

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

PRINTED: 03/03/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186174	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/17/2011
NAME OF PROVIDER OR SUPPLIER FLORENCE PARK CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 6975 BURLINGTON PIKE FLORENCE, KY 41042	
(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	F 000		
F 226 SS=D	<p>A standard abbreviated survey was initiated on 02/15/11 and concluded on 02/17/11 to investigate KY15933 and KY15934. KY15934 and KY15933 were found to be Unsubstantiated; however, deficiencies were identified during the survey and cited at a scope and severity of a "D".</p> <p>483.13(c)(1)(II)-(III), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225	<p>This plan of correction shall operate as Florence Park Care Center's written credible allegation of compliance. This plan of correction is not meant to establish any standard of care, contact, obligation, or position and Florence Park Care Center reserves the rights to raise all possible contentions and defenses in any civil or criminal claim, action or proceeding.</p> <p>F 225 483.13 Investigate/Report Allegations/Individuals</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law.</p> <ol style="list-style-type: none"> 1. Administrator in-serviced the Human Resource Director on 2/18/11 in regard to the regulations pertaining to conducting abuse checks. 2. Administrator will perform Bi-weekly QA's for 3 months to ensure compliance for all new hires. 	2/18/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [Signature] TITLE x Administrator (X6) DATE x 3-7-11

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

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If continuation sheet Page 1 of 8
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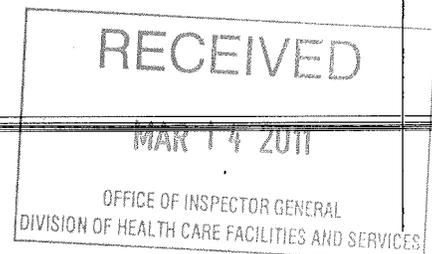
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F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to screen two (2) of ten (10) sampled employees for abuse findings prior to hiring the employees. Employee #4 lived in another state and abuse checks were not completed in that state. Employee #9 was hired on 01/07/11 and an abuse check was not conducted until 01/10/11.</p> <p>The findings include:</p> <p>Review of the facility policy on Abuse, undated, revealed the facility would screen all potential employees for a history of abuse, neglect, mistreatment of residents, or misappropriation of property.</p> <p>Review of Employee #4's personnel file revealed the employee lived in Ohio; however, the facility could provide no evidence an abuse check of this potential employee was completed in Ohio prior to hiring.</p> <p>Review of Employee #9's personnel file revealed the employee was hired on 01/07/11; however, the facility could provide no evidence the potential employee was screened for abuse prior to hiring and was not screened until three (3) days after being hired.</p>	F 225		



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F 225	Continued From page 2 Interview with the Human Resources Manager on 02/17/11 at 2:50pm revealed she was not aware potential employees were to be checked for abuse findings in other states, if applicable. She stated potential employees were offered conditional employment pending the results of abuse check findings. Interview with the Administrator on 02/17/11 at 3:00pm revealed he was not aware Employee #9 did not have an abuse check until three (3) days after hired or that potential employees were to be checked for abuse findings. In addition, he stated he was not aware other states where potential employees had worked were to be contacted for any abuse findings prior to being hired.	F 225			
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 record review and interview, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents for two (2) of ten (10) sampled employees. Employee #4 had lived in Ohio; however, the facility failed to implement their policy to screen all potential employees for abuse findings. Employee #9 was hired on 01/07/11 and the facility failed to implement their policy to screen potential employees for abuse findings.	F 226	F 226 483.13 Develop/Implement 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. 1. Administrator in-serviced the Human Resource Director on 2/18/11 in regard to the regulations pertaining to conducting abuse checks. 2. Administrator will perform Bi-weekly QA's for 3 months to ensure compliance for all new hires.	2/18/11	

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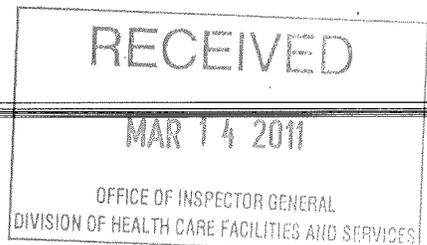
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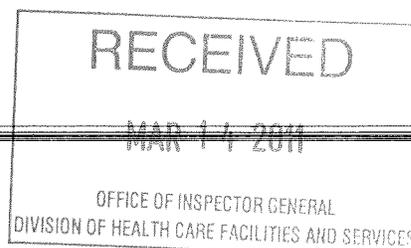
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F 226	Continued From page 3 The findings include: Review of the facility policy on Abuse, undated, revealed the facility would screen all potential employees for a history of abuse, neglect, mistreatment of residents, or misappropriation of property. Review of Employee #4's personnel file revealed the employee lived in Ohio; however, the facility could provide no evidence the policy for screening potential employees for abuse was followed. Review of Employee #9's personnel file revealed the employee was hired on 01/07/11; however, the facility could provide no evidence the potential employee was screened for abuse prior to hiring. Interview with the Human Resources Manager on 02/17/11 at 2:50pm revealed she was not aware potential employees were to be checked for abuse findings in other states, if known. She stated potential employees were offered conditional employment pending the results of abuse check findings and that at orientation (employees were paid for orientation time) these employees were not yet full employees. She stated the regulation did not require an abuse check prior to hiring an employee. Interview with the Administrator on 02/17/11 at 3:00pm revealed he was not aware of the regulation or the guidelines and felt the facility was correct in their interpretation.	F 226			
F 274 SS=D	483.20(b)(2)(II) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive	F 274			



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F 274	Continued From page 4 assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to conduct a comprehensive assessment for two (2) of eight (8) sampled residents (Residents #2 and #8) within fourteen (14) days after the facility determined, or should have determined, that there had been a significant change in the resident's physical or mental condition. Resident #8 showed significant improvement in two (2) or more areas. Resident #2 showed significant decline in two (2) or more areas. The findings include: The facility uses the Minimum Data Set Manual, 2010, as their policy and procedure for completion of significant changes in residents' comprehensive assessments. Review of the facility's roster matrix revealed Resident #8 was not interviewable.	F 274	F274 – The facility will conduct a comprehensive assessment of a resident within 14 days after the facility determines that there has been a significant change in the resident's physical or mental condition. 1. The Corporate MDS Coordinator in-serviced and educated the MDS nurses related to the facility policy listed in the CMS's RAI Version 3.0 Manual, "Significant Change in Status Assessment," on 2/18/2011. Resident #2 and resident # 8 showed no ill affects from the facility's failure to conduct a comprehensive assessment within fourteen days after the facility determined that there had been a significant change in the resident's physical or mental condition. A correction of the MDS for resident #2 was completed on 3/8/2011 and a correction of the MDS for resident # 8 was completed on 3/9/2011 and submitted to address the significant change. A house wide audit was conducted by the DON, on 2/18/2011, of all the MDS completed in the last month, to ensure no other residents were affected by the failure to identify a significant change in a resident's condition. A QA was initiated on 2/18/2011 and will continue to be conducted on every return admission by the MDS Coordinator or designee to determine if resident qualifies for a significant change assessment for a period of six months. A computer program was added to our Electronic Computer System in the form of a QA to alert and cue the MDS nurses when a resident shows a decline or improvement in two or more monitored areas. The MDS nurses will meet with the Corporate MDS Coordinator every two weeks to discuss all residents who showed a decline or improvement in two or more monitored areas and determine if a significant change MDS is indicated for a period of six months.	3/10/11	



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F 274	<p>Continued From page 5</p> <p>Review of the clinical record for Resident #8 revealed the resident was admitted to the facility with diagnoses of Failure to Thrive, Mood Disorder, Depression, and Hypertension. The facility completed an admission Minimum Data Set (MDS) assessment on 09/03/10 which revealed the resident required extensive assistance of one (1) person for dressing and hygiene and limited assistance of one (1) person to ambulate and transfer. The facility completed a quarterly MDS assessment on 12/03/11 which revealed the resident was ambulating and transferring independently, had been sustaining falls, and required only supervision to dress, groom, and manage hygiene. In addition, the resident had been prescribed an anti-anxiety medication for agitation and was using a wanderguard related to exit seeking behaviors since the admission MDS assessment.</p> <p>Observation of Resident #8 on 02/15/11 at 4:45pm, and 02/16/11 at 9:30am, 10:15am, 11:30am and 2:00pm and on 02/17/11 at 9:00am revealed the resident was calm and no agitation was noted. The resident was able to ambulate independently around the unit and was seen to stop at exit doors for several minutes before moving on.</p> <p>Interview with the MDS Nurse on 02/16/11 at 2:30pm revealed Resident #8 had improved; however, she did not complete a significant change MDS assessment as required as she had been taught that all Activities of Daily Living (ADL) only counted as one area of change so the resident did not meet the definition for significant change. She stated the resident did have deficits in long and short term memory and was not interviewable.</p>	F 274			

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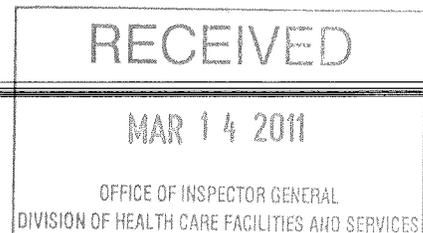
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F 274	Continued From page 6 Interview with the Corporate MDS Coordinator on 02/16/11 at 2:50pm revealed resident MDS assessments had not been audited to establish if significant change MDS assessments needed to be corrected or completed on other residents. Interview with the Director of Nursing (DON) on 02/17/11 at 3:00pm revealed she was not aware MDS assessments were not being completed as required. Observations of Resident #2 on 02/15/11 at 5:15pm revealed the resident was sitting in a wheelchair, smiling, and had a feeding pump attached to the back of the wheelchair. Additional observations on 02/16/11 at 9:40am, 1:30pm, and on 02/17/10 at 9:25pm and 1:00pm revealed the resident was turned and positioned while in bed and was up in the wheelchair for meals and activities. The resident appeared clean and appropriately attired and smiled when addressed. Review of the clinical record for Resident #2 revealed the resident was admitted to the facility with diagnoses of Hyperlipidemia, Hemiplegia, GERD, Narcolepsy, Coronary Artery Disease, Congestive Heart Failure, and Cerebral Thrombosis with Infarction. The facility completed an admission Minimum Data Set (MDS) assessment on 07/01/10 which revealed the resident required extensive assistance with two person physical assist for bed mobility and transferring. The resident ambulated independently with one person physical assist. The resident's eating skills were assessed as independent with setup help only. The facility completed a quarterly MDS assessment on	F 274			



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F 274	Continued From page 7 01/16/11 which identified the resident had declined and required extensive assistance with two person physical assistance for bed mobility and transferring. The resident's ambulation had declined to the activity did not occur during the seven day review period. The resident's eating skills had declined to total dependence with a gastric-tube placement documented on 12/15/10. The quarterly MDS assessment revealed a significant decline in the resident's functional status and included a hospitalization for a gastric-tube placement. The facility failed to provide evidence to explain why a significant change MDS assessment was not completed when the resident had declined. An interview with the Corporate MDS staff on 02/17/11 at 2:50pm revealed a significant change MDS should have been completed.	F 274			

