

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

PRINTED: 03/25/2014
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 R 03/25/2014
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NAME OF PROVIDER OR SUPPLIER KINGSBROOK LIFECARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 2500 STATE ROUTE 5 ASHLAND, KY 41102
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	INITIAL COMMENTS An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 03/19/14.	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ 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
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PRINTED: 02/27/2014
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 02/11/14 and concluded on 02/13/14. Deficiencies were cited with the highest Scope and Severity of a "D".	F 000	Stat labs were ordered for both Res. #4 and Res. #16. Res. #4 was on 02/12/14 and on 02/13/14 for Res. #16 as these were the days the errors were noted. Both Res. #4 and #16 lab results are current and up to date. All Stat labs were within normal range and zero adverse reactions were noted. The medical director reviewed Res. #4 and #16 lab results no orders were noted based on lab results. A building wide audit was completed by the Resident Care Managers on each unit, (Susan Kempf, RN, Brian Neely, RN, Violet Stewart, RN, and Pam Willis, RN) as well as the Quality Assurance Department nurses, (Christie Penick, RN, Robin Davis, LPN) on all labs ordered for all residents on 2/14/14 and all labs were current. The facility has implemented the process of entering all lab orders in the Electronic Medical Records to flag that a lab is due to be drawn. This will be entered by the LPN or RN caring for the individual resident that the lab is ordered for. All new orders are verified by an LPN or RN on midnight shift for accuracy and to follow through on all orders. A transfer report form was implemented for any resident that transfers from one unit to another and any resident that transitions from short-term care to long-term care. This audit will be completed by the Resident Care Manager on each unit.	2/22/14	
F 281 SS=D	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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure services provided met professional standards of quality for two (2) of twenty-four (24) sampled residents (Residents #4 and #16) as evidenced by the facility's failure to draw laboratory specimens (labs) as ordered. Resident #4 had standing orders for a weekly Comprehensive Metabolic Panel (CMP) labs; however review of the labs performed revealed no documented evidence of CMP labs obtained during January and February of 2014 as ordered. Resident #16 had an order to have routine labs performed every three months; however there was no documented evidence the labs were obtained as ordered. The findings include: Review of the facility's policy titled, "Physician Order / Transcribing New and Re-Admitted Residents", effective date December 2001,	F 281			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kate Moore* TITLE: ADMINISTRATOR (X6) DATE: 3/19/14

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

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F 281	<p>Continued From page 1</p> <p>revealed all residents admitted to the facility were to have Physician Orders in order to provide immediate and essential care to residents consistent with each resident's mental and physical status. Further review of the policy revealed Physician's Orders were to be accurately transcribed and carried out.</p> <p>Review of the facility's policy titled, "Medical Record Change Over Policy", dated August 2009, revealed "change over" was conducted once the new monthly records were obtained from pharmacy by the nurse to compare the current Physician Orders to the new month's records.</p> <p>Interview, on 02/13/14 at 4:46 PM, with the Director of Nursing (DON) revealed her expectation was staff were to transcribe Physician orders accurately when changing over orders and ensure Physician's Orders were followed.</p> <p>1. Review of the medical record of Resident #4 revealed the facility admitted the resident on 02/20/13, with diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, Hypertension, and Dementia. Review of the Significant Change Minimal Data Set assessment, dated 02/03/2014 revealed the facility assessed Resident #4 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated the resident was cognitively intact.</p> <p>Review of the Physician's Orders revealed an order dated 07/31/2013, for Resident #4 to have a CMP (a lab to check for conditions such as diabetes, liver disease, and kidney disease) lab drawn every Wednesday. However, review of the</p>	F 281	<p>All labs will be audited by the Quality Assurance nurses Angie Cisco LPN, and Rita Kirk, LPN during monthly changeover. An education was completed on 2/21/14, by Christie Penick, RN, Quality Assurance and Robin Davis, LPN, and Tom Cantrell, LPN, on how to schedule lab orders in Point Click Care for the labs to auto-populate into the EMAR. All audits will be monitored through the monthly QAPI meeting for a period of one year or longer if needed. The monthly QAPI meeting is made up of:</p> <p>Keith Moore (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Lisa Queen (Asst. Administrator), Pam Bryan (Asst Director of Nursing), Teria Maynard (MDS Coordinator), Christie Penick (Infection Control/QA), Adam Rucker (Resident Services Director), Glenna Greenslade (Social Services), Curtis Metzler (Cardiac Manager), Randy Payne (Environmental Services), Anthony Crance (Maintenance), Susan Kempf (RCM), Brian Neely (RCM), Pam Willis (RCM), Violet Stewart (RCM), Kayleigh Ticknor (Dietician), Gail Cunningham (Dietary Manager), Katie Davis (Finance Coordinator), Keith Carter (Risk Management), Arrin McKnight (Admissions), Charlie Pack (Activities), Annie Bishop (Therapy Manager), Robin Vanderpool (Treatment Nurse), Josie Armstrong (Restorative Coordinator), Jennifer McFarlin (Human Resources), Vicki Bailey (Medical Records), and Kathy Schaffer (Pharmacist).</p>		

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F 281	<p>Continued From page 2</p> <p>lab reports revealed no documented evidence of the weekly CMP having been obtained as ordered since 12/30/13.</p> <p>Interview, on 02/12/14 at 2:36 PM, with Licensed Practical Nurse (LPN) # 2, who cared for Resident #4, revealed the CMP lab had been ordered related to Resident #4's diagnosis of Congestive Heart Failure. The LPN stated ordered labs would "pop up" on the computer system; however Resident #4's lab had not that day, which was a Wednesday. She stated the resident's CMP lab should have however. LPN #2 reviewed Resident #4's medical record and stated there were no CMP lab reports for January and February 2014 in the record. She indicated the last CMP lab report in the resident's medical record had been obtained on 12/30/2013.</p> <p>Interview, on 02/12/14 at 4:30 PM and 02/13/14 at 1:22 PM, with Registered Nurse (RN) #2 / Resident Care Manager (RCM) Gardenside Unit revealed she had overlooked the order when doing the "change over" of orders. She stated she should have checked to see if the weekly CMP was still an active order when performing the "change over" and the lab should have been carried through into 2014.</p> <p>Interview, on 02/13/14 at 2:35 PM, with RN #3/Quality Assurance (QA) Nurse revealed labs were reviewed daily to see which labs were to be obtained. The RN#3/QA Nurse stated when staff did the yearly "change over" of 2013 lab orders into the lab computer system for 2014, Resident #4's CMP lab order had not been transcribed and was dropped. She further stated the facility's RCMs were responsible for ensuring lab orders were carried forward and Resident #4's had been</p>	F 281		

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F 281	<p>Continued From page 3 missed.</p> <p>Interview with the DON on 02/12/14 at 3:01 PM, revealed when the RCM performed the "change over" of lab orders from 2013 and inputted the orders into the computerized lab system for 2014, she should have checked with the Physician to see if Resident #4's weekly CMP order was to continue; and if so the lab should have continued to be obtained as ordered. She stated the facility had not noticed Resident #4's weekly CMP lab had not been done in 2014.</p> <p>2. Review of the medical record for Resident #16 revealed the facility admitted the resident on 09/09/12, with diagnoses which included Congestive Heart Failure, Chronic Kidney Disease, Diabetes, Hypertension, Decubitus (Pressure) Ulcer, Depression, and Dementia.</p> <p>Review of the Physician's Orders revealed the resident had Physician Lab Orders dated 07/29/13, for a Hemoglobin A1C (HGBA1C), a screening tool to evaluate blood sugar levels, and for Potassium Levels to be obtained every three (3) months beginning on 10/18/13. Review of the lab reports revealed no documented evidence of a HGBA1C and Potassium obtained since 07/17/13.</p> <p>Continued review of the Physician's Orders revealed an order for a Basic Metabolic Panel (BMP) lab; a basic screening lab to check for conditions such as diabetes and kidney function; and a B-Type Natriuretic Peptid (BNP), a screening lab for heart failure. Further review of the order revealed the BMP and the BNP were to have been collected very six (6) months starting on 01/18/14. Review of the lab reports revealed</p>	F 281		

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F 281	<p>Continued From page 4</p> <p>no documented evidence these labs were obtained as ordered on 01/18/14.</p> <p>Further review of the Physician's Orders revealed an order for a Microalbumin, a urine test to screen for kidney damage in diabetics, was to be obtained every twelve (12) months starting on 01/18/14. Review of the lab reports revealed no documented evidence the Microalbumin lab was obtained on 01/18/14 as ordered.</p> <p>Interview, on 02/13/14 at 3:00 PM, with RN #4 revealed Resident #16 was moved from the Forest Heights Unit on the second floor to the Shoreline Unit on the first floor on 10/01/13. RN #4 stated somehow during Resident #16's transition and the facility's new computer system the orders for the labs were not followed as ordered. RN #4 indicated the labs should have been obtained.</p> <p>Interview, on 02/13/14 at 3:15 PM, with RN #5 RCM for the Shoreline Unit, revealed she was responsible to ensure labs were collected as ordered by the Physician. RN #5/RCM revealed Resident #16's labs had not been obtained as ordered; however should have been. RN #5/RCM stated the labs would have indicated whether the resident's Insulin and/or other medications might have needed adjusting.</p> <p>Interview with RN #3/QA Nurse on 02/13/14 at 3:25 PM, revealed the RCM's were responsible for ensuring lab orders were carried forward; however the RCM had somehow missed Resident #16's labs. RN #3/QA Nurse stated she recognized this was an issue and was going to order "stat" labs for Resident #16.</p>	F 281			

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F 441 F 441 SS=D	Continued From page 5 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (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. (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 communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441 F 441	No residents were found to be affected by the deficient practice at this time. The facility sanitized the spas including all fixtures and equipment within the spa areas. The other two spas in the facility were free from any debris. Zero residents were affected by this as no residents were in the spas when inspected and were sanitized immediately upon notification of findings. The facility has implemented a two hour spa check system for all nurse aids in the building on every shift. The nurse aids will clean and sanitize the spa after every use to ensure proper infection control safety. The housekeeping department sanitizes all spas at the beginning of the day, and is also doing a sanitation log for each spa to be checked off by the housekeeper assigned to each unit. Education for the housekeeping staff was completed on 02-17-14, by Randy Payne (Environmental Services Manager. Education for the nurse aids was completed on 02-21-14, completed by the QA Infection control department, both nurse aids and housekeepers were educated on proper cleaning and infection control and how to properly fill out the nurse aid logs and housekeeping logs. (Christie Penick, RN, and Robin Davis, LPN.) A building wide education for all staff was completed on the facility infection control program and policy for compliance with the entire regulation was completed on 3-18-14, by the Quality Assurance/Infection Control Department. (Robin Davis, LPN) Spot checks will be completed randomly three times per week by the QA/Infection Control Department (Robin Davis) or nursing supervisor to cover all shifts, and will be checked during direct care times and non care times. The nursing logs are check sheets for nurse aids to sign off on that they have checked and cleaned the spa. These are filled out every two hours by the nurse aids on the unit and housekeeping logs will be monitored through QAPI for a period of one year or longer if needed. All results will be reported in the facilities monthly QAPI meeting. If a problem regarding infection control is observed, the individual staff will be re-educated at that time and shown proper infection control techniques.	3/19/14

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F 441	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the Infection Control Program was maintained to provide a safe, sanitary environment to help prevent the development and transmission of disease and infection as evidenced by observation of two (2) of the four (4) Unit Spas (bathroom/shower room) revealed a shower chair bucket in the the Forest Heights Unit Spa was observed to contain a brownish substance floating in cloudy water; and the toilet bowl in the Shoreline Unit Spa was smeared with a brownish substance. The findings include: Review of the facility's policy titled, "Infection Control Program", undated revealed the goals of the facility's Infection Control Program were to decrease the risk of infections for residents, monitor for the occurrence of infection and implement appropriate control measures, identify and correct problems related to infection control, and insure compliance with regulations. Review of the facility's policy titled, "Safety Management Policy: Bathroom/Spa Cleaning", effective date of 02/11/14, revealed it was the facility's policy the Bathroom/Spa areas would be maintained in a clean and sanitary manner, and were to be cleaned on a daily basis by housekeeping and nursing staff. Continued review revealed shower equipment and supplies were to be cleaned after each use; and blood, secretions and debris were to be removed after	F 441	The Facility QAPI members include: Keith Moore (Administrator), Phillip Fioret (Medical Director), Arlene Massie (Director of Nursing), Lisa Queen (Asst. Administrator), Pam Bryan (Asst. Director of Nursing), Teria Maynard (MDS Coordinator), Adam Rucker (Resident Services Director), Christie Penick (QA/Infection Control), Glenna Greenslade (Social Services), Curtis Metzler (Cardiac Manager), Susan Kempf (RCM), Brian Neely (RCM), Pam Willis (RCM), Violet Stewart (RCM), Kayleigh Ticknor (Dietician), Gail Cunningham (Dietary Manager), Katie Davls (Finance Coordinator), Keith Carter (Risk Management), Arin McKnight (Admissions), Charlie Pack (Activities), Annie Bishop (Therapy Manager), Robin Vanderpool (Treatment Nurse), Josie Armstrong (Restorative Coordinator), Jennifer McFarlin (Human Resources), Vicki Bailey (Medical Records), and Kathy Schaffer (Pharmacist).		

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F 441	<p>Continued From page 7 shower was given.</p> <p>1. Observation on 02/12/15 at 4:00 PM and 5:00 PM, of the Forest Heights Unit's Spa Room revealed a shower chair bucket half full of cloudy water with a brownish substance floating in the water.</p> <p>Interview on 02/12/14 at 5:10 PM with State Registered Nursing Assistant (SRNA) #5 revealed the shower chair bucket in the Forest Heights Unit's Spa Room appeared to have bowel movement (BM) in it and it was supposed to be cleaned after every shower.</p> <p>Interview with License Practical Nurse (LPN) #1 on 02/12/14 at 5:15 PM, a nurse on the Forest Heights Unit, revealed he would have the shower chair and the bucket cleaned immediately. He stated shower chairs and buckets were always supposed to be cleaned and sanitized after each use.</p> <p>2. Observation on 02/12/14 at 4:15 PM and 5:05 PM, of the Shoreline Unit's Spa Room revealed a brownish smear approximately one (1) inch by five (5) inches on the exterior of the toilet bowl.</p> <p>Interview with SRNA #6 on 02/12/14 at 5:30 PM, an SRNA on the Shoreline Unit, revealed the brown smear on the exterior of the toilet bowl should have been cleaned up after the toilet had been used. SRNA #6 stated the SRNAs were to clean up the Spa Rooms first; and then call Housekeeping to come clean the area. According to SRNA #6, the brown smear looked like BM and somehow it had been missed.</p> <p>Interview with Registered Nurse (RN) #3/Quality</p>	F 441		

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F 441	Continued From page 8 Assurance (QA)/Infection Control (IC) Manager on 02/12/14 at 5:45 PM, revealed SRNAs were supposed to clean the Spa Rooms first after each use; and then call Housekeeping if needed. RN #3/QA/IC Manager stated leaving the Spa Rooms with BM in shower buckets or on toilets was unacceptable as this could spread disease.	F 441			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: Construction Date 05/18/02</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) Story, Type II (222) Protected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM originally installed in 4-02 upgraded in 7-2011</p> <p>FULLY SPRINKLED, SUPERVISED (Wet SYSTEM) original in 4/02</p> <p>EMERGENCY POWER: Type II Diesel Generator. Original in 4/02</p> <p>A life safety code survey was conducted on 02/12/2014. The facility was found to be in substantial compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) the Requirements for Participation for Medicare and Medicaid. The facility is licensed for one hundred forty-three (143) beds and the census was one hundred thirty eight (138) the day of the survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kevin [Signature]</i>	TITLE ADMINISTRATOR	(X8) DATE 3-3-14
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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.