

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

PRINTED: 02/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/11/2012
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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) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 164 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey was initiated on 02/07/12 and concluded on 02/11/12. Deficiencies were cited with the highest Scope and Severity of an "E".</p> <p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 000 F 164	<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>F 164</p> <ol style="list-style-type: none"> LPNs #5, #6 and #9 reviewed and signed an educational acknowledgment form on 2/27/2012, issued by the Director of Nursing. Residents #2, #8, and #9 receive personal privacy during skin assessments. Residents #2, #9 and #8 were monitored by nursing management on 2/28/12 to ensure provision of personal privacy. No issues were identified. Residents are to be provided with personal privacy. All residents were monitored through interviews and observations by nursing 	

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BY: _____

DRATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> Executive Director	TITLE	(X6) DATE 3/5/12
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deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 accreditation participation.

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F 164	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide personal privacy during the examination of three (3) of seventeen (17) sampled residents (Residents #2, #8 and #9) during skin assessments.</p> <p>The findings include:</p> <p>Review of the facility's "Clinical Services Policies & Procedures, Nursing Volume I, General Resident Rights Guidelines" policy revealed if residents are in their room "knock on the door, wait for a response, and identify yourself". Further review of this policy revealed "screen and drape resident for maximum privacy".</p> <p>1. Observation, on 02/09/12 at 9:45 AM, of a skin assessment performed by Licensed Practical Nurse (LPN) #5 of Resident #8 revealed the LPN closed the resident's door, however did not pull the privacy curtain around the bed. LPN #5 initiated the head-to-toe skin assessment by having the resident remove his/her shirt, leaving his/her undergarment in place to the upper torso. A knock was heard at Resident #8's door, and the door was immediately opened by a Certified Nursing Assistant (CNA) leaving the resident exposed in his/her undergarment to anyone passing by the door in the hallway. The CNA left the door open for a few seconds, then left the room, shutting the door.</p> <p>Interview, on 02/09/12 at 10:05 AM, with Resident #8 revealed he/she was "very modest" about his/her body and didn't want anyone looking at his/her body. Resident #8 stated he/she was a</p>	F 164	<p>management to ensure provision of personal privacy on 2/28/2012. No other issues were identified.</p> <p>3. Staff will receive education regarding provision of personal privacy by the Director of Staff Development on 3/6/2012. All staff will receive education regarding providing privacy, upon hire, annually and as needed.</p> <p>4. Provision of personal privacy will be monitored through interviews and observations weekly times four weeks then monthly times three months by Department managers. Results of this monitoring will be brought to the Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2011</p> <p>Note: QA committee consists of facility Department Heads, Pharmacy Consultant and Medical Director.</p>	
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F 164	<p>Continued From page 2</p> <p>"Christian" and didn't know who might have been out in the hallway.</p> <p>Interview, on 02/09/12 at 10:09 AM, with LPN #5 revealed she closed the door for privacy however, should have additionally pulled the privacy curtain before initiating the skin assessment on Resident #8.</p> <p>Interview, on 02/09/12 at 10:09 AM, with CNA #5 revealed privacy curtains were supposed to be pulled anytime a resident had his/her clothes off. She stated she should have waited for a response before opening Resident #8's door on 02/08/12 at 5:10 PM.</p> <p>2. Observation, on 02/08/12 at 5:10 PM, of a skin assessment performed by LPN #6 on Resident #2 revealed the door to the hallway was left partially open and the privacy curtain was not pulled. LPN #6 proceeded to perform the head to toe skin assessment leaving the resident exposed to anyone passing in the hallway.</p> <p>Interview, on 02/08/12 at 6:00 PM, with LPN #6 revealed she should have closed the door and pulled the privacy curtain before beginning the head to toe skin assessment.</p> <p>3. Observation, on 02/08/12 at 2:25 PM, of a skin assessment performed by LPN #9 on Resident #9 revealed the LPN left the window blinds wide open and performed a head to toe skin assessment leaving the resident exposed to anyone looking in the window.</p> <p>Interview, on 02/08/12 at 4:22 PM, with LPN #9 revealed she had noticed the open blind "about</p>	F 164		

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F 164	Continued From page 3 half way through" the skin assessment and didn't want to stop the skin assessment and close them. She stated she should have ensured the blinds were closed prior to initiating the skin assessment. Interview, on 02/10/12 at 8:00 PM, with the Director of Nursing (DON) revealed staff should ensure residents' rights to privacy were protected by closing doors, pulling privacy curtains, closing window blinds, and asking permission to enter after knocking on doors. She stated staff failed to follow facility policy related to residents' rights to privacy. Additionally, she stated staff were trained on resident privacy. The DON stated that Department Managers rounds were performed to monitor for the provision of privacy and if a problem was identified staff would be re-educated.	F 164		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 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 promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality for two (2) of seventeen (17) sampled	F 241	F 241 1. Residents #5 and #8 are treated with dignity and respect. Residents #5 and #8 were monitored by nursing management on 2/28/2012 to ensure dignity and respect were maintained by staff. No issues were identified. 2. All residents are to be cared for in an environment that maintains and enhances their dignity and respect in full recognition of the	

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F 241	<p>Continued From page 4</p> <p>residents (Residents: #5 and #8) and two (2) unsampled residents as evidenced by facility staff failing to knock on residents' doors prior to entry or knocking and immediately entering residents' rooms without permission when appropriate. This failure to enhance dignity was further evidenced during general survey observation and interview with residents.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "General Resident Rights Guidelines", undated, had under: One (1), if resident is in his/her room, knock on the door, wait for a response, and identify yourself.</p> <p>1. Review of Resident #5's medical record revealed the facility admitted the resident on 10/22/04 with diagnoses which included Glaucoma, Dementia, Alzheimer's Disease, and Heart Failure. The resident was admitted to Hospice 10/14/10. Review of the Minimum Data Set (MDS) Assessment, completed on 12/28/11, revealed Resident# 5's Brief Interview for Mental Status identified the resident as being severely impaired in cognition.</p> <p>Family Interview performed, 02/08/12 at 11:15 AM; with family member of Resident #5, revealed staff came into the room at times without knocking. Further interview revealed staff did not always pull the curtain when providing care and sometimes other staff would come into the room and talk with the staff providing care to the resident.</p> <p>Observation, on 02/08/12 at 9:48 AM, during a</p>	F 241	<p>individuality. Residents were monitored through interview and observation by nursing management to ensure that dignity and respect were maintained by staff on 2/28/2012. No other issues were identified.</p> <p>3. All staff will receive education regarding dignity and respect of residents by the Director of Staff Development on 3/6/2012. Orientation upon hire includes review of resident rights, addressing providing dignity and respect for residents.</p> <p>4. Department managers will audit staff through observation weekly times four weeks then monthly times three months to ensure dignity and respect are being provided to the residents. The results of these audits will be brought to the monthly Quality</p>	

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F 241	<p>Continued From page 5</p> <p>skin assessment on Resident #8 revealed Certified Nursing Assistant (CNA) #5 knocked on the resident's door and immediately opened the door without waiting for a response. The resident had only an undergarment covering his/her upper torso.</p> <p>Interview, on 02/08/12 at 10:09 AM, with CNA #5 revealed she should have waited for a response before opening Resident #8's door on 02/08/12 at 5:10 PM.</p> <p>2. Review of Resident #8's medical record revealed the resident the facility admitted the resident on 11/16/10, with diagnoses which included Bipolar (mood disorder) and Depression. Review of the MDS Assessment, completed on 01/18/12, revealed Resident #8's Brief Interview for Mental Status identified the resident as being cognitively intact.</p> <p>Interview performed, on 02/08/12 at 2:30 PM, with Resident #8 revealed staff did not always respect his/her privacy. The resident stated staff did not knock all the time when they came in the door and did not always close the curtain when he/she was in the shower room and people had walked in and out. Continued interview revealed he/she used to have a sign on his/her door indicating to please knock and wait for answer before entering, but did not know what happened to the sign.</p> <p>3. Observation, on 02/08/12 at 2:40 PM, of Licensed Practical Nurse (LPN) #3 performing medication administration to two (2) unsampled residents revealed the LPN entered the residents' rooms without knocking, identifying herself, and waiting for a response prior to entering.</p>	F 241	<p>Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2012</p>	

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F 241	Continued From page 6 Interview, on 02/08/12 at 6:27 PM, with LPN #3 revealed she did not knock on residents' doors if she was looking at them face to face. She indicated she would just enter the room. She stated if the residents' door was closed then she would knock before entering. 4. General survey observation of meal service, on 02/08/12 between 5:50 PM and 5:55 PM, revealed Certified Nursing Assistant (CNA) #7 was observed entering Rooms: #316, #320, #321 (Resident #8's room), and #322 without knocking prior to entry when passing dinner trays to residents. Interview, on 02/08/12 at 5:58 PM, with CNA # 7 regarding the facility process for staff when entering residents' room revealed, they were supposed to knock before entering rooms. When interviewed further CNA #7 explained she was in a hurry and just forgot. Interview, on 02/10/12 at 8:05 PM, with the Director of Nursing (DON) revealed staff should knock on doors before entering. If it was someone who could respond she would expect staff to get permission before entering. This was an expectation of staff. Staff were trained to knock on doors. During rounds, Department Heads would be expected to monitor for dignity.	F 241		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the	F 274	F 274 1. Resident #1 is currently in an assessment period due to a significant change in condition. 2. All residents will have their current ADL abilities reviewed and compared against their previous MDS by Nursing Management to determine significant changes in condition. This audit will be	

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F 274	<p>Continued From page 7</p> <p>resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.)</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to conduct a Significant Change Minimum Data Set (MDS) Assessment for one (1) of seventeen (17) sampled residents (Resident #1), after a decline in activities of daily living: walk in room, walk in corridor, locomotion off/on unit, eating, urinary continence, and bowel continence.</p> <p>The findings include:</p> <p>Review of the Medical Record for Resident #1 revealed the facility admitted the resident on 08/11/11 with diagnoses which included Acute Systolic Congestive Heart Failure, Diabetes, and Chronic Kidney Disease.</p> <p>A review of the Admission MDS, dated 08/18/11, revealed the Activities of Daily Living (ADL) Assistance assessment revealed the resident needed: extensive assistance of two (2) persons when walking in their room, when walking in the corridor the resident required limited assistance of one (1) person, with locomotion off the unit</p>	F 274	<p>completed by 3/2/2012.</p> <ol style="list-style-type: none"> 3. Nursing staff will receive education by the MDS coordinator on or before 3/6/2012, regarding notification of any changes in condition. 4. A change of condition log as been initiated and will be audited weekly times four weeks then monthly times three months by the Director of Nursing or Assistant Director of Nursing in order to identify significant changes in condition. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed. 5. Compliance Date: 3/16/2012 	

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F 274	<p>Continued From page 8</p> <p>using his/her wheelchair, the resident was independent with set up only by staff, with bathing the resident required physical help with only part of the bathing activity, to dress the resident required limited assistance, with eating the resident needed supervision and setup help only. Further review of the MDS revealed the resident was frequently incontinent of urine, and always continent of bowel.</p> <p>A review of the Quarterly MDS, dated 01/30/12, revealed the (ADL) Assistance assessment noted the resident declined in the following areas from the the 08/18/11 MDS: the assessment of walking in room/corridor it was noted the activity did not occur, with locomotion off the unit using his/her wheelchair the resident was only able to perform this activity once or twice during the assessment and required one person physical assistance to perform, with bathing the resident was totally dependent on staff for his bathing needs, for dressing the resident needed extensive assistance, with eating the resident required extensive assistance of one person assistance. Further review of the MDS revealed the resident was always incontinent of urine, and always incontinent of bowel.</p> <p>Interview, on 02/09/12 at 9:20 AM, with Licensed Practical Nurse (LPN) #5 revealed Resident #1 had a functional decline after admission related to a Miocardial Infarction (MI) on 09/29/11. The resident was re-admitted on 10/06/11 and needed total care by staff. When the resident came back he/she could barely move his/her arms. The resident began Physical/Occupational/Speech Therapy upon re-admission. The resident had shown improvement with therapy, but</p>	F 274		

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F 274	<p>Continued From page 9 experienced a set back.</p> <p>Interview, on 02/09/12 at 10:45 AM, with the MDS Coordinator revealed the criteria for performing a Significant Change (MDS) Assessment was any decline in two (2) or more areas, if the decline was not self limiting, where the resident could recover after a short period of time such as with an infection. After reviewing the 08/18/11 and the 01/30/12 MDS, she revealed based on the criteria the facility should have performed a Significant Change MDS Assessment. The resident had a decline in urinary/bowel incontinence, a decline in bathing, dressing, eating, and the resident was not up walking. The MDS staff should have compared the resident's ADLs from when he/she was admitted after the MI to his/her prior function levels. Continued interview revealed this should have been a significant change. Because they did not generate a Significant Change Assessment, it could have had an impact on identifying Resident #1's care plan needs.</p> <p>Interview, on 02/10/12 at 7:50 PM, with the Director of Nursing (DON) revealed, after review of the resident's decline in ADLs and care areas, when there was a significant change of two or more care areas a Significant Change MDS should have been performed. The nursing staff should have notified the MDS nurse of changes in the resident's function so she could determine if it qualified for a Significant Change.</p>	F 274		
F 280 SS=D	<p>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</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> Resident #1's careplan was revised on 2/9/2012 with an order to not include a fluid restriction and to push fluids as stated in the previous order on 1/20/2012. Resident #4's careplan was revised on 2/13/2012 in order resolve an acute issue of pneumonia. 	

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F 280	<p>Continued From page 10</p> <p>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 observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Plans of Care were reviewed and or revised for four (4) of seventeen (17) sampled residents: Residents #1, #4, #6, and #8.</p> <p>The findings include:</p> <p>Review of the facility's policy: Resident Care Plan, undated, revealed the care plan is defined as a brief written portrait of the resident and an individualized guide of the nursing care needed. Review of the care plan is done at least quarterly and as needed to reflect the resident's current needs, problems, goals, treatment, and services.</p>	F 280	<p>Resident #6's careplan was revised on 2/13/2012 in order to resolve the issue of acute bronchitis.</p> <p>Resident #9's careplan was revised on 2/13/2012 in order to revise an acute issue regarding a sore throat.</p> <ol style="list-style-type: none"> An audit of all resident careplans was completed on 2/29/2012 by Nursing Management to ensure all acute issues were resolved appropriately and that careplans reflect current MD orders. Licensed nursing staff will receive education by the MDS Coordinator on 3/6/2012 regarding resolution of acute careplans and revisions of careplans to reflect new MD orders. The change in condition log will be audited weekly times 	

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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 280	<p>Continued From page 11</p> <p>Interview, on 02/10/12 at 3:45 PM, with the Director of Nursing (DON), revealed all Physician's orders were reviewed by nursing management to help ensure the Comprehensive Care Plans were revised as part of Quality Assurance. Continued interview revealed there was no current formal monitoring to ensure Acute Care Plans were revised when conditions were resolved.</p> <p>Interview, on 02/09/12 at 1:30 PM, with Assistant Minimum Data Set (MDS) Coordinator, revealed she reviewed the orders to make sure she addressed all the concerns on the care plan. The care plan was important because it allowed staff to be aware of the residents' needs.</p> <p>Interview, on 02/09/12 at 4:00 PM, with the Assistant Director of Nursing (ADON), revealed the care plans helped direct the care of the residents and nursing direct care staff was responsible for making revisions to the Comprehensive Plan of Care as orders changed and as the residents' condition changed.</p> <p>1. Review of Resident #1's medical record revealed the facility re-admitted the resident on 10/06/11 with diagnoses which included Dementia, Chronic Kidney Disease, and Acute Systolic Congestive Heart Failure. Review of the Physician's monthly orders for January 2012 revealed the resident was on a 1500 milliliter (ml) fluid restriction. Review of the Physician's order on 01/20/12 revealed an order to push fluid. Review of the Comprehensive Plan of Care included an intervention for 1500 ml fluid restriction under the the resident's care plan for</p>	F 280	<p>four weeks then monthly times three months by the Director of Nursing or ADON to ensure acute issues are resolved and that careplans are revised according to new MD orders. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2012</p>	

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F 280	<p>Continued From page 12</p> <p>potential for weight los/gain. Further review of the resident's Daily Care Guide sheet for direct care revealed it did not include any fluid restriction.</p> <p>Review of the resident's intake sheet for January/February 2012 revealed the resident was given more than 1500 ml of fluid on the following dates: 01/23/12 (1680 ml), 01/29/12 (1800 ml), 01/31/12 (1860 ml), 02/05/12 (2100 ml), 02/06/12 (1740 ml), and on 02/08/12 (1680 ml).</p> <p>Observation of Resident #1, on 02/07/12 at 4:00 PM, revealed the resident had a water pitcher, with water, at bedside within reach. Observation with Certified Nursing Asistan (CNA) #10, on 02/09/12 at 3:50 PM, revealed the resident had a Kennedy cup at bedside with ice and water.</p> <p>Interview, on 02/09/12 at 3:50 P.M, with CNA #10 revealed they give Resident #1 the fluid on his/her meal tray and he/she also had a Kennedy cup at bedside which he/she tried to keep full of water and encouraged the resident to drink. The resident would also request fluid at times. Further interview with CNA #10 revealed the aide care plan (Daily Care Guide) did not show the resident had a fluid restriction. Continued interview revealed if a resident was on fluid restrictions It was noted in the aide care plan.</p> <p>Interview, on 02/09/12 at 4:00 PM, with LPN #5 revealed Resident #1 was on a fluid restriction due to his/her heart failure. The Comprehensive Care Plan showed 1500 ml fluid restriction.</p> <p>Interview, on 02/09/12 at 5:45 PM, with Director of Nursing (DON) revealed the Physician had changed the fluid restriction order on 01/20/12 to</p>	F 280		

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F 280	<p>Continued From page 13 push fluids.</p> <p>2. Review of Resident #4's medical record revealed the resident was admitted on 4/19/10 with diagnoses which included Mild Mental Retardation, Difficulty Walking and Generalized Pain. Review of the Physician's monthly orders for December 2011 revealed the initiation of antibiotics to treat Acute Pneumonia. Record review revealed Resident #4's Comprehensive Care Plan reflected the Acute Condition, with the "problem" onset of 12/11/2011 which stated, "I have pneumonia".</p> <p>Interview with Licensed Practical Nurse (LPN) #13, on 02/08/12 at 2:30 PM, revealed Resident #4 no longer exhibited signs or symptoms of pneumonia, the problem was resolved and the interventions listed on the Comprehensive Plan of Care no longer related to the resident's current condition. Interview further revealed the antibiotic therapy and diagnostic studies of the chest were completed in December. Continued interview revealed the remaining interventions including Nebulizer (breathing treatments) and labwork was completed the first week of January 2012. She further stated the nurses should have revised the care plan as the resident's condition changed and the interventions were no longer appropriate.</p> <p>3. Review of Resident #6's medical record revealed the facility admitted the resident on 06/16/08 with diagnoses which included Generalized Pain, Diabetes Mellitus and Renal Dialysis. The medical record revealed the additional diagnosis of Acute Sinusitis on 01/14/12.</p>	F 280		

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F 280	<p>Continued From page 14</p> <p>Record review of the Comprehensive Care Plan revealed the care plan was revised to reflect the change in the resident's condition on 01/16/12 with the "problem onset... I have sinusitis..Infection will resolve in next ten (10) days."</p> <p>Interview with LPN #13, on 02/08/12 at 2:30 PM, revealed Resident #6's Acute Care Plan for sinusitis was not current. She further stated the interventions on the plan of care were no longer appropriate after the condition was resolved the end of January 2012.</p> <p>4. Review of Resident #9's medical record revealed diagnoses which included Anemia, Anxiety and Depression. Review of the Physician's orders revealed an order, dated 01/11/12, for ten (10) days of antibiotic therapy (medication) to treat the resident's Sore Throat.</p> <p>Record review of Resident #9's Comprehensive Care Plan revealed the "Problem Onset of Sore Throat" with the intervention of antibiotic therapy for ten (10) days, beginning 1/11/12.</p>	F 280		
F 281 SS=D	<p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 281	<p>F 281</p> <p>1. Resident #5 received an order on 2/10/2012 to discontinue the use of fall mats. Resident #7's MAR was corrected to include diet coke flushes, on 2/10/2012. Resident #14's diet order was clarified on 2/7/2012 and is receiving the correct diet consistency. Resident #14 discontinued the use of oxygen per physician order on 2/2/2012.</p>	

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F 281	<p>Continued From page 15</p> <p>by:</p> <p>Based on observation, interview, record review, and policy review, it was determined the facility failed to meet professional standards of quality according to acceptable standards of clinical practice for three (3) of nineteen (19) sampled residents (Residents: #5, #7 and #14). The facility failed to ensure the following Physician's orders were carried out: Resident #5 had a Physician's order for floor mats by the bed but no floor mats were in place; Resident #7 had a Physician's order for Coke flushes to his/her G-tube and the resident did not receive these flushes; Resident #14 had a Physician's order to discontinue oxygen treatment, but the resident was still on oxygen and another order for a regular diet and thin liquids, but the resident was observed to have a mechanical soft diet with honey thickened liquids.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #5's medical record revealed the resident was admitted by the facility on 10/22/04 with diagnoses which included Dementia, Glaucoma, Alzheimer's Disease, and Anxiety. Review of the February 2012 Monthly Physician's orders revealed an order for the resident to have fall mats on the floor on each side of the bed due to fall risk. <p>Observation of Resident #5's room, on 02/08/12 at 11:15 AM and 2:25 PM, and on 02/09/12 at 8:50 AM, 11:30 AM, and 7:45 PM revealed no floor mats by the bedside or in the room.</p> <p>Interview, on 02/09/12 at 7:55 PM, with Certified Nursing Assistant (CNA) #7, revealed the fall</p>	F 281	<ol style="list-style-type: none"> An audit of all diet orders was completed on 2/7/2012 by the Dietary Manager and the Director of Nursing to ensure all residents receive the correct diet. Review of physician orders written in the past 14 days for all residents were reviewed by the Director of Nursing on 3/2/2012 to ensure physician orders had been implemented and had been followed accordingly. Licensed nursing staff will receive education by the Director of Staff Development regarding the process for communicating diet orders and following physician orders on 3/6/2012. An audit of new physician orders will be completed by the Director of Nursing or ADON to ensure physician orders are implemented and are followed as written weekly times four weeks then monthly times three months. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed. Compliance Date: 2/16/2012 	

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F 281	<p>Continued From page 16</p> <p>mats were listed on the care guide and aides were supposed to make sure they were at the bedside when the resident was in bed since the resident was a fall risk. Further interview revealed the fall mats had not been down for awhile.</p> <p>Interview, on 02/09/12 at 7:45 PM, with Licensed Practical Nurse (LPN) #5 revealed Resident #5 had a current order for fall mats. The LPN verified the resident no longer had fall mats in the room. Further interview revealed it was the nurse's responsibility to verify the fall mats were in place.</p> <p>Interview, on 02/10/12 at 7:05 PM, with the Director of Nursing (DON) revealed if there was an order for fall mats she would expect them to be there. The nurse and the CNA were responsible for making sure the floor mats were in place. The nurses and aides failed to make sure the order was carried through. If staff felt the floor mats were no longer needed they should have notified the physician and gotten an order to discontinue the mats.</p> <p>2. Review of Resident #7's medical record revealed the facility admitted the resident on 12/01/11 with diagnoses which included Dementia, Diabetes, Feeding tube and Psychotic Disorder.</p> <p>Review of the medical record revealed an order, dated 01/10/12, to flush G-tube (gastric feeding tube inserted through a small incision in the abdomen into the stomach) with fifty (50) milliliters of diet coke every six (6) hours. Record review of the Medication Administration</p>	F 281		

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F 281	<p>Continued From page 17</p> <p>Record (MAR) for January 2012 revealed Resident #7 received "Diet Coke flushes" every six (6) hours as ordered. However, record review of the February 2012 MAR did not note an order for "Diet Coke flushes" and there was no documented evidence the flushes were continued in February 2012 as ordered.</p> <p>Interview with Resident #7's Physician, on 02/09/12 at 3:30 PM, confirmed he ordered the Diet Coke flushes to help maintain the patency of the G-tube and had not discontinued the Diet Coke flushes.</p> <p>Interview with LPN #13, on 02/09/12 at 6:00 PM, revealed there was Diet Coke available in the Medication Cart but according to the MAR the resident no longer received the Diet Coke flushes to G-tube. However, further interview and record review of the Physician's orders revealed no evidence the order was discontinued.</p> <p>3. Review of Resident #14's medical record revealed the resident was admitted by the facility on 11/10/12 with diagnoses which included Dementia with behaviors, Acute Bronchitis, Heart Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease.</p> <p>Review of the Physician's orders revealed, on 01/14/12, the Physician ordered a diet change for Resident #14 to mechanical soft diet and honey thickened liquids. Another physician order, dated 01/26/12, revealed a diet change for Resident #14 to a regular diet with thin liquids.</p> <p>Observation, on 02/07/12 at 11:55 AM, of Resident #14's food tray revealed the resident had a meal ticket showing the resident was to have a mechanical soft diet and honey thickened</p>	F 281		

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F 281	<p>Continued From page 18</p> <p>liquids. Observation of the resident's food revealed a mechanical soft diet and honey thickened liquids were served.</p> <p>Interview, on 02/07/12 at 11:55 AM, with LPN #12 revealed the resident had an order on 01/26/12 for a regular diet and thin liquids. The resident should have received a regular diet and had thin liquids. Further interview revealed when there was an order change, the kitchen was supposed to get Diet Order and Communication slip completed by the nurse who transcribed the order for the new diet. This was taken to the kitchen and it was entered into the computer. The LPN also stated the resident had a mechanical soft texture diet and honey thickened liquids on 02/07/12.</p> <p>Interview, on 02/10/12 at 3:45 PM, with the DON revealed when they received the 01/26/12 order to change Resident #14's diet to regular and thin liquids a diet communication slip should have been completed and sent to dietary for entry in the computer. The dietary manger was supposed to get a copy of the original order. The DON checked and they were unable to find a diet communication slip. The DON stated she did not know how the error occurred, but the new diet order was not in the system.</p> <p>Further review of Resident #14's Physician's orders revealed there was an order on 02/05/12 to discontinue the resident's oxygen treatment at two (2) liters per minute via nasal cannula (a device to have oxygen flow into the nose).</p> <p>Observation of Resident #14, on 02/10/12 at the following times: 8:30 AM, 10:45 AM, and 12:25</p>	F 281		

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F 281	<p>Continued From page 19</p> <p>PM revealed the resident was receiving oxygen treatment via the nasal cannula at two (2) liters.</p> <p>Interview, on 02/10/12 at 12:25 PM, with LPN #9 revealed, after observation of Resident #14, the resident was still getting oxygen treatment. It should have been discontinued by the nurse who took the order to discontinue the oxygen. It was the nurse's responsibility to make sure it was discontinued. There was a note on the resident's Medication Administration Record (MAR) showing the oxygen was to be discontinued on 02/05/12. The order should have been followed. If they determined the resident needed oxygen a new order should have been written.</p> <p>Further interview with the DON, on 02/10/12 at 3:45 PM, regarding the order to discontinue the oxygen treatment for Resident #14 revealed if there was an order to discontinue the oxygen treatment then it should have been discontinued. The nurse taking the order should have discontinued the oxygen. If staff assessed the resident still needed oxygen they should have gotten a new order for oxygen.</p>	F 281		
F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p>	F 323	<p>F 323</p> <ol style="list-style-type: none"> 1. The emergency carts were secured with a seal and breakaway key on 2/27/2012 by the Director of Maintenance. The supply closet door was closed completely and is secured with a keypad lock. 2. All residents have the potential to be affected, therefore a facility walk through round was conducted on 2/13/2012 by department managers to ensure the residents environment remains free of accident hazards as is possible. Any issues identified were corrected appropriately. 	

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F 323	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy and review of the Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure the residents' environment remained free of accident hazards as is possible as evidenced by unlocked emergency ("crash") carts on the West and South Units and an unlocked supply room on the North Unit that contained potentially hazardous materials.</p> <p>The findings include:</p> <p>Review of the facility policy, "Emergency Equipment" 6-50, undated, revealed under the Procedure subsection number three (3) "all emergency equipment storage areas will be secured with a seal. The storage units will be checked, re-stocked, and sealed each time the seal is broken". Further review of the policy under subsection number five (5) revealed "The DON (Director of Nursing) designee will verify that the cart is locked with a seal everyday".</p> <p>1. Observation, on 02/07/12 at 4:50 PM, revealed an unlocked emergency "crash" cart in the hallway of West Wing near the nurse's station. The emergency cart contained sharps devices, an IV cannula (needle device) and a suture kit.</p> <p>Interview, on 02/07/12 at 6:40 PM, with Registered Nurse (RN) #3, who observed the unlocked emergency cart with the surveyor, revealed the emergency cart should be locked. They do not want a cognitively impaired resident getting into the cart and getting the sharps. It is a safety issue.</p>	F 323	<p>3. All staff will receive education by Director of Staff Development on 3/6/2012 requiring ensuring the facility environment remains free of accident hazards as is possible.</p> <p>4. Audits will be conducted by the department managers through observations during facility rounds weekly time four weeks then monthly times three months to ensure the facility environment remains free of accident hazards as is possible and to ensure each resident receives adequate supervision and assistance to prevent accidents. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2012</p>	

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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 02/11/2012
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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 323	<p>Continued From page 21</p> <p>2. Observation, on 02/08/12 at 12:00 PM, revealed an unlocked emergency "crash" cart on the South Unit. Observation of the items stored in the "crash" cart revealed three (3) bottles of a liquid substance labeled Buffered Eye-Lert Emergency Eye & Skin Flush. Observation of the labels revealed a warning that stated if swallowed get medical help or call Poison Control right away.</p> <p>Review of the material supplied by the manufacturer revealed that the Buffered Eye-Lert solution was considered a drug and therefore a Material Safety Data Sheet (MSDS) did not exist for the product.</p> <p>Interview, on 02/08/12 12:20 PM, with LPN #7 revealed all "crash" carts were to be locked at all times. She stated the lock was broken on the cart however. She stated the Buffered Eye-Lert solution could pose a potential hazard to residents if swallowed.</p> <p>Interview, on 02/08/12 at 12:28 PM, with the Staff Development Coordinator/Infection Control Nurse revealed the Buffered Eye-Lert solution would be considered hazardous as it contained a warning to call Poison Control if swallowed. She stated she didn't realize there was anything hazardous stored in the "crash" cart.</p> <p>3. Observation, on 02/07/12 from 2:30 PM to 2:40 PM, revealed an open unlocked supply closet door across from the North Wing Nursing Station. No staff was present to monitor the open door at this time. The closet was observed to contain twelve (12) bottles of Hydrogen Peroxide</p>	F 323		

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F 323	<p>Continued From page 22</p> <p>Topical Solution and two (2) boxes containing disposable razors.</p> <p>Observation, on 02/08/12 at 11:30 AM, revealed the supply room door on the North Unit to be standing open with no staff present monitoring the door. Observation of the contents of the room revealed hazardous substances to be stored in it, such as bottles of Hydrogen Peroxide, boxes of Alcohol Prep Pads and Povidone-Iodine Prep Pads. Additionally, disposable razors were stored in this supply room. The bottles of Hydrogen Peroxide, and boxes of Alcohol Prep Pads and Povidone-Iodine Prep Pads contained warnings on the back that stated if the products were swallowed seek medical help or call Poison Control. Further observation of this room revealed it continued to remain unlocked and unsupervised on 02/08/12 until 11:55 AM when an Occupational Therapist pulled the door closed locking it. Observations on 02/09/12 at 8:40 AM, 9:15 AM, and 11:05 AM revealed the North Unit supply room to be unlocked.</p> <p>Review of the MSDS for the Hydrogen Peroxide revealed if the product was ingested it could cause irritation of the upper gastrointestinal (GI) tract, with potential distension of the esophagus or stomach. Review of the MSDS for the Povidone-Iodine Pads revealed if ingested "do not induce vomiting" and "obtain medical attention".</p> <p>Interview, on 02/07/12 at 2:40 PM, with Certified Nursing Assistant (CNA) #1 revealed the supply closet door should be closed at all times. It was a safety concern for the residents because there were chemicals and sharps in the closet.</p>	F 323		

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F 323	Continued From page 23	F 323		
F 431 SS=D	<p>Interview, on 02/11/12 at 2:30 PM, with Licensed Practical Nurse (LPN) #10/Charge Nurse revealed the supply room was supposed to be locked at all times. She stated there were "things in there that could potentially hurt a resident".</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the</p>	F 431	<p>F 431</p> <ol style="list-style-type: none"> 1. Identified medications were removed from the cart and secured in a locked storage area. 2. A facility walk through was conducted by nursing management on 2/29/2012 to ensure all medications were secured in a locked storage area with access restricted to authorized personnel only. 3. Nursing staff will receive education by the Director of Staff Development on 3/6/2012 to discuss the proper storage of all medications. 4. Audits will be conducted by nursing personnel through observation of nursing units weekly times four weeks then monthly times three months to ensure proper storage of 	

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F 431	<p>Continued From page 24 quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and policy review it was determined the facility failed to secure all medication in a locked storage area and limit access to authorized personnel only as evidenced by medication observed to be left on top of a medication cart unsupervised.</p> <p>The finding include:</p> <p>Review of the facility's policy: Medication Storage, last revised 06/21/06, revealed medications must be kept under continuous supervision. Medications for external use only must be stored separately from internal medications, and all must be accessible only to authorized personnel.</p> <p>Observation, on 02/07/12 at 5:00 PM, of a medication cart outside of rooms 204/205 revealed the following medications on top of the cart unsupervised: Triamcinolone Cream 0.1% and Santyl 250 unit ointment.</p> <p>Interview, on 02/07/12 at 5:05 PM, with LPN #13 revealed the medication creams should not have been left on top of the cart. They should have been kept in the locked drawer for the safety of residents.</p>	F 431	<p>medications is taking place. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2011</p>	
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441		

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F 441	<p>Continued From page 25</p> <p>Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441		

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F 441	<p>Continued From page 26</p> <p>by:</p> <p>Based on observation, interview, and review of the facility's policy it was determined the facility failed to maintain an Infection Control Program to help prevent the development and transmission of disease and infection for three (3) of seventeen (17) sampled residents (Residents #2, #5 and #7) related to the sanitizing and changing of gloves during skin assessments and perineal care.</p> <p>The findings include:</p> <p>Review of the facility policy, Personal Hygiene Care, undated revealed gloves should be removed and hands sanitized after performing perineal care.</p> <p>1. Observation, on 02/08/12 at 2:25 PM, of a head to toe skin assessment performed by Licensed Practical Nurse (LPN) #9 on Resident #7 revealed the nurse started at the resident's head and proceeded down his/her body. When the LPN checked the resident's perineal area she proceeded to check the rest of the resident's lower body without changing gloves or sanitizing her hands.</p> <p>Interview, on 02/08/12 at 4:22 PM, with LPN #9 revealed she should have sanitized her hands and put new gloves on after assessing the resident's perineal area and before continuing the skin assessment.</p> <p>2. Observation, on 02/08/12 at 5:15 PM, of a skin assessment for Resident #5 revealed after LPN #5 touched the resident's perineal area with her gloves she changed gloves, but failed to cleanse her hands before donning the new pair of gloves</p>	F 441		

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F 441	<p>Continued From page 27 to continue the skin assessment.</p> <p>Interview, on 02/08/12 at 5:25 PM, with LPN #5 revealed she should have used hand sanitizer after taking off her gloves and before donning new gloves. This was an infection control issue, because there could have been contamination with organisms on her hands after removing the gloves. The perineal area was considered a dirty area and she should have cleansed her hands after touching the area.</p> <p>3. Observation, on 02/08/12 at 5:25 PM, during a head to toe skin assessment on Resident #2 revealed the resident's perineal area and buttocks were soiled with feces. Two (2) Certified Nursing Assistants (CNAs) entered the room to cleanse the resident. CNA #6 cleansed the feces from the resident's perineal area and buttocks and assisted with application of a new adult protective garment without sanitizing his hands or changing gloves. After the CNAs finished the task, the nurse informed them a pillow needed a clean pillowcase. CNA #6 removed his gloves and proceeded out of the resident's room to the clean linen area obtaining a new pillowcase without sanitizing his hands.</p> <p>Interview, on 02/08/12 at 5:40 PM, with CNA #6 revealed he usually changed his gloves and sanitized his hands after "cleaning a resident up". He stated he should have sanitized his hands also prior to obtaining the new pillowcase. The CNA stated he had been in a hurry, however should have ensured hand sanitation was performed and new gloves were obtained prior to applying the new adult protective garment and prior to obtaining the new pillowcase from the</p>	F 441		

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F 441	Continued From page 28 clean linen area. Interview, on 02/10/12 at 8:25 PM, with the Infection Control/Staff Development Nurse revealed when performing a skin assessment, if staff was to touch an open area, the vaginal area, the perineal area, or the rectal area she would expect the staff to change gloves and to cleanse their hands before putting on the new gloves and continuing on with the skin assessment. The Infection Control Nurse stated she did not monitor staff when they perform skin assessment, but staff should know to do this because they were taught how to do this. She continued to state this the practiced posed a risk for the potential to spread organisms to other areas of the body and infection.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure an effective communication call system was available for one (1) of seventeen (17) sampled residents, Resident #7, as evidenced by observations of the call light not placed within reach of the resident.	F 463	F 463 1. Resident #7's call light was place back within reach of the resident. 2. A facility walk through was conducted by department managers on 2/28/2012 to ensure call lights were within reach of the residents. Any issues were corrected appropriately. 3. All staff will receive education by the Director of Staff Development on 3/6/2012 to discuss the proper placement of call lights.	

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F 463	<p>Continued From page 29</p> <p>The findings include:</p> <p>Review of the facility's policy, Use of Call Light, undated, states to position the call light conveniently. The policy further stated to be sure call lights are placed on the bed at all times, never on the floor or bedside stand.</p> <p>Review of the facility's policy, General Resident Rights Guidelines, undated, states to place call light within reach of the resident.</p> <p>Review of the facility's policy, Turning Rounds, undated, states it is the basic responsibility of staff to "refresh" non-ambulatory residents on a regular basis. This procedure includes to place call light within reach and instruct resident to call for assistance, if needed.</p> <p>Review of the medical record, revealed Resident #7 had diagnoses which included Dementia, Anxiety and Diabetes. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/08/11, revealed the facility had assessed Resident #7 as moderately impaired in cognition.</p> <p>Observation, on 02/07/12 at 5:15 PM, 5:45 PM, 6:10 PM, and 7:00 PM revealed the call bell and cord was on the floor underneath Resident #7's bed out of reach and the resident was in bed, positioned on his/her back with eyes closed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 02/07/12 at 7:00 PM, revealed call lights were to be within reach of the residents and even on Resident #7's "best days" he/she could not reach or retrieve the call bell from the location of</p>	F 463	<p>4. Audits will be conducted by department managers weekly times four weeks then monthly times three months to ensure proper placement of resident call lights. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Date of Compliance: 3/16/2012</p>	

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F 463	<p>Continued From page 30 underneath the bed.</p> <p>Observation, on 02/08/12 at 10:15 AM, 11:30 AM, 11:45 AM and 12:20 PM, revealed Resident #7 was noted to be in a reclining type of chair with his/her eyes shut without a call bell accessible. Further observation during those times revealed the call bell was located on the resident's bed, however, it was out of the Resident #7's reach and covered by bed linens.</p> <p>Interview at Resident #7's bedside with Certified Nursing Assistant (CNA) #3, on 02/08/12 at 12:25 PM, confirmed the call bell was not within reach of Resident #7 when it was located under the bed linens. Continued interview with CNA #4 revealed they had failed to notice the call bell was not accessible. She further stated the night shift had "spread up the bed" and confirmed the call bell had been "under the covers out of reach of the resident for about four (4) hours".</p>	F 463	<p>F 514</p> <ol style="list-style-type: none"> Resident #14's MAR was corrected to be reflective of current new orders. Resident #13's original MAR is accurate and unchanged. Director of Health Information was suspended on 2/10/2012. Resident #3's door tag was changed to the correct bed on 2/7/2012. Resident #3's picture was placed on the MAR on 2/7/2012. All MARs were audited by the Director of Nursing on 2/13/2012 to ensure they were complete and accurately documented and to ensure proper identification was in place to identify residents. Licensed nursing staff will receive education on 3/6/2012 by the Director of Staff Development to discuss accepted professional standards and practices regarding clinical records. 	
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p>	F 514		

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F 514	<p>Continued From page 31</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to maintain accurate clinical records on each resident in accordance with acceptable professional standards and practices that are complete and accurately documented for three (3) of seventeen (17) sampled residents (Residents #3, #13, and #14) as evidenced by: Resident #3 had no picture to identify the resident on the facility's Medication Administration Record (MAR) book; Resident #13 and Resident #14 had Medication Administration Records (MARs) which contained inaccurate information.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #14's medical record revealed the resident was admitted by the facility on 01/10/12 with diagnoses which included Dementia with behaviors, Acute Bronchitis, Heart Failure, Coronary Artery Disease, and Chronic Obstructive Pulmonary Disease. <p>Review of Physician orders revealed on 01/10/12 the Physician ordered Depakote Sprinkles 125 milligrams (mg) by mouth three times a day for Dementia. Then on 01/11/12 the Physician changed the order on 01/11/12 to Depakote 250 mg 8:00 AM and 12:00 PM and Depakote 500 mg at night by mouth each day.</p> <p>Review of Resident #14's January 2012 MAR revealed on 01/11/12 and 01/12/12 Licensed Practical Nurse (LPN) #10 had initialed giving both the Depakote Sprinkles 125 mg and the</p>	F 514	<ol style="list-style-type: none"> MARs will be audited by nursing management weekly times four weeks then monthly times three months to ensure MARs are complete and accurately documented and to ensure proper identification is in place to identify residents. Random chart audits will be conduct by Nursing Management monthly times three months then quarterly to ensure compliance with the regulation. Compliance Date: 3/16/2012 	

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F 514	<p>Continued From page 32</p> <p>Depakote 250 mg at 8:00 AM and 12:00 PM. Further review of the MAR revealed on 01/13/12 LPN #11 initiated giving both the Depakote Sprinkles 125 mg and the Depakote 250 mg at 8:00 AM and 12:00 PM.</p> <p>Interview, on 02/10/12 at 12:00 PM, with LPN # 9 who, after review of the January 2012 MAR, revealed when there is an order change the process is to update the MAR. LPN #9 stated according to documentation in the MAR both the Depakote Sprinkles 125 mg and the Depakote 250 mg have been initiated by the nurses as being given on 01/11/12, 01/12/12, and 01/13/12. Further interview revealed the concern would be this was a documentation error or the resident received both doses of the Depakote on these dates. The process when a new order is received is the nurse should go to the MAR and next to the old order they should clearly note the order was discontinued (DC'd) and put the new order on the MAR so staff is aware there has been a change in the dose.</p> <p>Interview, on 02/10/12 at 10:05 PM, with LPN #10 regarding the January MAR and both the Depakote Sprinkles 125 mg and the Depakote 250 mg being initiated by the LPN on 01/11/12 and 01/12/12 revealed this was a documentation error. The LPN only gave the Depakote 250 mg and would not have given both doses of the medication. It would have been a red flag if he had both of the Depakote doses, he would not expect both ordered given at the same time. After giving his 8:00 AM and 12:00 PM doses he probably went through the MAR and signed all the medications listed for these times. It was a documentation error on his part.</p>	F 514		

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

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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 02/11/2012
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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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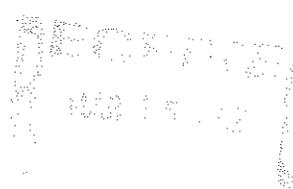
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F 514	<p>Continued From page 33</p> <p>Interview, on 02/10/12 at 10:15 PM, with LPN # 11 regarding the January MAR and both the Depakote Sprinkles 125 mg and the Depakote 250 mg being initialed by the LPN on 01/13/12 revealed this was a documentation error. The LPN only gave the ordered Depakote 250 mg on 01/13/12. Further interview revealed she clarified which dose was to be given by reviewing the orders. LPN # 11 stated she should have followed the facility process and circled her initials under the Depakote Sprinkles 125 mg because she did not give this medication on this date.</p> <p>Interview, on 02/10/12 at 10:30 PM, with the Director of Nursing (DON) revealed nurses signing medications should initial only the medication being given by the nurse in the MAR. When they got the order change, the process would be to remove the old medication dose from the medication cart and clearly identify in the MAR the medication had been discontinued. It is the expectation the nurse taking the new order for the Depakote 250 mg to have removed the Depakote Sprinkles 125 mg from the medication cart and clearly mark in the MAR this dose had been discontinued. It appears the Depakote Sprinkles was not clearly marked it had been discontinued and the nurses initialed both places. Nurses are expected to only document what medications they actually gave.</p> <p>2. Review of Resident #13's medical record revealed the facility admitted the resident on 11/04/11 with diagnoses which included Diabetes, Cellulitis and Neuropathy (condition which can present with symptoms of nerve pain).</p>	F 514		

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F 514	<p>Continued From page 34</p> <p>Record review of the Medication Administration Record revealed orders in November 2011 for Hydrocodone/Acetaminophen 7.5-500 milligram tablet every six (6) hours. A record review conducted on 02/10/12 at 4:30 PM of the November 2011 MAR revealed no documented evidence the medicine was given at 1AM, 7 AM, or 7 PM on 11/24/11. There was also no documented evidence the medication was given on 11/27/11 at 7 AM or 1 PM. However, record review conducted one hour later revealed initials in all five (5) previously blank time slots indicating the medication was given.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 02/10/12 at 5:45 PM, revealed she was unaware of any changes made to the MAR records being reviewed indicating medications previously noted to not have been available or given to the resident documented as given.</p> <p>Interview with the Health Information Management Assistant (HIM), on 02/10/12 at 5:50 PM, revealed she had "filled in the holes" on the MAR indicating the medication had been given. Further interview revealed she had never previously falsely documented records and had not been instructed to alter any documents. She further acknowledged she had no idea if the resident had received the medication. She also stated she intended the initials to look like the initials of the two (2) nurses who had given other medications to Resident #13 during those five (5) time slots she altered.</p> <p>Interview with the Director of Nursing, on 02/10/12 at 8:30 PM, revealed the facility policy would allow the nurse who had failed to record a</p>	F 514		

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F 514	<p>Continued From page 35</p> <p>medication make the change on the document within 72 hours. After that time period any changes would need to be noted as a late entry with the appropriate accompanying documentation.</p> <p>3. Review of the clinical record revealed the facility admitted Resident #3 on 7/28/10 with diagnoses which include; intellect disability, Anxiety, Depression, Hypertension, Convulsion Disorder, Hyperlipdemia and Psychosis</p> <p>Observation, on 2/7/12 at 4:25 PM, revealed Resident #3's bed number was incorrectly identified on door of the resident's room. Resident #3 was listed on the door of his/her room as being in bed #2, but was in bed #1</p> <p>Interview with License Practical Nurse (LPN) #8, on 2/7/12 at 4:25 PM, revealed the staff knew the residents and could be identified by pictures that were on the Medication Administration Record (MAR).</p> <p>Observation, on 2/7/12 at 4:27 PM, revealed that there was no identifying picture of Resident #3 on the MAR.</p> <p>Interview, on 2/7/12 at 4:50 PM, with Staff Development Coordinator (SDC) revealed that the name on the Resident's door should have been changed to reflect the bed that he/she was in and that a picture of the Resident should have been on the MAR for identification. The SDC revealed that it was the Social Service Department responsibility to make sure pictures were on the MAR for all Residents.</p>	F 514		

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F 514	Continued From page 36 Interview, on 2/8/12 at 10:00 AM with the Social Service Director (SSD) revealed the SSD took the pictures of the Residents, but was not responsible for putting them on the MAR. That was the responsibility of the Medical/Nursing Department.	F 514		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1967, 1970 Facility type: SNF/NF Type of structure: Type III Protected Smoke Compartment: Eight (8) Fire Alarm: Complete fire alarm with heat and smoke detectors in corridors and resident rooms on North and South Wings, all corridors on East and West Wing (software upgrade: 2011) Sprinkler System: Complete sprinkler system (dry) Generator: Type II powered by Natural Gas with Propane backup. A standard Life Safety Code survey was conducted on 02/07/12. Life Care Center of Morehead was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was eighty two (82). The facility is licensed for ninety seven (97) beds. The highest scope and severity was at an F level. The following demonstrate non compliance: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under	K 000	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.	
K 050 SS=F		K 050	<ol style="list-style-type: none"> A fire drill was scheduled by the Director of Maintenance to be conducted on March 6, 2012 for third shift at approximately 11:30 P.M. A review of all other fire drill times was conducted on 3/1/2012 by the Director of Maintenance and the Executive Director to identify any other drills that were being held consistently at the same time. No other issues were noted. The Maintenance Director was educated by the Life Safety inspector on 2/7/2012 regarding NFPA 101. The Maintenance Director signed an education acknowledgement form 	

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MAR 13 2012

RATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Executive Director	(X6) DATE 3/5/12
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Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued m participation.

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K 050	<p>Continued From page 1</p> <p>varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect ninety seven (97) residents, staff and residents.</p> <p>The findings include:</p> <p>Record review of the facility's fire drills documentation on 02/07/12 at 3:54 PM, revealed fire drills for Third Shift were consistently conducted at 5:00 AM. Fire Drills must be conducted at various times. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 02/07/12 at 3:54 PM, with the Maintenance Director, revealed he always conducted the Third Shift fire drills at 5:00 AM due to shift change.</p> <p>Reference: NFPA 101 (2000 edition) 4.7.5* Simulated Conditions. Drills shall be held at expected</p>	K 050	<p>regarding fire drills being conducted at different and unexpected times.</p> <p>4. Fire Drills will be audited monthly times six months by the Director of Maintenance and the Executive Director to ensure fire drills are being held at unexpected times. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed.</p> <p>5. Compliance Date: 3/16/2012</p>	

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K 050	Continued From page 2 and unexpected times and under varying conditions to simulate the unusual conditions that can occur in an actual emergency. 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.	K 050	K 056 1. A sprinkler head was placed in the housekeeping closet located on south wing on 2/16/12 by SafeCare Inc. 2. A facility walk through round was conducted by the Maintenance Director and the Executive Director on 3/2/2012 to identify any other required spaces that were not protected by an automatic sprinkler system. No other areas were identified.	
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper	K 056		

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K 056	<p>Continued From page 3</p> <p>switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure all required spaces were protected by the automatic sprinkler system, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments.</p> <p>The findings include:</p> <p>Observation, on 02/07/2012 at 12:07 PM, revealed the housekeeping closet for the South Wing, was not protected with an automatic sprinkler head. The facility is of Type 111 construction. Health care facilities of Type 111 construction are required to be fully sprinklered. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 02/07/2012 at 12:07 PM, with the Maintenance Director, revealed he was unaware the housekeeping closet was not protected with the automatic sprinkler system.</p> <p>Reference: NFPA 101 (2000 edition) 19.1.6.2 Health care occupancies shall be limited to the types of building construction shown in Table 19.1.6.2. (See 8.2.1.) Exception:* Any building of Type I(443), Type I(332), Type II(222),</p>	K 056	<ol style="list-style-type: none"> 3. An audit to identify required spaces being protected by an automatic sprinkler system will be added to the facility's monthly TELS preventive maintenance schedule. 4. The TELS preventive maintenance schedules will be audited monthly times three months then quarterly thereafter to ensure compliance with the regulation. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further recommendations if needed. 5. Compliance Date: 3/16/2012 	

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K 056	<p>Continued From page 4 or Type II(111) construction shall be permitted to include roofing systems involving combustible supports, decking, or roofing, provided that the following criteria are met:</p> <p>(a) The roof covering meets Class C requirements in accordance with NFPA 256, Standard Methods of Fire Tests of Roof Coverings.</p> <p>(b) The roof is separated from all occupied portions of the building by a noncombustible floor assembly that includes not less than 2 1/2 in. (6.4 cm) of concrete or gypsum fill.</p> <p>(c) The attic or other space is either unoccupied or protected throughout by an approved automatic sprinkler system.</p> <p>Table 19.1.6.2 Construction Type Limitations</p> <table border="1" data-bbox="105 1354 714 1732"> <thead> <tr> <th>Stories</th> <th>1</th> <th>2</th> <th>3</th> <th>4</th> </tr> </thead> <tbody> <tr> <td>I(443)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>I(332)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(222)</td> <td>X</td> <td>X</td> <td>X</td> <td>X</td> </tr> <tr> <td>II(111)</td> <td>X</td> <td>X*</td> <td>X*</td> <td>NP</td> </tr> </tbody> </table>	Stories	1	2	3	4	I(443)	X	X	X	X	I(332)	X	X	X	X	II(222)	X	X	X	X	II(111)	X	X*	X*	NP	K 056		
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I(332)	X	X	X	X																									
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K 056	<p>Continued From page 5</p> <table border="0"> <tr> <td>II(000)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(211)</td> <td>X*</td> <td>X*</td> <td>NP</td> <td>NP</td> </tr> <tr> <td>III(200) NP</td> <td>X*</td> <td>NP</td> <td>NP</td> <td></td> </tr> <tr> <td>IV(2HH) NP</td> <td>X*</td> <td>X*</td> <td>NP</td> <td></td> </tr> <tr> <td>V(111) NP</td> <td>X*</td> <td>X*</td> <td>NP</td> <td></td> </tr> <tr> <td>V(000) NP</td> <td>X*</td> <td>NP</td> <td>NP</td> <td></td> </tr> </table> <p>X: Permitted type of construction.</p> <p>NP: Not permitted.</p> <p>*Building requires automatic sprinkler protection. (See 19.3.5.1.)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was according to National Fire Protection</p>	II(000)	X*	X*	NP	NP	III(211)	X*	X*	NP	NP	III(200) NP	X*	NP	NP		IV(2HH) NP	X*	X*	NP		V(111) NP	X*	X*	NP		V(000) NP	X*	NP	NP		K 056	<p>K 147</p> <ol style="list-style-type: none"> The outlets in rooms 109, 110, 111 and 100 were grounded according to NFPA 70 by Electronic Services Inc. on 2/8/2012. A facility walk through round was conducted on 2/8/2012 by the Director of Maintenance and Electronic Services Inc. to identify any other outlets not grounded according to 	
II(000)	X*	X*	NP	NP																														
III(211)	X*	X*	NP	NP																														
III(200) NP	X*	NP	NP																															
IV(2HH) NP	X*	X*	NP																															
V(111) NP	X*	X*	NP																															
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K 147 3S=D		K 147																																

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/07/2012
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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
K 147	<p>Continued From page 6</p> <p>Association (NFPA) standards. The deficiency had the potential to affect eight (8) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 02/07/2012 at 11:50 AM, revealed when tested with an electrical outlet tester, an electrical receptacle in resident room 109 had an open ground. Electrical outlets must be grounded to prevent possible electrical shocks. Further observation revealed the same for resident room 110, 111, and resident room 100. The observations were confirmed with the Maintenance Director.</p> <p>Reference: NFPA 70 (1999) 517-13. Grounding of Receptacles and Fixed Electric Equipment.</p> <p>(a) Patient Care Area. In an area used for patient care, the grounding terminals of all receptacles and all non current carrying conductive surfaces of fixed electric equipment likely to become energized that are subject to personal contact, operating at over 100 volts, shall be grounded by an insulated copper conductor. The grounding conductor shall be sized in accordance with Table 250-122 and installed in metal raceways with the branch-circuit conductors supplying these receptacles or fixed equipment.</p> <p>Exception No. 1: Metal raceways shall not be required where listed Types MI, MC, or AC cables are used, provided the outer metal armor or sheath of the cable is identified as an acceptable grounding return path.</p> <p>Exception No. 2: Metal faceplates shall be</p>	K 147	<p>NFPA 70. Issues identified were corrected by Electronic Services on 2/14/2012.</p> <p>3. Education regarding NFPA 70 was provided to the Maintenance Director by the Life Safety surveyor on 2/7/2012. The Maintenance signed an educational acknowledgement form on 3/2/2012. Proper grounding of electrical outlets according to NFPA 70 will be added to the facility's TELS preventive maintenance schedule to ensure ongoing compliance.</p> <p>4. Audits of electrical outlets will be conducted monthly times three months then quarterly thereafter to ensure compliance with NFPA 70. The results of these audits will be brought to the monthly Quality Assurance meeting for review and further</p>	

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

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K 147	<p>Continued From page 7</p> <p>permitted to be grounded by means of a metal mounting screw(s) securing the faceplate to a grounded outlet box or grounded wiring device.</p> <p>Exception No. 3: Light fixtures more than 71/2 ft (2.2 m) above the floor and switches located outside of the patient vicinity shall not be required to be grounded by an insulated grounding conductor.</p>	K 147	<p>recommendations if needed.</p> <p>5. Date of Compliance: 3/16/2012</p>	