

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ RECEIVED OCT 2011 OFFICE OF INSPECTOR GENERAL	(X3) DATE SURVEY COMPLETED C 08/25/2011
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NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 641 SOUTH BENTON, KY 42025
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated survey (KY #16934) was conducted on 08/24/11 through 08/25/11 to determine the facility's compliance with Federal requirements. The facility was not in compliance with Federal regulations with deficiencies cited at the highest S/S of a "D." KY #16934 was substantiated with deficiencies cited.</p> <p>F 223 SS=D 483.13(b), 483.13(b)(1)(i) FREE FROM ABUSE/INVOLUNTARY SECLUSION</p> <p>The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.</p> <p>The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.</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 one resident (#1), in the selected sample of three, was free from sexual abuse by Resident #2.</p> <p>The findings include: A review of the facility's policy/procedure, "Allegations of Resident-to Resident Abuse," dated 02/09, revealed the facility would identify residents whose personal histories rendered them at risk for abusing other residents and would develop intervention strategies to prevent occurrences. Residents involved in allegations of</p>	F 000	<p>RESPONSE PREFACE</p> <p>Lake Way acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Lake Way's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way reserves the right to submit documentation to refute any of the stated deficiencies of this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any administrative or legal proceeding.</p> <p>1. Resident Number 2 supervised 1:1 from 8/25/11 thru 8/29/11 when they were transferred to a Behavior Unit. Resident Number 2 is no</p>	F 223
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Handwritten Signature]

TITLE

Administrator

(X6) DATE

10/5/2011

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 223	<p>Continued From page 1</p> <p>resident-to-resident abuse should be monitored by the facility to ensure that other incidents did not occur. The facility would assure that measures were taken to prevent occurrences. The plans of care would also include appropriate monitoring by the staff and appropriate interventions as indicated for the residents' behaviors/needs.</p> <p>A record review revealed Resident #2 was admitted to the facility, on 01/13/11, with diagnoses to include Bipolar Disorder, Cognitive Deficits due to Cerebrovascular Disease and Senile Dementia.</p> <p>A review of the "Early Family/Development History," undated, revealed there was no disruptive behavior identified for Resident #2 upon admission. The form did not include questions directed specifically in regard to identification of sexually inappropriate behavior.</p> <p>An interview with the Admissions Coordinator, on 08/25/11 at 11:20 AM, revealed she obtained information on the resident prior to his/her admission and spoke with the family. The admission paperwork contained no specific questions pertaining to sexually inappropriate behaviors. She revealed she addressed a resident's sexually inappropriate behavior with the Director of Nursing (DON) or Administrator, if known prior to admission.</p> <p>An interview with Resident #2's spouse, on 08/24/11 at 9:45 AM, revealed Resident #2 lived at home prior to placement in the facility. The resident's spouse revealed he/she had two different occasions, years ago, in which he/she</p>	F 223	<p>longer in the facility. Resident Number 1 was transferred to the hospital ER for eval by SANE Nurse on 8/21/11. No evidence of sexual abuse.</p> <p>2. All resident have the potential to be affected by this deficient practice. 100% audit of Care Plans and Behavior Sheets has been completed per DON/ADON of all residents to identify any history of sexually inappropriate behaviors with follow-up action taken as appropriate. This was completed by August 29, 2011.</p> <p>3. In-service initiated 9/1/2011 thru 9/5/2011 regarding Dealing with Inappropriate Behaviors by Administrator. All staff have received this in-service. All new hires will be trained on dealing with inappropriate behaviors during orientation by Staff Development Coordinator.</p> <p>4. With each Admission and/or Readmission QA audits will be performed by DON to ensure that any/all background history is obtained relating to inappropriate behaviors to include sexually</p>	

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F 223	<p>Continued From page 2</p> <p>touched a female inappropriately. The resident's spouse stated, "The facility never asked me about these behaviors on admission, and I did not tell them anything."</p> <p>A review of the progress notes, dated 01/17/11 at 11:36 AM, revealed the resident had made derogatory statements directed at staff related to the individual's appearance in their clothing. A second note at 5:13 PM, revealed the resident made inappropriate sexual comments to a staff member.</p> <p>A review of the Comprehensive Care Plan, dated 01/19/11, revealed the problem of inappropriate sexual behavior (verbal or physical) as the resident touched staff inappropriately and made inappropriate remarks to the staff. Interventions included provision of constant supervision in recreation programs and documentation of the behavior. However, the care plan did not address a potential risk for resident to resident abuse related to the behaviors exhibited by Resident #2 and specific interventions to prevent resident abuse.</p> <p>Observations of Resident #2, on 08/24/11 at 8:15 AM and at 4:35 PM, revealed the resident was in his/her room sitting up in a wheelchair and had the ability to move about in the wheelchair independently.</p> <p>A review of the Behavior Observation Profile (BOP), dated 01/11, revealed the resident displayed inappropriate behavior five days in January 2011, with no specific details describing the behavior. Further review of the BOP, dated 05/11, 06/11, and 07/11, revealed the resident</p>	F 223	<p>inappropriate behavior.</p> <p>Concerns/issues will be reported to Administrator immediately and will be addressed at this time. Findings will be reviewed in Executive QA Committee Meeting quarterly with follow-up as deemed appropriate and to determine the frequency and/or need for continued QI monitoring.</p>	9/13/11

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F 223	<p>Continued From page 3</p> <p>displayed sexually aggressive behaviors; however, there were no details describing the inappropriate behaviors or evaluation of the effectiveness of interventions.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1, on 08/24/11 at 1:00 PM, revealed Resident #2 made inappropriate sexually explicit comments to her, referring to specific areas of her body. She revealed she did not always report the inappropriate behavior because, "It was known to happen."</p> <p>An interview with SRNA #2, on 08/24/11 at 1:05 PM, revealed the resident made a sexually inappropriate comment to her and she heard the resident ask another female staff member to bend over so the resident could see her breasts.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 08/24/11 at 1:15 PM, revealed the resident touched her buttocks one day when she reached over to answer the phone at the nurse's desk. She revealed the resident laughed about the inappropriate behavior.</p> <p>An interview with SRNA #5, on 08/24/11 at 2:15 PM, revealed she observed the resident attempt to touch a female staff member's "private areas." She revealed she heard the resident tell other staff he/she wanted to perform explicit sexual acts and asked explicit sexual questions, which were considered vulgar in nature.</p> <p>An interview with LPN #3, on 08/24/11 at 4:00 PM, revealed the resident made a inappropriate sexual comment about a private area of her body.</p>	F 223			

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F 223	<p>Continued From page 4</p> <p>An interview with SRNA #7, on 08/25/11 at 9:25 AM, revealed she took the resident's socks off, on 08/20/11, and the resident told her he/she was going to perform a sexually explicit act against the staff member. She revealed she did not report the inappropriate comment.</p> <p>A review of the nurse's notes, dated 08/21/11 at 6:50 AM, revealed Resident #2 was observed with his/her hand in Resident #1's pants.</p> <p>An interview with SRNA #5, on 08/24/11 at 2:15 PM and on 08/25/11 at 9:50 AM, revealed she went into the dining room, on 08/21/11 at 6:20 AM, to clock out at the end of her shift. Resident #2 was sitting with Resident #1, facing toward the gazebo, with their backs to her. The residents were observed to be quiet at that time. After she clocked out, she observed the residents from the front and noticed Resident #2 with his/her left hand (up to the elbow) in Resident #1's pants. She revealed Resident #2 was questioned, and he/she responded, "I am not doing anything." The resident then removed his/her hand from Resident #1's pants at that time.</p> <p>An interview with SRNA #6, on 08/24/11 at 2:40 PM, revealed Residents #1 and #2 were in the dining room alone, on 08/21/11. She revealed something was "suspicious," so when she and another SRNA #5 came back in the dining room, another door was used to observe the residents. Resident #2 had his/her hand down the front of Resident #1's pants. Resident #1 was talking about "pretty flowers" and "baby dolls."</p> <p>An interview with LPN #1, on 08/24/11 at 1:15 PM and on 08/25/11 at 9:10 AM, revealed she was</p>	F 223			

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F 223	<p>Continued From page 5</p> <p>the nurse, who worked on 08/21/11, when the incident allegedly occurred between Resident #1 and #2. She revealed Resident #2 was brought to the nurse's station, and was supervised at the nurse's station the remainder of the shift, or he/she was in his/her room. She revealed the resident did not need supervision while in his/her room, as the resident was not on 1:1 supervision during that time. She stated she was told by the Director of Nursing (DON) to check on the resident "frequently" when he/she was in his/her room. Prior to the incident, on 08/21/11, there was no increased monitoring of the resident.</p> <p>An interview with MDS Coordinator #2, on 08/25/11 at 1:30 PM, revealed the behaviors exhibited by Resident #2, prior to 08/21/11, were directed toward the staff. The potential for resident abuse should be on the resident's care plan, because if there were inappropriate behaviors toward the staff, there was always a possibility of inappropriate behaviors toward another resident.</p> <p>An interview with MDS Coordinator #1, on 08/25/11 at 1:45 PM, revealed there were no reports of inappropriate behaviors toward another resident prior to 08/21/11, but there was a potential for it. The care plan should include interventions to prevent resident abuse.</p> <p>An interview with the DON, on 08/25/11 at 4:15 PM, revealed Resident #2 did not do anything to make us think he/she would abuse another resident. She revealed she was not aware of the content of the inappropriate comments the resident voiced to the staff. She expected the staff to document specific inappropriate behaviors</p>	F 223			

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F 223	Continued From page 6 or comments and report that information to her. She revealed staff were expected to know the resident's whereabouts at all times, even prior to the incident on 08/21/11. The resident was currently supervised by staff when out of his/her room, but the DON could not guarantee the resident would not go out of his/her room without supervision. She revealed the resident was not on 1:1 continuous monitoring, and stated the staff were on "high alert" to ensure the resident was supervised while out of his/her room.	F 223			