

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

Second SOD

PRINTED: 09/20/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 08/21/2012
NAME OF PROVIDER OR SUPPLIER LAUREL CREEK HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 1933 NORTH HIGHWAY 2 MANCHESTER, KY 40962		
(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 PRECEDED BY APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS --Amended-- An abbreviated standard survey (KY18932) was initiated on 08/20/12 and concluded on 08/21/12. The complaint was substantiated with deficient practice identified at "D" level.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update	F 157	1. Resident #1 physician and family was notified on 8-21-12 that resident #1 had a fall on 8-10-12 with no injuries. The facility's policy titled Changes in Resident's Condition or Status was updated to instruct facility staff to immediately notify the resident's physician and resident's legal representative or interested family member with any change of condition or status. This policy was updated 9-21-12 in the procedure section listing reasons for notifying the physician, the resident, his/her next of kin or representative (sponsor) as each situation indicates. See attachment A. 2. 100% audit was completed on 9-24-12 and 9-25-12 by the ADON, Unit Managers AND designees to ensure the physician and responsible party, etc. were notified of all incidents, changes in residents condition or status in the last 30 days per updated policy 9-21-12.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Olivia E. Berger

TITLE

Chief Director

(X6) DATE

09/22/12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting, providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to inform the resident's physician and/or family member when there was an accident involving the resident that had the potential for requiring physician intervention for one of three sampled residents (Resident #1). Based on interview and record review Resident #1 experienced a fall on 08/10/12, which resulted in no injury. Although the resident's fall did not result in an injury that required the physician and family member to be notified immediately, the facility had not reported the resident's fall to the MD from the day of the fall on 08/10/12 through the day of the visit conducted on 08/20/12, a timeframe of ten days. In addition, the facility policy, titled Changes in Resident's Condition or Status, failed to instruct facility staff related to the immediate notification of the resident's physician and the resident's legal representative or interested family member, as required by the Regulation.</p> <p>The findings include:</p> <p>A review of the facility policy on 08/21/12, titled Changes in Resident's Condition or Status, no date noted, revealed Nursing Services was responsible to notify the resident's physician when it was deemed necessary or appropriate and in the best interest of the resident. The facility policy failed to instruct facility staff related to the immediate notification of the resident's</p>	F 157	<p>3. All licensed staff was inserviced on 9-24-12 and 9-25-12 by the Staff Development Coordinator on the updated policy 9-21-12 related to notifying the physician, responsible, etc. on incidents and/or changes in resident condition or status.</p> <p>4. All Incident Reports, 24 Hour Shift Reports, and Physician orders will be reviewed daily, Monday through Friday, in the Clinical Meeting by the Director of Nursing, Asst. Director of Nursing, Unit Managers and or designee to ensure resident's physician and responsible party, etc. are notified of incidents, changes in condition or status per updated policy 9-21-12. All the above will be reviewed daily, Monday through Friday, ongoing.</p> <p>The results will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the system as indicated.</p>	10-1-12	

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F 157	<p>Continued From page 2</p> <p>physician and the resident's legal representative or interested family member as required in the Regulatory Guidelines.</p> <p>Interview with RN #1 on 08/21/12, at 10:15 AM, revealed Resident #1 experienced a fall on 08/10/12. RN #1 further stated she had not notified the resident's physician or family member of the fall.</p> <p>Review of the medical record for Resident #1 revealed the facility admitted the resident on 08/27/10, with diagnoses of Congestive Heart Failure, Hypertension, and Osteoporosis. A review of the resident Quarterly Minimum Data Set Assessment (MDS) dated 06/07/12, revealed facility staff had assessed the resident to require extensive assistance with bed mobility, transferring, and bathing. Continued review of the medical record revealed no evidence had been documented related to the fall the resident experienced on 08/10/12.</p> <p>Interview with the Director of Nursing (DON) on 08/20/12, at 2:45 PM, confirmed Resident #1 experienced a fall with no injury on 08/10/12. The DON acknowledged, based on documentation in the medical record, that facility staff failed to notify the resident's physician and/or responsible party of the resident's fall.</p> <p>An interview with Resident #1's responsible party on 08/20/12, at 11:30 AM, confirmed facility staff had failed to notify him/her of the fall Resident #1 sustained on 08/10/12.</p> <p>Interview with the Director of Nursing (DON) on 08/21/12, at 4:15 PM, revealed RN #1 should</p>	F 157			

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F 157	Continued From page 3	F 157			
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy it was determined the facility failed to ensure that a resident who was incontinent of bladder, with or without a catheter, received appropriate treatment and services to prevent urinary tract infections to the extent possible for two of two unsampled residents (Residents A and B). Observations conducted on 08/20/12, revealed the two residents were in need of perineal care (cleansing of the genitals).</p> <p>The findings include:</p> <p>A review of the facility's undated policies related to the provision of perineal care for male and female residents revealed staff was to provide perineal care at a minimum of a daily basis.</p> <p>1. Review of Resident A's Quarterly Minimum</p>	F 315 1.	<p>Peri Care was performed on residents A & B on 8-20-12 at 1:50 p.m. by C.N.A. #1. Please note order for Peri Care was q shirt and as needed. The Unit Manager completed a head to toe assessment on resident A & B and no adverse effects noted related to Peri Care being performed later in shift.</p> <p>2. 100% audit was completed on 8-25-12 and 8-26-12 by the Unit Managers on all incontinent residents to ensure Peri Care was being provided timely as ordered and with every 2 hour bed checks. No issues noted.</p> <p>3. All nursing staff was inserviced on 8-27-12 by the Staff Development Coordinator related to providing Peri Care every 2 hours and thoroughly cleansing Peri area with each incontinent episode. SDS will complete Peri Care Competencies by 9-21-12. Any CNA not completing a Peri Care Competency by 9-21-12 will not be allowed to provide direct resident care.</p>		

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F 315	<p>Continued From page 4</p> <p>Data Set Assessment (MDS) dated 06/08/12, revealed facility staff had assessed the resident to require extensive assistance from staff with bed mobility, toilet use, and bathing. Further review of the MDS revealed Resident A was frequently incontinent of urine and bowel.</p> <p>Observations conducted on 08/20/12, at 1:50 PM, of Certified Nursing Assistant (CNA) #1 providing perineal care to Resident A revealed the resident had a significant amount of white residue present to the genital area, including the folds of the skin.</p> <p>2. Review of Resident B's last Minimum Data Set Assessment (MDS) dated 08/05/12, revealed facility staff assessed the resident to have an indwelling Foley catheter, and to always be incontinent of bowel. Further review of the MDS revealed Resident B was able to be understood and to understand others.</p> <p>Observations conducted on 08/20/12, at 2:00 PM, revealed CNA #1 provided perineal care to Resident B. Resident B was observed to have an indwelling urinary catheter. Further observations revealed a white discharge present to the resident's genitalia.</p> <p>During an interview with Resident B on 08/20/12, at 2:05 PM, the resident indicated staff was not always thorough when they provided perineal care.</p> <p>An interview with CNA #1 on 08/20/12, at 2:08 PM, revealed she had only assisted with the skin assessment and had not been the staff person assigned to provide care to Residents A and B on 08/20/12. CNA #1 acknowledged both residents</p>	F 315 4.	<p>The Director of Nursing, Assistant Director of Nursing, and Unit Managers will perform audits on five (5) residents daily, Monday through Friday, x 2 weeks, then weekly for 2 months, then monthly for 2 months, during Incontinent Care to ensure proper Peri Care is being provided per facility policy. The results of the audits will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated.</p>	10-1-12	

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F 315	Continued From page 5 were in need of "good peri care." An interview with CNA #2 on 08/20/12, at 2:10 PM, revealed she had been assigned to provide care to Residents A and B at 7:00 AM on 08/20/12. Further interview revealed the CNA stated she was required to ensure the residents were properly cleaned. CNA #2 stated she had not provided peri care to Residents A and B during her shift because she had "not had time," and acknowledged she had not reported to anyone that she had been unable to provide the care the residents required. An interview with Licensed Practical Nurse (LPN) #1, Unit Coordinator, on 08/21/12, at 1:20 PM, revealed she conducted "rounds" every two hours and conducted skin assessments at random to ensure perineal care had been provided. An interview with the Director of Nursing (DON) on 08/21/12, at 1:45 PM, revealed the facility had not identified any concerns related to staff failing to provide personal care, including perineal care, to residents. According to the DON, the Staff Development Nurse provided staff with in-service training related to perineal care and had also observed staff in the performance of perineal care to determine if staff was competent to provide the care. According to the DON, the Staff Development Nurse had assessed the staff to be competent to provide care. The DON stated staff was required to provide perineal care to those residents that needed assistance, including Residents A and B.	F 315			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 6</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on interview, record review, and review of facility policy it was determined the facility failed to ensure the resident environment remained as free from accident hazards as possible for one of three sampled residents (Resident #1). Interview with Registered Nurse (RN) #1 revealed Resident #1 experienced a fall without injury on 08/10/12. However, RN #1 failed to document the fall, failed to evaluate the fall, and failed to identify potential hazards in the environment that could result in a fall. In addition, RN #1 failed to identify Resident #1's risk for falls or modify interventions to ensure the resident's environment was free from accident/fall hazards in an effort to prevent and/or lessen the resident's potential for additional falls and potential injuries as a result of falls.</p> <p>The findings include:</p> <p>A review of the facility policy titled Falls Management, no date noted, revealed residents who experienced a fall in the facility would have a plan identified and implemented to protect the resident from a fall recurrence.</p> <p>Interview with RN #1 on 08/21/12, at 10:15 AM,</p>	F 323	<ol style="list-style-type: none"> 1. On 8-17-12 the DON was made aware of resident #1 having a fall on 8-10-12, RN #1 completed a written statement with details related to the fall, the assessment of the resident, and the resident's environment. M.D. and family was notified on 8-20-12. Resident #1's Fall Risk Assessment and Care Plan was updated related to the fall on 8-12-10 to reflect the cause of the fall and interventions implemented once the resident returned to the facility. 2. 100% audit of all residents experiencing a fall in the last 30 days was completed on 8-28-12 by the Unit Managers. The audit included reviewing the resident's Care Plan and Fall Risk Assessment, and to ensure proper documentation to aid in the implementation of appropriate interventions in an effort to prevent further falls. Any issues identified were addressed. 3. R.N. #1 was educated on 8-25-12 by the Director of Nursing related to the policy and procedure on documentation of a fall in the medical record, filling out an incident report, investigating the fall, and investigation of causative factors of the fall, putting interventions in place in an effort to prevent and/or lessen the resident's potential injuries from a fall. 	

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F 323	<p>Continued From page 7</p> <p>revealed Resident #1 had been observed to be sitting on the floor, with the resident's fall alarm sounding, on 08/10/12. Further interview with RN #1 revealed the RN assessed the resident but did not document Resident #1's fall, or investigate possible causative factors for the resident's fall. In addition, the interview revealed RN #1 failed to assess/modify interventions to prevent further accidents for Resident #1. RN #1 stated she had not documented any record of Resident #1's fall because the resident had no injury, and she felt like the resident had scooted out of the bed, and had not actually experienced a fall.</p> <p>Record review revealed Resident #1 was admitted on 08/27/10, with diagnoses of Congestive Heart Failure, Hypertension, and Osteoporosis. A review of the Quarterly Minimum Data Set Assessment (MDS), dated 06/07/12, revealed Resident #1 was usually understood, and usually understands others. Further review of the MDS revealed the resident required extensive assistance from facility staff for bed mobility, transferring, and bathing. A review of the comprehensive care plan for Resident #1 dated 04/10/12, revealed facility staff had assessed the resident to be at high risk for falls and had fall interventions in place for the resident. However, continued record review confirmed facility staff failed to document the fall Resident #1 sustained on 08/01/12.</p> <p>Interview with the Director of Nursing (DON) on 08/21/12, at 4:15 PM, revealed RN #1 should have documented the fall sustained by Resident #1 on 08/10/12, in the medical record, filled out an incident report, and investigated/identified causative factors of the resident's fall. Further</p>	F 323	<p>All licensed nursing staff was inserviced on 8-25-12 by the Staff Development Coordinator related to the policy and procedure on documentation of a fall in the medical record, filling out an incident report, investigating the fall, and investigation of causative factors of the fall, putting interventions in place in an effort to prevent and/or lessen the resident's potential injuries from a fall.</p> <p>4. Audits will be completed by the Director of Nursing, Assistant Director of Nursing, and Unit Managers on all residents experiencing a fall, daily Monday through Friday times 4 weeks, weekly times four weeks, then monthly times 4 months to ensure proper documentation, revisions to Assessments and Care Plans and for physician and responsible party notification were completed.</p>	10-1-12	

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F 323	Continued From page 8 interview with the DON revealed if Resident #1's fall had been properly documented and evaluated, interventions could have been evaluated and/or modified in an effort to prevent and/or lessen the resident's potential for future falls and potential injuries as a result of falls.	F 323			

Changes in Resident's Condition or Status

Policy

The facility will immediately notify the resident, his/her attending physician, and representative (sponsor) of changes in the resident's condition and/or status. The following will outline the process.

Procedure

1. Facility will be responsible for notifying the resident's attending physician when:
 - a. The resident is involved in any accident or incident that results in injury.
 - b. There is significant change in the resident's physical, mental, or emotional status.
 - c. The resident refuses treatment or medications and reason(s) why.
 - d. There is a need to alter the resident's treatment or medications significantly.
 - e. A decision has been made to transfer or discharge the resident from the facility deemed necessary or appropriate in the best interest of the resident.
 - f. If it is necessary to transfer the resident to a hospital.
2. Facility will be responsible for notifying the resident, his/her next of kin, or representative (sponsor) as each case may apply when:
 - a. The resident is involved in any accident or incident that results in injury.
 - b. There is significant change in the resident's physical, mental, or emotional status.
 - c. The resident refuses treatment or medications and reason(s) why.
 - d. There is a need to alter the resident's treatment or medications significantly.
 - e. A decision has been made to transfer or discharge the resident from the facility deemed necessary or appropriate in the best interest of the resident.
 - f. There is a change in the resident's room and/or roommate assignment.
 - g. If the resident is to be transferred to the hospital.