

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

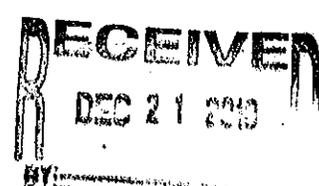
PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
--	--	--	---

NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS AMENDED A Recertification/Abbreviated Survey was conducted 11/02/10 through 11/05/10, and a Life Safety Code Survey was conducted on 11/04/10. Deficiencies were cited with the highest Scope and Severity of a "G". ARO #KY00014835, ARO KY00015504, ARO KY00015505, ARO KY00015507 and KY00015509 were substantiated with no deficiencies cited. ARO KY00015284 was unsubstantiated with deficiencies cited. ARO KY00015006, ARO KY00014836 and ARO KY00015508 were substantiated with deficiencies cited. ARO KY00015283 and ARO KY00014837 were unsubstantiated with no deficiencies cited.	F 000		
-------	--	-------	--	--

F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed implement its policies related to immediately reporting alleged violations involving misappropriation of resident property to the State Agency for one (1) of twenty-seven (27) sampled residents (Resident #1). The findings include: Review of Resident #1's medical record revealed diagnoses which included Anxiety, Seizure	F 226	Please see next page 	12-20-10
---------------	--	-------	--	----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Krista Mann</i> Admin 15 Street 12-21-10	TITLE	(X6) DATE
--	-------	-----------

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.

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 226	<p>Continued From page 1</p> <p>Disorder, and Osteoarthritis. Review of the Annual Minimum Data Set (MDS) Assessment dated 08/06/10 revealed the facility assessed the resident as having modified independence in daily decision making.</p> <p>Interview with Resident #1 on 11/03/10 at 10:00 AM, revealed someone had "swiped" the resident's keys off of his/her belt, which was on the resident's pants. Resident #1 reported going to bed on the evening of 08/27/10 at approximately 7:00 PM, with the keys on his/her belt. Further interview revealed the resident noticed the keys were missing the following morning when he/she awoke. Resident #1 stated he/she reported the missing keys to staff late on the morning of 08/28/10. Resident #1 further stated that on 08/30/10, when maintenance staff were able to unlock the cabinets in his room (which the lost keys opened), it was determined \$15.00 dollars was missing.</p> <p>Review of the Resident Abuse Report Form revealed the incident occurred either the evening of 08/27/10 or the morning of 08/28/10. Further review of the Report Form revealed a search for Resident #1's keys was initiated on 08/28/10; however, a charge nurse failed to immediately inform Administration of the missing keys. Facility Administration was not informed of the missing keys until 08/30/10. The Report Form further stated the state agencies were informed of the incident on 08/30/10. Facility Administration conducted interviews in an effort to determine whether keys had been misappropriated or lost, but were unable to identify a perpetrator. An interview with the charge nurse conducted as part of the facility investigation indicated the charge nurse believed the keys may have been</p>	F 226	<p>Resident #1 had a new lock installed on the cabinet in the room on 9-3-10. A new key was given to the resident for the new lock. Social Services will interview every resident in the facility to determine a master list of residents with locks/keys for personal items. This will be completed by 12-17-10. The Nursing Staff will be educated on the facility Abuse Policies and Procedures, which includes misappropriation of property. They will be educated by the Staff Development Coordinator that all alleged abuse violations must be reported immediately to their supervisor who in turn will report to the facility administration for follow up and who will then report to the state agency immediately (as soon as possible, not to exceed 24 hours). Education conference for nursing staff on 12-2-10 and nursing meeting on 12-14-10. The nursing supervisor will make rounds every shift that will include inquiring of the charge nurse about any incidents, including but not limited to, alleged abuse violations. This would then be reported to administration for follow up which would then report to the state agency immediately (as soon as possible, not to exceed 24 hours).</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102	
(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)	(X8) COMPLETION DATE
F 226	Continued From page 2 misplaced and called laundry in an effort to locate them. An interview with the Social Worker on 11/05/10 at 10:45 AM revealed he/she was aware the allegation was not reported in a timely manner. The alleged violation was reported by Resident #1 on Saturday, 08/28/10 to Certified Nursing Aide (CNA) #5, who then reported to his/her charge nurse. The charge nurse failed to forward the report to administration. The alleged violation was not reported to state agencies until 08/30/10. Review of facility policy, "Social Services, Resident Abuse," dated 12/01, stated "all alleged abuse violations and all substantiated incidents shall be reported to the state agency immediately (as soon as possible, and ought not to exceed 24 hours)."	F 226		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. 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	F 280	Res. #7's care plans and orders have been revised on 11-4-10 to reflect discontinuation of splints to the elbows and hands. In order to identify any residents with incorrect orders/care plans, every chart was thoroughly reviewed during facility change-over which was completed 11-30-10 for any errors. Copies of all changes faxed to pharmacy for updates were provided for the MDS office who then corrected any care plans by 12-3-10. The Staff Development Nurse will educate the nursing staff to update care plans at time of order changes. The MDS office will be educated to ensure that changes are made to the care plans by verifying order changes against the care plan no later than the next business day. Education conference for nursing staff on 12-2-10 and nurses meetings conducted on 12-14-10.	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	<p>Continued From page 3 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the Care Plan was reviewed and/or revised to reflect Physician's Orders for one (1) of twenty-seven (27) sampled residents (Resident #7). Resident #7 had an Order to discontinue splints to elbows and hands. However, the intervention remained on the active Care Plan fourteen (14) months after the Order was written.</p> <p>The findings include:</p> <p>Review of the Clinical Record revealed Resident #7 was admitted with diagnoses which included Cerebral Palsy with Congenital Quadriplegia and Seizure Disorder. Review of the Physician's Orders for November 2010 revealed an Order for a splint to elbows and hands for (4) hours a day. Review of the Care Plan, revised on 07/20/10, revealed an intervention for splints to elbows and hands four (4) hours a day.</p> <p>Observation of the resident on 11/02/10 and 11/03/10 revealed no splint was present.</p> <p>Interview with Certified Nursing Assistant (CNA) #5 on 11/04/10 at 11:50 AM revealed she took care of Resident #7 most days she was on duty. She stated she had never applied a splint to the resident. Review of the Daily Care Record, used by the CNAs revealed no instructions regarding the application of splints.</p>	F 280	<p>The MDS CP Coordinator will conduct routine audits on a monthly basis to verify order changes are being reflected on the care plans. This will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 280	Continued From page 4 Interview with Registered Nurse (RN) #1 on 11/04/10 at 12:10 PM revealed Resident #7's splints had been discontinued "for a while". She produced a copy of the original Order, dated 09/11/09, to discontinue the splints. The Verbal Physician's Order was signed by the resident's attending physician. Interview with Licensed Practical Nurse (LPN) #4 on 11/04/10 at 2:45 PM revealed when Orders were received, the transcribing nurse updated the Resident Daily Care Record. She stated a copy of all new Orders was sent to the Minimum Data Set (MDS) reviewers who were responsible for revising the Care Plan to reflect the Orders.	F 280		
F 281 SS=G	Interview with LPN #12 (MDS Nurse) on 11/04/10 at 2:50 PM revealed Care Plans were revised quarterly. She stated MDS staff was responsible for reviewing all new Orders and updating the Care Plans accordingly. Continued interview revealed, regarding Resident #7's splints, the Order was overlooked. 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services provided meet professional standards of quality for four (4) of twenty-seven (27) sampled residents (Residents #8, #6, #3, and #24).	F 281	Res. #24 was a closed record review. Res. #6 has since been discharged from the facility. Res. #3 and #8 have had their care plans revised in regards to areas of identified deficient practice. Res. #3 was revised on 11-4-10. Res. #8 was revised on 11-3-10. Each RN Mgr. will audit each res. comparing current physician orders for appliances, safety devices, etc. with what is in place. They will audit all orders, not just those to be on the plan of care. This will be done by 12-17-10. Any discrepancies will be immediately	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185448	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 8 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 5 Resident #8 was identified by the facility as being at risk for pressure ulcers; however, the facility failed to develop an Initial Plan of Care related to this issue. Resident #1 developed a Pressure Sore to the Left Heel which was unidentified by the facility, before the surveyor requested a skin assessment be conducted. In addition, Resident #8 had a Physician's Order for the use of an abductor splint/wedge, to be used while the resident was in bed. The facility failed to implement the order. Resident #6 was admitted with an abdominal incision site. The facility failed to develop an Admission/Initial Plan of Care related to the need to monitor the resident's incision site for signs and symptoms of infection, or to address the need to monitor the resident for risks and complications related to receiving anti-coagulant medication. The facility failed to develop an Admission/Initial Plan of Care which addressed the need to monitor Resident #24's incision sites for signs and symptoms of infection. Resident #3 had Physician's Orders for mats at the bedside at all times however, the facility failed to ensure the order was implemented/followed. The findings include: 1. Review of Resident #8's clinical record revealed the resident was admitted to the facility on 10/27/10 with diagnoses which included Status Post Left Hip Fracture on 10/23/10 and IM Nailing (Intramedullary Nailing; a surgical procedure used to treat fractures of long bones in which a metal rod is forced into the medullary cavity of a bone)	F 281	updated by 12-17-10. This will then be audited on a monthly basis and followed up through the performance improvement program. The Staff Development Nurse will educate the nursing staff on implementation of admission and readmission care plans to address all areas of concern for a resident such as pain, alteration in mobility, potential for skin breakdown, potential for infection, etc. Nursing staff will be educated to update and revise all care plans as orders are changed and/or care needs are identified. The MDS office will be educated to ensure that changes are made to the care plans by verifying order changes against the care plan no later than the next business day. The MDS CP Coordinator will conduct routine audits monthly to verify order changes are being reflected on the care plans. Nursing Supervision will conduct routine audits on admissions and re-admissions to verify that care plans are in place and verify that areas of concern identified for the resident are such noted. The wound nurse will assess each admission and readmission on a daily basis and verify that any skin areas of concern are such noted on the care plans. The wound nurse will conduct a monthly audit to ensure compliance with turning and repositioning and validate correct care plans in regards to skin needs and to ensure res. are being turned and repositioned as needed/ordered. Nsg.	12-28-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 6 of the Left Hip. Further review revealed no Minimum Data Set (MDS) Assessment had been completed because of the recent admission date.</p> <p>Review of the Admission Physician's Orders dated 10/27/10, revealed orders which included the use of an abductor splint/wedge to be provided while the resident was in bed.</p> <p>Review of the facility's, "Risk Factors that Increase a Resident's Susceptibility to Develop or Not Heal Pressure Ulcers" form, revealed the facility assessed the resident as being at risk to develop pressure ulcers related to drugs affecting awareness; pain, altering mobility; fracture; and impaired mobility.</p> <p>Review of the Admission/Initial Care Plan dated 10/27/10, revealed no documented evidence the facility developed a Plan of Care to address the resident's potential for the development of pressure ulcers, although the facility had identified risk factors.</p> <p>Review of the "Resident Daily Care Record" dated 10/10 and 11/10, revealed the resident required the assistance of two (2) staff related to turning and repositioning, but it did not specify how often the resident was to be turned/repositioned. The Resident Daily Care Record failed to address the use of the abductor wedge, as a positioning device.</p> <p>Review of the Nurse's Note dated 10/27/10 at 5:00 PM, revealed the resident was admitted to the facility from the hospital with a Left Hip IM Nailing. Further review revealed the resident had a three (3) inch incision with eleven (11) staples and a two and a half (2.5) inch incision with ten</p>	F 281	<p>Supervision education on 11-16-10. Education conference 12-2-10 and nurses meeting on 12-14-10. This will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 7</p> <p>(10) staples from the hip surgery, and a linear skin tear to the left thigh. According to the Note, the resident was alert and oriented, continent of bowel and bladder, and required the assistance of two (2) staff for transfers.</p> <p>Observation on 11/03/10 at 9:50 AM, during a skin assessment performed by the Wound Nurse, revealed the resident had a 3.25 cm x 2.5 cm Pressure Sore, located on the left heel. The Wound Nurse described the area as being purple in color with "suspected deep tissue injury". Observation, at this time, revealed the resident's abductor wedge was on a chair, by the resident's bed.</p> <p>Interview on 11/03/10 at 9:50 AM and at 10:30 AM with the Wound Nurse, revealed the resident's Pressure Ulcers had not been identified by the facility. He indicated he was not sure why the abductor pillow was not being used.</p> <p>Interview with Certified Nursing Assistant (CNA) #9 on 11/03/10 at 10:15 AM and 1:40 PM; Licensed Practical Nurse (LPN) #8 on 11/01/10 at 10:20 AM; and, CNA #30 on 11/03/10 at 2:30 PM revealed staff were unaware the resident should be utilizing an abductor wedge.</p> <p>Interview on 11/03/10 at 1:50 PM and on 11/04/10 at 4:00 PM with the Unit Manager, who was assigned to Resident #8's unit, revealed the resident should have had a Plan of Care, on admission, related to the risk for pressure due to decreased mobility and the need for turning and repositioning, as well as utilizing the abduction wedge.</p> <p>Interview on 11/03/10 at 3:30 PM with LPN</p>	F 281		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 8</p> <p>#6/Evening Shift Supervisor, revealed she had completed the Admission Care Plan for the resident on 10/27/10 and should have ensured the resident had a Plan of Care to prevent skin breakdown due to decreased mobility. LPN #6 stated interventions to ensure turning and repositioning, and the use of the abductor wedge should have been in place.</p> <p>Interview on 11/04/10 at 9:00 AM with the resident, revealed he/she could turn him/herself to the right side but, had not been turning him/herself much. Resident #8 further stated he/she could not turn self to the right side due to pain. The resident stated staff had not been assisting him/her with turning in bed until yesterday when they found a "bedsore".</p> <p>2. Review of Resident #6's clinical record revealed the resident was admitted to the facility on 10/22/10 with diagnoses which included Perforation of the Intestines with Total Colectomy, and Diabetes Mellitus. Further review revealed there was no Minimum Data Set (MDS) Assessment or Comprehensive Assessment due to the recent admission date.</p> <p>Observation of a skin assessment on 11/03/10 at 9:45 AM revealed steri-strips were in place along the abdominal incision site.</p> <p>Review of the Admission Nurse's Notes dated 10/22/10 (no time noted) revealed the resident had an abdominal wound with thirty (30) staples which were intact with slight redness around the staples and scant drainage on the dressing.</p> <p>Review of the Physician's Orders dated 10/22/10, revealed orders for an Island Dressing to the</p>	F 281		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 9</p> <p>abdominal wound every day after cleansing with Sea Clens. Further review of Physician's Orders dated 10/29/10, revealed orders to remove the thirty (30) staples and monitor steri-strips to abdomen.</p> <p>Review of the Admission Plan of Care revealed there was no plan of care to address the resident's abdominal incision site or the need to monitor the site for signs and symptoms of infection.</p> <p>Further review of the Physician's Orders dated 10/22/10, revealed orders to start Coumadin five (5) milligrams (anti-coagulant medication) every day, and Lovénox Injection (anticoagulant medication) forty (40) milligrams every day for twenty (20) days. Physician's Orders dated 10/28/10, revealed orders to hold Coumadin today, administer Vitamin K ten (10) milligrams by mouth for one dose, and recheck the PT/INR (Prothrombin Time /International Normalized Ratio (test used to determine the clotting tendency of blood) tomorrow. Further review of the Physician's Orders dated 10/29/10, revealed orders for Vitamin K ten (10) milligrams for one day and check INR Sunday. Review of Physician's Orders dated 10/31/10, revealed orders for Coumadin three (3) milligrams every day and recheck INR Wednesday.</p> <p>Review of the Admission Plan of Care revealed the anticoagulants, and complications and risk factors associated with the medication were not addressed.</p> <p>Interview on 11/05/10 at 9:50 AM, with Licensed Practical Nurse (LPN) #8 revealed she had admitted the resident on 10/22/10 and completed</p>	F 281		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 281	<p>Continued From page 10</p> <p>the Admission Plan of Care. She stated she should have completed a care plan to address monitoring the resident's abdominal incision site for signs and symptoms of infection. She further stated she should have completed a care plan to address the anticoagulant medication due to the risk of bleeding. Continued interview revealed, "I haven't had too much experience with Care Plans".</p> <p>3. Review of Resident #24's closed record revealed the resident was admitted to the facility on 08/16/10 with a diagnosis of Coronary Artery Bypass Graft (CABG) on 08/11/10.</p> <p>Review of the Resident Data Collection dated 08/16/10, revealed the resident had a midsternal incision, two (2) harvest site incisions on the right lower leg and a one and a half (1.5) centimeter incision to the right groin catheter site.</p> <p>Review of the Admission Plan of Care revealed no plan of care to address the resident's incision sites or the need to monitor the sites for signs and symptoms of infection.</p> <p>Interview on 11/05/10 at 5:00 PM with the Director of Nursing revealed the Unit Managers were to review the new admission medical records the day of admission, or the next day, and should be checking the Admission Care Plans. She further stated she was unaware the Admission Care Plans were "not thorough".</p> <p>4. Review of Resident #3's medical record revealed diagnoses which included Dementia and Cerebrovascular Accident (CVA). Review of the Quarterly Minimum Data Set (MDS) dated 08/30/10, revealed the facility assessed the</p>	F 281		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	<p>Continued From page 11</p> <p>resident as having moderate impairment in cognitive skills and requiring extensive assistance with most Activities of Daily Living. Further review of the MDS revealed the facility assessed the resident as sustaining a fall in the past thirty-one (31) to one hundred eighty days (180).</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/08/10, revealed the resident had a history of falls in the past 31-180 days, was non-ambulatory, and was to have a tab alarm and mats at the bedside at all times.</p> <p>Review of the Comprehensive Plan of Care dated 01/18/10, revealed the resident was at high risk for falls. The interventions included mats to the bedside while in the bed.</p> <p>Observation of Resident #3 on 11/02/10 at 4:45 PM, and 5:30 PM; and, on 11/03/10 at 9:10 AM, 10:00 AM, 1:45 PM and 3:05 PM revealed the resident was in bed and there was a fall mat on the floor on the left side of the bed. However, there was no fall mat on the right side of the bed.</p> <p>Interview on 11/03/10 at 4:00 PM with Certified Nursing Assistant (CNA) #31 revealed she was assigned to the resident consistently. She checked the State Registered Nursing Assistant (SRNA) Record and stated the resident was to have floor mats at all times. She further stated, she did not realize the resident was to have floor mats on both sides of the bed.</p> <p>Interview on 11/03/10 at 4:10 PM with the Unit Manager, who was assigned to the resident's unit, revealed she was not sure if the resident was to have fall mats. After reviewing the Physician's Orders she stated there were orders for fall mats</p>	F 281		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 281	Continued From page 12 at all times. Further observation of the resident on 11/04/10 at 9:00 AM and 11:30 AM revealed the resident had a fall mat on the left side of the bed, but no fall mat was observed on the right side of the bed, as per physician's orders. Interview with the Unit Manager on 11/04/10 at 11:30 AM, revealed she had forgotten to tell anyone the resident needed another mat. Further interview with the Nurse Manager on 11/05/10 at 9:55 AM revealed the CNAs were to check safety devices to ensure they were in place at change of shift when they did walk through rounds from room to room.	F 281		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure services were provided in accordance with each resident's written Comprehensive Plan of Care for three (3) of twenty-seven (27) sampled residents (Resident #3, #11, and #12). The findings include: 1. Review of Resident #3's medical record revealed diagnoses which included Dementia and Cerebrovascular Accident (CVA). Review of the	F 282	Res. #3, #11, and #12 are current with routine weekly skin assessments from 11-2-10 to 12-14-10. Res. #3 had mats to bedside discontinued by the physician on 11-4-10. All RN Mgr.'s conducted an audit of each neighborhood to verify compliance and completion of weekly skin assessments. This was completed by 12-14-10. All resident charts with assessments from 11-2-10 to 12-14-10 are current. Res. #3 had mats d/c'd by physician on 11-4-10. Each RN Mgr. will audit each res. comparing current physician orders for appliances, safety devices, etc. with what is in place. They will audit all orders, not just those to be on the plan of care. This will be done by 12-17-10. Any discrepancies will be immediately updated by 12-17-10. This will then be audited on a monthly basis and	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 282	<p>Continued From page 13</p> <p>Quarterly Minimum Data Set (MDS) dated 08/30/10, revealed the facility assessed the resident as being moderately impaired in cognitive skills, resisted care, and as physically abusive. Further review of the MDS revealed the facility assessed the resident to require extensive assistance with most Activities of Daily Living, incontinent of bowel/bladder, and sustained a fall in the past thirty-one (31) to one hundred eighty days (180).</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/08/10, revealed the resident had a history of falls in the past 31-180 days and was to have the bed at the lowest position when in bed, a tab alarm when in bed, and mats at the bedside at all times.</p> <p>Review of the Comprehensive Plan of Care dated 01/18/10, revealed the resident was at high risk for falls. The goal stated the resident would be free of self injury related to falls, and the interventions included; mats to the bedside while in the bed.</p> <p>Observation of Resident #3 on 11/02/10 at 4:45 PM, and 5:30 PM; and, on 11/03/10 at 9:10 AM, 10:00 AM, 1:45 PM and 3:05 PM revealed the resident was in the bed and there was a fall mat on the floor on the left side of the bed. Further observation revealed there was no fall mat on the right side of the resident's bed.</p> <p>Interview on 11/03/10 at 4:00 PM with Certified Nursing Assistant (CNA) #31 revealed she was assigned to the resident consistently and was not sure if the resident was to have fall mats on both sides of the bed. After checking the State Registered Nursing Assistant (SRNA) Record,</p>	F 282	<p>followed up through the performance improvement program for one year and then re-evaluated.</p> <p>The Staff Development Nurse will educate the nursing staff on implementation of physician orders to be placed on the SRNA flow record and the care plans on 12-14-10. Nursing staff will be educated to update and revise all care plans as orders are changed and/or care needs are identified on 12-14-10. The IDT Team will be educated to carry over any care planned interventions that would affect daily care (behaviors, etc.) on to the SRNA daily care record on 12-14-10. The MDS office will be educated to ensure that changes are made to the care plans by verifying order changes against the care plan no later than the next business day. The MDS CP Coordinator will conduct routine audits monthly to verify order changes are being reflected on the care plans. Nsg. Supervision education on 11-16-10. Education conference 12-2-10 and nurses meeting on 12-14-10. This will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated. The Staff Development Nurse will educate the SRNA's on following the SRNA daily care record 12-2-10.</p>	12-20-10	

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(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)	(X8) COMPLETION DATE	
F 282	<p>Continued From page 14</p> <p>she stated the resident was to have floor mats at all times on both sides of the bed.</p> <p>Interview on 11/03/10 at 4:10 PM with the Unit Manager assigned to the resident's unit, revealed she was not sure if the resident was to have fall mats on both sides of the bed.</p> <p>Further observation of the resident on 11/04/10 at 9:00 AM and 11:30 AM revealed the resident had a fall mat on the left side of the bed. However, there was still no fall mat on the right side of the bed.</p> <p>Interview with the Unit Manager on 11/04/10 at 11:30 AM, revealed she had failed to tell anyone the resident needed another mat. Further interview with the Nurse Manager on 11/05/10 at 9:55 AM revealed it was the CNAs responsibility to check safety devices to ensure they were in place at change of shift when they did walk through rounds from room to room.</p> <p>In addition, Resident #3's Resident Assessment Protocol Summary (RAPS) dated 01/08/10, revealed the resident was resistive to care and combative with staff at times. The RAPS also revealed the resident was occasionally incontinent of bladder and required staff support for incontinence care.</p> <p>Review of the Comprehensive Plan of Care dated 01/18/10 revealed the resident resisted care at times and had episodes of combative behavior. The interventions included leaving the resident alone for a few minutes when an episode occurred; and returning later to continue care.</p> <p>Review of a Nurses' Note, written by the Unit</p>	F 282	<p>The Staff Development Nurse will educate the nursing staff on timeliness of the weekly nursing skin assessment and the schedule to follow for such on 12-14-10. The Resident Care Managers will conduct a weekly audit of the weekly nursing assessments to ensure timely completion.</p> <p>The MDS CP Coordinator will conduct random (10 per month) audits to be reported with quarterly and annual reviews to verify specialized interventions that affect daily care are also placed on the SRNA daily care record.</p> <p>This will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated.</p>	12-20-10	

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 282	<p>Continued From page 15</p> <p>Manger and dated 10/12/10 at 12:00 PM, revealed the resident was upset and combative with staff changing his/her depends. The Note further stated the resident ripped off the clean depends and refused to allow staff to assist the resident with putting another depends on.</p> <p>Interview on 11/05/10 at 10:40 AM with Certified Nursing Assistant (CNA) #21, revealed she was assigned to the resident on 10/12/10 at 12:00 PM when the resident was being combative. She stated the resident initially agreed to have his/her adult brief changed, and then began "screaming and hitting" her while she was changing him/her. She stated she went to get CNA #20 to assist her because she did not think she could leave the resident lying on a soiled pad and exposed with no brief. Continued interview revealed the two (2) aides finished the incontinence care and applied a new brief while the resident was resistive, "fighting, yelling, and screaming". Further interview revealed she was unaware the resident had a Care Plan intervention to leave the resident alone and come back later if the resident was angry.</p> <p>Further review of the RAPS dated 01/08/10, revealed the resident was at risk for pressure ulcers related to decreased mobility due to diagnoses of Congestive Heart Failure, Asthma, Lung Cancer, and Incontinence of bowel/bladder. The RAPS further stated weekly skin assessments were to be completed and documented by licensed nurses.</p> <p>Review of the Comprehensive Plan of Care dated 01/18/10 revealed the resident had the potential for skin breakdown. The interventions included a head to toe skin assessment which was to be</p>	F 282		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 16 completed weekly.</p> <p>Review of the Weekly Skin Assessments revealed there was no documented evidence of a skin assessment completed from 08/13/10 through 08/27/10, (14) fourteen days, and from 08/27/10 through 09/11/10. (A skin assessment was attempted on 09/11/10 and the resident refused).</p> <p>Interview on 11/05/10 at 9:55 AM with the Unit Manger, who was assigned to Resident #3, revealed Skin Assessments were to be done weekly. She stated she tried to audit every chart weekly and was aware there were issues with the Skin Assessments not being completed. She further stated, she had not implemented a plan of correction yet regarding the skin assessments.</p> <p>2. Review of the clinical record revealed Resident #11 was admitted with diagnoses which included Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and Depression. In addition, the resident was Status Post Cerebrovascular Accident (CVA) and required assistance with bed mobility and transfers.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 07/02/10, revealed Resident #11 had a history of pressure ulcers. Due to the resident's history and ongoing dependence for bed mobility, high risk for the development of new pressure areas, the resident required a head to toe skin assessment weekly. Review of the Care Plan dated 09/11/10, revealed an intervention for "head to toe skin assessments weekly and PRN (as needed)."</p> <p>Review of Resident #11's Weekly Nursing</p>	F 282		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 17</p> <p>Assessments, which included a head to toe skin assessment, revealed no assessment was completed between 09/15/10 and 10/06/10. After the 10/06/10 assessment, the resident was not assessed again until 10/27/10.</p> <p>3. Record review revealed Resident #12 was admitted on 03/15/10 with diagnoses which included Hypertension, Congestive Heart Failure, Depression, Weakness and Debility.</p> <p>Review of the RAPS dated 05/18/10, revealed the facility identified that Resident #12 required assistance with bed mobility and was frequently incontinent of bowel, which increased the risk of pressure ulcer formation. The RAPS indicated the resident was to have a head to toe skin assessment completed weekly.</p> <p>Review of the Care Plan dated 08/19/10 revealed Resident #12 was a high risk for skin breakdown. The Plan of Care included an intervention for a "head to toe skin assessments weekly and PRN (as needed)."</p> <p>Review of Resident #12's Weekly Nursing Assessments revealed no skin assessments were completed between 09/28/10 and 10/19/10. Interview with the Resident Care Manager on 11/03/10 at 10:00 AM revealed the weekly skin assessments should have been conducted.</p> <p>Observation of the head to toe assessment, by Licensed Practical Nurse (LPN) #20 on 11/03/10 at 3:10 PM revealed a Stage II Ulcer on the coccyx which was covered with DuoDerm dressing. Review of the Wound Care Nurses' Note dated 11/03/10 at 1:00 PM revealed the newly identified area measured 0.5 centimeters</p>	F 282		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 18 (cm) by 0.5 cm. Interview with Licensed Practical Nurse #13 on 11/03/10 at 2:25 PM revealed the floor nurse was responsible for performing weekly skin assessments on each resident. She stated if a new pressure area was identified, the Wound Care Nurse was notified. Continued Interview revealed while the resident was receiving treatment by the Wound Care Nurse, the floor nurse should still be completing the weekly assessments. Interview with the Resident Care Manger on 11/03/10 at 2:40 PM revealed the Wound Care Nurse measured all identified ulcers on Mondays, but did not perform full skin assessments. She stated the floor nurse was responsible for completing weekly head to toe skin assessments. Review of the facility's Wound Care Policies and Procedures revealed "the Charge Nurse will assess all residents weekly using Skin Assessment Form".	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 309	Res. #22 was a closed record review. Res. #3 has had follow up evaluations conducted by the physician and the MD and interdisciplinary team have reviewed and revised the plan of care as of 11-4-10. The Staff Development Nurse will conduct education with the nursing staff in regards to the proper procedures regarding falls, the investigative process for incidents, and necessary documentation for such on 12-2-10 via education conference and nurses	12-26-10	

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 309	<p>Continued From page 19</p> <p>review, it was determined the facility failed to ensure each resident received the necessary care and services to attain or maintain the highest practicable physical well being for two (2) of twenty-seven (27) sampled residents (Resident #22 and #3).</p> <p>Resident #22 sustained a fall on 02/18/10. The resident was not assessed by the nurse, no fall investigation was initiated, and the nurse failed to report the incident to any other nurse or to the supervisor.</p> <p>Resident #3 was assessed to have pain and bruising to the left hand and wrist on 10/18/10. The physician was notified and X-rays ordered. There was no documented evidence of further assessment and monitoring of the resident's left hand and wrist. Observation on 11/03/10 revealed the resident's left hand was flexed and the resident was unable to fully extend the left hand without complaints of pain.</p> <p>The findings include:</p> <p>1. Review of the Nurses' Notes, dated 02/18/10 at 5:00 AM, revealed a Certified Nursing Assistant (CNA) approached Licensed Practical Nurse (LPN) #11 and reported Resident #22 had been found on the floor beside the bed. The CNA assisted the resident back to bed and reported the resident had no problems. Review of the Nurse's Notes, dated 02/18/10 at 6:00 AM, revealed the CNA assisted the resident to the bathroom and reported the resident exhibited no problems and voiced no complaints related to the "recent incident".</p> <p>Continued review of the clinical record revealed</p>	F 309	<p>meeting on 12-14-10 which included the above in addition to the definition of a fall and the requirement for a nurse to assess the resident.</p> <p>A change in condition form will be placed with nursing shift report. This form will list the resident name, condition that needs to be monitored and followed up with documentation. The documentation guidelines will be attached for quick review. The form will be revised on a weekly and/or as needed basis by each Resident Care Manager. Nursing Supervision will utilize this form to conduct routine weekly audits on follow up documentation completed by the staff nurses.</p> <p>All residents from 11-2-10 to 12-14-10 have had weekly pain assessments completed and any new pain has been addressed via the new change in condition form and followed up with nursing supervision audits.</p> <p>The facility will monitor this via the performance improvement process for one year and then will re-evaluate.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20</p> <p>no documented evidence the resident was assessed at the time of the fall. In addition, although the fall occurred on 02/18/10 at 5:00 AM, there was no documented evidence the resident was assessed after the fall until 02/19/10 at 7:45 PM.</p> <p>Review of the Nurses' Notes, dated 02/19/10 at 5:00 AM, revealed a CNA reported the resident was complaining of pain and the nurse took a pain pill to the resident. According to the Note the resident was lying in bed with eyes closed, and showing no grimacing, or signs of distress.</p> <p>Continued review of the Nurses' Notes, dated 02/19/10 at 7:30 PM, revealed during shift report the resident informed the oncoming CNA she/he needed to be assisted with breakfast because of a fall the previous night. Review of the Note at 7:45 PM revealed the nurse entered the resident's room and noted the resident was in the bed, and bruising and swelling was noted to the right upper arm and shoulder area. Continued review of the Notes at 8:30 PM, revealed the Physician was assessing the resident for complaints of right shoulder pain and ordered an X-Ray. The Note timed 5:00 PM revealed a call was received from Mobile Imaging, stating there was preliminary finding of a Fracture of the Right Shoulder.</p> <p>Review of the Physician's Order dated 02/19/10 at 6:00 PM, revealed Orders to send the resident to the hospital emergency room. Review of the Hospital Discharge Summary dated 02/24/10 revealed the resident was diagnosed with a Closed Fracture of the Humerus.</p> <p>The facility was unable to provide evidence an investigation was initiated for the fall on 02/18/10.</p>	F 309			

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 309	<p>Continued From page 21</p> <p>Interview with LPN #11 on 11/05/10 at 4:30 PM revealed the nurse learned from a CNA, Resident #22 had fallen to the floor beside the bed. The nurse stated she did not check the resident herself, as the aide reported the resident did not seem to be having any problems. Continued interview revealed the nurse did not consider the incident a true fall since the resident had a low bed and was found on the fall mat beside the bed. She further stated she probably should have gone and checked on the resident herself.</p> <p>Upon further interview, LPN #11 explained the procedure to follow after a fall. The nurse should check the vital signs, assess the resident for injury, initiate a fall incident report, and add a note to the "shift report" for the supervisor. The nurse acknowledged she did not follow the procedure: she did not assess the resident, initiate a fall report, or inform the supervisor of the fall.</p> <p>Interview with the Director of Nursing (DON) on 11/05/10 at 4:40 PM revealed if a resident was found on a mat beside the bed, it was considered a fall. She stated the nurse should check the vital signs, complete an assessment, notify the Physician and family, and initiate a "falls packet".</p> <p>2. Review of Resident #3's medical record revealed diagnoses which included Dementia and Cerebral Vascular Accident (CVA). Review of the Quarterly Minimum Data Set (MDS) dated 08/30/10, revealed the facility assessed the resident as having short term memory loss and moderate impairment in cognitive skills. Further review of the MDS revealed the facility assessed the resident as requiring extensive assistance with most Activities of Daily Living, and having no</p>	F 309			

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 309	<p>Continued From page 22</p> <p>functional limitations with Range of Motion (ROM).</p> <p>Review of the Nurses' Notes dated 10/18/10 at 10:00 AM revealed the resident's Power of Attorney (POA) was in to visit and the resident had complained of pain in the left hand and wrist area. The Note further stated there was purple bruising noted to the area. Further review of the Note revealed the nurse attempted to assess the area and the resident yelled out when touched. The Note revealed the resident's hand was up on a pillow and pain medication was given as scheduled. The Note further stated the Physician was notified and an order was received to do a Stat-X-Ray.</p> <p>Further review of the Nurses' Notes revealed there was no documented evidence of further assessment and monitoring of the resident's left hand and wrist after 10/18/10.</p> <p>Review of the Physician's Order Sheet and Progress Notes dated 10/18/10 revealed orders for a Stat X-Ray to the left lower arm, wrist, and hand, due to pain and a cold pack to the left hand three (3) times a day for five (5) days.</p> <p>Review of the X-Rays obtained 10/18/10 revealed no evidence of fractures of the left forearm and the left hand, and no evidence of acute fracture or significant chronic arthritic change in the left wrist.</p> <p>Observation of a skin assessment on 11/03/10 at 1:45 PM, with the Wound Nurse, revealed the residents left hand was flexed, and the resident would not allow the nurse to extend his/her hand. The resident complained of pain with touching the hand. Interview with the Wound Nurse at the time</p>	F 309		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 6 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 23</p> <p>of the skin assessment revealed he was unaware the resident was having pain and was unable to extend the left hand.</p> <p>Interview with Resident #3 on 11/03/10 at 3:15 PM revealed the resident could not open his/her left hand due to pain and soreness, although the resident used to be able to open his/her hand.</p> <p>Interview on 11/03/10 at 4:00 PM with Certified Nursing Assistant (CNA) #31 revealed she was assigned to the resident. She stated the resident used his/her right hand for everything and complained of his/her left hand being sore. She stated she did range of motion (ROM) during care and the resident would not allow ROM to the left hand.</p> <p>Interview on 11/04/10 at 2:00 PM with CNA #18 revealed she had been assigned to the resident the past month. She stated, the resident's left hand "worked fine" in the past. However, the resident no longer used his/her left hand. She stated she had informed the nurses of continued soreness of the left hand.</p> <p>Interview on 11/04/10 at 3:00 PM with the evening supervisor/ LPN #6, who was in charge of Resident #3's unit on the evening shift, revealed the facility protocol was to assess and monitor for seventy-two (72) hours or longer if needed after a change in condition or injury. She further stated no one had reported the resident was still having pain and usually the aides would tell the nurses if there was a change in condition.</p> <p>Interview on 11/05/10 at 9:50 AM with LPN #8 who was assigned to the resident, revealed when she completed skin assessments prior to</p>	F 309		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	<p>Continued From page 24</p> <p>10/18/10 the resident was able to open and extend the left hand. However, the resident's left hand was more stiff now. She further stated the resident would occasionally ask for pain medication which was usual for the resident.</p> <p>Observation of the resident on 11/03/10 at 4:15 PM with the Unit Manager assigned to the resident, revealed she was unable to open the resident's left hand. The Unit Manager stated no one had reported the resident was still having pain with the left hand or not able to extend the left hand. Further interview with the Unit Manager on 11/05/10 at 9:55 AM revealed the nurses were to write changes in resident's condition on the Twenty-Four Hour (24) report and the nurses were to follow up. She further stated there should have been follow up assessment, monitoring and documentation after the resident was noted to have pain in the left hand on 10/18/10.</p> <p>Interview on 11/04/10 at 6:00 PM with the Director of Nursing (DON) revealed Resident #3 should have been assessed and monitored with documentation every shift for at least twenty-four (24) hours after complaints of pain in the left hand.</p> <p>Interview on 11/04/10 at 12:00 PM with the Attending Physician revealed she was unaware the resident was still having pain in the left hand, and the pain may be related to Pseudogout. She further stated she saw the resident "today" and noted he/she was able to open the hand "most of the way". Continued interview revealed she had just ordered Occupational Therapy and a repeat X-Ray after being notified of the continued pain/soreness of the left hand.</p>	F 309		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 25 Interview on 11/04/10 at 4:00 PM with the Occupational Therapist revealed she had screened the resident 08/10 and there were no concerns with the resident's left hand at that time. She further stated she had just screened the resident and he/she would not allow her to open the left hand. She stated the resident was holding his/her hand closed from soreness and the hand could become contracted if not addressed. Review of the Interdisciplinary Therapy Screening dated 11/04/10 revealed the resident was screened for left wrist/hand ROM and pain. Further review of the Screening revealed recommendations for a Occupational Therapy Evaluation pending the results of the X-Ray for ROM and Splinting as needed. Although the resident complained of left hand pain on 10/18/10; there was no documented evidence of further assessment, monitoring and documentation after 10/18/10. In addition; although the resident was unable to extend the left hand due to soreness and pain, there was no evidence the facility addressed the issue until surveyor intervention. Review of the facility, "Documentation-Change in Condition Policy", revealed "aside from weekly charting, incidents or changes with residents that arise will require more frequent documentation." The Policy further stated, a Incident or Fall required every shift documentation for 24 hours if there was no emergency room visit, and required every shift documentation every shift for three (3) days if there was an emergency room visit. Further review revealed a change in physical or functional status required every shift documentation until resolved; or for 24 hours.	F 309		
F 314	483.25(c) TREATMENT/SVCS TO	F 314	See next page	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314 SS=G	<p>Continued From page 26 PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure a resident who enters the facility without pressure sores did not develop pressure sores for one (1) of twenty-seven (27) sampled residents (Resident #8).</p> <p>Resident #8 acquired a Pressure Ulcer to the Left Heel which was described as a three (3) centimeter (cm) x two and a half (2.5) cm area, purple in color, with suspected deep tissue injury. The Pressure Ulcer was acquired at the facility, and unidentified by the facility, until the surveyor requested a skin assessment on 11/03/10, at 9:50 AM.</p> <p>The findings include:</p> <p>Review of Resident #8's medical record revealed the resident was admitted to the facility on 10/27/10 with diagnoses which included Status Post Left Hip Fracture on 10/23/10 with IM Nailing (Intramedullary Nailing (surgical procedure used to treat fractures of long bones in which a metal</p>	F 314	<p>Res. #8's care plan has since been reviewed and revised on 11-3-10. All residents from 11-2-10 to 12-14-10 have had weekly skin assessments completed which would identify if they had any skin areas which were not previously noted. All resident skin conditions have been addressed where applicable.</p> <p>The Staff Development Nurse will conduct education with the Nursing staff on facility protocols on turning and repositioning on 12-2-10 via education conference and 12-14-10 nurses meeting.</p> <p>The Wound nurse will assess each admission and readmission on a daily basis and verify that any skin areas of concern or potential for skin breakdown is addressed through applicable orders and care plans. This will include prevention methods and treatments.</p> <p>The facility Wound Nurse will conduct monthly audits to ensure compliance with turning and repositioning. The Wound Nurse and/or designee will review admission and readmission care plans to ensure any skin areas of concern and potential for skin breakdown/pressure areas have been identified in the care planning process. The treatment nurse will report monthly in the facility performance improvement program meeting in regards to the audit findings related to pressure sore prevention, treatments and services.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 27</p> <p>rod is forced into the medullary cavity of a bone)) of the Left Hip. Further record review revealed the Minimum Data Set (MDS) Assessment had not been completed due to the recent admission date.</p> <p>Review of the facility's, "Risk Factors that Increase a Resident's Susceptibility to Develop or to Not Heal Pressure Ulcers" form, revealed the resident was at risk of developing pressure ulcers related to drugs affecting awareness, pain altering mobility, fracture, impaired mobility, Thyroid Disease, Chronic Obstructive Pulmonary Disease (COPD), and abrasions/bruises.</p> <p>Review of the Admission Care Plan dated 10/27/10, revealed the resident had a Hip Fracture with a goal stating the resident would have maximum functional mobility. The interventions included full weight bearing status and monitor for pain. There was no plan of care to address the resident's potential for skin breakdown.</p> <p>Review of the Resident Daily Care Record (Nurse Aide Care Plan) dated 10/10 and 11/10, revealed the resident required the assistance of two (2) staff for turning and repositioning. However, the Record did not specify how often the resident was to be turned/repositioned.</p> <p>Review of the Nurses' Notes dated 10/27/10 at 5:00 PM, revealed the resident was admitted to the facility from the hospital with a three (3) inch incision with eleven (11) staples and a two and a half (2.5) inch incision with ten (10) staples from the hip surgery, and a linear skin tear to the left thigh. According to the Note, the resident was alert and oriented, was continent of bowel and</p>	F 314	The facility will monitor this via the performance improvement process for one year and then will re-evaluate.	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 28</p> <p>bladder, and required the assistance of two (2) staff for transfers. Continued review of the Notes revealed there was no documented evidence of skin breakdown to the left heel.</p> <p>Review of the Wound Care Nurse's Notes dated 10/27/10 at 10:00 PM revealed the resident had staples to the left hip incision site and a skin tear to the left thigh. Continued review of the Wound Care Nurse's Notes dated 10/28/10 through 11/02/10, revealed there was no evidence of pressure ulcers on the left heel.</p> <p>Further review of the Nurse's Notes dated 10/28/10 through 11/02/10 revealed there was no documented evidence of skin breakdown to the left heel. In addition, there was no documented evidence the resident was being assisted with turning and repositioning.</p> <p>Review of the Admission Physician's Orders dated 10/27/10 revealed orders for Aloe Vesta to the buttocks due to redness, every shift and as needed until resolved.</p> <p>Review of the Physician's Orders dated 10/28/10 revealed orders to discontinue the Aloe Vesta to the buttocks secondary to no redness.</p> <p>Observation on 11/03/10 at 9:50 AM during a skin assessment performed by the Wound Nurse/Licensed Practical Nurse #14, revealed the resident had a Pressure Ulcer which the nurse described as a 3.25 cm x 2.5 cm Pressure Ulcer, purple in color with "suspected deep tissue injury." Further observation revealed the resident had staples in the left hip.</p> <p>Interview on 11/03/10 at 9:50 AM and at 10:30</p>	F 314		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 29</p> <p>AM with LPN #14 revealed the pressure area was new and had not been identified by the facility. He further stated staff relied on the resident to turn him/herself; however, the resident "was not doing that real well".</p> <p>Interview on 11/03/10 at 10:15 AM and 1:40 PM with Certified Nursing Assistant (CNA) #29 revealed she was assigned to the resident. She stated the resident turned and repositioned him/herself and the only thing she had done for the resident during the shift was to deliver the resident his/her breakfast tray. Continued interview revealed she was unaware the resident had any skin breakdown to the left heel. Continued interview revealed she checked the "nurse aide care plan" which was the "Resident Daily Care Record" when providing care.</p> <p>Interview on 11/03/10 at 10:20 AM with LPN #8 who was assigned to the resident on 11/02/10 and 11/03/10 on the day shift, revealed she was unaware the resident had skin breakdown. She stated she did rounds during the shift and the resident was to be assisted as needed with turning and repositioning.</p> <p>Phone interview on 11/03/10 at 2:30 PM with CNA #30, who was assigned to the resident on the evening and night shift for 11/02/10, revealed the resident turned and positioned him/ herself in the bed and did not need assistance. She stated the resident was continent and only needed the urinal emptied so she did not check his/her skin. She stated the aides went by the "Resident Daily Care Record" when providing care.</p> <p>Phone interview on 11/03/10 at 3:00 PM with CNA #19 revealed she was assigned to the resident on</p>	F 314			

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 314	<p>Continued From page 30</p> <p>11/02/10 on the day shift, and had assisted the resident with a bath on 10/28/10 and 11/01/10. She stated she was unaware of the resident having Pressure Ulcers; however, she did notice the resident's "bottom was kind of red". She further stated she Informed LPN #8 and Aloe Vesta was applied. Further interview revealed she did not assist the resident with turning and repositioning because the resident turned him/herself.</p> <p>Interview on 11/03/10 at 1:50 PM and 11/04/10 at 4:00 PM with the Unit Manager, who was assigned to the resident, revealed the resident was unable to completely turn self to the side in the bed and should be assisted with turning and positioning. She was unaware staff were not turning and positioning the resident.</p> <p>Interview on 11/03/10 at 3:30 PM with LPN #6/Evening Shift Supervisor, revealed she had admitted the resident to the facility on 10/27/10 and completed the Admission/Initial Care Plan. She further stated the resident should have had a Plan of Care to prevent skin breakdown due to decreased mobility, with interventions to ensure turning and positioning.</p> <p>Interview on 11/05/10 at 5:00 PM with the Occupational Therapist (OT) revealed the resident was currently receiving Occupational Therapy and she had completed an evaluation to assess the resident's ability to to turn and position in the bed. She stated she would not depend on the resident to turn on his/her own because the resident needed reminders, guidance, and minimal assistance to turn in the bed. Review of the Plan of Treatment for Rehabilitation dated 10/28/10 completed by the OT, revealed the</p>	F 314			

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 314	Continued From page 31 resident required minimum assistance to roll. Interview on 11/04/10 at 9:00 AM with Resident #8, revealed he/she could turn him/herself to the right side; however, had not been turning him/herself much. Resident #8 further stated he/she could not turn self to the left side due to pain. Continued interview, revealed staff had not been assisting the resident with turning and positioning in bed until yesterday when they found a "bedsore". Review of the facility's, "Wound Care Policies and Procedures" revealed the purpose of the policy was to ensure residents admitted to the facility did not develop pressure ulcers, unless the clinical condition demonstrated they were unavoidable. The Policy further stated residents would be assessed for potential for pressure ulcer development on admission and a pressure ulcer risk assessment would be completed by the licensed nurse to determine appropriate interventions to prevent the development of pressure sores.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 323	Res. #22 was a closed record review. The Goal of Kingsbrook is to ensure that the resident environment remains as free of accident hazards as much as possible and that each resident receives adequate supervision and assistance devices to prevent accidents. All staff will be educated on identifying hazards that could lead to falls such as chemicals, medications, side effects of medications, underlying medical conditions, unsafe wondering, etc. The education will be given to staff on 12-	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	<p>Continued From page 32</p> <p>review, it was determined the facility failed to ensure each resident received adequate supervision and assistance devices to prevent accidents for two (2) of twenty-seven (27) sampled residents (Resident #22, and #3).</p> <p>Resident #22 sustained a fall on 02/18/10. The resident was not assessed by the nurse, and the nurse failed to report the fall to any other nurse or to the supervisor. In addition, a fall investigation was not initiated. On 02/19/10, the resident was sent to the hospital emergency room after complaints of pain and diagnosed with a Closed Fracture of the Humerus.</p> <p>Resident #3 had Physician's Orders for fall mats at all times; however, observation during the survey revealed there was a fall mat on the left side of the bed; there was no fall mat on the right side of the bed.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Review of Resident #22's closed record revealed the resident was admitted to the facility on 01/22/10 with diagnoses which included Congestive Heart Failure, Hypertension, and Anxiety. Review of the Admission Minimum Data Set (MDS) Assessment dated 02/04/10 revealed the facility assessed the resident as having modified independence in cognitive skill for decision making and as requiring limited to extensive assistance with Activities of Daily Living. <p>Review of the Comprehensive Plan of Care dated 02/02/10, revealed the resident was at high risk for falls. The interventions included a chair alarm;</p>	F 323	<p>17-10. Res. #3 has had follow up evaluations conducted by the physician and the MD and interdisciplinary team have reviewed and revised the plan of care as of 11-4-10.</p> <p>The Staff Development Nurse will conduct education with the nursing staff in regards to the proper procedures regarding falls, the investigative process for incidents, and necessary documentation for such on 12-2-10 via education conference and nurses meeting on 12-14-10 which included the above in addition to the definition of a fall and the requirement for a nurse to assess the resident.</p> <p>A change in condition form will be placed with nursing shift report. This form will list the resident name, condition that needs to be monitored and followed up with documentation. The documentation guidelines will be attached for quick review. Areas to be followed up on for documentation include: falls, new pain, accidents, etc. The form will be revised on a weekly and/or as needed basis by each Resident Care Manager. Nursing Supervision will utilize this form to conduct routine weekly audits on follow up documentation completed by the staff nurses. A monthly audit will be completed by the RN Mgr to verify that all safety devices, appliances, etc. that are ordered for the resident are on the SRNA flow record and are in use in the resident room. The first audit is to be completed by 12-17-2010.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	<p>Continued From page 33 however, there was no intervention for a floor mat</p> <p>Review of the Fall Risk Assessment dated 01/22/10, revealed the resident was at high risk for falls related to intermittent confusion, poor vision, decreased muscular coordination, and required the use of assistive devices.</p> <p>Review of the Nurse's Notes dated 02/18/10 at 5:00 AM, revealed a Certified Nursing Assistant (CNA) informed Licensed Practical Nurse (LPN) #11, the resident had been found on the floor beside the bed. Further review revealed the CNA assisted the resident back to bed and reported the resident had no problems. According to the Nurse's Notes dated 02/18/10 at 6:00 AM, the CNA assisted the resident to the bathroom and reported the resident exhibited no problems and voiced no complaints related to the "recent incident".</p> <p>Further review of the clinical record revealed no documented evidence of an assessment and/or monitoring of the resident at the time of the fall or after the fall until 02/19/10 at 7:45 PM.</p> <p>Review of the Nurse's Notes dated 02/19/10 at 5:00 AM, revealed a CNA reported the resident was complaining of pain. According to the Note, the nurse took a pain pill to the resident who was lying in bed with eyes closed, and showing no grimacing, or signs of distress.</p> <p>The next entry in the Nurse's Notes dated 02/19/10 at 7:30 PM, revealed during shift report the resident stated to the oncoming CNA she/he needed to be assisted with breakfast due to falling the previous night. Review of the Note at 7:45 PM revealed the nurse entered the resident's</p>	F 323	<p>All residents from 11-2-10 to 12-14-10 have had weekly pain assessments completed and any new pain has been addressed via the new change in condition form and followed up with nursing supervision audits. The facility will monitor all audits via the performance improvement process for one year and then will re-evaluate.</p> <p>An audit was conducted on 12-17-10 to verify that the resident environment was free of potential accident hazards. No areas of concern were identified. This audit will be conducted on a monthly basis by the RN Mgr or designee and any areas of potential accident hazard will be addressed immediately and forwarded to the Maintenance department if warranted.</p>	12-20-10	

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 323	<p>Continued From page 34</p> <p>room and noted the resident was in the bed, was alert and confused with bruising and swelling noted to the right upper arm and shoulder area. Further review of the Notes, revealed at 8:30 PM, the Physician was assessing the resident for complaints of right shoulder pain and an x-ray was ordered. According to the Notes, at 5:00 PM a call was received from the x-ray imaging company, stating there was preliminary finding of a fracture of the Right Shoulder.</p> <p>Review of the Physician's Order on 02/19/10 at 6:00 PM revealed orders to send the resident to the emergency room.</p> <p>Review of the Hospital Discharge Summary dated 02/24/10, revealed the resident was diagnosed with a Closed Fracture of the Humerus.</p> <p>The facility was unable to provide evidence an investigation was initiated for the fall on 02/18/10.</p> <p>Interview on 11/05/10 at 4:30 PM with LPN #11, revealed the nurse learned from a CNA, Resident #22 had sustained a fall from a low bed to the fall mat on the floor. The nurse stated she did not assess the resident, because the aide reported the resident did not seem to be having any problems. Further interview revealed the nurse did not consider the incident a "true fall" since the resident had a low bed and was found on the fall mat beside the bed. Continued interview, revealed the nurse probably should have gone and checked on the resident herself.</p> <p>Further interview with LPN #11, revealed the procedure to follow after a fall included; checking vital signs, assessing the resident for injury, initiating a Fall Incident Report, and adding a note</p>	F 323		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 35</p> <p>to the "shift report" for the supervisor. The nurse acknowledged the procedure was not followed after the resident sustained the fall on 02/18/10. She stated she did not assess the resident, initiate a fall report, or inform the supervisor of the fall.</p> <p>Interview on 11/05/10 at 4:40 PM with the Director of Nursing (DON) revealed it was considered a fall if a resident was found on a mat beside the bed. She stated after a resident sustained a fall, the nurse should check the vital signs, complete an assessment, notify the Physician and the family, and initiate a "falls packet".</p> <p>2. Review of Resident #3's medical record revealed diagnoses which included Dementia and Cerebrovascular Accident (CVA). Review of the Quarterly Minimum Data Set (MDS) dated 08/30/10, revealed the facility assessed the resident as having moderate impairment in cognitive skills, required extensive assistance to transfer, was unable to ambulate, and had sustained a fall in the past thirty-one (31) to one hundred eighty days (180).</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 01/08/10, revealed the facility noted Resident #3 had a history of falls in the past 31-180 days and was to have mats at the bedside, at all times.</p> <p>Review of the Physician's Orders dated 11/10, revealed orders for mats at the bedside at all times.</p> <p>Review of the Comprehensive Plan of Care dated 01/18/10, revealed the resident was at high risk for falls. The interventions included mats to the</p>	F 323		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE	
F 323	<p>Continued From page 36 bedside while in the bed.</p> <p>Observation of Resident #3 on 11/02/10 at 4:45 PM, and 5:30 PM; and, on 11/03/10 at 9:10 AM, 10:00 AM, 1:45 PM and 3:05 PM revealed the resident was in the bed. Further observation revealed there was a fall mat on the floor on the left side of the bed, and no fall mat on the right side of the bed.</p> <p>Interview on 11/03/10 at 4:00 PM with Certified Nursing Assistant (CNA) #31 revealed she was assigned to the resident consistently; however, she was unsure if the resident was to have fall mats on both sides of the bed. She reviewed the State Registered Nursing Assistant (SRNA) Record and indicated the resident was to have floor mats at all times on both sides of the bed.</p> <p>Interview on 11/03/10 at 4:10 PM with the Unit Manager assigned to the resident's unit, revealed she was unsure if the resident was to have fall mats on both sides of the bed. After reviewing the Physician's Orders, she stated there were orders for fall mats at all times.</p> <p>Further observation of the resident on 11/04/10 at 9:00 AM and 11:30 AM revealed the resident had a fall mat on the left side of the bed; however, there was no fall mat on the right side of the bed.</p> <p>Further interview with the Unit Manager on 11/04/10 at 11:30 AM, revealed she had failed to alert staff of the need for the resident to have a mat on the right side of the bed. Continued interview with the Nurse Manager on 11/05/10 at 9:55 AM revealed the CNAs did walk through rounds from room to room at the end of the shift, and were responsible for checking safety devices</p>	F 323			

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 8 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323	Continued From page 37 to ensure they were in place.	F 323			
F 441 SS=D	<p>Review of the facility's, "Documentation-Change in Condition Policy", revealed "aside from weekly charting, incidents or changes with residents that arise will require more frequent documentation." The Policy further stated, an incident or fall required every shift documentation for 24 hours if there was no emergency room visit, and required every shift documentation every shift for three (3) days if there was an emergency room visit. Further review revealed a change in physical or functional status required every shift documentation until resolved; or for 24 hours.</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an 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 - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a</p>	F 441	<p>The facility Infection Control Program is overseen by the infection control nurse who is also the staff development nurse. All nurses are trained in infection control guidelines upon new hire orientation and annually at a minimum. Before admission, residents are screened for any potential infections. This is then communicated to the nursing staff through the admission paperwork to implement the appropriate transmission based precautions. Once a resident is admitted to the facility, any Nosocomial infections are noted by the charge nurse on the Infection Notification Form and education for any necessary transmission based precautions is passed along to the staff via education conferences. The IC/SD nurse then checks these on a daily basis to monitor for any new infections. On a weekly basis a monitoring/tracking and identification report is completed. A monthly review is conducted as well.</p>	12-20-10	

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 38</p> <p>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 by: Based on observation, interview, and record review, it was determined the facility failed to maintain an Infection Control Program to provide a safe, and sanitary environment and to help prevent the development and transmission of disease and infection.</p> <p>The findings include:</p> <p>1. Observation of medication pass on 11/02/10 at 5:15 PM revealed LPN #6 obtained a fingerstick blood sugar (FSBS) from Unsampled Resident #2, removed her gloves, sanitized her hands, and placed the glucometer in a plastic cup on the medication cart. There was no evidence the LPN sanitized the glucometer after use.</p> <p>Further observation revealed LPN #6 obtained a FSBS from Unsampled Resident #3 with the same glucometer, removed her gloves, and sanitized the glucometer with an alcohol pad.</p>	F 441	<p>Any patterns or trends identified are then reviewed on a daily, weekly, and monthly basis as needed and corrective actions taken immediately. The facility is changing pharmacy providers effective 1/6/2011. In addition to a monthly audit by the IC/SD nurse, the new pharmacy will provide a monthly audit of monitoring the nurses/cmt's with medication passes. The IC/SD audit will ensure compliance with all aspects of infection control from proper handling/transport of linens, handwashing guidelines including when it is applicable, monitoring contact with resident foods, and standards of professional practice. The Staff Development Nurse will educate the nursing staff on proper procedures for medication administration, including application of nasal spray, proper cleaning of glucometer machines, and sanitizing and washing of hands on 12-2-10 and 12-14-10. It is the goal of Kingsbrook Lifecare Center to maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the development and transmission of disease and infection. The monthly audits will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 39</p> <p>Interview on 11/02/10 at 5:30 PM with LPN #6 revealed she had not cleaned the glucometer after obtaining the FSBS on Unsampled Resident #2 and prior to obtaining the FSBS on Unsampled Resident #3. Further interview revealed she had attended a recent inservice related to cleaning the glucometers after each use with alcohol pads.</p> <p>Interview on 11/02/10 at 9:00 AM with the Infection Control Nurse revealed staff were informed in June 2010 of the need to use "Virex" to clean the glucometers.</p> <p>Review of the facility's Policy entitled "Care of Glucose Equipment", revealed it was the facility's policy to prevent the indirect transmission involving the transfer of an infectious agent through a contaminated intermediate object or person. Further review revealed the glucose monitoring equipment was to be cleaned in between every use following the manufacturer's recommendations.</p> <p>2. Observation of medication pass on 11/02/10 at 5:00 PM revealed Licensed Practical Nurse (LPN) #15 administered Astelin Nasal Spray to Unsampled Resident #1 with ungloved hands, exited the resident's room, moved the medication cart to the dining room, opened the dining room refrigerator, and obtained a bottle of Ensure. There was no evidence the LPN washed or sanitized her hands after administering the Nasal Spray, and prior to moving the medication cart, and opening the refrigerator to obtain the Ensure.</p> <p>Interview on 11/02/10 at 5:10 PM with LPN #15 revealed she normally wore gloves when administering Nasal Spray. Further interview</p>	F 441		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010	
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 40 revealed she should have washed her hands after administering the Nasal Spray.</p> <p>3. Observation of the medication pass on 11/02/10 at 4:50 PM revealed Licensed Practical Nurse (LPN) #19 administered medications to Unsampled Resident #4. Before leaving the room, the nurse assisted the resident to secure her/his shoes with Velcro tabs.</p> <p>Further observation revealed LPN #19 proceeded to prepare the medications for Unsampled Resident #5, who refused the pills. The resident told the nurse she thought her/his doctor had changed her medication. LPN #19 walked to the nurses' station and checked the resident's chart for new orders. She returned to the medication cart, crushed the pills, and flushed them down the sink in the resident's bathroom.</p> <p>Continued observation of medication pass revealed Resident #16 required Phenergan which was not available on the cart. The surveyor observed LPN #19 go to the medication room where she discovered the medication was not available there either. The nurse then walked to another unit to obtain the drug, returned to the resident and administered the pill along with the resident's other medications.</p> <p>Unsampled Resident #6 called out, requesting a pain pill. LPN #19 entered the resident's room and talked to the resident prior to preparing the medication. She then returned to the cart, obtained the pain pill from the locked narcotic drawer, and administered the medication.</p> <p>Throughout the medication pass, LPN #19 did not wash or sanitize her hands. During interview on</p>	F 441		

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	Continued From page 41 11/02/10 at 5:45 PM, the nurse acknowledged her failure to wash her hands. She stated she was nervous but should have washed her hands "in and out of every room".	F 441		
F 514 SS=D	Review of the facility's Policy entitled "Handwashing", revealed handwashing was indicated; before and after contact with a resident, after touching a source which was likely to be contaminated, and as appropriate throughout medication distribution. 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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. 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the clinical record was accurately maintained for one (1) of twenty-seven (27) sampled residents (Resident #7). Resident #7 had an order to discontinue elbow and hand splints. However, it remained on the active orders from September 2009, until noted by the	F 514	Res. #7's care plans and orders have been revised to reflect discontinuation of splints to the elbows and hands on 11-4-10. A monthly audit will be completed by the RN Mgr. to verify that all safety devices and appliances, etc. ordered for a resident are on the SRNA flow record and in use. This audit is being done to determine no other residents were affected by the deficient practice. This audit will be completed by 12-17-10 with any inconsistencies identified addressed and corrected immediately. The Staff Development Nurse will educate the nursing staff to update care plans at time of order changes. The MDS office will be educated to ensure that changes are made to the care plans by verifying order changes against the care plan no later than the next business day. Education conference 12-2-10 and nurses meeting 12-14-10. The facility change over nurses will be educated to look back at all ancillary order changes for 2 months vs. one in case something is inadvertently missed by the pharmacy.	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2600 STATE ROUTE 5 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 42 surveyor.</p> <p>The findings include:</p> <p>Review of the clinical record revealed Resident #7 was admitted with diagnoses which included Cerebral Palsy with Congenital Quadriplegia and Seizure Disorder. Review of the Physician's Orders for November 2010 revealed an order for a splint to elbows and hands four (4) hours a day.</p> <p>Observation of the resident on 11/02/10 and 11/03/10 revealed no splint was present.</p> <p>Interview with Certified Nursing Assistant (CNA) #5 on 11/04/10 at 11:50 AM revealed she took care of Resident #7 most days she was on duty. She stated she never applied a splint to the resident.</p> <p>Interview with Registered Nurse (RN) #1 on 11/04/10 at 12:10 PM revealed Resident #7's splints had been discontinued "for a while". She produced a copy of the original Physician's Order, dated 09/11/09, to discontinue the splints. The Verbal Physician's Order was signed by the resident's attending physician. Continued interview revealed the order should have been faxed to the pharmacy to be removed from the active Physician's Orders, which were computer generated each month. The facility was unable to show evidence the order was faxed to the pharmacy.</p> <p>Further review of the Physician's Orders revealed the order for splints continued to be carried over each month, from September 2009 to the present.</p>	F 514	<p>The facility is obtaining services from a new pharmacy provider effective 1/6/2011. On 11-17-2010 a meeting was held with the new pharmacy medical records personnel and all expectations for records to be maintained in a complete manner were reviewed. All aspects of the record and how changes are made were documented for follow up by the medical records person.</p> <p>The MDS CP Coordinator will conduct monthly audits to verify order changes are being reflected on the care plans. The Medical Records department at the facility will be responsible for auditing every chart once per month for verification that the clinical records are complete, accurate, accessible, and organized. Any areas of needed improvement will be addressed immediately where applicable or noted and forwarded to the Resident Care Mgr. for follow up.</p> <p>All audits will be monitored by the facility via the performance improvement process for one year to ensure compliance is achieved and maintained and then will be re-evaluated.</p>	12-20-10

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

PRINTED: 12/20/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/05/2010
NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2800 STATE ROUTE 6 ASHLAND, KY 41102	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 514	<p>Continued From page 43</p> <p>Interview with the pharmacy's General Manager on 11/04/10 at 3:05 PM revealed the nurse was responsible for faxing all orders to the pharmacy. She explained the order would remain month to month if the pharmacy did not receive the order. Continued interview revealed the pharmacy received three (3) orders for Resident #7 on 09/11/09 and 09/12/09. She further stated no order related to splints was received by the pharmacy.</p> <p>Interview with the Director of Nursing (DON) on 11/04/10 at 5:50 PM revealed during the monthly changeover, all orders received during the previous month were reviewed by a nurse and checked against the newly generated orders, for each resident. She stated the nurse should have caught the error when the Orders received during September 2009 were checked against the new Order sheet for October 2009. Continued interview revealed if the error was not caught the first month, there would be nothing to suggest the mistake on subsequent months. However, if the nurse checking the Orders each month was aware Resident #7 was not using splints, the presence of the Order should inflite an attempt at clarification.</p>	F 514		

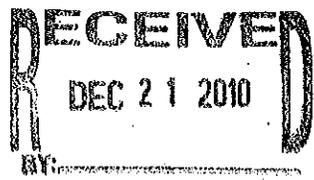
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000		
K 025 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview during the survey on 11/04/2010, it was determined the facility failed to ensure the fire barrier walls would resist the passage of smoke/fire to other areas of the facility in the event of a fire. The deficient practice could affected staff and residents. The facility has the capacity for 147 beds and at the time of the survey the census was 142.</p> <p>The findings include:</p> <p>Observation on 11/04/2010 at 10:30 AM with the Maintenance Director, revealed penetrations in the fire barriers in the following areas: The Vent</p>	K 025	<p>All fire/smoke wall barriers were corrected with fire resistant caulking on 11-4-2010.</p> <p>The fire barrier walls will be visually inspected on a monthly basis by the maintenance department.</p> <p>This will be monitored by the facility via the performance improvement program for one year and then will be re-evaluated.</p> <p>12/21/10</p>	12/21/10



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Keira Mann</i>	TITLE ADMINISTRATOR	(X8) DATE 12-21-10
--	------------------------	-----------------------

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.

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
--	--

(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 025	Continued From page 1 Hall fire barrier next to room 248 and the Data Room; the fire barrier next to the Shoreline Library; and the fire barrier next to room 201. Interview with the Maintenance Director on 11/04/2010 at 10:30 AM, indicated he had not seen the openings. NFPA 101 19.3.7.3 Standard: Smoke barriers shall be continuous from an outside wall to an outside wall. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces per NFPA 101 8.3.2. When pipes, conduits, cables, wires, air ducts and similar building service equipment pass through smoke barriers, the space between the penetrating item and the smoke barrier shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier or protected by an approved device that is designed for the specific purpose per NFPA 101 8.3.6.1.	K 025		
K 040 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. 19.2.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure exit discharge doors opened in the direction of egress. The findings include:	K 040	The exit door on Forest Heights will be reversed to swing in the direction of egress. Any future doors installed in the facility will be installed so that they swing in the direction of egress. Compliance will be monitored by the Maintenance Manager when construction applications occur.	12/20/10

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

PRINTED: 11/22/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185449	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 11/04/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 6 ASHLAND, KY 41102
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
K 040	<p>Continued From page 2</p> <p>Observations during the life safety code inspection on 11/04/10 at 10:34 AM revealed the exit door in Forest Heights Hall did not swing in the direction of egress. This deficiency affected staff and thirty-eight (38) residents. The facility is licensed for one hundred forty-seven (147) and the census, on the day of the survey, was one hundred forty-five (145). This observation was confirmed by the Maintenance Director.</p> <p>Interview with the Maintenance Director on 11/04/10 at 10:34 AM revealed the Maintenance Director was not aware the exit discharge door needed to open in the direction of egress.</p> <p>NFPA 2000 7.2.1.4.3 A door shall swing in the direction of egress travel where used in an exit enclosure or where serving a high hazard contents area, unless it is a door from an individual living unit that opens directly into an exit enclosure.</p>	K 040		