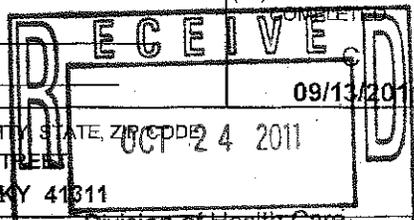


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/20/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/13/2011
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NAME OF PROVIDER OR SUPPLIER  LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 249 EAST MAIN STREET BEATTYVILLE, KY 41311
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F 000	INITIAL COMMENTS  An abbreviated standard survey (KY16965, KY17050) was conducted on 09/08/11-09/13/11 in conjunction with a revisit. KY16965 was unsubstantiated with no deficient practice identified. KY17050 was substantiated. Deficient practice was identified with the highest scope and severity at 'G' level, with no opportunity to correct.	F 000	Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on interview, Fall/Change in Functional Status report, written statements, Care Plan policy, and record review, it was determined the facility failed to ensure services were provided to one (1) of three (3) sampled residents (Resident #38) in accordance with the resident's Comprehensive Care Plan (CCP). The facility assessed and care planned that staff was to place Resident #38 in a high visual area at times of confusion. However, on 09/04/11, Resident #38 had increased restlessness and confusion, staff did not place the resident in a high visual area, and the resident sustained a fall which resulted in a right hip fracture.  The findings include:  Review of the facility's Care Plan policy (dated	F 282		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE Administrator	(X6) DATE 10/24/11
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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 282	Continued From page 1 December 2010) revealed resident care plans provided guidance to all staff caring for residents.  A review of the medical record revealed the facility admitted Resident #38 on 04/27/07, with diagnoses that included Debility, Difficulty Walking, Chronic Pain, Dementia, and Visual Loss.	F 282	<u>Address what corrective action will be accomplished for those residents found to be affected by the deficient practice/specific corrective action.</u>  Resident #38: The director of nursing and the MDS coordinators reviewed the resident's care plan for any revision needed. The SRNAs and the Nurse working the night of the incident were educated on 9-13-11 by the Director of Nursing and Administrator to read the C.N.A. care record or the comprehensive care plan to ensure the care plan is being followed.	
	A review of Resident #38's psychosocial CCP, dated 07/21/11, revealed the resident was easily annoyed, had mood symptoms, was short-tempered, and experienced episodes of increased confusion. A review of interventions related to the facility's assessment of Resident #38 revealed the resident was to be placed in a high visual area when upset or annoyed. Staff was to monitor for the resident being short-tempered and annoyed and provide distractions such as activities, one-to-one visits, and wheelchair rides.  Interview with State Registered Nurse Aide (SRNA) #1, on 09/08/11, at 6:36 PM, revealed the SRNA had provided care to Resident #38 on the evening of 09/04/11, stating the resident had been restless and "kept getting up" numerous times. SRNA #1 had been in Resident #38's room and provided assistance to the resident with toileting, redirecting the resident and assisting the resident back to the recliner six to seven times. SRNA #1 further stated Resident #38 was confused and continually talked about the need to "put the baby away" on the night of the fall. Further interview revealed Resident #38 had been restless the previous night, 09/03/11, and staff had placed the resident at the nurses' station for closer observation. However, SRNA #1 stated		<u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u>  The director of nursing and the MDS coordinators reviewed other residents' care plans for any revisions needed.  On 10/03/11, the Director of Nursing or Staff Development Coordinator completed in-services with nursing staff regarding the direct care services and expected outcomes of the care plan for each resident. On 10/03/11, nursing staff was in-	

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F 282	Continued From page 2 facility staff had not moved Resident #38 to the nurses' station, as per care plan, on the night of the resident's fall on 09/04/11.	F 282	serviced on implementing the interventions on the care plan and to notify the charge nurse for further direction when interventions are not working.	
	<p>Review of a written statement by SRNA #5, dated 09/04/11, revealed she heard an alarm sounding from Resident #38's room and when she arrived to the room Resident #38 was on the floor in front of a chair. The SRNA's written statement also revealed Resident #38 had been "confused all evening worried about her babies and how she was going to get them home." Further review of the statement revealed staff had toileted Resident #38 prior to the fall, the resident had non-skid socks on both feet, and a chair sensor pad alarm was in place. The written statement further revealed the resident had been "up &amp; down all day I had put her back in her chair several times this evening."</p> <p>Interview on 09/12/11, at 9:55 AM, with Registered Nurse (RN) #2, revealed on the night of 09/04/11, Resident #38 had been upset and "up and down" numerous times. According to the RN, she had been in the resident's room several times on the evening of 09/04/11, to either assist the resident to the bedside commode or to talk with the resident. The RN further revealed when the resident was restless and getting up and down on previous occasions, facility staff assisted the resident to the nurses' station in order to observe the resident. RN #2 stated she did not know why Resident #38 was not taken to the nurses' station, as per care plan, on the night of the fall.</p> <p>A review of the Fall/Change in Functional Status report, dated 09/04/11, revealed facility staff had</p>		<p><u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u></p> <p>The nursing administrative team developed and implemented a revised C.N.A. care plan record to include more of the falls, skin, and behavior interventions from the comprehensive care plan. Also, the C.N.A. care plan gives instructions to notify the charge nurse for further direction when interventions are not working. The nursing administrative team initiated new shift change walking rounds for nurses and SRNAs, and implemented a communication board at each nurses station to communicate resident change in condition and/or change in resident plan of care. Each nurse and nurse aide will sign a log sheet to verify walking round report is given at each shift change.</p> <p>The Director of Nursing or Staff Development Coordinator</p>	

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F 282	Continued From page 3 assessed Resident #38 as restless on the evening of 09/04/11. Continued review revealed the resident sustained a fall on the same evening, 09/04/11, complained of right hip pain, and was assessed to have an outwardly rotated leg that was not equal in length to the resident's other leg.	F 282	completed in-services with nursing staff on the implementation and use of the revised SRNA care record, the shift change rounds, and the communication boards at each nursing station on 10-3-11.	
F 323 SS=G	<p>Interview with the Director of Nursing (DON) on 09/12/11, at 11:33 AM, revealed Resident #38 did have increased confusion at times especially if the resident's family had been to the facility to visit the resident. The DON further stated Resident #38 should have been assisted to the nurses' station when the resident exhibited signs of increased confusion.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, written statements, and the facility's Incident/Occurrence Investigation, it was determined the facility failed to ensure that one (1) of three (3) sampled residents (Resident #38) received adequate supervision to prevent injuries. The facility assessed Resident #38 as a falls risk due to having a history of unsafe transfer attempts and</p>	F 323	<p><u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained.</u></p> <p>The Director of Nursing/nursing administration team will make rounds and review 10% of the residents weekly to ensure the resident care plans are being carried out. The administrative team will monitor walking rounds once daily on different shifts for compliance of rounds with the SRNAs and nurse. Any issue will be addressed, immediately. All findings will be reported to the QA Committee monthly, with revisions, staff training, and/or disciplinary actions, as needed.</p> <p><u>Include dates when corrective action will be completed.</u></p> <p>F 323 <u>Address what corrective action will be accomplished for those residents found to be affected by the deficient</u></p>	10/03/11

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F 323	Continued From page 4 falls. The facility failed to follow the developed care plan to bring the resident to a high visual area for closer observation when confused. On the evening of 09/04/11, Resident #38 had been restless and confused; staff did not place the resident in a high visual area for closer observation. Resident #38 sustained a fall which resulted in a fractured hip.	F 323	<u>practice/specific corrective action.</u>  Resident #38 was assessed by the nurse Debbie Wilson, RN and sent to Marcum and Wallace hospital for treatment and evaluation.	
	The findings include:  A review of the falls policy (dated December 2010) revealed it was the intent of the facility to provide residents with assistance and supervision in an effort to avoid falls and minimize injury and complications that may result from a resident falling.  A review of the medical record revealed the facility admitted Resident #38 on 04/27/07, with diagnoses that included Debility, Difficulty Walking, Chronic Pain, Dementia, and Visual Loss. Review of the facility's fall risk assessment, dated 07/12/11, revealed the facility had assessed Resident #38 as a high risk for falls. Review of the Comprehensive Care Plan (CCP), dated 07/12/11, revealed Resident #38 was easily annoyed, had mood symptoms, was short-tempered, and experienced episodes of increased confusion. Interventions, dated 07/12/11, revealed staff was to place the resident in a high visual area when upset or annoyed, monitor the resident for being short-tempered and annoyed, and provide distractions such as activities, one-to-one visits, and wheelchair rides.  A review of the nurse's notes written by RN #2, dated 09/04/11, and timed 10:15 PM, revealed		The Director of Nursing and the MDS coordinators reviewed the resident's care plan for any revision needed. The SRNAs and the Nurse working the night of the incident were educated on 9-13-11 by the Director of Nursing and Administrator to read the C.N.A. care record or the comprehensive care plan to ensure the care plan is being followed.  <u>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</u>  All residents have the potential to be affected regarding accidents as numerous and various accident hazards exist in everyday life. The facility staff understands the facility's responsibility as well as their own, to ensure the safest environment possible for residents.  On 9/12/11, fall assessments were done on all residents by the Unit	

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F 323	Continued From page 5 between 9:00 PM and 9:30 PM, Resident #38's alarm was heard, staff went into the room and observed the resident walking to the bedside commode, at which time staff assisted the resident to sit on the commode. At 9:40 PM, Resident #38's alarm sounded again and the nurse aide from across the hall answered the alarm and found the resident sitting in the floor in front of the chair. Resident #38 complained of right hip and leg pain at the time the nurse aide entered the room.  Interview on 09/08/11, at 6:36 PM, with SRNA #1 revealed Resident #38 attempted to get up unassisted on numerous occasions on the evening of 09/04/11. SRNA #1 stated Resident #38 "was having a bad night." SRNA #1 further stated she went into the resident's room six to seven times to assist the resident back to the chair because the resident "kept getting up," causing the chair alarm to sound. She stated Resident #38 was very confused, "talking about putting the 'baby away.'" SRNA #1 stated the resident continually got up to attempt to get facial tissues even though the tissues were within reach. SRNA #1 stated on the evening of 09/04/11, she left the floor to chart on the computer, leaving SRNA #5 on the floor to care for the residents. During the time she was gone, Resident #38 sustained the fall. Further interview revealed Resident #38 had been restless the previous night, 09/03/11, and staff had placed the resident at the nurses' station for closer observation. SRNA #5 stated that when Resident #38 had periods of increased confusion and restlessness facility staff would place her at the nurses' station, in a high visual area, for closer observation. However, SRNA #1 stated facility	F 323	Managers and the Director of Nursing. The care plans were revised if needed. The Director of Nursing or Staff Development Coordinator completed in-services with nursing staff regarding the direct care services and expected outcomes of the care plan for each resident.  <u>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</u>  On 10/3/11, the Director of Nursing completed in services with licensed staff on falls, skin and any change in resident condition and placing all new interventions on the white board to communicate to the SRNA's any new interventions for that resident. On 10/3/11, the Director of Nursing completed in-services with nursing staff on the implementation of interventions for residents with a change of condition such as falls, skin, behaviors, illness or weight loss. The Administrator implemented a daily schedule from 1:00 PM to 9:00 PM for a member of the management team to provide additional		

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F 323	Continued From page 6 staff had not moved Resident #38 to the nurses' station, as per the care plan, the night of the resident's fall on 09/04/11.  Review of a written statement from SRNA #5, dated 09/04/11, revealed SRNA #5 was answering a call light in another resident's room and heard Resident #38's chair alarm sounding. The statement revealed when SRNA #5 arrived in Resident #38's room, the resident had fallen and was on the floor in front of a chair. The written statement further revealed the resident had been confused all evening, "worried about her babies & how she was going to get them home." SRNA #5's statement further revealed Resident #38 had been "up & down all day I had put her back in her chair several times this evening."	F 323	supervision during that time period. The schedule will be on-going and times revised, as necessary  <u>Indicate how the facility plans to monitor its performance to ensure that solutions are sustained</u>	
	Interview with Registered Nurse (RN) #2 on 09/12/11, at 9:55 AM, revealed on the evening of 09/04/11, Resident #38 had been upset and "up and down" numerous times. RN #5 had been in the resident's room to assist the resident to the bedside commode, talk with the resident, or assist another resident from Resident #38's room. Interview further revealed when the resident was restless and getting up and down on previous occasions, facility staff assisted the resident to the nurses' station in order to observe the resident. RN #2 stated she did not know why Resident #38 was not taken to the nurses' station on the evening of 09/04/11.  A review of the facility's Incident/Occurrence Investigation, dated 09/04/11, revealed Resident #38 had been restless, up and down, and staff had been in the resident's room several times prior to the resident's fall.		Administrative staff will be performing daily monitoring and observation of the residents. The monitoring will include walking rounds to observe the residents and their environment for any safety concerns, observing social areas, and the dining room at various times. Administrative staff will also monitor at various times to ensure that staff is utilizing walking rounds and the white board for communication of change in resident condition and/or change in plan of care. A member of the management team will provide additional supervision from 1:00PM to 9:00 PM. Any issue identified will be addressed, immediately. All findings will be reported to the QA Committee monthly, with revisions, staff training, and/or disciplinary actions, as needed.  <u>Include dates when corrective action will be completed.</u>	10/03/11

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F 323	<p>Continued From page 7</p> <p>A review of the Fall/Change in Functional Status report, dated 09/04/11, revealed facility staff had assessed Resident #38 as restless on the evening of 09/04/11. Continued review revealed the resident sustained a fall on the same evening, 09/04/11, complained of right hip pain, and was assessed to have an outwardly rotated leg that was not equal in length to the resident's other leg.</p> <p>A review of the hospital record for Resident #38 revealed the resident had surgical repair of a right hip fracture on 09/05/11.</p> <p>Interview with the Director of Nursing (DON) on 09/12/11, at 11:33 AM, revealed Resident #38 should have been taken to the nurses' station on the evening of 09/04/11, and further stated there was no staff to monitor the resident at the nurses' station since the nurse aide on the floor was in another resident's room at the time of the fall.</p>	F 323		