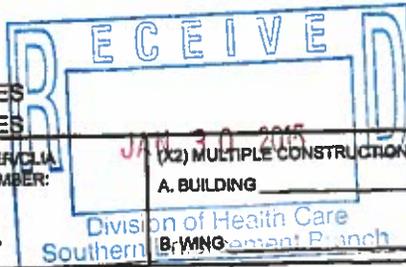


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/22/2015  
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 _____  Division of Health Care Southern Branch	(X3) DATE SURVEY COMPLETED  C 01/08/2015
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NAME OF PROVIDER OR SUPPLIER  LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311
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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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<p>F 000</p> <p>F 225 SS=D</p>	<p><b>INITIAL COMMENTS</b></p> <p>An abbreviated standard survey (KY22646) was conducted on 01/08/15. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "D" level.</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>	<p>F 000</p> <p>F 225</p>	<p>Lee County Care and Rehabilitation 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.</p> <p>F225 SS D</p> <p>1. Unit Manager #1 was re-educated verbally and</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>Susan Bush</i> NHA	TITLE	(X6) DATE  1/30/15
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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 225	<p>Continued From page 1</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 observation, interview, record review, facility policy review, and facility investigation, it was determined the facility failed to ensure all alleged violations involving misappropriation were reported to the Administrator and to state agencies, and were thoroughly investigated for one (1) of three (3) sampled residents (Resident #1). On 01/03/15, at approximately 11:45 PM, staff observed Licensed Practical Nurse (LPN) #1 to be impaired and smelled alcohol on the LPN. The facility conducted an investigation and terminated LPN #1's employment because the LPN was arrested for being intoxicated; however, the facility failed to identify that Resident #1 was missing 300 milliliters of bourbon, which LPN #1 had told staff that she had spilled. When the Administrator identified that the resident's bourbon was missing, after the investigation was completed, the facility failed to report the allegation that the resident's property was misappropriated.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Abuse, Neglect, and Misappropriation," with a revision date of 03/04/13, revealed the Administrator would be notified immediately of any allegation of abuse, neglect, or misappropriation of a resident's property. The Administrator or a</p>	F 225	<p>written on the Abuse, Neglect &amp; Misappropriation Policy on 1-19-15 by the Administrator by failing to inform Administrator that resident # 1 had bourbon missing and that LPN #2 had stated to her that LPN #1 had told her she had spilled resident's bourbon when pouring his HS bourbon. The Unit Manager had not followed the Abuse, Neglect &amp; Misappropriation Policy when the initial investigation was completed. Please note resident #1 did receive 120 ml of bourbon at H.S, per MD order.</p> <p>Resident #1 was notified by the Administrator of the possibility that LPN #1 taking approximately 300ml of bourbon. The facility did purchase a new bottle of bourbon for Resident #1.</p> <p>2. All resident's have the potential to be affected by the facility investigation failing to ensure all alleged violations involving misappropriation were</p>	

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F 225	<p>Continued From page 2</p> <p>designated person would then make an immediate report to state agencies and to local law enforcement. The policy stated a thorough investigation would begin immediately.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 05/28/14, with diagnoses that included Alcoholism and Severe Cranial Cervical Stenosis. Review of the most current quarterly Minimum Data Set (MDS) assessment dated 11/09/14, revealed Resident #1 was assessed by the facility to have a BIMS score of 15, which indicated the resident was interviewable. Further review of the resident's medical record revealed the resident had a physician's order dated 06/19/14 for 4 ounces of bourbon every day. According to the nurse's notes, facility staff monitored and estimated the amount of bourbon in the bottle every shift.</p> <p>Interview conducted with Unit Manager #1 on 01/08/15, at 4:10 PM, revealed on 01/03/15, staff observed LPN #1 to be impaired at the facility after the LPN's shift had ended. Unit Manager #1 stated staff reported the LPN smelled of alcohol. Unit Manager #1 stated Resident #1 was the only resident who had alcohol in the facility. Unit Manager #1 stated she checked the resident's bourbon count and identified the count was incorrect. She stated she spoke with LPN #2, who told her that LPN #1 reported that she had spilled some of Resident #1's bourbon and that was the reason for the discrepancy. Unit Manager #1 stated she did not document the alcohol discrepancy information, nor did she notify the Administrator, even though the facility's policy required the Administrator to be notified.</p>	F 225	<p>reported to the Administrator, state agencies, and were thoroughly investigated.</p> <p>Unit Managers interviewed all cognitive residents residing on C wing Unit on 1/4/15 to ensure no residents had any property missing. No residents had any property missing.</p> <p>The Social Services Director completed interviews with residents POA, RP and/or contact person with a BIMS score of 7 or less to ensure no personal property was missing. No one reported any property missing.</p> <p>3. The Regional Nurse completed education for the Administrator on 1/13/15 on the Abuse, Neglect, and Misappropriation of resident property. Emphasis was placed on completing a thorough investigation, reporting to the Administrator and state agencies findings.</p>	



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F 225	Continued From page 4 became aware that approximately 300 milliliters of the resident's bourbon was missing when she checked the bourbon count herself on 01/05/15. The Administrator stated she did not report the incident to state agencies, nor had the facility identified that the missing alcohol could have led to the impairment of LPN #1.	F 225	ensure a thorough investigation is completed.  Employees will receive education on the Abuse, Neglect, and Misappropriation upon hire, quarterly and as needed.  The Social Service Director and Administrator will audit all investigations completed daily x 4 weeks, weekly x 4 weeks, 5 observations monthly x 3 months to ensure all investigations are reported to the administrator, state agencies and thoroughly investigated.  Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services Director, Dietary Manager, Human Resource Director,		

**Maintenance Director, and  
Quality of Life Director.**

**5. Date of compliance 2-6-15.**