

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

PRINTED: 09/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED.  C 09/02/2011
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NAME OF PROVIDER OR SUPPLIER  NURSING HOME CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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>An Abbreviated Survey investigating ARO#KY00016808, ARO#KY00016723, ARO#KY00016924, ARO#KY00016976, ARO#KY00016622, and ARO#KY00016785 was initiated on 08/29/11 and concluded on 09/02/11.</p> <p>ARO#KY00016924 and ARO#KY00016785 were substantiated with deficiencies cited. ARO#KY00016808 was unsubstantiated with unrelated deficiencies cited. ARO#KY00016622 was unsubstantiated with deficiencies cited. ARO#KY00016723 and ARO#KY00016976 were unsubstantiated with no deficiencies cited.</p> <p>483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to implement the facility's policy that prohibits misappropriation of resident by failing to have an effective system in place to hold, safeguard, manage, and account for the personal funds of residents in the facility for one (1) of eight (8) sampled residents (Resident #6).</p> <p>Resident #6 had monies removed from the Resident Trust Fund by the responsible party,</p>	F 000	<p>This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.</p> <p>Resident #6's Responsible Party was informed that they would no longer be allowed to withdrawal funds from resident #6's account unless they received prior permission from Resident #6. Otherwise, they will be required to obtain Durable Power of Attorney or became Legal Guardians of resident #6.</p> <p>2. A 100% audit was done of all residents in the facility by the Accounts Receivable Clerk to insure responsible party members were Durable Power of Attorneys of Legal Guardians.</p>	
F 224 SS=D		F 224		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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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NAME OF PROVIDER OR SUPPLIER  NURSING HOME CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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224	<p>Continued From page 1</p> <p>who was not the Power of Attorney (POA) or the legal guardian; however, there was no documented evidence the facility ensured there was permission from the resident to have the funds removed.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled Misappropriation of Resident Property Investigation, undated, revealed residents have the right to live at ease without the fear of losing irreplaceable personal property. Further review, revealed reports of misappropriation of resident property shall be promptly and thoroughly investigated and the following agencies would be promptly notified: law enforcement, Adult Protective Services, Resident's responsible party, and State licensing and certification.</p> <p>Review of Resident #6's clinical record revealed the facility admitted the resident, on 07/21/10, with diagnoses which included Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/25/11 revealed the facility assessed the resident as having severe impairment in cognitive skills for decision making.</p> <p>Review of the Comprehensive Plan of Care, undated, revealed the resident had short and long term memory loss related to dementia with a goal that the resident would have needs met on a daily basis.</p> <p>Review of Resident #6's "Resident Fund Management Services Authorization and Agreement to Handle Resident Funds" form revealed, "by my signature below, I hereby</p>	F 224	<ol style="list-style-type: none"> <li>3. The Business Office personnel received an in-service on 9/6/2011 by the Executive Director pertaining to the facility's policy regarding misappropriation of resident property.</li> <li>4. The Business Office will keep a log of who withdrawals funds from resident accounts to insure proper appropriation of funds are being managed.</li> <li>5. Completion Date: 10/12/2011</li> </ol>	
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NAME OF PROVIDER OR SUPPLIER  <b>HEALTH CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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F 224	<p>Continued From page 2</p> <p>authorize the facility named above to establish and manage an FDIC insured interest bearing resident fund with the options as specified above. The areas marked were; Resident Fund Account, and direct deposit of social security benefit payments. Further review of the form, revealed a section which stated, "I, the undersigned, certify that I am the legal representative as stated below for the above named resident and agree to all the terms stated above and will provide valid legal supporting documentation of my legal capacity and authority upon the facility's request". The form was signed by the resident's son on 07/21/10.</p> <p>Further review revealed there was \$1, 647.00 removed from the account posted as "Resident Advance Cash/Check and "Snack Bar", from 07/21/11 through 08/19/11. This included large sums of money drawn out on 03/01/11 for \$100.00, 03/25/11 for \$110.00, 04/05/11 for \$250.00, 05/16/11 for \$175.00, 06/13/11 for \$140.00, 06/21/11 for \$150.00, and 07/01/11 for \$200.00.</p> <p>Interview, on 08/31/11 at 3:30 PM, with the Accounts Receivable/ Receptionist, revealed the resident's son and daughter-in-law cared for the resident at home before the resident was admitted to the facility and signed the admission paperwork on the day the resident was admitted. She stated the son also signed as the person allowed to obtain money from the Resident's Trust Fund. She further stated, in order for anyone to obtain money from the trust fund, they would have to sign as the resident's responsible party, legal guardian or POA. Continued interview revealed the responsible party could</p>	F 224		
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NAME OF PROVIDER OR SUPPLIER  NURSING CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 224	<p>Continued From page 3</p> <p>obtain money from the account if they were purchasing items for the resident. She stated the resident would sometimes ask for money for the snack machine. She further stated the daughter-in-law would bring items in that she had bought for the resident which was usually \$15.00 to \$20.00, and then ask for money for the items. However, the receptionist stated she did not ask for receipts for the items.</p> <p>Continued interview with the Receptionist, revealed on 04/05/11 the daughter-in-law asked for \$250.00, and told her Resident #6 wanted to loan the money to the resident's grandson for the Prom. She stated she did not question Resident #6 to ensure the resident wanted to loan the money; however, notified the Administrator and was told to ask for copies of the receipts. She stated she asked the daughter-in-law to bring in the receipts; however, did not receive them. She further stated the daughter-in-law asked for \$200.00 on 07/01/11 to obtain supplies to throw the resident a birthday party. She stated the daughter-in-law received the money because she agreed to bring in guardianship papers and receipts for the items bought with the money; however, did not bring in either the guardianship papers or the receipts.</p> <p>Interview, on 08/31/11 at 4:00 PM, with the Social Worker revealed the resident had no Power of Attorney or legal guardian; although he had encouraged the resident's family to get guardianship. He stated he had talked to the daughter-in-law about the process for application of guardianship. He stated this situation was being investigated by the Department of Community Based Services; however, he was</p>	F 224		
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NAME OF PROVIDER OR SUPPLIER  <b>THE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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224	<p>Continued From page 4</p> <p>unsure if this was misappropriation of property. He further stated after the facility realized there could be a problem with the son and/or daughter-in-law who were listed as the responsible parties in the resident's medical record obtaining money from the Trust Fund, the facility no longer allowed family members who were not the Power of Attorney or Guardian to obtain money from the Resident Trust Funds.</p> <p>Interview, on 09/02/11 at 4:45 PM, with the Business Manager, revealed in the past whoever signed the resident into the facility was able to get money out of the Resident Trust Fund, and it did not have to be the POA or legal guardian. She further stated the facility had no issue with exploitation until this situation. She stated the facility did not ask Resident #6 for permission prior to money being removed from the Trust Fund. Continued interview revealed when the son and daughter-in-law found out the resident had refunds from Medicaid, they started asking for large amounts of money more often. She stated the facility had the responsibility to protect the resident's from exploitation and the facility contacted the ombudsman.</p> <p>Phone interview, on 09/01/11 at 7:10 PM with Resident #6' son, revealed the facility told him, he and his wife could take out money for items needed for the resident such as snacks and clothes. Further interview revealed he was not the legal guardian or POA and did not know if he wanted to pursue that; however, he was over the resident's affairs, and talked with the Physician regarding the resident's health. He further stated he was unaware of the \$250.00 being drawn out of the resident's account for a Prom; however</p>	F 224		

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F 224	<p>Continued From page 5</p> <p>was aware of the \$200.00 being drawn out for the resident's birthday party. He stated the money was spent to make the resident's room more "homey", and for clothes for the resident. He further stated the facility did not ask for receipts until recently.</p> <p>Phone interview, on 09/01/11 at 7:30 PM, with the daughter-in-law revealed the money removed from the account was for stocking the resident's refrigerator with items, clothes, and a birthday party for the resident. She stated she was never told until recently, she needed to bring in receipts for the items bought.</p> <p>Interview, on 09/02/11 at 10:45 AM, with Resident #6, revealed the son and daughter-in-law had asked to borrow money in the past but she/he did not have any money to loan. She/he further stated they never brought her/him snacks or clothes, and didn't visit much. The resident further stated her/his daughter brought her/him in "hand me down" clothes. Further interview revealed the resident did not want her/his son and daughter-law to take care of her/his financial affairs because they couldn't take care of themselves. "They are not to get money out of my Trust Fund".</p> <p>Interview, on 09/02/11 at 12:45 PM, with the Administrator revealed he was notified by the Receptionist of large amounts of money being drawn out of the Resident Trust Fund by the responsible party in 04/11. He stated there was no written policy; however in the past the responsible party could draw out funds although the facility would prefer it be the guardian or POA. He stated there was no investigation done by the</p>	F 224		
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NAME OF PROVIDER OR SUPPLIER  <b>DELFORD CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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F 224	Continued From page 6	F 224		
F 225 SS=D	<p>facility except to call the Ombudsman and inform her of the situation. He stated he called the Ombudsman when he was notified in 04/11 of the \$250.00 being drawn out for the grandson's Prom.</p> <p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance</p>	F 225	<p>F 225</p> <ol style="list-style-type: none"> <li>1. Resident #5 stated on 6/19/2011, to a direct care giver while providing care, that she was abusing her and that she was going to report her to the Social Services Director. Resident #5 informed different direct care give on 6/21/2011 of the alleged incident. The employee relayed the statement to management who in return notified the Office of Inspector General and Adult Protection Services on 6/21/2011.</li> <li>2. Staff files were audited by Human Resources to ensure appropriate background checks were completed on 9/16/2011. The Director of Nursing to ensure compliance with the facility's policy audited</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 225	<p>Continued From page 7</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse were reported immediately to the Administrator of the facility and to State Agencies in accordance with state law. In addition, the facility failed to have an effective system to ensure residents were protected after an allegation of abuse for one (1) of eight (8) sampled residents (Resident #5).</p> <p>An allegation of abuse involving Resident #5 was not reported immediately to the Administrator of the facility, and therefore not reported immediately to State Agencies. This delay in notification of the alleged abuse prevented the facility from protecting the residents from further potential abuse while the investigation was in progress.</p> <p>The findings include:</p> <p>Review of the "Reducing the Threat of Abuse and Neglect" Policy, revised 02/09, revealed all personnel were mandated to promptly report suspended resident abuse and/or neglect to their immediate supervisor and all alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown source would</p>	F 225	<p>reportable incidents for the past six months.</p> <p>3. All staff will be inserviced regarding the facility's abuse policy on 10/4/2011 by the Staff Development Coordinator to ensure proper knowledge of the abuse policy.</p> <p>4. Audits will be conducted weekly time four weeks then monthly times 2 months by departmental managers to ensure continued acknowledgement of the facility's abuse policy. Results of these audits will be reviewed monthly times three months at the Quality Assurance meeting for any additional recommendations.</p> <p>5. Completion Date: 10/12/2011</p>	
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F 225	<p>Continued From page 8</p> <p>be promptly reported to the administrator and/or Director of Nursing (DON). "If the accused individual is an employee, they will be placed on suspension pending results of the investigation while the incident is being investigated".</p> <p>Review of Resident #5's medical record revealed the facility admitted the resident with diagnoses which included Anxiety and Depression. Review of the Annual Minimum Data Set (MDS) Assessment dated 07/21/11 revealed the facility assessed the resident as moderately impaired in cognitive skills for decision making.</p> <p>Review of the Comprehensive Plan of Care dated 02/09/11 revealed the resident had the inability to handle problems or situations in a calm manner as evidenced by becoming verbally abusive and accusing staff. Further review revealed the resident had a problem of attention seeking behavior such as throwing things. There were several interventions listed including two (2) staff members to provide care.</p> <p>Review of the facility investigation dated 06/24/11, revealed Resident #5 stated that "day before yesterday" (06/19/11) Certified Nursing Assistant (CNA) #2 pulled her/his left arm and smacked her/him on the left side of the face. Further review revealed the assessment completed on 06/21/11 revealed no injury and the accused CNA was suspended on 06/21/11 pending investigation.</p> <p>Interview on 08/31/11 at 10:00 AM with Resident #5 revealed CNA #2 had slapped her/him in the face after the resident refused to give the CNA her/his call bell. Resident #5 could not remember</p>	F 225		
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F 225	<p>Continued From page 9</p> <p>the date the incident occurred. Observation of the resident during the interview revealed there was no bruising or signs of injury on the resident's face.</p> <p>Interview on 08/31/11 at 4:00 PM with CNA #2, revealed Resident #5's elbow was lying on her/his call bell and it was ringing. She stated she explained to the resident if the call bell rang continuously, the staff wouldn't know if the resident needed anything. She further stated she attempted to remove the call bell from under the resident's elbow and the resident stated, "you smacked me in the face, you attacked me, and you tried to throw me out of the bed". Further interview revealed she told one of the nurses about it and thought she told either Licensed Practical Nurse (LPN) #7 or Licensed Practical Nurse (LPN) #6. She stated the nurses "brushed it off" because it was Resident #5. "She does that to everybody". She further stated she also told CNA #3 who she was working with at the time, and wouldn't go back in the resident's room by herself afterwards. Continued interview revealed CNA #2 continued to work the rest of the shift and 06/20/11 was her day off. She stated when she arrived for work on 06/21/11 she was sent to the Director of Nursing (DON) and was suspended for three (3) to four (4) days.</p> <p>Interview on 09/01/11 at 9:50 AM with LPN #6 who worked the west unit where Resident #5 resided on 06/19/11, revealed CNA #2 did not notify her of any allegation of abuse by Resident #5. She further stated she was unaware of the situation until she was questioned by the DON.</p> <p>Interview on 09/01/11 at 9:30 AM with LPN #7</p>	F 225		
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F 225	<p>Continued From page 10</p> <p>who was assigned to Resident #5 on 06/19/11 revealed CNA #2 did not inform her of an allegation of abuse for Resident #5 in 06/11. She stated she became aware of the incident when the DON questioned her for a statement. She further stated she was consistently assigned to Resident #5 and CNA #2 should have reported the allegation to her.</p> <p>Interview was attempted with CNA #3 who no longer worked at the facility; however, there was no working phone number.</p> <p>Interview on 09/01/11 at 2:45 PM with the DON, revealed CNA #4 had informed her on 06/21/11 of Resident #5 making the allegation of abuse against CNA #2. She stated she interviewed Resident #5 on 06/21/11 and the resident stated CNA #2 had pulled her/his arm and slapped her/him on the left side of the face. Continued interview revealed if CNA #2 had reported the allegation to LPN #6 or LPN #7, they should have reported the allegation immediately. Also, she stated if CNA #2 had reported the allegation to the nurses and was aware the nurses were not following through with notification to Administration, CNA #2 should have followed through with reporting the allegation to Administration. Continued interview revealed CNA #2 worked the entire shift on 06/19/11 after the accusation as a result of staff failing to inform Administration of the allegation on 06/19/11. She further stated the CNA did not work again until 06/25/11, after the investigation was completed. This was verified by the time clock print out.</p> <p>Interview was attempted with CNA #4; however she was unable to be reached due to having</p>	F 225		
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/02/2011
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 11 recent surgery.	F 225		
F 280 SS=D	<p>Interview on 09/02/11 at 12:45 PM with the Administrator, revealed staff should have notified Administration of the accusation on 06/19/11 in order to implement the Abuse Policy. 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</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, record review and review of the facility's policy it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for two (2) of eight (8) sampled residents (Resident #8 and #6).</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> <li>1. Resident #8's careplan was revised to include the use of a wheelchair for transportation to and from the shower on 9/2/2011. Resident #6's careplan was revised to include interventions for urinary incontinence on 9/2/2011.</li> <li>2. A 100% audit of current resident careplans was initiated on 9/6/2011 by nurse management for inclusion of new interventions and revisions made as necessary. These audits will be completed by 9/27/2011.</li> <li>3. Interdisciplinary team members were inserviced by the Regional Director of Clinical Services on 9/2/2011 regarding the revisions of resident careplans.</li> </ol>	

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NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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 280	<p>Continued From page 12</p> <p>Resident #8 sustained a fall on 06/17/11 and a new intervention to prevent further falls was to be initiated as per the Incident Follow Up Form. However, review of the Care Plan revealed there was no documented evidence of a revision to include the intervention to ensure staff used a wheelchair to transport the resident to the shower room.</p> <p>Resident #8's Care Plan was not revised to address urinary incontinence.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the Incident Management Process Policy related to Falls Management, undated, revealed each resident's Care Plan was to be updated following a fall to reflect current health status and fall reduction interventions.</li> </ol> <p>Review of Resident #8's medical record revealed the facility admitted the resident with diagnoses which included Cerebral Hemorrhage related to Renal Cell Carcinoma. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/25/11 revealed the facility assessed the resident as oriented, as requiring limited assistance of one person for ambulation, and as sustaining a fall.</p> <p>Review of the Incident/Accident Data Entry Questionnaire, revealed Resident #8 sustained a fall on 06/17/11 at 10:00 AM while ambulating in the hallway to the shower room. According to the Questionnaire the resident slipped and fell in the floor, scrapping his/her arms on the shower room door.</p>	F 280	<ol style="list-style-type: none"> <li>Resident careplans will be audited by the Director of Nursing or designee weekly times four weeks then monthly times two months <del>for inclusion of current</del> interventions. The results of these audits will be reviewed monthly times three months at the facility Quality Assurance meeting for additional recommendations.</li> <li>Completion Date: 10/12/2011</li> </ol>	
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY. 40351</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280	<p>Continued From page 13</p> <p>Review of the Incident Follow Up and Recommendation Form dated 06/20/11 revealed the recommendation related to the fall sustained 08/17/11, was to use a wheelchair to transport the resident to the shower room.</p> <p>Review of the Comprehensive Plan of Care dated 03/02/11, revealed the resident was at risk for falls due to low endurance. There were several fall prevention interventions noted; however, there was no documented evidence the Care Plan was revised to include the intervention to use a wheelchair for transport to the shower room.</p> <p>Interview, on 09/02/11 at 2:45 PM, with the Director of Nursing (DON), revealed any nurse could place an immediate intervention on the Care Plan after a fall. She further stated falls were discussed every morning in the stand up meeting and decisions were made at that time regarding new interventions to prevent further falls. Continued interview revealed the MDS Nurses were ultimately responsible for ensuring the Care Plans were updated with new fall interventions.</p> <p>Interview, on 09/02/11 at 2:50 PM, with Licensed Practical Nurse (LPN) #5/MDS Nurse, revealed she did not always attend the stand up meetings. She stated on the days she did not attend, staff was to call her for any Care Plan updates that were needed after the meeting or staff was to update the Care Plans during the meeting. She further stated she did not always receive the Incident Reports to review and if the new fall interventions were not noted in the Nurse's Progress Notes, she would not be aware of the</p>	F 280		
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ELEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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
F 280	<p>Continued From page 14 new interventions needed when updating the Care Plans after a fall.</p> <p>2. Review of Resident #6's medical record revealed the facility admitted the resident with diagnoses which included Dementia. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 08/25/11 revealed the facility assessed the resident as severely impaired in cognitive skills for decision making and as having frequent incontinence of bladder and occasional incontinence of bowel. Further review revealed the facility assessed the resident as requiring extensive assistance of two (2) for toileting.</p> <p>Review of the Comprehensive Plan of Care revealed the resident's urinary incontinence was not addressed.</p> <p>Interview on 09/02/11 at 2:00 PM with Certified Nursing Assistant (CNA) #5, who was assigned to the resident, revealed the resident could tell the staff when she/he needed to go to the bathroom. She further stated staff checked on the resident and offered toileting every two (2) to two and a half (2-1/2) hours and the resident would sometimes dribble; however, would not be soaking wet. Continued interview revealed the resident was more incontinent at night when in bed.</p> <p>Interview, on 09/02/11 at 2:00 PM, with LPN#5/MDS Nurse revealed she completed Bowel/Bladder Assessments every three (3) months; and audited to ensure they were completed on all residents. However there was no documented evidence a Bowel/Bladder Assessment had been completed for this</p>	F 280		

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 09/02/2011
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NAME OF PROVIDER OR SUPPLIER  NURSING HOME CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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(4) 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 280	Continued From page 15 resident. She further stated the Care Plans related to urinary incontinence were to be completed and revised after the Bowel/Bladder Assessments were completed; however, there was an oversight and urinary incontinence was not addressed in the Care Plan for this resident.  Interview, on 09/02/11 at 2:30 PM, with the Director of Nursing (DON), revealed the MDS Nurse should have ensured the resident had a Care Plan for urinary incontinence. She stated the MDS Nurses were to update the Care Plans during the Care Plan conference every three (3) months and the nurses on the floor were responsible for daily updating of the Care Plans as needed.	F 280		
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS  The services provided or arranged by the facility must meet professional standards of quality.  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 professional standards of quality was provided for three (3) of eight (8) sampled residents (Resident #4, #8, #2).  Resident #2 was seen for an outside consult to have a surgical procedure and came back to the facility with an order to hold Plavix (a medication to thin the blood) for six (6) days before the surgical procedure. The Plavix was held; however, the facility failed to notify Resident #2's	F 281	F 281  1. Resident #2's physician was notified on 9/2/2011 regarding holding resident #2's plavix, as stated on the pre-op instruction sheet, however the facility did not obtain an order. Resident #8's fall was reviewed on 9/6/2011 by the Interdisciplinary team to access for any additional measures the facility could utilize to reduce the risk of resident #8 from falling. Resident #4's flexion boot was clarified on 9/1/2011 to be worn only while in bed. Resident #4's chair alarm was discontinued on 9/2/2011.  2. Review of consultation reports for all residents having had outside consultation for the previous thirty days was	

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40361
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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 281	<p>Continued From page 16</p> <p>facility Physician and receive the order to hold the medication.</p> <p>Resident #8 sustained a fall on 06/17/11. There was no documented evidence of follow up assessment and documentation every shift for three (3) days as per facility policy after the fall.</p> <p>Resident #4's Physician's Orders were not followed regarding a flexion boot, and a chair alarm.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Review of the facility's policy, "Ancillary Physician Orders" not dated, revealed when an ancillary physician (a physician not credentialed with privileges at the facility) writes a physicians order, this must be placed on the facility approved physicians order form. A telephone or verbal order must be obtained from the facility physician by the unit licensed nurse and then documenting his/her response. The ancillary physician's order cannot be followed without the approval of the attending physician.</li> </ol> <p>The facility admitted Resident #2 on 12/17/10, with diagnosis's, which included Hypertension, Hyperlipidemia, Esophageal Reflux, Mental Disorder, Herpes Zoster (Shingles), Coronary Artery Anomaly, and Dizziness and Giddiness.</p> <p>Record review of Resident #2's medical chart revealed the resident was to have a surgical procedure on 06/21/11. Record review of the Medication Administration Record (MAR) for the month of June 2011 revealed the facility staff had marked to hold the Plavix on the MAR for 06/12/11 until 06/21/11. Record review of</p>	F 281	<p>initiated by nursing management on 9/19/2011 to ensure attending physicians were notified regarding consultant recommendations. This review will be completed by 9/23/2011. Incident reports for the previous thirty days were reviewed on 9/6/2011 by nursing management to ensure proper follow up had been utilized. Facility rounds are conducted daily by department managers and licensed nursing staff to ensure physician orders are being followed according to individual resident careplans.</p> <ol style="list-style-type: none"> <li>Licensed nurses will be inserviced by the Director of Nursing on 10/4/2011 regarding follow up of consultation reports, follow up after resident falls and following specific physician orders.</li> </ol>	
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>RESIDENT CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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 281	<p>Continued From page 17</p> <p>Resident #2's Physician's Orders for the month of June 2011 revealed no documented evidence of a verbal or telephone order was obtained to hold the Plavix by a facility Physician. Record review of Resident #2's nursing progress notes for the month of June 2011 revealed no progress note stating the facility physician had been notified of the order from the ancillary physician to hold the Plavix.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/01/11 at 1:50 PM, revealed he was working the day Resident #2 came back from consult for surgical procedure on 06/08/11 and was unable to recall if he received the order from the ancillary Physician to hold the Plavix. He further stated he could not find an order from the facility Physician to hold the Plavix or a nursing progress note stating staff had notified the facility Physician notifying him of the order. He further stated since the order was noted on the MAR to hold the Plavix, there should have been a telephone/verbal order by the facility Physician written and also there should have been a nurses progress note addressing the new order.</p> <p>Interview with LPN #3, on 09/01/11 at 1:30 PM, revealed there should have been an order in Resident #2's chart by the facility Physician to hold the Plavix. She further stated, after reviewing the chart, she was unable to find an order by the facility physician to hold the Plavix.</p> <p>Interview with the Director of Nursing (DON), on 09/02/11 at 9:30 AM, revealed when a resident comes back to the facility from a consult, it was the unit nurse's responsibility to follow up on the orders written by the ancillary Physician with the</p>	F 281	<p>4. Consultation reports will be audited daily Monday through Friday times four weeks by nursing management to ensure attending physician notification. Incident reports will be monitored daily Monday through Friday times four weeks for appropriated assessment and follow up. Implementation of physician orders will be monitored daily by the department managers via resident care giver guides to insure individual resident care plans are being followed. The results of these audits will be reviewed monthly times three months during the facility's Quality Assurance meeting for additional recommendations.</p> <p>5. Completion Date: 10/12/2011.</p>	
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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
F 281	<p>Continued From page 18</p> <p>facility Physician. The unit nurse was to notify the facility Physician and review the ancillary Physician's orders and receive a telephone/verbal order from the facility Physician and document this in the resident's medical chart on the Physician's Orders form. Further interview with the DON revealed she had looked through Resident #2's medical chart and was unable to find an order by the facility Physician to hold the Plavix. She further stated she had also reviewed the June 2011 MAR and it was noted to hold the Plavix on the MAR without a facility Physician's Order.</p> <p>2. Review of the facility Incident Management Process Policy; Follow up for Falls, undated, revealed each shift nurse was responsible for seventy-two (72) hour "alert" charting, in addition to recording the resident's mobility and comfort status, vital signs, new orders or interventions, and the resident's response to the fall.</p> <p>Review of Resident #8's clinical record revealed the facility admitted the resident with diagnoses which included Cerebral Hemorrhage related to Renal Cell Carcinoma. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 07/25/11 revealed the facility assessed the resident as oriented, as requiring limited assistance of one staff for ambulation, and as sustaining a fall.</p> <p>Review of the Incident/Accident Data Entry Questionnaire, revealed Resident #8 fell on 06/17/11 at 10:00 AM while ambulating in the hallway to the shower room. Further review revealed the resident slipped and fell in the floor, scrapping his/her arms on the shower room door.</p>	F 281		

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NAME OF PROVIDER OR SUPPLIER  NIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 281	<p>Continued From page 19</p> <p>Review of the Interdisciplinary Progress Notes, dated 06/17/11 at 10:00 AM, revealed the nurse was called to the shower room by a Certified Nursing Assistant (CNA) and the resident was found on the floor with skin tears on both arms. Further review revealed the skin tears were rinsed with Normal Saline and steri-strips were applied with dry guaze. The Physician was notified and new treatment orders were received and the responsible party was notified.</p> <p>Review of the Incident Accident Data Entry Questionnaire, dated 08/17/11 revealed the resident's vital signs immediately after the fall were Temperature 97.1, Pulse 74, Respirations 12, and Blood Pressure 116/67.</p> <p>Further review of the Interdisciplinary Progress Notes, revealed there was no documented evidence of further vital signs or assessment of the resident after the fall.</p> <p>Interview, on 09/02/11 at 2:45 PM and 3:00 PM, with the Director of Nursing (DON), revealed staff should have assessed the resident to include obtaining vital signs every shift for three (3) days after the fall. She further stated when falls occurred, they were discussed the next morning in the Stand Up Meeting and a green sticker which stated "Fall" was placed on the chart at that time to alert staff of the need for follow up assessment and documentation for three (3) days. Continued interview revealed the fall information was transcribed to the Twenty-Four (24) Hour Report also, to ensure staff were alerted to the need for assessment and documentation.</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  NIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 281	<p>Continued From page 20</p> <p>3. Review of the Clinical Record revealed the facility admitted Resident #4 on 04/23/09 with diagnoses which included Parkinson's Disease, Seizure Disorder, Anxiety and Depression.</p> <p>Review of the active Physician's Orders revealed an order, dated 12/30/10, for a flexion boot to be worn on the left foot at all times. Continued review revealed another order, dated 01/08/11, for a chair alarm to be in place when the resident was up.</p> <p>Observation, on 08/30/11 at 3:50 PM, revealed Resident #4 was up in a Broda chair. Continued observation revealed the resident was not wearing a flexion boot and no alarm was in place. Observations on 08/31/11 at 9:10 AM, 10:15 AM and 11:50 AM revealed Resident #4 was up in a Broda chair. Continued observation revealed the resident was not wearing a flexion boot.</p> <p>Interview with Resident #4, on 08/31/11 at 9:10 AM, revealed the resident wore the flexion boot "when they put it on me".</p> <p>During interview, on 08/30/11 at 4:00 PM, Licensed Practical Nurse (LPN) #10 confirmed Resident #4 was to wear a flexion boot and have an alarm in place when up in the chair. The LPN stated she did not know why the devices were not in place. Continued interview revealed the resident had been readmitted to the facility after a hospitalization "sometime last year". The nurse stated she admitted the resident at that time and there was no order for the chair alarm. Further interview revealed she had not realized the alarm</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  <b>HOME CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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F 281	<p>Continued From page 21 had been ordered.</p> <p>Interview with Certified Nursing Assistant (CNA) #10, on 08/30/11 at 4:15 PM, revealed she knew the resident was supposed to wear the flexion boot. She stated the resident refused to wear the boot.</p> <p>Interview with CNA #11, on 08/31/11 at 10:35 AM, revealed she had applied an alarm to the resident's chair that morning. She stated the alarm "wasn't there before". During continued interview the CNA revealed the resident preferred to wear shoes and couldn't wear the boot with shoes.</p> <p>Interview with LPN #8, on 08/31/11 at 11:00 AM, revealed she was new and didn't know if Resident #4 was supposed to have a chair alarm or a flexion boot. She stated she would have to look it up. Review of the CNA Care Guide with the nurse revealed interventions related to the chair alarm and the flexion boot were included. The nurse further stated it was the CNA's job to make sure everything on the Care Guide was done. Continued interview revealed the nurse did not perform any monitoring to ensure all ancillary orders, including the boot and the alarm, were followed.</p> <p>Interview with CNA #12, on 08/31/11 at 11:20 AM, revealed she was not aware Resident #4 was supposed to have a chair alarm. Review of the Care Guide with the CNA confirmed the intervention was present. When asked how she used the Care Guide, the CNA stated, "I don't look at it much". Continued interview revealed the CNA was aware the resident was supposed to</p>	F 281		
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NAME OF PROVIDER OR SUPPLIER  <b>THE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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F 281	Continued From page 22 wear a flexion boot. Observation with CNA #12, on 08/31/11 at 11:25 AM, revealed the boot was in the resident's closet. The CNA stated the resident sometimes refused to wear the boot. She further stated she had not attempted to put the boot on the resident that morning.  During interview, on 08/31/11 at 4:00 PM, the Director of Nursing confirmed Resident #4 should be wearing a flexion boot and have a chair alarm in place. She stated she did not know why the resident was not wearing the boot. Continued interview revealed the resident had gotten a new Broda chair and staff failed to move the alarm to the new chair.	F 281	F 282  1. Resident #4 received an order on 9/1/2011 to clarify that the flexion boot was to only be worn while in bed. Changes were made to resident #4's caregiver guide and are being followed appropriately. Furthermore, an order was obtained from resident #4's physician to discontinue the use of her chair alarm.	
F 282 SS=D	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 observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure services were provided in accordance with the written plan of care for one (1) of eight (8) sampled residents, (Residents #4). The Care Plan contained interventions related to a flexion boot and a chair alarm. Observations revealed the devices were not in place when the survey was initiated.  The findings include:	F 282	2. Facility rounds are conducted daily by the department managers and licensed nursing staff to ensure resident careplans are being followed accordingly.  3. Nursing staff will be <del>inserviced on 10/4/2011</del> by the Director of Nursing regarding following resident careplan interventions.	

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NAME OF PROVIDER OR SUPPLIER  NURSING HOME CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 833 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 282	<p>Continued From page 23</p> <p>Review of the policy titled "Resident Care Plan", dated 12/08, revealed the Care Plan was "a brief written portrait of the resident and an individualized guide of the nursing care needed". Continued review revealed the Care Plan should reflect the resident's "current needs, problems, goals, care, treatment, and services".</p> <p>Review of the Clinical Record revealed the facility admitted Resident #4 on 04/23/09 with diagnoses which included Hypertension, Anxiety, Depression, Parkinson's Disease, and Seizure Disorder.</p> <p>Review of the Physician's Orders, dated 12/30/10 and 01/08/11 respectively, revealed Resident #4 was to wear a left flexion boot at all times, and was to have an alarm to the chair when out of bed.</p> <p>Review of the Comprehensive Care Plan, dated 07/10/09, revealed Resident #4 was at risk for falls and was to have a chair alarm in place. Continued review revealed the resident had the potential for skin breakdown. Interventions included a flexion boot to be worn on the left foot at all times.</p> <p>Observation of Resident #4, on 08/30/11 at 3:50 PM, revealed the resident was not wearing a flexion boot and no alarm was in place. Observations on 08/31/11 at 9:10 AM, 10:15 AM, and 11:50 AM revealed the resident was not wearing a flexion boot.</p> <p>Interview with Resident #4 on 08/31/11 at 9:10 AM revealed the resident wore the flexion boot "when they put it on me".</p>	F 282	<p>4. Careplan interventions will be audited by department managers daily times four weeks then monthly two months to ensure interventions are implemented as ordered by the physician. Results of these audits will be brought to the monthly Quality Assurance meeting for any additional recommendations.</p> <p>5. Completion Date: 10/12/2011.</p>	
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 282	<p>Continued From page 24</p> <p>During interview, on 08/30/11 at 4:00 PM, Licensed Practical Nurse (LPN) #10 confirmed Resident #4 was to wear a flexion boot and have an alarm in place when up in the chair. The LPN stated she did not know why the devices were not in place. Continued interview revealed the resident, on her last readmission from a hospital visit, "sometime last year", did not have an order for the chair alarm. The nurse stated the order had been received at some point, but had not been initiated.</p> <p>Interview with Certified Nursing Assistant (CNA) #10, on 08/30/11 at 4:15 PM, revealed she knew the resident was supposed to wear the flexion boot. She stated the resident refused to wear the boot.</p> <p>Interview with CNA #11, on 08/31/11 at 10:35 AM, revealed she had applied an alarm to the resident's chair that morning. She stated the alarm "wasn't there before". During continued interview the CNA revealed the resident preferred to wear shoes and couldn't wear the boot with shoes.</p> <p>Interview with LPN #8, on 08/31/11 at 11:00 AM, revealed she was new and didn't know if Resident #4 was supposed to have a chair alarm or a flexion boot. She stated she would have to look it up. Review of the CNA Care Guide with the nurse revealed it was consistent with the comprehensive Care Plan, and included interventions for the flexion boot and the chair alarm. The nurse further stated it was the CNA's job to make sure all the interventions were in place. Continued interview revealed the nurse</p>	F 282		

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F 282	<p>Continued From page 25</p> <p>did not perform any monitoring to ensure all interventions were followed.</p> <p>Interview with CNA #12, on 08/31/11 at 11:20 AM, revealed she was not aware Resident #4 was supposed to have a chair alarm. Continued interview revealed the CNA was aware the resident was supposed to wear a flexion boot. Observation with CNA #12, on 08/31/11 at 11:25 AM, revealed the boot was in the resident's closet. The CNA stated the resident sometimes refused to wear the boot. She further stated she had not attempted to put the boot on the resident that morning.</p> <p>During interview, on 08/31/11 at 4:00 PM, the Director of Nursing confirmed Resident #4 should be wearing a flexion boot and have a chair alarm in place. She stated she did not know why the resident was not wearing the boot. She further stated the resident had gotten a new Broda chair and staff failed to move the alarm to the new chair.</p>	F 282	<p>F 312</p> <ol style="list-style-type: none"> <li>1. Resident #4 is receiving necessary services to maintain good nutrition, grooming, personal and oral hygiene.</li> <li>2. All residents were assessed for ADL completion with specific focus on oral care. All residents received appropriate oral care by staff on 9/1/2011 and continue to receive oral care daily.</li> <li>3. Nursing staff will be inserviced on 10/4/2011 by the Staff Development Coordinator regarding ADL completion with specific focus on proper oral care.</li> <li>4. Departmental managers and licensed nursing staff will conduct audits weekly times four weeks then monthly times two months to ensure completion of ADLs. The results of these</li> </ol>	
F 312 SS=D	<p>483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure each dependent resident received oral</p>	F 312		

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F 312	<p>Continued From page 26</p> <p>care per facility policy for one (1) of eight (8) sampled residents (Resident #4).</p> <p>The findings include:</p> <p>Review of the Clinical Record revealed Resident #4 was admitted by the facility on 06/23/09 with diagnoses which included Hypertension, Gastroesophageal Reflux Disease and Diabetes.</p> <p>Review of the policy titled "Oral Hygiene" (no date) revealed oral care was to be provided before breakfast and at bedtime.</p> <p>Review of the quarterly Minimum Data Set (MDS) Assessment dated 07/07/11 revealed Resident #4 required extensive assistance with the activities of daily living (ADLs). Review of the Daily Care Guide, developed for use by the nursing assistants, revealed interventions included the provision of oral care every shift and as needed.</p> <p>Review of the Monthly Flow Report for the month of August 2011 revealed Resident #4 received mouth care twenty-seven (27) of thirty-one (31) days during the night shift. Continued review revealed mouth care was provided only six (6) times during the day shift for the entire month.</p> <p>Interview with a sister of Resident #4 on 08/30/11 at 11:10 AM revealed she had concerns that the resident was not receiving adequate oral care.</p> <p>During interview with another sister of Resident #4, on 08/30/11 at 2:15 PM, she stated facility staff were not brushing the resident's teeth regularly, even though she had provided toothbrushes and toothpaste on 08/05/11.</p>	F 312	<p>audits will be brought to the monthly Quality Assurance meeting for additional recommendations.</p> <p>5. Completion Date: 10/12/2011.</p>	

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F 312	<p>Continued From page 27</p> <p>Interview with Resident #4, on 08/31/11 at 9:10 AM, revealed the resident had not received oral care that morning. When asked if teeth were brushed daily, the resident stated "no". Continued interview revealed the resident had "six or seven" toothbrushes and toothpaste in the drawer.</p> <p>Subsequent interview with Resident #4, on 08/31/11 at 10:15 AM, revealed oral care had still not been provided. Observation revealed white matter was noted between the resident's teeth and along the gumline. In addition, a foul odor was noted from the resident's mouth.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 08/31/11 at 11:00 AM, revealed residents should receive oral care upon getting up in the mornings and after meals. She stated Resident #4 was a reliable source and able to report whether or not oral care had been provided.</p> <p>Interview with Certified Nursing Assistant (CNA) #12, on 08/31/11 at 11:20 AM, revealed the CNAs not assigned to shower duty should provide oral care. She stated when she had time, she included oral care on her morning rounds. She further stated oral care would be something left undone at the end of the day when there wasn't enough time. Continued interview revealed Resident #4 did not receive regular oral care on the day shift because "we just don't have time".</p> <p>Observation on 08/31/11 at 2:10 PM revealed the resident's sister was at the bedside. When questioned, the resident stated no oral care had been provided all day. Continued observation</p>	F 312		
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F 312	<p>Continued From page 28</p> <p>revealed the resident's sister pointed out six (6) toothbrushes in the resident's bedside table drawer. Four (4) of the brushes were still in the package. Two (2) brushes had been opened and showed no visible wear. In addition, two (2) full tubes of toothpaste were observed.</p> <p>During interview with the roommate of Resident #4, on 08/31/11 at 2:40 PM, it was revealed the roommate had never observed staff brushing Resident #4's teeth. The roommate stated he/she tried to watch, and noticed staff did not take Resident #4's toothbrush and toothpaste to the shower room.</p> <p>Interview with the Director of Nursing (DON), on 08/31/11 at 4:00 PM, revealed oral care should be performed at a minimum of every morning on arising and before bed each night. She stated she had not observed Resident #4's teeth and could not say if or when her teeth had been brushed.</p>	F 312	<p>F 329</p> <ol style="list-style-type: none"> <li>1. Resident #2's medications were reviewed by the Director of Nursing 9/6/2011 and revealed no current medications that required a stop date.</li> <li>2. A 100% audit of resident medication orders was performed on 9/21/2011 by nursing management to ensure no stop dates were required.</li> <li>3. Licensed nurses will be inserviced on 10/4/2011 by the Director of Nursing or designee regarding obtaining stop dates for medications requiring a specific duration in order to prevent unnecessary medications being provided.</li> <li>4. Nursing management will audit new physician orders daily Monday through Friday times four weeks</li> </ol>	
F 329 SS=D	<p>483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not</p>	F 329		

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F 329	<p>Continued From page 29</p> <p>given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all residents were kept free of unnecessary drugs when one (1) of eight (8) sampled residents, Resident #2, continued to receive a medication beyond the manufacturer's recommended time frame and beyond the length of time advised by current standards of practice when the facility administered Acyclovir (an anti-viral medication) 800 mg five (5) times a day for nineteen (19) days when manufacturer recommends no longer than ten (10) days.</p> <p>Record review of Resident #2's Medical Chart revealed the resident was started on Acyclovir 800 mg five (5) times a day on 12/17/10 for a Diagnosis of Shingles, and the facility continued to administer the Acyclovir until 01/04/11. Record review of Resident #2's medical records revealed the Pharmacy had sent a request for a stop date on the medication of Acyclovir on 12/17/11 and the facility failed to obtain a stop date for the medication from the physician.</p>	F 329	<p>then monthly times two months to ensure that medications requiring a specific duration will be followed appropriately. The results of these audits will be brought to the monthly Quality Assurance meeting for any additional recommendations.</p> <p>5. Completion Date: 10/12/2011.</p>	
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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 329	<p>Continued From page 30</p> <p>Record Review of Resident #2's Medication Administration Record (MAR) revealed the resident received Acyclovir from 12/17/10 until 01/14/11. Review of the Saunders Nursing Drug Book, dated 2011, revealed this medication when being taken for Shingles is not to be taken for over ten (10) days.</p> <p>The findings include:</p> <p>The facility admitted the resident on 12/17/10, with diagnosis, which included Hypertension, Hyperlipidemia, Esophageal Reflux, Mental Disorder, Herpes Zoster (Shingles), Coronary Artery Anomaly, and Dizziness and Giddiness.</p> <p>Record review of Resident #2's Physician's Orders revealed Acyclovir 800 mg five (5) times a day for Herpes Zoster (Shingles) was ordered 12/17/11 with no stop date. Further record review of the monthly Physician Order sheet, for the month of January 2011 revealed the pharmacy had requested a stop date for the Acyclovir.</p> <p>Record Review of Resident #2's Nurses Progress notes revealed no documented evidence the facility had notified the Physician for a stop date.</p> <p>Record Review of Resident #2's MAR revealed the resident received the Acyclovir from 12/17/10 until 01/04/11, for a total of nineteen (19) days.</p> <p>Record review of the Saunders Nursing Drug Book, dated 2011, revealed Acyclovir 800 mg five (5) times a day for a Diagnosis of Shingles should be given for ten (10) days.</p> <p>Interview with License Practical Nurse (LPN) #1, on 09/01/11 at 1:50 PM, revealed when the pharmacy sends a request for a stop date on a medication, the unit nurse would notify the</p>	F 329		
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/16/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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 329	<p>Continued From page 31</p> <p>physician and make a note in the nurses progress notes detailing the request from the pharmacy, stating the physician was notified, and any new orders received from the physician. LPN #1 further stated if a stop date was requested the medication should not be give until the physician had been notified.</p> <p>Interview with the facility's contracted Pharmacist, on 09/01/11 at 3:20 PM, revealed the pharmacy had requested a stop date for the Acyclovir the day the order was received, 12/17/11. She further stated the pharmacy only sent a seven (7) day supply of the medication because they still had not received a stop date from the facility. Interview with the Pharmacist further revealed the facility sent a request for a refill of the Acyclovir yet still had not sent a stop date for the medication; the Pharmacy sent the refill order for seven (7) days with another request for a stop date. Further interview revealed for Shingles, Acyclovir should only be given for ten (10) days.</p> <p>Interview with the Physician, on 09/02/11 at 10:30 AM, revealed Acyclovir should have had a stop date after ten (10) days. He further stated he should have written a stop date and he should have followed up on why Resident #2 was still receiving Acyclovir. Further interview revealed there was no maintenance dose for Acyclovir when it was given for Shingles.</p> <p>Interview with the Director of Nursing (DON), on 09/01/11 at 9:30 AM, revealed when the unit nurse received the notification from pharmacy requesting a stop date, it was the unit nurse's responsibility to contact the physician for the clarification order. Further interview with the</p>	F 329		
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185155</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/02/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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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
F 329	Continued From page 32 DON revealed staff should not have continued giving the Acyclovir to Resident #1 without a stop date and clarification order from the physician.	F 329		