessment on 1-16-12. No other residents identified to be affected.</p> <p>Social service/designee are conducting a daily rounds observing resident mood/behavior throughout the facility.</p>	3-13-12

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

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F 279	Continued From page 38 determined the facility failed to properly assess and develop a comprehensive care plan that described the services to be furnished by the facility for one (1) of fifty-nine (59) sampled residents (Resident #22) related to sexual behaviors. The facility failed to develop a care plan addressing Resident #22's known sexual history to ensure the safety of the residents of the facility. On 12/25/11 at 11:30 AM, Resident #22 was observed, by State Registered Nursing Assistant (SRNA) #2, in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth. Resident #1 had been adjudicated legally incompetent by a court of law. Facility staff observed Resident #22 later that day at approximately 4:00 PM, touching and rubbing Resident #2's thigh. Review of the Nurses Notes revealed on 01/03/12, the facility discontinued the fifteen (15) minute checks. However, on 01/05/12 between 9:43 AM and 9:50 AM, Resident #22 was observed by the Kentucky State Agency Surveyor, rubbing Resident #29's left hand on his/her upper right thigh in the dining room on the locked unit during an activity while female residents were having their nails painted. There was one (1) Activity Aide in the room, sitting about ten (10) feet away, but within direct vision of the incident, with approximately twelve (12) residents. No other staff was observed in the area. Resident #22 was also observed rubbing on Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 backwards, by his/her arm while he/she was sitting in a Geri chair. The Kentucky State Agency Surveyor brought this incident to the attention of the Activity Aide when Resident #22 began pulling Resident #29 backwards. No staff	F 279	Nursing staff education on when a resident is identified as having sexual behaviors the care plan must be revised with specific interventions, the physician must be notified, and nursing will fill out social service notification form, when there is a behavior noted, this is a triplicate copy. The QI/ Staff Development Manager completed education on 1-17-12 which addressed behavior care plans as well as the development of all care plans, reviewing, revisions and interventions. One copy goes to social services, one to the social service director and one to the QAPI manager. Social services will track/trend resident behavior discussed during weekly focus. Patterns/trends noted will be followed up with physician notification and care plan specific interventions. MDS nurses/or designee will monitor compliance with the development of care plans and track and report through the QAPI meeting at a minimum of at least quarterly in the facility quarterly QAPI meeting, for a period of one year and reevaluate at that time.	

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

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F 279	<p>Continued From page 39</p> <p>was observed supervising/monitoring this resident to ensure no sexual behaviors were forced upon other residents.</p> <p>The facility failed to develop and implement interventions to ensure supervision and monitoring of Resident #22 in order to prevent and deny him/her access to thirty-two (32) cognitively impaired residents.</p> <p>Based on the above findings, it was determined the facility's failure to properly assess and develop a comprehensive plan of care related to a resident's sexual behaviors is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 01/12/12 and was determined to exist, on 12/25/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The State Agency verified IJ was removed prior to exit on 02/03/12, with remaining non-compliance at 42 CFR 483.20 Resident Assessment at a S/S of a "E", while the facility's Quality Assurance continues to monitor the development of Care Plans related to residents' behaviors.</p> <p>(Refer to F-323 and F-226)</p>	F 279	<p>Any modifications to the plan of care will be completed at the time in which they are identified by the interdisciplinary team.</p> <p>Social service director will audit for compliance. All findings will be reviewed and discussed quarterly in QAPI meeting. These findings will be reviewed and discussed at a minimum in the facility quarterly QAPI meeting. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	<p>Continued From page 40 The findings include:</p> <p>Review of the facility's policy titled "Care Conference-Interdisciplinary", revised 07/04, revealed the duties of all conference members were to assess resident's problems/needs, rehabilitation potential, educational needs and discharge plans. Continued review of the policy revealed the Minimum Data Set (MDS) Coordinator is responsible for ensure the comprehensive Plans of Care are implemented and maintained and responsible for reviewing all existing entries on care plans and revising as necessary. Further review revealed no documented evidence of who was responsible for developing the plan of care; however, interview with the Director of Nursing (DON), on 01/16/12 at 7:41 PM, revealed nursing should revise or develop a care plan when there was a behavior change or an acute problem developed.</p> <p>Review of the facility's policy titled, "Social Services. Preventing Resident Abuse", dated 12/2001, revealed all alleged allegations will be responded to through an investigation process. The policy detailed the facility would assess, care plan, and monitor residents with behaviors that may lead to conflict in order to assist in resolving behavior issues. It continued to state, the program included assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues.</p> <p>Review of the facility's policy titled, "Social Services. Resident-to-Resident Abuse", dated 12/2001, revealed the facility was to develop a plan of care that included interventions to prevent</p>	F 279		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102
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F 279	<p>Continued From page 41 the recurrence of such incident.</p> <p>Record review revealed the facility admitted Resident #22, on 09/13/10, with diagnoses which included Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/10/11, revealed the facility assessed the resident as being severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three (3), indicating severe impairment. On 01/13/12 at 11:27 AM, interview with Physician #1 revealed Resident #22 was not capable of making decisions.</p> <p>Interview with SRNA #5, on 01/06/12 at 9:00 AM, revealed she had cared for Resident #22 since 2010 and he/she had always made sexual comments. Interview with Licensed Practical Nurse (LPN) #1, on 01/07/11 at 4:58 PM, revealed she recalled Resident #22 unzipping his/her pants and exposing himself/herself several weeks ago. Interview with SRNA #1, on 01/04/12 at 1:16 PM, revealed when she provided care for Resident #22, he/she was often "touchy feely". Interview with SRNA #3, on 01/04/12 at 1:40 PM, revealed when she cared for Resident #22, he/she made sexual statements and gestures. Interview with LPN #3, on 01/13/12 at 12:16 PM, revealed she had heard Resident #22 making sexual remarks and hand gestures (as though he/she was touching his/her genitals).</p> <p>Interview with State Registered Nursing Assistant (SRNA) #2, on 01/06/12 at 9:47 AM, revealed on 12/25/11 at approximately 11:30 AM, she observed Resident #1 (adjudicated legally incompetent by a court of law) laying across the foot of the bed with his/her pants and pull-up</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 8 ASHLAND, KY 41102	
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F 279	<p>Continued From page 42</p> <p>(adult brief) pulled down below his/her knees. Resident #22 was observed by SRNA #2 behind Resident #1 touching his/her perineal area with his/her mouth and hands. SRNA #2 further stated she removed Resident #22 from Resident #1's room and told Licensed Practical Nurse (LPN) #2 what she had observed.</p> <p>Interview with LPN #2, on 01/05/12 at 12:42 PM, revealed she did not recall SRNA #2 reporting Resident #22's sexual behavior towards Resident #1, therefore a care plan was not initiated related to this behavior.</p> <p>Interview with LPN #1, on 01/07/12 at 4:58 PM, and interview with SRNA #2, on 01/08/12 at 10:00 AM, revealed they observed Resident #22, on 12/25/11 at approximately 4:30 PM, touching and rubbing Resident #2's upper leg. They further stated they redirected Resident #22 and encouraged him/her to stay with LPN #1 while she finished passing medication. LPN #1 continued to state that SRNA #2 informed her of a similar incident of sexual behavior with Resident #22 and Resident #1 earlier in the shift. Interview further revealed no care plan was developed and implemented to address Resident #22's sexual behaviors towards staff and residents despite the two incidents on 12/25/11.</p> <p>Review of the census report for 12/25/11 revealed there was a total of thirty-two (32) residents living on the locked Dementia Unit. Review of the facility's Roster Matrix revealed the facility assessed all thirty-two (32) residents residing on the locked Dementia Unit as having cognitive impairment.</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
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F 279	<p>Continued From page 43</p> <p>Review of the Care Plan revealed no documented evidence the facility developed a plan of care to address Resident #22's sexual behavior towards other residents after either incident. Continued review revealed the facility did not develop a care plan until 12/27/11 related to sexual behavior. Review of Resident #22's Plan of Care for sexual behaviors, dated 12/27/11, revealed the approaches to deal with the behavior were to tell the resident calmly and firmly that this behavior was not acceptable whenever it occurred. It further stated to separate from peers if behavior becomes offensive to them, take Resident #22 to his/her room and provide privacy, and to teach the resident about acceptable behavior. The Care Plan approaches further stated be non-judgmental when confronting negative behavior and establish consistent staff approaches to deal with problem. The facility did not detail what consistent staff approaches were to be provided to deal with the problem. There was no documented evidence of any increased supervision being implemented related to the resident's sexual behaviors towards other residents since 12/25/11, or to deny the resident access to other residents in order to prevent abuse recurrence.</p> <p>On 01/05/12 between 9:43 AM and 9:50 AM, Resident #22 was observed by the Kentucky State Agency Surveyor, rubbing Resident #29's left hand on his/her upper right thigh in the dining room on the locked unit during an activity while female residents were having their nails painted. There was one (1) Activity Aide in the room, sitting about ten (10) feet away, but within direct vision of the incident, with approximately twelve (12) residents. No other staff was observed in</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 279	<p>Continued From page 44</p> <p>the area. Resident #22 was also observed rubbing on Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 backwards, by his/her arm while he/she was sitting in a Geri chair. The Kentucky State Agency Surveyor brought this incident to the attention of the Activity Aide when Resident #22 began pulling Resident #29 backwards. No staff was supervising/monitoring this resident to ensure no sexual behaviors were forced upon other residents despite the facility's knowledge of the resident's history since 12/25/11.</p> <p>Interview with LPN #4, the Evening Weekend Supervisor and LPN #3, on 01/13/12 at 12:15 PM, revealed when asked about the accuracy of Resident #22's Comprehensive Care Plan they stated they thought the Social Services Worker or MDS Coordinator was responsible for developing the Care Plans. Interview with the Social Service Manager, on 01/14/12 at 12:48 PM, revealed behaviors were discussed in the weekly focus meetings; however, the facility did not track and trend individual resident behaviors and there was no specific behavioral management program. Based on the discussion in the weekly meeting about resident behaviors, care plans were developed.</p> <p>Interview with the Director of Nursing (DON), on 01/13/12 at 7:41 PM, revealed if nursing identified a change in behavior, then someone from nursing should have developed/updated a care plan to address the sexual behavior and put interventions in place to prevent further sexual behaviors.</p> <p>While the facility transferred Resident #22 to a</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 279	<p>Continued From page 45</p> <p>psychiatric facility on 01/05/12 the facility anticipated the resident's return on 01/16/12; however, review of the facility's training documentation and Resident #22's current Care Plan revealed no detailed evidence of action the facility would take to ensure adequate supervision and resident safety to prevent sexual abuse recurrence.</p> <p>Additionally, there was no documented evidence that the facility had attempted to identify other incidents of abuse/neglect through assessment of all residents of the unit. Interview with the SSM, who was responsible for conducting investigations and assessments, revealed that she had not assessed any other residents on the unit to identify other incidents of abuse.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the IJ effective on 01/21/12, based on the following:</p> <ol style="list-style-type: none"> 1) The Social Services Manager contacted all Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other knowledge of relevant safety concerns by 01/16/12. 2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/16/12. 3) All residents and their family members or 	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 279	<p>Continued From page 46</p> <p>healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12.</p> <p>4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/16/12. The resident was placed on one (1) to one (1) supervision.</p> <p>5) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p> <p>8) All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102
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F 279	<p>Continued From page 47 and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will become an annual requirement.</p> <p>12) All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12.</p> <p>On 02/03/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following:</p> <p>Observations, on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on one (1) supervision since returning from the Psychiatric Hospital.</p> <p>Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:55 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:05 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 279	<p>Continued From page 48</p> <p>on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Asslatant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:45 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes, the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety</p>	F 279		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 279	Continued From page 49 at the facility and the resident stated he/she felt safe. Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on-one (1) supervision.	F 279		
F 280 SS=E	The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented to ensure residents care plans are developed to address behaviors and while the facility develops and implements the Plan of Correction (POC). 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	All identified care plans for residents #10, #18, #22, #27, #14, #19, #5 have been corrected by the MDS/care plan team. All residents care plans in the facility have been reviewed for	3-13-12

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

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OMB NO. 0938-0391

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F 280	<p>Continued From page 50</p> <p>participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure Plans of Care were reviewed and/or revised for seven (7) of fifty-nine (59) sampled residents (Residents #10, #18, #22, #27, #14, #19 and #6). The facility failed to ensure care plan interventions were appropriate to the plan and the needs of the resident.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Conference-Interdisciplinary", revised 07/04, revealed the Minimum Data Set (MDS) Coordinator is responsible for ensuring comprehensive Plans of Care are implemented and maintained in a timely fashion. The policy</p>	F 280	<p>accuracy with problem, goal and specific approaches. Any errors/ glitches were removed by the MDS/care plan team.</p> <p>MDS/care plan team will review aloud each care plan in the care plan meeting which is held weekly on Wednesdays and Thursday and any other times as requested per resident/families and it will be audited for accuracy and specificity related to the problem, goal, and resident cognitive ability. A care plan audit form is being completed by the MDS team to also ensure care plans are revised as needed. The MDS nurses or designee will monitor compliance with the revision of care plans and track and report through the QAPI meeting at least quarterly. The MDS nurses will monitor through the QAPI meeting for 1 year and will re-evaluate at that time.</p> <p>This will be reviewed and discussed in the facility quarterly QAPI meetings by the MDS nurse.</p>	

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

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F 280	<p>Continued From page 51</p> <p>further indicated the MDS Coordinator is to review all existing entries on care plans and revise as necessary. Interview, on 01/13/12 at 4:00 PM, MDS Coordinator, revealed she was ultimately responsible for the Comprehensive Care Plans.</p> <p>1. Review of Resident #10's medical record revealed diagnoses which included Dementia, Contractures, and Urinary Incontinence. Review of the Annual-Minimum Data Set (MDS) Assessment completed on 03/10/11 and Quarterly MDS dated 11/17/11, revealed the facility assessed Resident #10 as being at risk for Pressure Ulcers and as being incontinent of bowel and bladder. Continued review of the record revealed documentation dated 12/04/11, that stated the resident had a Stage II Pressure Ulcer to his/her coccyx. In addition, the resident was noted to have contractures to his/her bilateral hands, bilateral knees, and left foot.</p> <p>Review of the Comprehensive Care Plan, dated 03/11/11, revealed an "At risk for skin breakdown due to high risk". There was no documented evidence the Care Plan had been updated to include Resident #10's Pressure Ulcer discovered on 12/04/11 or of interventions for the treatment of the Pressure Ulcer. Additionally, this care plan included an intervention for scheduled toileting every two (2) hours; however, interview, on 01/13/12 at 10:22 AM, with State Registered Nursing Assistant (SRNA) #18 revealed Resident #10 was incontinent of bowel and bladder and was not on a scheduled toileting program. Interview, on 01/13/12 at 9:52 AM, with Licensed Practical Nurse (LPN) #11 revealed Resident #10 was not on a scheduled toileting program. She</p>	F 280	<p>The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 280	<p>Continued From page 52</p> <p>stated the resident's care plan should have been updated to include the current Stage II Pressure Ulcer and the treatment ordered.</p> <p>Interview, on 01/13/12 at 4:15 PM, with Minimum Data Set (MDS) Nurse #10 revealed the scheduled toileting every two (2) hours was not appropriate for Resident #10 and should have been deleted from the Comprehensive Care Plan for risk for skin breakdown. Additionally, she stated she should have updated the Comprehensive Care Plan to include Resident #10's current Stage II Pressure Ulcer to his/her coccyx.</p> <p>2. Review of Resident #18's medical record revealed diagnoses which included Dementia, and Congestive Heart Failure. Review of the Annual MDS Assessment, completed on 11/08/11, revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) scores of 11, which indicated Resident #18 had a moderately impaired cognitive status. Further review of this MDS revealed the facility assessed the resident to have no skin conditions. Continued review of the record revealed on 01/03/12 the resident had developed a "boil like" area on his/her left buttock.</p> <p>Review of the Comprehensive Care Plan, dated 01/03/12, revealed a problem of "Alteration in skin integrity d/t (due to) boil-like area to left buttock" with a goal that stated "skin tear will heal without s/s (signs and symptoms) infection by 01/14/12".</p> <p>Interview, on 01/13/12 at approximately 5:30 PM, with Licensed Practical Nurse (LPN) #3 revealed the area was not a skin tear as indicated in the</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 280	<p>Continued From page 53</p> <p>goal of the Comprehensive Care Plan. She stated she did not think the care plan should have skin tear in the goal, as the area was a pimple-like area.</p> <p>Interview, on 01/13/12 at 4:15 PM, with LPN #7 who was an MDS Nurse revealed she had forgotten to alter the resident's care plan related to the goal stating "skin tear" will heal by 01/14/12. She stated the goal should have referenced the area as "boil-like" area.</p> <p>3. Review of the medical record revealed the facility admitted Resident #22 on 09/13/10, with diagnoses which included Dementia, Left Humeral Fracture and Chronic Heart Failure.</p> <p>Review of the Quarterly MDS Assessment, dated 11/10/11, revealed the facility assessed the resident as being severely cognitively impaired with a Brief Interview of Mental Status (BIMS) score of three (3), indicating severe impairment.</p> <p>Review of Resident #22's Comprehensive Plan of Care, dated 12/27/11, revealed the resident had a care plan for inappropriate behaviors. Further review revealed an intervention to teach the resident about appropriate behaviors.</p> <p>Interview with the Social Services Worker, on 01/13/12 at 3:23 PM, revealed this was an inappropriate intervention as Resident #22 had significant cognitive impairment and would be unable to benefit from education.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 and the Evening Weekend Supervisor #4, on 01/13/12 at 12:15 PM, revealed Resident #22</p>	F 280		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
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OMB NO. 0938-0391

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F 280	<p>Continued From page 54</p> <p>would be unable to learn from education due to his/her cognitive impairment.</p> <p>4. Review of Resident #27's medical record revealed diagnoses which included Parkinson's Disease and Diabetes Mellitus. Review of the Annual MDS Assessment, completed on 12/26/11, revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) scores of 15, which indicated Resident #19 was cognitively intact. Further review of the MDS revealed the facility assessed the resident to have a surgical wound and no other skin conditions.</p> <p>Review of the Comprehensive Care Plan, dated 12/26/11, revealed a problem entitled "Discomfort r/t (related to) rash scrotum" with an intervention that stated "encourage resident not to touch or scratch ears".</p> <p>Interview, on 01/14/12 at 6:10 PM, with the Director of Nursing (DON) revealed the approach to encourage the resident not to touch or scratch his/her ears was not an appropriate intervention. The DON stated she did not know what the rash on the resident's scrotum had to do with his/her ears. In addition, she stated it must be a "glitch" in the facility's system.</p> <p>5. Review of Resident #14 's medical record revealed diagnoses which included Congestive Heart Failure. Review of the Significant Change MDS Assessment, completed on 09/15/11 and Quarterly MDS dated 12/01/11, revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) scores of 3, which indicated the resident had severely</p>	F 280		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 280	<p>Continued From page 55 impaired cognitive status.</p> <p>Review of the Comprehensive Care Plan, dated 12/08/11, revealed "...exhibits sexually inappropriate behavior" that included an approach to administer treatment to wound as ordered. Additional review of the Comprehensive Care Plan revealed a care plan for "episodes of combative behavior", with an approach to administer treatment to wound as ordered.</p> <p>Interview, on 01/13/12 at 4:15 PM, with MDS Coordinator revealed the approach to administer treatment to wound as ordered was a "glitch" in the system and should have been "errored out".</p> <p>6. Review of Resident #19's medical record revealed diagnoses which included Dementia and Psychotic Disorder. Review of the Significant Change MDS Assessment, completed on 09/12/11, revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) scores of 10, which indicated Resident #19 had a moderately impaired cognitive status.</p> <p>Review of the Comprehensive Care Plan, dated 12/27/11, revealed "Resident has episodes of inappropriate sexual behaviors" with an intervention that stated to administer tx (treatment) to wound as ordered.</p> <p>Interview, on 01/13/12 at 4:15 PM, with the MDS Coordinator revealed the intervention on Resident #19's inappropriate sexual behavior care plan, to administer treatment to wound as ordered, should have been errored out as it was a "glitch" in the system.</p>	F 280		

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

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OMB NO. 0938-0391

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F 280	<p>Continued From page 56</p> <p>7. Review of the clinical record revealed the facility admitted Resident #5 on 11/29/11 with diagnosis which included Anxiety Disorder.</p> <p>Review of the Significant Change MDS Assessment, completed on 12/28/11, revealed the facility assessed the resident to have Brief Interview for Mental Status (BIMS) score of 15, which indicated Resident #5 was not cognitively impaired.</p> <p>Review of the Comprehensive Care Plan, dated 12/29/11, revealed Resident #5 had, "alteration in sleep patterns including insomnia", with an intervention listed, "administer tx (treatment) to wound as ordered".</p> <p>Record review of weekly skin assessments revealed no evidence of any areas of skin breakdown, ulcerations or wounds.</p> <p>Interview with Resident #5, on 1/11/12 at 10:06 AM, during an observation of the resident's skin assessment revealed Resident #5 had no areas of skin breakdown, skin ulcers or wounds.</p> <p>Interview, on 01/13/12 at 4:00 PM, with the MDS Coordinator, revealed she is ultimately responsible for the comprehensive care plans. She further stated she had reviewed every care plan in the building, including Resident #5's, but not in detail.</p> <p>Interview with MDS Coordinator, on 01/13/12 at 4:15 PM, revealed the intervention, "administer tx to wound as ordered", on the residents' comprehensive plan of care was an error. She further stated she was unaware that the</p>	F 280		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 280	Continued From page 67 Intervention was listed on the residents' care plans and it was a "glitch" in the system and printed out on the residents' care plans by mistake.	F 280		
F 314 SS=D	483.26(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents who enter the facility without pressure sores did not develop pressure sores for one (1) of fifty-nine (59) sampled residents (Resident #6). The findings include: Interview, on 01/14/12 at 12:00 PM, with the QA/Staff Development Nurse revealed the facility had a system for weekly head-to-toe skin assessments performed by nursing staff. She stated State Registered Nursing Assistants (SRNAs) were to view the residents' skin in between for any new areas of concern. The SRNAs were to report any findings to the nurses. According to the QA/Staff Development Nurse	F 314	Resident #6 received physician orders for aloe vera and to float the elbow. The resident is on a special turning and repositioning program, which ensures that residents who need to be on a turning and repositioning program are placed on one to prevent skin breakdown if none noted and prevent further skin breakdown if it already exists and to monitor and re-evaluate the effectiveness of the program according to schedule and make changes as needed. The wound care nurse contacted the physician on 1-11-12. All residents house-wide had a head to toe weekly nursing assessment completed. The house wide assessments were completed by the charge nurse on each unit on 1-17 and 1-18-12, and 1-22-12 dealing with a code protect being issued. However a weekly head to toe assessment are completed on every resident every week by the charge nurse on	3-13-12

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

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F 314	<p>Continued From page 58</p> <p>any new areas would have treatment obtained and would be care planned. The QA/Staff Development Nurse stated audits were being performed by the Wound Care Nurse.</p> <p>Review of Resident #6's medical record revealed diagnoses which included Cerebral Palsy, Quadriplegia, and placement of a Percutaneous Gastrostomy (PEG) tube. Review of the Annual Minimum Data Set (MDS) Assessment, dated 06/16/11 and the Significant Change MDS dated 11/24/11 revealed the facility assessed the resident as being at risk for developing Pressure Ulcers.</p> <p>Review of the Comprehensive Care Plan, dated 06/21/11, revealed a care plan that noted the resident was at risk for skin breakdown. Interventions included to "monitor skin condition daily during routine care". Review of the Resident Weight Record revealed on 01/05/12, Resident #6's weight was documented at 74.2 pounds. Review of the Weekly Skin Assessment, dated 01/10/12 revealed no documented evidence of redness or skin break down was noted.</p> <p>Observation, on 01/11/12 at 9:42 AM, of a skin assessment performed by the Wound Care Nurse revealed Resident #6 had a dark red non-blanchable area on his/her right elbow that measured 0.3 centimeters (cm) by 0.6 cm.</p> <p>Interview, on 01/11/12 at 9:50 AM, with the Wound Care Nurse during the skin assessment revealed he was not aware of this area prior to performing the skin assessment. He stated the area observed on Resident #6's right elbow was a</p>	F 314	<p>the particular unit. No other residents were found to have skin areas.</p> <p>A new skin check sheet has been put into place for SRNA's on all shifts to document if a resident has a noted alteration in skin integrity or bruise noted. The SRNA puts a "C" in the box to refer to communication tool.</p> <p>(SRNA to Nurse) The SRNA puts an "X" in the box if no new skin areas are present. The nurse will check the skin check sheet every shift. The nurse will follow up on all skin areas of concern noted on the SRNA to nurse communication tool.</p> <p>The communication tool is a duplicate copy. One copy goes to the charge nurse for notification and intervention necessary the other copy goes to Resident Care Manager (RCM) for follow-up to ensure charge nurse addressed skin concerns as needed. Once RCM reviews copy goes to QAPI manager. RCM will monitor and audit for compliance. QAPI manager will randomly audit compliance quarterly and report findings in QAPI meetings.</p>		

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

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F 314	Continued From page 59 Stage I Pressure Ulcer and he would notify the Physician for treatment orders. Continued observation, on 01/11/12 at 10:30 AM, revealed the area on Resident #6's right elbow continued to be dark red and was observed as the same size as the earlier observation. Interview, on 01/12/11 at 10:20 AM, with State Registered Nursing Assistant (SRNA) #12 revealed she was caring for Resident #6 on 01/11/12 and had not been aware of the Stage I Pressure Ulcer on his/her right elbow. She stated the resident was turned every two (2) hours, sometimes more frequently but she did not inspect all areas of the resident's skin. Review of the Physician's orders revealed an order, dated 01/11/12 at 10:00 AM, for Aloe Vesta to a Stage I on the right elbow and keep the elbow floated. Interview, on 01/12/11 at 10:25 AM, with Registered Nurse (RN) #4, the Resident Care Manager on the unit on which Resident #6 resided, revealed he was unaware of the Stage I Pressure Ulcer to the resident's right elbow until it was reported to him by the Wound Care Nurse. He stated the nursing assistants were good about reporting any skin issues, however this area had not been reported.	F 314	The QAPI committee will monitor at least quarterly, these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time. All staff education on systemic changes on 1-18-12 by Stephanie Hicks, RN, QI/Staff Development Manager.	
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services	F 322	The formula hanging was not connected to the resident via gastrostomy tube. Order indicated that formula was not to be running at that time. Upon notation of the formula hanging in the room it was discarded immediately.	3-13-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 322	<p>Continued From page 60</p> <p>to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure the use of tube feeding hang time recommendations to prevent excessive microbial growth for one (1) of fifty-nine (59) sampled residents (Resident #6). The facility failed to follow its policy related to proper hang times for Resident #6's tube feeding which was observed hanging for seventy-five (75) hours.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Enteral Feeding System", dated 12/01, revealed formula in a closed system may hang up to thirty-six (36) hours.</p> <p>Review of Resident #6's medical record revealed diagnoses which included Cerebral Palsy, Quadriplegia, and placement of a Percutaneous Gastrostomy (PEG) tube. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 11/24/11, revealed the facility assessed the resident to have a feeding tube and to require total dependence on staff for all Activities of Daily Living (ADLs). Further review of the record revealed an order for Resident #6's Jevity 1.5 tube feeding to run at forty (40) cc (cubic centimeters) per hour for eighteen (18)</p>	F 322	<p>QI/Staff Development Manager provided nursing staff education on proper hang time of tube feedings to prevent excessive microbial growth. An audit was conducted on all residents in house with current orders for tube feeding to verify facility staff are following tube feeding hang time by nursing administration. On 1-26-12 an audit was completed by Ashley Miller, RN on the six residents in the facility on tube feedings to ensure that all was in compliance. The audit includes checking the residents name, room number, formula, cc/hr, #hrs (infusing and infusing at the proper feeding times), HOB up, bottle labeled, spike dated, pump set correct, pump cleaned, syringe dated, order correct, MAR correct, weekly weights done. Education was completed in a nurses meeting on 2-24-12 by the staff development/quality manager and the following was discussed: Tube feeding totals must be completed every night. Tube feeding formula can hang only for 36 hours, per facility policy.</p>	

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

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F 322	Continued From page 61 hours per day. The tube feeding was to be off every day from 8:00 AM to 2:00 PM. Observation, on 01/10/12 at 9:51 AM, during the initial tour of the facility revealed Resident #6 had a closed system bottle of Jevity 1.5 tube feeding hanging with a date of 01/07/12 and timed 8:00 AM with approximately one hundred and fifty (150) milliliters left in it. Further observation revealed the tube feeding was not running. According to the time and date on the bottle, the closed system tube feeding formula had been hanging for greater than seventy-five (75) hours. Interview, on 01/13/12 at 6:35 PM, with the Resident Clinical Manager (RCM) revealed the bottle of tube feeding dated 01/07/12 was past due to be changed. He stated it should have been changed within thirty-six (36) hours per facility policy as it was a closed system.	F 322	per facility policy. After this it must be thrown away in order to prevent microbial growth. There will be an audit conducted weekly by nursing supervisor to verify compliance with tube feeding recommendations. Audits /findings will be reviewed and discussed in the facility QAPI meeting quarterly. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.		
F 323 SS=K	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review it was determined the facility failed to ensure residents' safety through	F 323	1. Resident #22 was placed on Q15 minute checks on 12-25-11 to 1-3-12. Resident #22 was then placed on Q15 minute checks on 1-5-12 and was sent out later on 1-5-12 for a psychiatric evaluation and hospitalized. Resident #22 returned on 1-16-12 and was immediately placed on 1:1 staff supervision. On 2-5-12 resident #22 was sent out for behavioral health evaluation and was admitted. Resident returned on	3-13-12	

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

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F 323	<p>Continued From page 62</p> <p>monitoring and supervision. The facility failed to ensure adequate supervision was provided to prevent resident to resident sexual abuse. The facility failed to adequately assess Resident #22's inappropriate sexual history and failed to develop and implement a Plan of Care to address Resident #22's sexual behaviors that would be effective in managing the resident's behaviors and protecting other residents of the facility. On 12/25/11, at approximately 11:30 AM State Registered Nursing Assistant (SRNA) #2 observed Resident #22 in Resident #1's room, Resident #1's pants and pull-up were pulled down below his/her knees while the resident was laying across the foot of the bed on his/her stomach and Resident #22 was behind Resident #1 touching Resident #1's perineal area with his/her hands and mouth. Later on 12/25/11, staff observed Resident #22 touching and rubbing Resident #2's thigh. On 01/05/12, Resident #22 was observed inappropriately touching and kissing Resident #29's arm and attempting to pull the resident backwards in his/her Geri chair. The facility failed to identify the incidents as abuse and failed to identify Resident #22's behavior as a risk to the other thirty-two (32) cognitively impaired residents on the locked Dementia Unit. The facility failed to implement interventions to ensure residents' safety and failed to provide adequate supervision to protect residents and prevent recurrence of sexually inappropriate behaviors towards residents. Additionally, the facility failed to identify other incidents of abuse/neglect through the assessment of all residents of the unit after 12/25/11 to ensure adequate supervision was provided to protect residents from further abuse.</p> <p>Based on the above findings, it was determined</p>	F 323	<p>2-9-12 and was immediately placed on 1:1 staff supervision. Resident was referred to a long term behavioral health facility for potential placement at this time. On 2-14-12 resident #22 had 1:1 staff supervision discontinued due to a decline in overall health condition. Resident #22 was placed on palliative care at this time. Resident #22 expired on 2/24/12.</p> <p>Staff received education on 1-18-12 in regards to the 7 components of abuse, abuse definitions, types of abuse, identifying signs and symptoms of abuse that staff should recognize as such, immediate procedures for suspected abuse and a new suspected abuse communication reporting form which has implemented. Administrative staff and clinical leadership received training on 1-20-12 on the impact of mental capacity and the determination of abuse. All staff completed a competency validation on abuse and neglect and the new "Code Protect" system.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(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 323	<p>Continued From page 63</p> <p>the facility's failure to properly assess and implement a plan of care to ensure adequate supervision for Resident #22 and to protect other residents from further abuse recurrence is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) were identified on 01/12/12 and was determined to exist on 12/25/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The State Agency verified IJ was removed prior to exit on 02/03/12, with remaining non-compliance at 42 CFR 483.25 Quality of Care at a S/S of a "E", while the facility's Quality Assurance continues to monitor Administration's oversight in the facility's system to ensure adequate supervision to prevent accidents.</p> <p>In addition the facility failed to ensure a safe environment by failing to ensure the Soiled Utility Closet which contained hazardous chemicals was locked.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Incident/Accident Reports, Resident", dated 09/2006, revealed an incident is defined as an</p>	F 323	<p>A revised social services, resident abuse policy was put in place which addressed the immediate procedures for suspected abuse which includes placing any residents involved in suspected abuse. February all staff education includes preventing, recognizing and reporting abuse by the facility on-line training program. As well the facility will conduct a monthly training on abuse, overseen by the facility staff development educator. The nursing staff will notify social services of any behaviors via the social service notification form, to implement interventions and follow-up as necessary. All staff will be mandated to pass the competency on abuse and neglect and the new "Code Protect" annually. A house wide psychosocial and physical assessment will be conducted when an instance of suspected abuse is noted. All referrals to the facility are screened by the admissions office for any unmanaged high risk behaviors.</p>		

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

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F 323	<p>Continued From page 64</p> <p>unusual or unexpected event that is not consistent with the routine operation of the facility or the routine care of the resident. It continued to state, this includes every incident that occurs involving a resident, visitor, volunteer, other non-employee or employee.</p> <p>Review of the facility's policy titled, "Social Services. Resident-to-Resident Abuse", dated 12/2001, revealed the facility was to develop a plan of care that included interventions to prevent the recurrence of such incident.</p> <p>Record review revealed the facility admitted Resident #22, on 09/13/10, with diagnoses which included Dementia, Hypertension, Chronic Heart Failure, Left Humeral Fracture and a history of a Right Humeral Fracture. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/10/11, revealed the resident was assessed as being severely cognitively impaired with a Brief Interview for Mental Status (BIMS) score of three (3). Further review revealed no documented evidence the facility assessed Resident #22 for sexually inappropriate behaviors. Review of Resident #22's Comprehensive Care Plan, last revised on 11/22/11 revealed no documented evidence the facility developed a plan of care to ensure adequate supervision related to sexual behaviors.</p> <p>Interview with SRNA #5, on 01/06/12 at 9:00 AM, revealed she had cared for Resident #22 since 2010 and he/she had always made sexual comments. Interview with Licensed Practical Nurse (LPN) #1, on 01/07/11 at 4:58 PM, revealed she recalled Resident #22 unzipping his/her pants and exposing himself/herself</p>	F 323	<p>To monitor performance, the facility will utilize our quarterly QAPI meeting. Audits will be conducted to verify a 1:1 staff supervision was put in place anytime a suspected abuse is reported.</p> <p>Audits will also be conducted on the social service notification form to verify if behavior noted warranted increased staff supervision and staff compliance with policy and protocol by the social service director. These audit findings will be discussed and reported in the quarterly QAPI meeting by the social service director.</p> <p>All residents house-wide had a head to toe weekly nursing assessment completed. The house wide assessments were completed on 1-17 and 1-18-12, and 1-22-12 dealing with a code protect being issued by the nurses on the particular units. However a weekly head to toe assessment are completed on every resident every week by the charge nurse on the particular unit.</p>	
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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 65</p> <p>several weeks ago. Interview with SRNA #1, on 01/04/12 at 1:15 PM, revealed when she provided care for Resident #22, he/she was often "touchy feely". Interview with SRNA #3, on 01/04/12 at 1:40 PM, revealed when she cared for Resident #22, he/she made sexual statements and gestures. Interview with LPN #3, on 01/13/12 at 12:15 PM, revealed she had heard Resident #22 making sexual remarks and hand gestures (as though he/she was touching his/her genitals).</p> <p>Interview with SRNA #2, on 01/06/12 at 9:47 AM, revealed on 12/25/11 at 11:30 AM, she observed Resident #1 (adjudicated legally incompetent) laying across the foot of the bed on his/her stomach with his/her pants and pull up pulled down below his/her knees. Resident #22 was observed by SRNA #2 behind Resident #1 touching Resident #1's perineal area with his/her mouth and hands. SRNA #2 further stated she removed Resident #22 from Resident #1's room and told Licensed Practical Nurse (LPN) #2 what she had observed. She continued to state LPN #2 laughed and said did you remove him/her from Resident #1's room to which she replied yes. She cleaned Resident #22 and then left him/her at the nurses station and went back to clean Resident #1. Interview with SRNA #6, on 01/05/12 at 10:22 AM, revealed she was at the Nurse's station and heard SRNA #2 tell LPN #2 she had observed Resident #22 in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth. Interview with LPN #2, on 01/05/12 at 12:37 PM, revealed she had not initiated any special monitoring or supervision for Resident #22 or Resident #1 and had not done any physical assessments of either resident or Resident #1's roommate. Record review</p>	F 323	<p>The social service department completed psychosocial assessments on 1-17 and 1-18-12, and 1-22-12 due to a code protect being issued. 2. The facility had a professional locksmith install locks and customize keys for all parlor, and kitchen doors, biohazard doors, and soiled utility doors throughout the facility. The secure unit has a clean storage utility room behind the nursing station. This door was locked when staff noted it unlocked during survey. All clean utility doors are being keyed the same throughout the facility and will remain locked when not in use. All items found in the soiled utility on the "200 unit" were removed. There will be a daily audit by environmental services conducted verifying that doors are locked that should be. There will be a daily environmental audit conducted by environmental services that checks all resident rooms when cleaned for any items in the room that could be potentially harmful such as chemicals, sprays, etc. If such items are found, they are removed immediately and family/poa is notified to please pick up.</p>	
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F 323	<p>Continued From page 68</p> <p>revealed no documented evidence the facility staff notified Administration, the Director of Nursing or Social Services of the incident even though review of the facility's Social Services Resident Abuse Policy, dated 09/2008, detailed all Abuse allegations must be immediately reported to the facility Administrator and the Social Services Manager.</p> <p>Interview with SRNA #4, on 01/05/12 at 9:36 AM, revealed he came to work on 12/25/11 at 2:30 PM and was told Resident #22 was in Resident #1's room with his/her face between Resident #1's legs. He further indicated LPN #1 was present. Further interview revealed he was in charge of providing care to Resident #22 on 12/25/11 and there were no special checks initiated on the resident while he was working and his shift ended at 11:00 PM.</p> <p>Interview with SRNA #5, on 01/06/12 at 9:00 AM, revealed she came to work at 6:30 PM on 12/25/11 and SRNA #2 told her she had observed Resident #22 in Resident #1's room. She stated SRNA #2 told her Resident #1's pants and pull-up were down and Resident #22 was touching Resident #1's perineal area with his/her hands and mouth. She further stated she was not aware of any special monitoring being put into place for Resident #22 or Resident #1.</p> <p>Interview with LPN #1, on 01/07/12 at 4:58 PM, revealed LPN #2 had told her nothing in report about the incident with Resident #22 and Resident #1. LPN #1 further stated there was no special monitoring for Resident #22 or Resident #1 initiated during her shift and there were no physical assessments of either residents or</p>	F 323	<p>A letter was mailed to current residents and placed in admission paperwork for new admits addressing areas for families to assist us in maintaining compliance in regards to keeping rooms free of chemicals, cleaners, etc.</p> <p>All resident wheelchairs in the facility are checked for proper function and need for repairs on a monthly basis by the maintenance department. Any items needing repairs will be repaired or replaced. The maintenance manager will track this in the facility quarterly QAPI meeting. A change in condition will be placed with nursing shift report. This form will list the resident name, condition that needs monitored and followed up with documentation. The documentation guidelines will be attached for quick review. Areas to be followed up on for documentation include: falls, new pain, accidents, etc. The form will be revised on a weekly and/or as needed basis by each Resident Care Manager.</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102
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F 323	<p>Continued From page 67</p> <p>Resident #1's roommate completed during her shift.</p> <p>Further interview with SRNA #2 and LPN #1 revealed they had observed Resident #22 touching and rubbing Resident #2's thigh between 4:00 PM and 4:30 PM. It wasn't until after this incident that SRNA #2 informed LPN #1 of the previous incident with Resident #22 and #1 that had occurred that same date. LPN #1 revealed she did not take action related to either incident occurring with Resident #22 until 8:30 PM, when she notified the Weekend Supervisor of the incidents.</p> <p>Interview with the Evening Weekend Supervisor, on 01/05/12 at 3:24 PM, revealed she was doing her rounds, on 12/26/11 between 10:00 PM and 10:30 PM when she was told about the incident with Resident #22 and Resident #1. She stated she then called the Day Weekend Supervisor because she had received nothing in report from him and he had stated he knew nothing about the incident and then she called SRNA #2 and asked her what had happened and she stated she had found Resident #22 in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth, she said she had separated the residents and told the Nurse. The Evening Weekend Supervisor stated she then called LPN #2 who said she had not been told about the incident. She stated then she called the Assistant Director of Nursing (ADON) and Social Services. She stated the facility began fifteen (15) minute checks at 11:00 PM for Resident #22, twelve (12) hours after the incident.</p> <p>Review of Resident #22's Comprehensive Care</p>	F 323	<p>Nursing supervision will utilize this form to conduct routine weekly audits on follow up documentation completed by the staff nurses. A monthly audit will be completed by the RN manager/designee to verify that all safety devices, appliances, etc. that are ordered for the resident are on the SRNA flow record and are in use in the resident room. The RN manager/designee will report at least quarterly in QAPI to ensure compliance. The pharmacy will conduct two medication pass audits to ensure safety and prevention of hazards related to side effects of medication, any potential for adverse side effects and the preparation and administration of medications. The findings from these audits will be reviewed in the facility QAPI meeting by the facilities consultant pharmacist at least quarterly.</p> <p>The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	

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

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F 323	<p>Continued From page 68</p> <p>Plan revealed there was no Care Plan developed to address the resident's sexual behaviors until 12/27/11, two (2) days after the incidents involving Residents #22, #1 and #2. Review of Resident #22's Plan of Care for sexual behaviors, dated 12/27/11, revealed the facility had implemented several approaches to deal with the behavior which were to tell the resident calmly and firmly that this behavior was not acceptable whenever it occurred. It further stated to separate from peers if behavior becomes offensive to them, take Resident #22 to his/her room and provide privacy and to teach the resident about acceptable behavior. The Care Plan detailed staff was to be non-judgmental when confronting negative behavior and establish consistent staff approaches to deal with the problem; however, further review revealed the care plan did not detail what consistent approaches staff was to provide to deal with the problem. There was no documented evidence of any increased supervision being implemented related to the resident's sexual behaviors towards residents, nor interventions to deny Resident #22 access to other residents of the facility to ensure their safety and to prevent further recurrence of abuse.</p> <p>Review of the Nurses Notes revealed on 01/03/12 the facility discontinued the fifteen (15) minute checks. On 01/5/12, between 9:43 AM and 9:50 AM, Resident #22 was observed by the Kentucky State Agency Surveyor, rubbing Resident #29's left hand on his/her upper right thigh in the dining room on the locked unit during an activity while female residents were having their nails painted. There was one (1) Activity Aide in the room, sitting about ten (10) feet away, but within direct</p>	F 323		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 69</p> <p>visual field of the incident, with approximately twelve (12) residents. No other staff was observed in the area. Resident #22 was also observed rubbing on Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 backwards, by his/her arm while he/she was sitting in a Geri chair. The Kentucky State Agency Surveyor brought this incident to the attention of the Activity Aide when Resident #22 began pulling Resident #29 backwards. No staff was supervising/monitoring this resident to ensure no sexual behaviors were forced upon other residents despite the facility's knowledge of the resident's sexually inappropriate behavior history since 12/25/11.</p> <p>Interview with Activities Assistant #33, on 02/02/12 at 2:16 PM, revealed she observed Resident #22 holding Resident #29's arm and stating "you're coming with me". She further stated had she observed Resident #22 kissing Resident #29's arm and hand and rubbing Resident #29's hand on Resident #22's leg she would have separated them immediately.</p> <p>Interview with the ADON, on 01/06/12 at 11:45 AM, revealed the facility had disciplined LPN #2, as she was the Charge Nurse on 12/25/11 and it was LPN #2's responsibility to have reported the incident between Resident #22 and Resident #1 to Administration.</p> <p>Interview with the Social Services Manager and Director of Nursing (DON), on 01/11/12 at 10:00 AM, revealed the facility's investigation did not determine abuse had occurred and it was determined the facility's failure existed secondary</p>	F 323		

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

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OMB NO. 0938-0391

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F 323	<p>Continued From page 70</p> <p>to the failure of LPN #2 to report the incident with Resident #22 and Resident #1. These staff stated they believed the residents had a right to have sex because those desires did not recede due to their cognition. However, record review revealed Resident #22 was assessed by the facility to have cognitive impairment. Interview with Resident #22's Power of Attorney, on 01/13/12 at 9:50 AM, revealed while the facility had previously informed him of the resident's increased sexual behaviors the resident was incapable of making decisions. Interview with Resident #22's Physician, Physician #1, on 01/13/12 at 11:27 AM, revealed he believed Resident #22 was unable to make decisions and did not have the cognitive ability to act willfully. Furthermore, Resident #1 was assessed by the facility to have cognitive impairment and had been adjudicated legally incompetent, with a court appointed guardian. Furthermore, interview with Resident #1's Guardian, on 01/12/12 at 6:40 PM, revealed if Resident #1 was in his/her right mind, this incident would not have occurred. She further stated Resident #1 was incapable of making decisions and she, as the resident's guardian, had given no permission for Resident #1 to perform sexual acts.</p> <p>Interview with the Administrator, on 01/14/12 at 4:12 PM, revealed he did review the investigation of the incident and determined LPN #2 not reporting the incident immediately to her supervisor was the failure; however, the facility could not provide evidence that they had identified the facility's failure to deny Resident #22 and #1 access to other residents to prevent further incidence or recurrence of potential sexual abuse. The Administrator was unable to provide</p>	F 323		

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

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F 323	<p>Continued From page 71</p> <p>evidence the facility adequately supervised or monitored Resident #22 and #1 after the incident which occurred on 12/25/11 at 11:30 AM to ensure the safety and well-being of other residents. Review of the census report for 12/25/11 revealed a total of thirty-two (32) residents living on the locked Dementia unit. Review of the facility's Roster Matrix revealed all thirty-two (32) residents residing on the locked Dementia unit were assessed as having cognitive impairment.</p> <p>Due to the facility's lack of supervision and monitoring, approximately five (5) hours later, Resident #22 inappropriately touched and rubbed Resident #2's thigh. Again, twelve (12) days later, there was no evidence the facility was adequately supervising or monitoring Resident #22 when Resident #22 was observed rubbing on Resident #29's left arm and kissing up and down Resident #29's arm and hand and Resident #22 was observed pulling Resident #29 by his/her arm while he/she was sitting in a Geri chair in the dining room of the locked unit during an activity which a staff member was leading.</p> <p>Even though the facility transferred Resident #22 to a psychiatric facility on 01/05/12 the facility anticipated the resident's return on 01/16/12; however, review of the facility's training documentation and Resident #22's current Care Plan revealed no detailed evidence of action the facility would take to ensure adequate supervision and resident safety to prevent sexual abuse recurrence.</p> <p>Additionally, there was no documented evidence that the facility had attempted to identify other</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102
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F 323	<p>Continued From page 72</p> <p>Incidents of abuse/neglect through assessment of all residents on the unit. Interview with the Social Service Manager, on 01/14/12 at 12:46 PM, who was responsible for conducting investigations and assessments, revealed that she had not assessed any other residents on the unit to identify other incidents of abuse. Therefore this failure to identify other incidents of abuse prevented the facility from assessing, developing and implementing necessary supervision that would be required to protect the residents of the locked unit.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the IJ effective on 01/21/12, based on the following:</p> <ol style="list-style-type: none"> 1) The Social Services Manager contacted all Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other knowledge of relevant safety concerns by 01/16/12. 2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/16/12. 3) All residents and their family members or healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12. 	F 323		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 323	<p>Continued From page 73</p> <p>4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/16/12. The resident was placed on one (1) to one (1) supervision.</p> <p>5) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p> <p>8) All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 74</p> <p>policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will become an annual requirement.</p> <p>12) All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12.</p> <p>On 02/03/12, it was verified the immediacy of the L was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following;</p> <p>Observations; on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on one (1) supervision since returning from the Psychiatric Hospital.</p> <p>Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:55 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:05 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3 on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Assistant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:45 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff</p>	F 323			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 166449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 323	<p>Continued From page 76</p> <p>Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes, the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety at the facility and the resident stated he/she felt safe.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed</p>	F 323		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 323	<p>Continued From page 76</p> <p>the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on one (1) supervision.</p> <p>2. Observation during initial tour of the facility, on 01/10/12 at 10:05 AM, revealed the 'Soiled Utility' room on the 200 Unit was unlocked. Further observation revealed the room contained a bottle of Sanizide Plus Germicidal Solution, a container of PDI Sani-Dex ALC Antimicrobial Alcohol Gel Hand Wipes, and a paint can closer with a sharp edge.</p> <p>Review of the Sanizide Plus Germicidal Solution Material Safety Data Sheet (MSDS), dated 06/01, revealed exposure to this product may cause irritation to the upper respiratory tract if inhaled; burning and redness to the eyes if eye contact; skin irritations if contact with the skin; and if ingested may cause gastrointestinal irritation, nausea, vomiting and diarrhea.</p> <p>Review of the Material Safety Data Sheet (MSDS), dated 04/25/06, revealed PDI Sani-Dex</p>	F 323			

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 77</p> <p>ALC Antimicrobial Alcohol Gel Hand Wipes had the potential to cause moderate eye irritation; prolonged inhalation was irritating to the eyes and the respiratory tract and may cause headaches and dizziness, and other central nervous system effects; and if ingestion, get medical help or contact the Poison Control Center immediately.</p> <p>Observation, on 01/12/12 at 7:50 PM, revealed Resident #19, who the facility had assessed as being cognitively impaired wheeled herself/himself behind the nursing station on the 200 Unit where the unlocked Oxygen Storage/Soiled Utility Room was located.</p> <p>Interview, on 01/10/12 at 10:10 AM, with Registered Nurse (RN) #1 revealed the door was to be locked at all times because there were cognitively impaired residents who resided on the 200 Unit. Additional interview revealed staff must get a key from the nurse in charge to unlock the door.</p> <p>Interview, on 01/10/12 at 10:11 AM, with State Registered Nursing Assistant (SRNA) #9 revealed the 'Soiled Utility' room door was never locked and he had never had to obtain a key to unlock the door.</p> <p>Interview, on 01/10/12 at 10:12 AM, with SRNA #10 revealed she had never had to ask for a key to enter the 'Soiled Utility' room because she "just walked right in" when she needed to enter the room.</p> <p>The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency</p>	F 323		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	Continued From page 78 with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented to ensure residents are adequately supervised to prevent accidents and while the facility develops and implements the Plan of Correction (POC).	F 323			
F 333 SS=D	483.26(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure one (1) of fifty-nine (59) sampled residents, Resident #55, was free of significant medication error which may cause the resident discomfort or jeopardize his/her health and safety when the resident was given the wrong medication via the wrong route. The findings include: Review of the facility's policy, titled "Medication Administration (General)", dated 02/2002, revealed medications are to be administered according to the five (5) rights of medication administration including the right patient and the right route. Further review of the policy revealed a resident that is Nothing Per Oral (NPO) are not to receive medications by mouth. Record review revealed the facility admitted Resident #55 on 06/23/03 with Diagnosis which	F 333	Resident #55 was noted to actually spit out the ativan pill. Resident #55 was ordered medications via g-tube, but was not made NPO until 12-19-11. The LPN who administered the medication to bed A versus bed B received disciplinary action and education on the 5 rights of medication administration on 12-12-11 by Pam Pennington, LPN Supervisor. No other residents were affected or identified by deficient practices at this time. All resident identification labels on the wall next to the room are being changed to reflect a letter (A) or (B) next to the residents name. Along with a (L) or (R) to represent the bed on the left or the right. Nursing staff have been educated on resident bed on the left is (A) bed and right is (B) bed and the (L) and (R).	3-13-12	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 333	Continued From page 79 included Delirium, Esophageal Reflux, Cerebral Vascular Accident (CVA), and Aspiration. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 01/10/12, revealed the facility assessed the resident as having severe impairment in cognitive skills, and requiring total assistance with all Activities of Daily Living (ADLs). Record review of Resident #55 Physician's Orders revealed the resident was made NPO related to risk for aspiration. Record review of the facility Medication Error Report, revealed on 12/12/11 LPN #16 gave Resident #55 the wrong medication via the wrong route. Interview with Licensed Practical Nurse (LPN) #16, on 02/01/12 at 12:00 PM, revealed she was working with another nurse who asked her to give the resident in bed B Ativan (which is a class three (3) narcotic used for anxiety) 1 mg per oral (po). She further stated she got confused and gave the resident in bed A the medication. Interview with Registered Nurse (RN) #2, on 02/01/12 at 1:00 PM, revealed she was the unit supervisor the day the medication error occurred. She further stated LPN #16 failed to identify the right resident, the right medication, and the right route before she administered the medication. Interview with the Director Of Nursing, on 02/01/12 at 2:00 PM, revealed LPN #16 received written disciplinary action because of the incident.	F 333	Pharmacy will conduct 2 medication pass audits per month along with any random audits as requested to ensure that residents are free from significant medication errors. The pharmacist consultant will track this through the QAPI at meeting at least quarterly for a period of one year and will re-evaluate at that time. The activity department will audit every resident room identification label for accuracy and the photograph on the chart according to the MDS/ care plan schedule of admission, quarterly, annually, and significant change of status. All findings will be reviewed and discussed in the facility quarterly QAPI meetings. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time. The milk was not served to any resident at 50 degrees Fahrenheit. It was replaced with milk of appropriate temperature. A formal process has been put in place to check point of service temperature in the facility of resident food.	
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides	F 364		3-13-12

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F 364	<p>Continued From page 80</p> <p>food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide food served at the proper temperature related to point of service milk temperature of fifty (50) degrees Farenheit.</p> <p>The findings include:</p> <p>During the Quality of Life Assessment Group Interview, conducted on 01/10/12 at 3:10 PM, residents voiced foods were not always served at palatable temperatures.</p> <p>Observation of a test tray, on 01/12/12 at 6:35 PM, revealed an individual beverage carton of milk to be fifty (50) degrees Farenheit for point of service.</p> <p>Interview with the Dietary Cook #19, on 01/10/12 at 6:30 PM, revealed there was no formal process to check point of service temperatures in the facility of resident food.</p> <p>Record review revealed no documented evidence that point of service temperatures were routinely monitored throughout the facility.</p> <p>Interview with the Dietary Manager, on 01/12/12 at 6:45 PM, revealed cold food point of service for milk should be colder than forty two (42) degrees</p>	F 364	<p>The policy on point of service temperatures has been revised to include that dietary manger/ designee will conduct 3 checks weekly on point of service temperature.</p> <p>The dietary staff have been educated on the policy revision, point of service temperature, infection control practices and complete review of F364 and F371. Education provided by dietary manager and overseen by the facility staff development educator.</p> <p>Dietary manager/designee will randomly monitor 3 trays per week at various times for point of service temperatures. The dietary staff has been educated on the point of service temperatures and process for monitoring them. The dietary staff have been educated on placing the milk in the frøezer 30-40 minutes prior to tray line. Staff, date, time, and initial on form when milk is put in and taken out of the freezer. Dietary manager will conduct audits on compliance of milk being put in to the freezer at appropriate times. Dietary manager will track point of service temperatures for temperature that</p>	

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F 364	Continued From page 81 Farenheit. Further interview revealed to ensure the temperature remained below forty two (42) degrees Farenheit, milk was placed in the freezer for thirty (30) to forty (40) minutes prior to tray line. The Dietary Manager stated the temperature would be near twenty-eight (28) degrees Farenheit if left in the freezer for thirty (30) to forty (forty) minutes and would therefore be below forty two (42) degrees Farenheit at point of service. Continued interview revealed on 01/12/12, the milk did not remain in the freezer for an adequate amount of time during the evening meal tray line preparation prior to be sent out on the unit, which resulted in the temperature at point of service being fifty (50) degrees Farenheit.	F 364	do not fall within accepted parameters three times a week. Any foods that have temperature beyond accepted parameters will not be served to residents. All findings will be reported, by the Dietary Manager/designee and reviewed and discussed in the facility QAPI meeting at least quarterly. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.		
F 371 SS=F	483.36(b) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to prepare and distribute food under sanitary conditions as evidenced by grease build-up on an oven and improper glove changing and hand washing during resident meal service.	F 371	The sticky substance along the side of the single oven and range and the larger oven and range and the oven door of the smaller range and oven has been removed on 1-10-12. The dietary staff, including DA #20, cook #19, DA #22, and DA #21, have been educated on proper infection control practices and handwashing and cross-contamination by the dietary manager and overseen by the staff development/QI manager on 2-23-12. Complete review of F371 and F364 were also reviewed.	3-13-12	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 371	Continued From page 82 The findings include: Observation, on 01/10/12 at 8:22 AM, revealed a sticky substance with food particles imbedded in it along the side of the single oven and range and the larger oven and range. Continued observation revealed the substance was thick, blackish/brownish in color and was also noted to be around the oven door of the smaller range and oven. Interview, on 01/10/12 at 8:22 AM, with the Dietary Manager revealed the substance appeared to be grease; it needed to be cleaned and could potentially attract pests. Observation, on 01/10/12 at 4:30 PM, revealed Dietary Aide (DA) #20 rubbed her nose and readjusted her glasses before continuing on resident tray line. Interview, on 01/10/12 at 6:26 PM, with DA #20 revealed she should have washed her hands after touching her glasses before continuing to plate silverware on resident trays. Observation, on 01/10/12 at 4:35 PM, revealed Cook #19 rubbed under her nose and continued to plate residents' food on tray line without washing her hands or changing her gloves. Observation, on 01/10/12 at 4:50 PM, revealed Cook #19 rubbed the corner of her eye with her right pointer finger and did not change gloves or wash hands prior to continuing to plate residents' food on tray line.	F 371	The above mentioned areas are deep cleaned on a weekly basis and as needed. A professional de-greaser company services the kitchen every six months. A daily audit will be conducted to check for grease, dirt, food particles, etc by the dietary manager or designee. If any areas are found needing to be cleaned in between routine cleaning it will be addressed immediately. A daily observation will be conducted at various times with the dietary staff ensuring compliance with infection control practices by the dietary manager or designee. Any deficient practice will be immediately addressed and corrected. The QI/Staff Development Manager tracks facility infections and monitors trends and patterns in the weekly focus meeting, no trends or patterns were identified by the deficient practice. These finding will be reviewed and discussed in the facility quarterly QAPI meeting by the dietary manager.	

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

PRINTED: 02/17/2012
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F 371	<p>Continued From page 83</p> <p>Interview, on 01/10/12 at 6:27 PM, with Cook #19 revealed she should have washed her hands prior to donning new gloves before continuing on tray line to reduce the risk of cross contamination.</p> <p>Observation, on 01/10/12 at 6:38 PM, revealed DA #22 rubbed her hands on her pants, changed her gloves and failed to wash her hands prior to donning new gloves.</p> <p>Interview, on 01/10/12 at 6:25 PM, with DA #22 revealed she should have washed her hands when she changed her gloves to reduce the risk of cross contamination.</p> <p>Observation, on 01/10/12 at 5:45 PM, revealed DA #21 wiped off food which had been spilled on the top of the serving line. Continued observation revealed she changed her gloves; however, she failed to wash her hands prior to replacing her gloves.</p> <p>Observation, on 01/10/12 at 5:55 PM, revealed DA #21 opened the storage room door and came back out with milk from the cooler. Continued observation revealed she mixed mash potatoes and heated them in the microwave. Further observation revealed she returned to resident tray line, picked up the plates and insulated bottoms and distributed them to Cook #19 for residents' food to be plated without washing her hands or changing gloves.</p> <p>Interview, on 01/10/12 at 6:28 PM, with DA #21 revealed she should have washed her hands when she changed her gloves before continuing on resident tray line to reduce the risk of cross contamination.</p>	F 371	<p>The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>

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

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F 441 SS=E	<p>489.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p>The IV poles and IV pump were immediately removed from the clean utility room. The feeding pumps were removed from the clean utility room immediately. The above items were disinfected properly covered with plastic bags and placed in the clean utility.</p> <p>Nursing staff were educated on awareness of touching hands to face/other body parts during feeding. Staff education to wash hands anytime this occurs prior to resuming feeding. This was done by Stephanie Hicks, RN, QI/Staff Development on 1-17-12 and 1-18-12.</p> <p>Nursing supervision will conduct random observation of meal times weekly for one year and will re-evaluate at that time. Any SRNA observed not following infection control practices will be immediately re-educated and corrected.</p> <p>Nursing supervision will conduct daily audits on verifying only clean/sanitized items are in the clean supply room. The facility Infection Control Program is overseen by the QI/ Staff Development Manager,</p>	3-13-12

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

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F 441	Continued From page 85 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies, it was determined the facility failed to maintain and Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. The facility failed to ensure dirty equipment was stored separately from clean resident equipment and failed to ensure staff used proper hand sanitation during the meal service. The findings include: 1. Review of the facility's policy titled 'Equipment and Department Cleaning and Maintenance', dated April 2009, revealed each piece of equipment is to be cleaned with a surface disinfectant before each patient use and staff must be sure it is in good condition prior to use and that all dirty equipment is to be taken to the soiled utility room for housekeeping to clean and sanitize. Furthermore, any items may be cleaned as needed at any time by any staff member. Once cleaned and sanitized, housekeeping will take clean equipment and place in clean utility room. Each item cleaned will be covered with a plastic bag to notify staff it has been cleaned. Observation, on 1/10/12 at 10:30 AM, during initial tour of the Shoreline Unit revealed four (4) intravenous poles (IV) and one (1) IV pump was in the 'Oxygen/Clean' room. The items were not	F 441	Stephanie Hicks, RN. All nurses are trained in infection control guidelines upon new hire orientation and annually at a minimum. Before admission, residents are screened for any potential infections. This is then communicated to the nursing staff through the admission paperwork to implement the appropriate transmission based precautions. Once a resident is admitted to the facility, any nosocomial infections are noted by the charge nurse on the infection notification form and education for any necessary transmission based precautions is passed along to the staff via education conferences. The QI/ Staff Development Manager then checks these on a daily basis to monitor for any new infections and reports findings in the weekly focus meeting. On a weekly basis a monitoring/tracking and identification report is completed. A monthly review is conducted as well. Any patterns or trends identified are then reviewed on a daily, weekly, and monthly basis as needed and corrective actions taken immediately.	

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

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F 441	<p>Continued From page 86 covered with a plastic bag.</p> <p>Interview, on 01/10/12 at 10:30 AM, with RN #1 revealed IV poles and pumps should not be in the 'Oxygen/Clean' room until cleaned by housekeeping and covered with plastic bags to let staff know they have been sanitized and ready for use.</p> <p>Observation, on 01/10/12 at 1:20 PM, revealed the 'Oxygen/Clean' room on the Gardenview Unit had two (2) feeding pumps that were not covered in plastic.</p> <p>Interview, on 01/10/12 at 1:20 PM, with LPN #11 revealed the feeding pumps should not be stored in the clean room until they have been sanitized by housekeeping as evidenced by covering the pumps with a plastic bag to let staff know they were clean and ready for use.</p> <p>2. Observation, on 01/11/12 at 12:33 PM, revealed State Registered Nursing Assistant (SRNA) #7 was feeding an Unsampled Resident. Further observation revealed she rubbed her nose with her right hand and continued to feed the resident with her right hand.</p> <p>Interview with SRNA #7, on 01/11/12 at 1:00 PM, revealed SRNA #7 should have washed her hands after rubbing her nose before continuing to feed the resident his/her meal.</p> <p>Observation, on 01/11/12 at 12:36 PM, revealed SRNA #8 was feeding an Unsampled Resident. Continued observation revealed she rubbed her ear with her right hand and continued to feed the resident with her right hand.</p>	F 441	<p>These audits will be reviewed and discussed in the facility QAPI meetings quarterly by the QAPI manager. The QAPI committee will monitor these areas to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>		

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

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F 441	Continued From page 87	F 441		
F 490 SS=K	<p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to be administered in a manner which enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical well-being of each resident, related to provision of care. The facility failed to ensure abuse and care plan policies and procedures were followed by staff. The facility failed to develop and implement a behavior management program to ensure residents' behaviors that could lead to conflict were assessed, care planned and monitored. The facility's administration failed to ensure residents' safety in regards to adequate supervision and monitoring, and failed to ensure the residents' environment remained as free of accident hazards as possible. The facility had been knowledgeable of Resident #22's history of</p>	F 490	<p>The facility will be administered in a manner that enables it to use its resources effectively and efficiently to attain the highest practicable physical, mental, and psychosocial well-being of each resident by the following: The Administrator/designee will oversee the QAPI meeting and the QI/Staff Development manager to ensure systemic compliance with the QAPI meeting and facility practices effectively and efficiently. Social Service Notification Form (This form is used to enhance better communication and monitoring of residents behaviors and managing their care more effectively with nursing and the social services departments.) Social Service Daily Rounds, observing resident mood and behaviors. Review and revision of abuse policies by administration. Review and revision of care plan policies by administration.</p>	3-13-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 490	Continued From page 88. sexually inappropriate behaviors towards other residents since 12/25/11; however, failed to assess, care plan and monitor Resident #22 related to these sexual behaviors in order to deny the Resident's access to other residents. On 12/25/11, a State Registered Nursing Assistant (SRNA) found Resident #22 in Resident #1's room. Resident #1's pants and pull-up (adult brief) were pulled down below his/her knees, and Resident #22's mouth and hands were noted to be touching Resident #1's perineal area. On that same date, facility staff observed Resident #22 inappropriately touching Resident #2. The facility failed to report the incidents timely to the Administrator and Social Services, failed to initiate an investigation timely and failed to deny the perpetrator access to residents. On 01/05/12, the Kentucky State Agency Surveyor observed Resident #22 inappropriately touching and kissing Resident #29's arm and attempting to pull the resident backwards in his/her Geri chair. The surveyor had to notify the facility staff of the situation, as no staff was observed monitoring Resident #22. The facility failed to identify the incidents as abuse and failed to identify Resident #22's behavior as a risk to the other thirty-two (32) cognitively impaired residents on the locked Dementia Unit. The facility failed to implement interventions to ensure residents' safety and failed to provide adequate supervision to protect residents and prevent recurrence of sexually inappropriate behaviors towards residents. Additionally, the facility failed to identify other incidents of abuse/neglect through the assessment of all residents of the unit after 12/25/11 to ensure adequate supervision was provided to protect residents from further abuse.	F 490	Review and revision of abuse training by administration. Monthly abuse education overseen by staff development. Tracking and trending of behaviors in weekly focus meetings by social services. Review and revision of "Code Protect" system by administration. Daily stand-up meeting discussion with all departments. Education with interdisciplinary team on behavior management program by the QAPI manager. All residents with behavior symptoms will receive an individualized care plan and/or program designed to address behavioral symptoms by the interdisciplinary care plan team. The facility QAPI team will review and discuss all findings in the quarterly meeting. If systems are deemed ineffective the QAPI team will reevaluate the system and implement changes as necessary to ensure systematic approaches are in place to ensure safety, choices, resident rights and quality of care.		

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

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F 490	<p>Continued From page 89</p> <p>Based on the above findings it was determined the facility's failure to have an effective system in place to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently was likely to cause serious injury, harm, impairment, or death: Immediate Jeopardy was identified on 01/12/12, was determined to exist on 12/25/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The state agency verified IJ was removed prior to exit on 02/03/12, with remaining non-compliance at 42 CFR 483.75 Administration at a S/S of a "E", while the facility's Quality Assurance continues to monitor Administration's oversight in the facility's system to ensure adequate assessment, identification and implementation of it's system for supervision to prevent accidents.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Social Services, Resident Abuse", dated 09/2008, revealed all residents had the right to be free of verbal, sexual, physical, and mental abuse. Additionally, the policy stated all abuse allegations were to be reported immediately to Administration and Social Services. Further review revealed while the investigation is being conducted, accused</p>	F 490	<p>The QAPI manager will ensure QAPI program is in compliance by conducting random audits and ensuring all departments have completed all audits and any patterns or trends have been identified and plans of action are put in place. Any identified areas of concerns will be followed up with the facility administrator. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>		

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

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F 490	<p>Continued From page 90</p> <p>individuals will be denied unsupervised access to residents.</p> <p>Review of the facility's policy titled, "Social Services. Reporting Abuse to Facility Management", dated 12/2001, revealed employees must report any suspected abuse or incidents of abuse to the Director of Nursing and/or Director of Social Services.</p> <p>Review of the facility's policy titled, "Social Services. Preventing Resident Abuse", dated 12/2001, revealed all alleged allegations will be responded to through an investigation process. The policy detailed the facility would assess, care plan, and monitor residents with behaviors that may lead to conflict in order to assist in resolving behavior issues. The program included assessing residents with signs and symptoms of behavior problems and developing and implementing care plans that can assist in resolving behavioral issues. Review of the facility's policy titled "Care Conference-Interdisciplinary", revised 07/04, revealed the duties of all conference members were to assess resident's problems/needs, rehabilitation potential, educational needs and discharge plans. Further review revealed no documented evidence of who was responsible for developing the plan of care; however interview with the Director of Nursing (DON), on 01/13/12 at 7:41 PM, revealed nursing should revise or develop a care plan when there was a behavior change or an acute problem developed.</p> <p>Interview with the Social Service Manager, on 01/14/12 at 12:46 PM, revealed the facility had weekly focus meetings where behaviors were</p>	F 490		

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

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F 490	<p>Continued From page 91</p> <p>discussed; however the facility did not track and trend individual resident behaviors and there was no specific behavioral management program. Based on the discussion in the weekly meeting about resident behaviors, care plans were developed. Interview with the Administrator, on 01/14/12 at 4:12 PM, revealed it was his understanding the facility monitored behaviors by typically documenting behaviors in the medical record and he believed Social Services monitored resident behaviors.</p> <p>Interview with SRNA #5, on 01/08/12 at 9:00 AM, revealed she had cared for Resident #22 since 2010 and he/she had always made sexual comments. Interview with Licensed Practical Nurse (LPN) #1, on 01/07/11 at 4:58 PM, revealed she recalled Resident #22 unzipping his/her pants and exposing himself/herself several weeks ago. Interview with SRNA #1, on 01/04/12 at 1:15 PM, revealed when she provided care for Resident #22, he/she was often "touchy feely". Interview with SRNA #3, on 01/04/12 at 1:40 PM, revealed when she cared for Resident #22, he/she made sexual statements and gestures. Interview with LPN #3, on 01/13/12 at 12:15 PM, revealed she had heard Resident #22 making sexual remarks and hand gestures (as though he/she was touching his/her genitals).</p> <p>Interviews revealed on 12/25/11, at approximately 11:30 AM Resident #22 was observed in Resident #1's room whose pants and pull-ups (adult brief) were pulled down. Resident #22 was observed touching Resident #1's perineal area with his/her hands and mouth. Per interview with two (2) SRNA's, Licensed Practical Nurse (LPN) #2 was notified of this incident. Additionally, on 12/25/11</p>	F 490		

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

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F 490	<p>Continued From page 92</p> <p>at approximately 4:00 PM, Resident #22 touched Resident #2's legs and LPN #1 separated Resident #22 from Resident #2. Record review revealed no documented evidence the facility staff "immediately notified" the Administrator, Social Services, and the Director of Nursing. Interview, on 01/14/12 at 3:10 PM, with the Administrator revealed he was not notified of the incident with Resident #22 and Resident #1 immediately on 12/25/11 as per the facility's policy and procedure, but was notified later that evening. (Refer to F-226)</p> <p>Additionally, staff interviews (LPN #1 and #2) revealed the facility did not implement increased supervision or measures to deny Resident #22 (the perpetrator) access to other residents of the facility. Further interview with the Administrator revealed no interventions were implemented until 11:00 PM, approximately twelve (12) hours after the first incident. There was no documented evidence the facility supervised or denied Resident #22 access to other residents from 11:30 AM on 12/25/11 until 11:00 PM that evening when fifteen (15) minute checks were implemented. However, with fifteen (15) minute checks the facility did not follow the policy by not denying Resident #22 access to other residents (Refer to F-226, F-279, and F-323). Additionally, a care plan was not developed for the resident's sexual behaviors until 12/27/11, two days after the two incidents. Furthermore, the care plan did not address supervision of Resident #22 in order to protect other residents of the facility from further abuse.</p> <p>The Director of Nursing and Social Services revealed, on 01/11/12 at 10:00 AM, that the</p>	F 490		

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102		
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F 490	<p>Continued From page 93</p> <p>findings of their investigation determined that abuse had not occurred because neither resident was resistant to the acts and the residents had a right to have sex because those desires did not recede due to their cognition. However, record review revealed Resident #1 had been adjudicated incompetent by a court of law and appointed a guardian. Interview with the resident #1's Physician revealed that legally Resident #1 could not make decisions for him/herself. Record review for Resident #22 revealed he/she was assessed and determined cognitively impaired. Interview with Resident #22's Physician revealed Resident #22 could not make decisions for him/herself and could not act with willful intent. Thus, neither resident, per Physician interviews, Guardian interview and record review, were capable of making decisions for themselves in order to give consent for sexual relations. However, the facility's investigation failed to identify neither resident could give consent; therefore had a finding that no abuse had occurred. The facility proceeded to discontinue fifteen (15) minutes checks for Resident #22 on 01/03/12 with no specific care plan documenting behavior management interventions to address Resident #22's history of sexually inappropriate behaviors since 12/25/11.</p> <p>On 01/05/12, the Kentucky State Agency Surveyor observed Resident #22 inappropriately touching and kissing Resident #29's arm and attempting to pull the resident backwards in his/her Geri chair. The Surveyor had to notify the facility staff of the situation, as the one activity aide staff leading the activity, who was sitting about ten (10) feet away and in direct visual field of the incident, did not intervene. No other staff</p>	F 490		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 490	<p>Continued From page 94</p> <p>member was observed monitoring Resident #22. There was no documented evidence that the facility identified Resident #22's behavior as a risk to the other thirty-two (32) cognitively impaired residents on the locked Dementia Unit. This failure prevented the facility from developing and implementing effective interventions to ensure residents' safety and prevented the facility from providing adequate supervision and protection for the residents in an effort to prevent recurrence of sexually inappropriate behaviors towards residents.</p> <p>Additionally, there was no documented evidence the facility had attempted to identify other incidents of abuse/neglect through assessment of all residents of the unit. Interview with the Social Services Manager, who was responsible for conducting investigations and assessments, revealed that she had not assessed any other residents on the unit to identify other incidents of abuse.</p> <p>Further interview with the Administrator, on 01/14/12 at 4:12 PM, revealed he did review the investigation of the incident and determined the facility's failure was in LPN #2 not reporting the incident immediately to her supervisor. The Administrator informed staff to put Resident #22 on one (1) to one (1) supervision after he was notified of the incident. While Nurses Notes revealed multiple entries of documentation stating staff was providing one to one supervision of Resident #22, interviews with staff revealed only one staff person, SRNA #6, on 12/26/11 provided one to one supervision during day shift. The facility could provide no other evidence that one to one supervision was being carried out.</p>	F 490			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 95</p> <p>Interview with the Administrator, on 01/14/12 at 4:12 PM, revealed the Administration provided oversight for the facility by participating in the daily stand-up meeting or through informal discussions. He stated there was no system in place to follow-up on issues with the facility or residents other than having follow-up meetings.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the IJ effective on 01/21/12, based on the following:</p> <ol style="list-style-type: none"> 1) The Social Services Manager contacted all Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other knowledge of relevant safety concerns by 01/16/12. 2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/16/12. 3) All residents and their family members or healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12. 4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/16/12. The resident was placed on one (1) to one (1) supervision. 	F 490			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	<p>Continued From page 98</p> <p>6) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p> <p>8). All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will</p>	F 490		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 97 become an annual requirement. 12). All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12. On 02/03/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following; Observations, on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on one (1) supervision since returning from the Psychiatric Hospital. Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:55 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:05 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3 on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Assistant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:45 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes, the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response	F 490		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 490	<p>Continued From page 98</p> <p>protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety at the facility and the resident stated he/she felt safe.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with</p>	F 490		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 490	Continued From page 99 the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on one (1) supervision. The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented to ensure the facility's Administration provides oversight and while the facility develops and implements the Plan of Correction (POC).	F 490		
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to obtain laboratory services to meet the needs of its residents for one (1) of fifty-nine (59) sampled residents. Resident #26 had a blood specimen drawn to obtain a B-Natriuretic Peptide (BNP) level used to	F 502	Resident #26 had a STAT BNP obtained on 1-14-12. Results obtained and addressed by medical doctor. All resident labs in the facility have been reviewed to ensure accuracy by the Resident Care Managers on 2-24-12. New protocol for routine ordered labs requisition form in place: midnight shift nurse will fill out demographic information on form.	3-13-12

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

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FORM APPROVED
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F 502	<p>Continued From page 100</p> <p>evaluate heart failure. Laboratory service couriers failed to pick-up the specimen which resulted in a re-draw which was processed as a Basic Metabolic Panel (BMP) instead of a BNP as ordered. A BMP is a general blood test used as a screening tool which measures sugar (glucose) level, electrolyte and fluid balance, and kidney function.</p> <p>The findings include:</p> <p>Review of the clinical record revealed the facility admitted Resident #26 on 12/01/11 with diagnoses which included Pulmonary Hypertension, Coronary Artery Disease, Heart Failure, and Cardiomyopathy (deterioration of the heart muscle).</p> <p>Review of the Physician's Order Sheet and Progress Notes, dated 01/05/12, revealed Resident #26 had swelling in both legs. Review also revealed an increase in a diuretic (used to reduce swelling and fluid retention) medication and an order for "BNP in AM".</p> <p>Review of the Nurses Notes, dated 01/06/12 at 2:05 PM, revealed blood specimen was obtained from Resident #26 without difficulty. Resident tolerated the procedure well. Pressure (to the site of the blood draw) applied.</p> <p>Review of the Physician's Order Sheet and Progress Notes, dated 01/06/12, revealed the order to "Redraw BNP on 01/07/12".</p> <p>Interview with Registered Nurse (RN) #5, on 01/14/12 at 6:30 PM, revealed the lab had apparently failed to pick up the specimen on</p>	F 502	<p>Day shift nurse obtaining the lab will verify the physician order, the lab calendar and mark the appropriate lab to be drawn on the requisition form. Nursing supervision will audit all labs daily for accuracy and verification of receipt of results for a period of one year and will re-evaluate at that time.</p> <p>These findings will be reviewed in the facility QAPI quarterly meeting. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>	

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

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F 502 F 520 SS=K	<p>Continued From page 101 01/06/12 which resulted in a redraw the following day.</p> <p>Interview with the Unit Manager, on 01/14/12 at 6:45 PM, revealed the facility failed to write BNP as the Physician ordered and instead wrote BMP on the Laboratory Manifest Log. This transcription error resulted in the incorrect laboratory test requisition being generated. Therefore Resident #26 never received the diagnostic laboratory test (BNP) as ordered.</p> <p>483.75(o)(1) QAA COMMITTEE MEMBERS/MEET QUARTERLY PLANS</p> <p>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.</p> <p>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.</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>	F 502 F 520	<p>The facility Quality Assurance Process has been revised to "QAPI" (Quality Assurance/ Performance Improvement). The program is ongoing, comprehensive and includes a full range of departments. The QAPI team meets quarterly at a minimum to monitor the deficient practice. The best available evidence will be used to define and measure goals.</p> <p>A systematic approach will be utilized to ensure safety, choices, resident rights and quality of care. Both are audit driven quality assurance process and performance improvement projects will be utilized to efficiently maintain and obtain the highest practicable physical, mental and psychosocial well-being of each resident.</p>	3-13-12

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 520	<p>Continued From page 102</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Plan of Correction (POC) with a compliance date of 12/10/10, it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality deficiencies. This was evidenced by repeated deficiencies related to the facility's failure to implement it's Abuse Policies, failure to ensure Comprehensive Plans of Care were reviewed and/or revised, failure to ensure services were provided in accordance with residents' Comprehensive Plan of Care, failure to ensure residents who enter the facility without pressure sores did not develop pressure sores, failure to ensure residents received adequate supervision and monitoring to ensure residents' safety, failure to ensure there was an effective Infection Control Program, and failure to ensure accurate maintenance of clinical records.</p> <p>Based on observation, Interview, record review and review of the facility's policies, it was determined the facility failed to ensure three (3) of fifty-nine (59) sampled residents, Residents #1, #2 and #29, were free from sexual abuse related to the facility's failure to follow it's Abuse Policies to ensure residents' safety through assessment, care planning and monitoring behaviors that lead to conflict; failed to report abuse to the Administration and Social Service Manager; and failed to deny the perpetrator unsupervised access to residents. State Registered Nursing Assistant (SRNA) #2 observed Resident #22 in</p>	F 520	<p>All departments plans of corrections and current practices will be randomly audited for compliance by the facility QAPI manager and or designee.</p> <p>The QAPI manager will ensure the QAPI program is in compliance by conducting random audits and ensuring all departments have completed all audits and any patterns or trends have been identified and plans of action are put in place. Any identified areas of concern will be followed up with the facility administrator/designee. The QAPI committee will monitor these areas at least quarterly to ensure that the deficient practice does not recur for one year and the QAPI committee will re-evaluate at that time.</p>		

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

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F 520	<p>Continued From page 103</p> <p>Resident #1's room touching Resident #1's perineal area with his/her hands and mouth on 12/25/11 at 11:30 AM. Resident #1 had been adjudicated legally incompetent and incapable of making decisions for him/herself. Facility staff observed Resident #22 later that day, at approximately 4:00 PM, touching and rubbing Resident #2's thigh. On 01/05/12 at 9:50 AM, a Kentucky State Agency Surveyor observed Resident #22 rubbing Resident #29's left hand on his/her upper right thigh in the dining room and was observed rubbing Resident #29's left arm and kissing up and down his/her arm and hand. Resident #22 was then observed pulling Resident #29 by his/her arm while he/she was sitting in a Geri chair. No staff was monitoring Resident #22's behavior, despite the resident's sexual history beginning 12/25/11, in order to prevent recurrence of sexual abuse. The facility allowed Resident #22 access to thirty-two (32) cognitively impaired residents without establishing an effective behavior management policy and implementing effective supervision of Resident #22 to deny access to the residents of the facility and to prevent further abuse. Furthermore, the facility failed to identify other incidents of abuse/neglect through assessment of all residents of the unit after the 12/25/11 incident. (Refer to F-226)</p> <p>Based on the above findings, it was determined the facility's failure to ensure it's Quality Assurance identified and implemented appropriate plans of action to correct identified quality deficiencies; failure to follow it's abuse policies by failing to assess, implement a care plan and monitor a resident with a known history of sexual behavior since 12/25/11; failure to</p>	F 520		

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

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FORM APPROVED
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
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F 520	<p>Continued From page 104</p> <p>report sexual abuse immediately to administration; failure to deny the perpetrator access to other residents; and failure to provide adequate supervision to prevent further abuse recurrence is likely to cause serious injury, harm, impairment or death to a resident. Immediate Jeopardy (IJ) was identified on 01/12/12 and was determined to exist on 12/25/11.</p> <p>After quality review conducted by the State Agency and the Center for Medicare and Medicaid Services (CMS) it was determined the investigation required reopening to gather additional information. The Survey was reopened for further investigation from 01/30/12 through 02/03/12. An acceptable credible Allegation of Compliance (AOC) for the removal of IJ was received on 01/23/12 with the facility alleging removal of IJ on 01/21/12. The State Agency verified Immediate Jeopardy was removed prior to exit on 02/03/12, with remaining non-compliance at 42 CFR 483.75 Administration at a S/S of a "E", while the facility's Quality Assurance continues to monitor.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Based on observation, interview and record review, it was determined the facility failed to implement it's Abuse policies. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10. <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed nursing staff was to be educated on the Abuse Policies. Nursing staff was to be educated by the Staff Development Coordinator regarding all</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
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F 520	<p>Continued From page 105</p> <p>alleged abuse violations must be reported immediately to their supervisor who in turn would report to facility Administration. The Nursing Supervisor was to make rounds every shift to inquire of Charge Nurses about any incidents, including but not limited to, alleged abuse violations. This information was to be reported to Administration who would then report to the State Agency immediately.</p> <p>During the current survey interviews revealed Resident #22, who had a known history of sexual abuse towards staff, was observed by a State Registered Nursing Assistant (SRNA) to be in Resident #1's room touching Resident #1's perineal area with his/her hands and mouth on 12/25/11 at 11:30 AM. Later that day, at approximately 4:00 PM, Resident #22 was observed by staff touching and rubbing Resident #1's thigh. Staff failed to immediately report the alleged abuse to the facility's Administration as per facility policy.</p> <p>Interview with SRNA #2, who observed the alleged sexual abuse on 12/25/11, revealed he/she reported the incident to Licensed Practical Nurse (LPN) #2. Interview with SRNA #1 revealed he/she had witnessed SRNA #2 informing LPN #2 of the incident. Interview with LPN #2 revealed she did not recall the SRNA reporting the alleged sexual abuse to her, therefore the incident was not reported immediately to facility Administration as per facility policy.</p> <p>Interview with the Assistant Director of Nursing (ADON) revealed LPN #2 was disciplined for not reporting the alleged sexual abuse immediately</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 520	<p>Continued From page 106</p> <p>as per the facility's policy. Interview with the Social Services (SS) Manager and Director of Nursing (DON) revealed the facility determined the facility's failure existed related to LPN #2's failure to report the incident involving Resident #22 and Resident #1. (Refer to F-226)</p> <p>2. Based on observation, interview and record review, it was determined the facility failed to ensure Comprehensive Plans of Care were reviewed and/or revised. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed nursing staff was to be educated to update care plans. Minimum Data Set (MDS) staff was to be educated to ensure that changes were made to the care plans by verifying order changes against the care plan no later than the next business day. The MDS Coordinator was to conduct monthly audits of care plans. This was to be monitored through the facility's Performance Improvement (PI)/Quality Assurance (QA) process for one (1) year to ensure compliance and was then to be re-evaluated.</p> <p>Record review during the current survey revealed Comprehensive Plans of Care reviewed were not reviewed and/or revised to contain interventions which described residents' needs.</p> <p>Interview, on 01/14/12 at 12:00 PM, with the Quality Assurance (QA)/Staff Development Nurse revealed the MDS Coordinator was terminated in the fall. The QA/Staff Development Nurse stated this MDS Coordinator was to have performed</p>	F 520		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 107</p> <p>random audits. According to the QA/Staff Development Nurse this MDS Coordinator had reported to the facility no concerns with her audits. However, concerns were identified and the MDS Coordinator was terminated. She stated a new MDS Coordinator was in place and had identified further concerns with residents' records. In addition, the QA/Staff Development Nurse stated she was going to "come up" with a more structured system to put in place to ensure this didn't happen again.</p> <p>3. Based on observation, interview and record review, it was determined the facility failed to ensure services were provided in accordance with residents' Comprehensive Plan of Care. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed Registered Nurse (RN) Managers were to audit residents' records to compare all current Physician's orders to what was in place. The Staff Development Nurse was to educate nursing staff on implementation of Physician's orders to be placed on the residents' Care Plans. The MDS staff was to be educated to ensure that changes were made to Care Plans by verifying orders against the Care Plan no later than the next business day. This was to be monitored by the facility via the PI/QA process for one (1) year to ensure compliance was achieved and maintained and then was to be re-evaluated.</p> <p>Record review during the current survey revealed the facility failed to ensure a written Do Not Resuscitate (DNR) order was obtained for one(1)</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 108 resident.</p> <p>Interview, on 01/14/12 at 12:00 PM, with the QA/Staff Development Nurse revealed forms were being filled out for residents' DNR status, however orders were not being written. She stated therefore when audits were performed on the orders, the DNR status wasn't being "caught" related to the failure to obtain the change status.</p> <p>4. Based on observation, interview and record review, it was determined the facility failed to ensure residents who enter the facility without pressure sores did not develop pressure sores. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed the Staff Development Nurse was to conduct education with nursing staff on facility protocols. Monthly audits were to be conducted. The Wound Nurse and/or designee was to review admission and readmission care plans to ensure any skin areas of concern and potential for skin breakdown/pressure areas were identified in the care planning process. This nurse was to report monthly in the PI/QA program meeting related to audit findings regarding pressure sore prevention, treatments, and services. This was to be monitored by the facility via the PI/QA process for one (1) year and then was to re-evaluate.</p> <p>Observation, on 01/11/12 of a skin assessment performed during the current survey revealed Resident #6 had an area of unidentified pressure on his/her right elbow. Interviews with staff revealed they were unaware of the Stage I</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

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F 520	<p>Continued From page 109 Pressure Ulcer to Resident #6's right elbow.</p> <p>Interview, on 01/14/12 at 12:00 PM, with the QA/Staff Development Nurse revealed the facility had a system for weekly head-to-toe skin assessments performed by nursing staff. She stated SRNAs were to view the residents' skin in between for any new areas of concern. The SRNAs were to report any findings to the nurses. According to the QA/Staff Development Nurse any new areas would have treatment obtained and would be care planned. The QA/Staff Development Nurse stated audits were still being performed by the Wound Care Nurse.</p> <p>5. Based on observation, interview, and record review, it was determined the facility failed to ensure residents received adequate supervision and monitoring to ensure residents' safety. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed the Staff Development Nurse was to conduct education with nursing staff on the investigative process for incidents, and necessary documentation for such. A Change in Condition form was to be put in place. Nursing Supervisors were to utilize the form to conduct weekly audits of follow up documentation by nursing staff. This was to be monitored by the facility via audits by the PI/QA process for one (1) year and then was to re-evaluate.</p> <p>Interview with facility staff revealed Resident #22, who had a history of sexual abuse towards staff, was not monitored and adequately supervised on</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
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F 520	<p>Continued From page 110</p> <p>12/25/11. Resident #22 was found in a female resident's room. The female resident's pants and pull up were pulled down and Resident #22 had his/her mouth and hands on the female resident's perineal area. Later that day Resident #22 was observed to be touching and rubbing another female resident's thigh.</p> <p>Interview with the Assistant Director of Nursing (ADON) revealed the nurse who SRNA #2 reported the alleged sexual abuse to had been disciplined for not reporting the allegations immediately to Administration.</p> <p>Interview with the QA/Staff Development Nurse revealed she felt the Plan of Correction (POC) had worked. She stated there was a failure of a particular nurse who did not follow up and report the allegation of sexual abuse.</p> <p>6. Based on observation, interview and record review, it was determined the facility failed to ensure there was an effective Infection Control Program. This was a repeat deficiency for the facility which was cited for this deficiency 11/05/10.</p> <p>Review of the facility's Plan of Correction (POC), with a compliance date of 12/10/10, revealed all nurses were trained in infection control guidelines upon hire and annually thereafter at a minimum. The Infection Control/Staff Development Nurse was to conduct monthly audits. The monthly audits were to be monitored by the facility via the PI/QA process for one (1) year to ensure compliance was achieved and maintained and was then to be reevaluated.</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 520	<p>Continued From page 111</p> <p>Observations during the environmental tour during the current survey revealed dirty equipment stored with clean equipment in clean utility rooms on two (2) of the facility's four (4) units. Additionally, during the dietary tour observations revealed improper hand sanitation during meal service. Interview with nursing staff revealed equipment was supposed to be sanitized prior to being placed in the clean utility rooms.</p> <p>Interview with the Infection Control (IC)/QA/Staff Development Nurse revealed staff were educated on Infection Control measures, and she felt the education worked. However, it was staff's non-compliance that caused the deficient practice identified during this survey.</p> <p>An acceptable credible Allegation of Compliance (AOC) was received on 01/23/12 which alleged removal of the TJ effective on 01/21/12, based on the following:</p> <ol style="list-style-type: none"> 1) The Social Services Manager contacted all Power of Attorneys and/or applicable members of the residents on the locked dementia unit by telephone and interviewed them to determine whether they had observed or had any other knowledge of relevant safety concerns by 01/16/12. 2) All residents on the locked dementia unit were questioned by the Social Services Manager in an attempt to determine if any of the other residents were subjected to the behaviors of Resident #22 by 01/16/12. 3) All residents and their family members or 	F 520			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/03/2012
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F 520	<p>Continued From page 112</p> <p>healthcare representatives on the unit were also informed about the potential safety issue on the unit and the measures being taken to resolve the issue by 01/19/12.</p> <p>4) Resident #22 was sent out to an Psychiatric Hospital on 01/05/12 for evaluation and returned to the facility on 01/16/12. The resident was placed on one (1) to one (1) supervision.</p> <p>5) Resident #1 was placed on fifteen (15) minute checks on 12/26/11 due to behaviors which were discontinued on 01/03/12. Resident #1 was placed on one (1) to one (1) supervision on 01/13/12.</p> <p>6) Alteration of Resident #22's psychoactive medications were made and the addition of pain medications was added during Resident #22's stay at the Psychiatric Hospital between 01/05/12 and 01/16/12.</p> <p>7) Comprehensive Plans of Care were updated for Resident #22 on 01/19/12 and Resident #1 on 01/20/12 to address specific behaviors and specific interventions to ensure needs were being met.</p> <p>8) All residents on all units received a physical and psycho-social evaluation to establish a safe base-line for implementation of house-wide corrective action measures by 01/18/12. The social services department conducted a psycho-social/safety evaluation on all residents on all units by 01/19/12.</p> <p>9) The facility revised it's policies and procedures for reporting and investigating potential abuse</p>	F 520			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 8 ASHLAND, KY 41102		
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F 520	<p>Continued From page 113 and created a new rapid response protocol called "Code Protect" by 01/19/12.</p> <p>10) All staff was educated regarding the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse by 01/18/12.</p> <p>11) All staff was required to pass a competency with a score of 100 percent. This competency will become an annual requirement.</p> <p>12) All leadership attended a one (1) hour in-service on the topics of abuse, resident competency, and the role of resident competency on the determination of abuse by 01/20/12.</p> <p>On 02/03/12, it was verified the immediacy of the IJ was removed and the facility implemented corrective actions as alleged in the AOC, effective 01/21/12 based on the following:</p> <p>Observations, on 01/31/12, 02/01/12, 02/02/12 and 02/03/12 revealed Resident #22 was receiving one (1) on one (1) supervision. Review of the medical record and review of the Behavior/Mood and Behavior Patterns Sheet revealed the resident was receiving one (1) on one (1) supervision since returning from the Psychiatric Hospital.</p> <p>Interviews with staff including SRNA #18, on 02/03/12 at 12:40 PM, SRNA #19, on 02/03/12 at 12:55 PM, SRNA #20, on 02/03/12 at 2:35 PM, SRNA #21, on 02/03/12 at 1:45 PM, Charge Nurse #11, on 02/03/12 at 12:50 PM, Charge Nurse #12, on 02/03/12 at 1:05 PM, Midnight Supervisor #13 on 02/03/12 at 2:40 PM, LPN # 3</p>	F 520		

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/03/2012	
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F 520	<p>Continued From page 114</p> <p>on 02/03/12 at 2:38 PM, Activities Assistants #32, on 02/03/12 at 1:10 PM and Activity Assistant #33, on 02/03/12 at 12:35 PM, the Risk Manager on 02/03/12 at 12:45 PM, the Dietary Manager, on 02/03/12 at 1:00 PM, and the Staff Development Coordinator, on 02/03/12 at 1:15 PM, revealed staff was aware of the facility's policy changes, the facility's revised policies and procedures for reporting and investigating potential abuse and the new rapid response protocol called "Code Protect". They were also aware of the detection of abuse, definition of abuse, facility policy and the impact of mental capacity on determinations of abuse and the requirement to pass a competency exam before working with residents.</p> <p>Interview with the Social Services Manager, on 02/03/12 at 3:15 PM, revealed she had completed the psycho-social evaluations to establish a safe base-line for implementation of house-wide corrective action measures and the Charge Nurses had completed the physical assessments of residents. Further review of documented evidence revealed physical assessments had been completed for all residents. Continued interview revealed she had contacted family members and interviewed residents as part of the psycho-social assessment. Review of the documented evidence revealed residents and/or families had been interviewed related to safety. Interview with Resident #58's responsible party, on 02/02/12 at 10:10 AM, revealed the facility had contacted him/her related to the resident's safety at the facility. Interview with an Unsampled Resident, on 02/02/12 at 11:15 AM, revealed someone had asked him/her how he/she felt about their safety</p>	F 520		

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

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F 520	<p>Continued From page 115 at the facility and the resident stated he/she felt safe.</p> <p>Interview with the Director of Nursing (DON) and Administrator, on 02/03/12 at 5:30 PM, revealed the plan for Resident #22's care was to continue to re-evaluate him/her and seek guidance from the Medical Director (Physician #1) and would obtain additional psychiatric evaluations to see if there may be anything underlying occurring with the resident's psychiatric condition. The DON further stated Resident #1 and #22's Comprehensive Plans of Care had been updated to reflect the changes in care and supervision. Review of the Comprehensive Plans of Care reflected these changes. The Administrator and DON stated it will be determined by the Medical Director when Resident #22 is removed from one (1) on one (1) observation because he/she could not be allowed to co-mingle with other residents at this point without guidance and re-direction from the one (1) on one (1) supervision.</p> <p>The facility remained out of compliance at a lower scope and severity of an "E", a pattern deficiency with potential for more than minimal harm while the facility's Quality Assurance continues to monitor the effectiveness of the new systems and policies implemented and while the facility develops and implements the Plan of Correction (POC).</p>	F 520			

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 8 ASHLAND, KY 41102	
(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
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Construction Date 05/18/02</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) Story, Type II (222) Protected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 4-02 upgraded in 7-2011</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) original in 4/02</p> <p>EMERGENCY POWER: Type II Diesel Generator. Original in 4/02</p> <p>A life safety code survey was initiated and concluded on 01/10/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred forty-three (143) beds and the census was one hundred forty-one (141) the day of the survey.</p>	K 000		

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Keith M... TITLE ADMINISTRATOR (X6) DATE 3-13-12

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.

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

PRINTED: 02/17/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/10/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102	
(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	Continued From page 1	K 000		
K 062 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure sprinkler heads were maintained as required. The facility is licensed for one hundred forty-three (143) beds and the census the day of the survey was one hundred forty-one (141).</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey tour, on 1/10/12, at 3:04 PM, with the Maintenance Director revealed corrosion on six (6) sprinkler heads under canopy outside of library. Not maintaining sprinkler heads can decrease their ability to react as intended.</p> <p>Interview with the Maintenance Director, on 11/09/11 at 1:56 PM, revealed he was not aware of that requirement.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of</p>	K 062	<p>As of 2-21-12 all sprinkler heads under the canopy outside the library have been replaced.</p> <p>All other sprinkler heads in all areas outside of the facility have been checked by a professional fire protection contractor for corrosion, foreign materials, paint, physical damage and proper orientation.</p> <p>The facility will ensure that all sprinkler heads are free from corrosion, foreign materials, paint, physical damage, or in improper orientation by conducting an inspection on a quarterly basis. Any sprinkler shall be replaced that is painted, corroded, damaged, loaded or in the improper orientation.</p> <p>The environmental services manager will report the findings and any corrections needed in the facility QAPI program meeting quarterly.</p>	2-21-12

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____		(X3) DATE SURVEY COMPLETED 01/10/2012
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102		
(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	
K 082	Continued From page 2 corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			