

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM TO SNFS AND NFs	PROVIDER # <b>185155</b>	MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETE: <b>12/2/2010</b>
NAME OF PROVIDER OR SUPPLIER <b>THE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY</b>		

FLX  
SUMMARY STATEMENT OF DEFICIENCIES

**153** 483.10(b)(2) RIGHT TO ACCESS/PURCHASE COPIES OF RECORDS

The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

This REQUIREMENT is not met as evidenced by:  
Based on interview and record review, it was determined the facility failed to release the medical record in a timely manner for one (1) of eighteen (18) sampled residents (Resident #17).

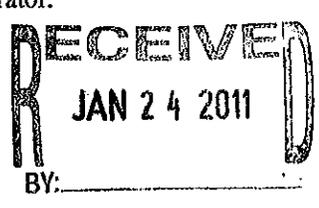
The findings include:

Review of Resident #17's clinical record revealed he/she was admitted to the facility on 08/03/08 with diagnoses which included Dementia and Depression.

Review of a document provided by the resident's family revealed the Attorney for the family made the initial request for Resident #17's medical record on 10/14/10. Further review of this document revealed the Attorney had spoken to corporate counsel on 11/10/10 regarding the record and was told the records were being organized and should be ready to be sent by 11/12/10. According to the document the requested medical record had not been received, as of 11/23/10.

Interview with the facility's Medical Records Clerk on 12/02/10 at 3:45 PM revealed she had spoken to the resident's Attorney several times after the initial request for the records which was received on 10/14/10. However, no explanation was given as to why there was no documentation of these conversations.

Interview with the Administrator on 12/02/10 at 10:45 AM revealed that record requests had to go to the facility's Legal Department before being sent to the Attorney. The Administrator and two (2) Administrative Assistants in the Legal Department did not know why it had to go to the Legal Department first. The Administrator indicated if a complete record was requested, it had to come from the corporate office. However, there was no documentation/policy to validate the process, per the Administrator.

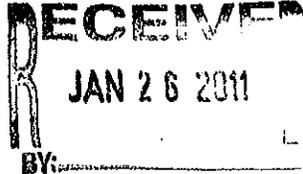


efficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. In 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 must be submitted.

above isolated deficiencies pose no actual harm to the residents

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>	
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F 000	<b>INITIAL COMMENTS</b>  A Recertification Survey and an Abbreviated Survey Investigating ARO#KY00015001, ARO#KY00015002, ARO#KY00015287, ARO#KY00015288, ARO#KY00015450, ARO#KY00015451, ARO#KY00015474, ARO#KY00015629, and ARO#KY00015647 was initiated on 11/30/10 and concluded on 12/02/10. Deficiencies were cited on the Standard Survey. ARO#KY00015001, KY00015287, KY00015451, KY00015474, KY00015629 and KY00015647 were substantiated with deficiencies. ARO#KY00015288 was substantiated with no deficiencies cited. ARO#KY00015002 and KY00015450 were unsubstantiated with no deficiencies. A Life Safety Code inspection was conducted 12/01/10. The highest scope and severity cited was a "F".	F 000	<b>This prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.</b>	
F 157 SS=D	<b>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b>  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).	F 157	 <p><b>F157: Notification of Change</b></p> <p>1. Physician was notified of change in condition for # 7 on 12/2/10. New orders were obtained.</p>	
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE
		Executive Director		1/25/11

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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F 157	Continued From page 1 The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157	2.) 24 hour reports were audited by nurse management for the last 14 days to ensure physician notification of changes in condition on 12/28/2010. The Director of Nursing or designee notified the MD of any notifications not completed by the charge nurses.  3.) Licensed Nursing staff will be inserviced by the Director of Nursing or designee regarding physician notification of changes in resident condition on 1/8/2011.  4.) Change in conditions will be audited by nursing management to ensure physician notification daily x 4 weeks, then monthly X 3, and results reviewed in the PI meeting.  5.) Date of compliance: 1/12/2011		
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to notify the Physician when there was a change in the resident's physical status and a need to alter treatment for one (1) of twenty-one (21) sampled residents (Resident #7).  The findings include:  Review of the facility's "Changes in Resident's Condition or Status" Policy revealed, Nursing Services were responsible for notifying the resident's attending physician when: there was a significant change in the resident's physical, mental, or emotional status, and when there was a need to alter the resident's treatment or medications significantly. Further review revealed all notifications must be made as soon as practical, but in no case will such notification exceed twenty-four (24) hours.  1. Review of Resident #7's medical record revealed diagnoses which included Mental				

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F 157	<p>Continued From page 2</p> <p>Retardation and a History of a Pressure Ulcer. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/04/10, revealed the facility assessed the resident as having cognitive impairment, required extensive to total assistance with Activities of Daily Living (ADLs), and as having a Pressure Ulcer.</p> <p>Observation of a skin assessment performed by Licensed Practical Nurse (LPN) #6 on 12/01/10 at 10:00 AM for Resident #7, revealed the resident's penis, scrotum, and bilateral groin were red. Further observation revealed there was an area on the resident's right heel which measured 1.5 centimeters (cms) x 1 cm. and appeared purple in color. The nurse described the area as a "new darker area".</p> <p>Interview with LPN #6, at the time of the skin assessment, revealed she was aware the resident had redness to the penis, scrotum, and groin area and the resident was receiving Calmoseptine Ointment to the areas, which she applied. Further interview revealed the resident was receiving a Mediplex dressing to the right heel every three (3) days; however, the darker area on the right heel was new.</p> <p>Review of the Weekly Skin Integrity Data Collection dated 11/24/10 revealed there was no documented evidence of the redness of the penis, scrotum and groin. Review of the Weekly Pressure Sore Tracking Report dated 11/19/10 completed by the wound nurse, revealed the area to the resident's right heel was closed. Review of the Weekly Skin Integrity Data Collection dated 11/24/10, revealed there was no documented evidence of skin breakdown on the resident's right heel.</p>	F 157		

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F 157	<p>Continued From page 3</p> <p>Review of the Physician's Orders dated 12/10 revealed there was no Physician's Order for a treatment to the penis, scrotum, and groin. Further review revealed Orders for Alleevyn dressing with Kerlex every three (3) days and as needed to the right heel.</p> <p>Review of the clinical record on 12/02/10 revealed there was no documented evidence the Physician had been notified of the dark purple area on the resident's right heel or the redness of the penis, scrotum, and groin areas.</p>	F 157		
	<p>Interview on 12/02/10 at 4:15 PM with the Director of Nursing (DON), revealed the nurse who identified the skin breakdown for Resident #7 should have notified the Physician "right away for treatment orders".</p> <p>Interview on 12/02/10 at 5:00 PM with LPN #6, revealed the dark spot on the resident's left heel could be tissue damage. She further stated the Physician should have been notified when she identified the area to see if the treatment should be changed. Continued interview revealed she should have notified the Physician of the redness of the genitalia and groin areas on 12/01/10; however, she thought all residents could be treated with Calmoseptine without a Physician's Order since the facility had the medication "in stock".</p> <p>Interview and observation of the resident's right heel with the Wound Nurse on 12/02/10 at 5:20 PM, revealed the area on the resident's right heel was purple and was unstageable. She further stated the right heel wound was closed at the time of her last skin assessment on 11/19/10 and</p>			

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F 157	Continued From page 4 the Allevyn dressing which was ordered was for protection. Continued interview, revealed if staff identified new wounds they were to notify the Physician, and notify her. She further stated she had not been notified of any change in the resident's right heel.  Although LPN #6 was aware of the redness to the resident's penis, scrotum and groin areas, and the new area to the resident's right heel on 12/01/10; there was no evidence the Physician was notified until 12/02/10, after surveyor intervention.	F 157	<b>F167: Right to Survey results readily accessible</b>  1.) Survey results were replaced for display in clearly marked binder in the lobby of the facility on 12/3/2010.	
F 167 SS=C	<b>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</b>  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the results of the most recent survey and the plan of correction were readily accessible and available for examination.  The findings include:  Observation from 11/30/10 through 12/02/10	F 167	2.) Survey results were replaced for display in clearly marked binder in the lobby.  3.) A sign will be placed by survey binder informing residents, visitors, etc... to please return binder after reviewing to ensure availability for everyone. An extra copy of the survey binder will be kept in the Executive Director's office in the event it is misplaced again.  4.) Availability of survey binder will be audited by the Executive	

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F 167	Continued From page 5 revealed the most recent survey results and Plan of Corrections were not in the location the facility had specified for this information. Interview with the Administrator on 12/02/10 at 10:00 AM revealed the book with the survey results was usually located in the front lobby on a table, but sometimes residents would take the book. Interview further revealed the Administrator did not have a copy of the results and would have to obtain the documents from the corporate office.	F 167	Director weekly X 4, then monthly X 3, and results reviewed in the PI meeting.  5.) Date of Compliance: 1/12/2011		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) <b>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</b>  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.  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).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	<b><u>F225: Investigate/Report allegations/individuals</u></b>  1.) An incident report for a fractured foot for Resident # 4 was completed. Incident report originally called to agency on 9/20/10 and secondary bruise on 9/21/10. Follow-up report was then faxed to agency on 9/29/10.  <b>Note: This was a total of one (1) day late not four (4).</b>		

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F 225	Continued From page 6  The results of all investigations must be reported to the administrator or his designated 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.  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to have an effective system to ensure all alleged violations involving abuse, or injuries of unknown source were reported immediately to the Administrator of the facility and to other officials in accordance with State Law.  In addition, the facility failed to have an effective system to ensure all alleged violations or injuries of unknown source were thoroughly investigated.  Also, the facility failed to have an effective system to ensure the results of all investigations involving abuse or injuries of unknown source were reported to State agencies within five (5) working days of the incident for one (1) of twenty-one (21) sampled residents (Resident #4).  The findings include:  Review of the facility's policy entitled "Reporting Alleged Abuse", dated 02/09 revealed all alleged or suspected violations involving mistreatment, abuse, neglect, or injuries of unknown origin would be promptly reported to the Administrator	F 225	2.) 24 hour reports will be audited by the nursing management for the last 14 days to ensure investigations are completed as indicated on 12/28/2010. A log of reportable incidents will audited by Executive Director or designee to ensure that they are reported within five working days.  3.) Policy of Incident Management and Reporting was reviewed with the Executive Director, the Director of Nursing and the Director of Social Services by the Regional Director of Clinical Services on 12/14/2010.  A log of reportable incidents will be maintained by the Director of Nursing.  The Executive Director will review the log of newly hired employees to ensure proper checks have been performed prior to the employees working.	

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F 225	Continued From page 7 and/or Director of Nursing". The Policy further stated, when an allegation of abuse and/or neglect had occurred, the Administrator, DON, or designee, would promptly notify State agencies in accordance with State laws. The Administrator, DON, or designee would complete an investigation of the incident including a written summary of the findings no later than five (5) working days after the reported occurrence. The results of the investigation should be reported to the State agencies within five (5) working days from the date of the incident.	F 225	4.) Changes in Condition will be audited by Nursing Management to ensure incident investigation completed as indicated weekly X 4, then monthly X 3, and results reviewed in the PI meeting.  Log of reportable incidents will be audited to ensure timely follow-up by the Executive Director weekly X 4, then monthly X 3, and results reviewed in the PI meeting.  5.) Date of compliance: 1/12/2011		
	1. Review of Resident #4's medical record revealed diagnoses which included Mental Retardation, Parkinson's Disease, and Paralysis Agitans. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/30/10, revealed the facility assessed the resident as having cognitive impairment, and as requiring extensive assistance with transfers, ambulation, dressing, and hygiene.  Review of the Resident Assessment Protocol Summary (RAPS) dated 05/20/10, revealed the resident had short term memory loss, and was able to make most needs known. Further review revealed the resident required assistance with bed mobility, transfers, dressing, and hygiene. Continued review revealed the resident was unsteady on his/her feet related to the diagnosis of Parkinson's Disease, and staff had to observe the resident for getting up on his/her own due to the resident's risk for falls.  Review of the Comprehensive Plan of Care revealed the resident had a fracture of the right medial malleolus (with no onset date), with a goal which stated the resident would have no				

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F 225	Continued From page 8 complications due to the fracture by 08/24/10. The interventions included observing for pain and swelling, pain medications as ordered, and boot in place.  Review of the Nurses' Notes dated 05/21/10 at 9:00 PM, revealed the resident's right ankle was swollen with bruising noted to the right inner ankle and the resident complained of pain and discomfort with range of motion. Further review revealed the Physician was paged.	F 225		
	<p><del>An entry in the Nurses' Notes dated 05/22/10 (with no time noted), revealed the Physician was paged in reference to the resident's right ankle and an x-ray was ordered of the right ankle and foot. Review of the X-ray Report of the right ankle obtained on 05/23/10 revealed an acute fracture of the medial malleolus.</del></p> <p>Review of Nurses' Notes dated 05/24/10 at 4:00 PM, revealed x-ray results were received and faxed to the the Physician's Office and the office was called. Further review of the Nurse's Notes dated 05/25/10 at 9:30 AM, revealed the resident was out of the facility to the clinic. An entry dated 05/25/10 at 11:00 AM, revealed the resident returned to the facility with a boot.</p> <p>Physician's Orders dated 05/25/10 revealed orders for a low tide boot while sitting during the day for one (1) month.</p> <p>Review of the Care Plan Conference Record dated 05/25/10, revealed the resident returned with a fracture to the ankle from the Physician's appointment and stated he/she may have fallen. Further review revealed the resident told the family he/she "fell last night."</p>			

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F 225	Continued From page 9  Interview on 12/02/10 at 3:30 PM with the Director of Nursing (DON) revealed the Care Plan Conference Notes dated 05/25/10, revealed the resident stated he/she fell; however, there was no documented evidence of a fall, and there was no investigation completed which would have involved questioning staff to attempt to find the cause of the fracture. She stated, she normally did an investigation related to an "injury of unknown source"; however, she could find no Incident Report or investigation related to Resident #4's fracture diagnosed 05/23/10, and no evidence the injury of unknown source was reported to state agencies.  2. Further review of Resident #4's medical record revealed a Nurses' Note dated 09/20/10 at 6:30 PM, which stated the resident complained of someone shoving him/her down in the bed a few days ago and the family and Physician were notified. Further review of Nurses' Notes dated 09/21/10 at 7:15 PM revealed a large bruise was noted to the resident's left upper arm and a small bruise was noted to the resident's groin area. Continued review revealed the Director of Nursing was notified and the resident's family was present and aware.  Review of the facility's investigation revealed the facility became aware of the incident on 09/20/10, and the State agencies were notified on 09/20/10 and 09/21/10 (within twenty-four (24) hours). However, the facility's investigation revealed the final investigation was completed and the State agencies were notified of the findings on 09/29/10 (four (4) days late). There was no documented evidence the results of the investigation were reported to state agencies	F 225			

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F 225	Continued From page 10 within five (5) working days of the incident.  Interview on 12/02/10 at 9:40 AM with the Director of Nursing (DON) revealed she was unsure of the reason the State agencies were not notified of the results of the investigation until 09/29/10. However, she stated, the reason may have been because the facility did not receive a statement from the alleged perpetrator until 09/29/10. Continued interview revealed State agencies were to be notified of the investigation results of an alleged abuse incident within five (5) days.	F 225		
F-278 SS=D	483.20(g) - (j) - ASSESSMENT ACCURACY/COORDINATION/CERTIFIED  The assessment must accurately reflect the resident's status.  A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  A registered nurse must sign and certify that the assessment is completed.  Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.	F-278	<b>F278: Assessment accuracy/coordination/certified</b>  1.) Quarterly assessment dated 8/23/10 for Resident # 12 was not signed or dated to verify completion. The most recent MDS was certified completed by the Registered nurse/MDS Coordinator on 12/4/2010 upon completion.  2.) Completed MDS for the past 30 days were audit by Medical Records on 1/8/2011 to ensure completion was certified by a Registered nurse/MDS Coordinator.  3.) The MDS coordinator was inserviced by the Regional Director of Clinical Services regarding certification of completion of MDS on 12/14/2010.	

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F 278	Continued From page 11  Clinical disagreement does not constitute a material and false statement.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure a Registered Nurse certified the assessment completed for one (1) of twenty-one (21) sampled residents. (Resident #12) as evidenced by no signature on the Quarterly Minimum Data Set assessment dated 08/10.  The findings include:  Review of Resident #12's medical record revealed diagnoses which included Chronic End Stage Lung Disease, hospital acquired Pneumonia, Multiple Cerebrovascular Accidents, Traumatic Head Injury, Depression and Diabetes Mellitus.  Review of the Minimum Data Set (MDS) Quarterly Assessment for Resident #12 revealed the assessment reference date of 08/23/10 and the signatures on the front sheet of the MDS revealed four (4) signatures of persons who completed a portion of the accompanying assessment dated 08/30/10. Further review revealed no signature of the Registered Nurse (RN) Assessment Coordinator and no date when the assessment was completed.  Interview with the MDS Coordinator on 12/02/10 at 10:55 AM revealed the Quarterly MDS should have been signed.	F 278	4.) Completed MDS's will be audited by the HIM/Medical records Director to ensure completion certification weekly X 4, then monthly X 3, and results reviewed in the PI meeting.	
			5.) DATE OF COMPLIANCE: 1/12/2011	

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F 279 SS=D	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p>	F 279	<p><b>F279: Develop Comprehensive Careplans</b></p> <p>1.) Resident # 6 careplan was revised to include non compliance with diet order on 12/3/2010,</p> <p>2.) A 100% audit of current</p>	
	<p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to develop a Comprehensive Plan of Care based on the resident's Comprehensive Assessment, which included measurable objectives and individualized interventions to meet resident needs for one (1) of twenty-one (21) sampled residents (Resident #6). Resident #6's Plan of Care failed to reflect the resident's non-compliance with the therapeutic diet.</p> <p>The findings include:</p>		<p>resident's careplans will be completed by nurse management by 1/8/2011 to ensure careplans are based on the resident's Comprehensive Assessment, which includes measurable objectives and individualized interventions to meet residents needs.</p> <p>3.) Interdisciplinary care plan team members were inserviced by the Regional Director of Clinical Services regarding Development of Careplans on 12/14/2010.</p> <p>4.) Careplans will be audited by the Director of Nursing or Designee to ensure they are based on the resident's Comprehensive</p>	

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F 279	<p>Continued From page 13</p> <p>Review of the clinical record revealed Resident #6 was admitted to the facility on 05/14/10 with diagnoses which included Hypertension, Depression, and End Stage Renal Disease. Continued review revealed the resident had several hospitalizations, with the most recent readmission to the facility being 11/21/10.</p> <p>Review of the Physician's Admission Orders dated 11/21/10, revealed an order for a Liberal Renal diet. Review of the Resident Assessment Protocol dated 05/21/10, revealed Resident #6 was on a "therapeutic diet due to dialysis and renal failure."</p>	F 279	<p>Assessment, which includes measurable objectives and individualized interventions to meet residents needs weekly X 4, then monthly X 3, and results reviewed in the PI meeting.</p>	
	<p>Review of the Care Plan dated 05/10/10, revealed it was active until 02/15/11. Continued review of the Care Plan revealed Resident #6 was on a renal diet, with interventions including "provide diet as ordered." The Care Plan had not been revised to reflect resident/family non-compliance with dietary restrictions.</p> <p>Observation on 11/30/10 at 5:45 PM revealed the resident's supper tray set up on the overbed table. The tray card indicated Resident #6 was on a liberal renal diet. Continued observation revealed an open can of V-8 on the table.</p> <p>Review of the nutritional information panel revealed the juice contained 470 milligrams (mg) potassium and 420 mg. sodium per serving. Continued observation revealed two (2) more cans of V-8 juice on the corner cupboard next to the resident's bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #4 on 12/02/10 at 9:45 AM revealed a liberal renal diet included decreased salt, and the avoidance</p>		<p>5.) DATE OF COMPLETION: 1/12/2011</p>	

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F 279	Continued From page 14 of high-potassium foods. Continued interview revealed V-8 juice was high in sodium (salt) and potassium. The nurse stated the family of Resident #6 provided the juice per the resident's request. She further stated the resident was non-compliant with diet restrictions.  Interview with the Director of Nursing on 12/02/10 at 11:00 AM, revealed the resident was non-compliant with diet restrictions and the facility needed to schedule a Care Plan meeting with the family to determine the resident's desires and understanding-of-the-renal-diet.	F 279	<b>F280: Right to participate planning care Revision of Careplan</b>  1.) Residents # 4's careplan was revised to include interventions for urinary incontinence and the use of a chair alarm on 12/7/2010.	
F 280 SS=E	Interview with Certified Nursing Assistant (CNA) #2 on 12/02/10 at 11:20 AM, revealed the aides were trained on fluid restrictions and food consistency, but not on specific diets, like the renal diet. She stated the tomato juice was provided by the resident's daughter per the resident's request.  Interview with the Assistant Director of Nursing on 12/02/10 at 1:30 PM, revealed she was aware Resident #6 had a history of noncompliance related to the diet restrictions. She stated she knew the family brought in food and drink from outside.  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	F 280	Resident # 7's careplan was revised to include interventions for the use of a bed alarm, air mattress, and the risk factors associated with the use of Plavix on 12/2/2010  Resident # 8's careplan was revised to discontinue intervention to be up in a Broda chair in the dining room for meals with set up for self feeding on 12/3/2010.  Resident # 3's careplan was revised to include up for meals on 12/6/2010.  Resident # 5's careplan was revised re regarding new orders to d/c noted heel boot on 12/1/2010.	

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F 280	Continued From page 15 comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	2.) A 100% audit of all current resident's careplans will be completed by 1/8/2010 by nurse management for inclusion of new interventions and revisions made as necessary.  3.) Interdisciplinary team members	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure Plans of Care were reviewed/ revised for five (5) of twenty-one (21) sampled residents (Resident #4, #7, #8, #3, and #5).  Resident #4 failed to have a Plan of Care related to Urinary Incontinence. and the use of a tab alarm. Resident #7 failed to have a Plan of Care to reflect the resident's use of a bed alarm as well as an air mattress, and the risk factors associated with the use of Plavix (antiplatelet medication). Resident #8 failed to have a Plan of Care to reflect interventions to be up in the Broda chair daily, and to be in the dining room for meals with set up for self feeding. Resident #3 failed to have a Plan of Care to reflect the intervention to be up for meals and Resident #5 did not have an intervention on the Plan of Care related to the use of a heel boot.  The findings include:		were inserviced by the Regional Director of Clinical Services regarding Revision of Careplans on 12/14/2010.  4.) Careplans will be audited by the Director of Nursing or Designee for inclusion of current interventions weekly X 4, then monthly X 3, and results reviewed in the PI meeting.  5.) DATE OF COMPLIANCE: 1/12/2011	

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F 280	Continued From page 16 1. Review of Resident #4's medical record revealed diagnoses which included Mental Retardation, and Parkinson's Disease. Review of the Annual Minimum Data Set (MDS) Assessment dated 05/27/10 revealed the facility assessed the resident as usually continent of bladder with incontinence episodes once a week or less. Review of the Quarterly MDS dated 08/23/10 and 11/30/10 revealed the facility indicated the resident was occasionally incontinent two (2) or more times per week.	F 280		
	<p>Review of the Comprehensive Plan of Care dated 06/19/08, revealed there was no Plan of Care to address the resident's urinary incontinence.</p> <p>Interview on 12/01/10 at 9:00 AM with Certified Nursing Assistant (CNA) #19, revealed she was assigned to the resident and the resident wore pull ups. She further stated the resident ambulated to the bathroom with assistance and she offered to toilet the resident every two hours when she did rounds. She stated the resident was "usually" continent, but had incontinent episodes.</p> <p>Interview on 12/02/10 at 6:15 PM with Registered Nurse (RN) #2/MDS Coordinator revealed she "missed" completing a Plan of Care related to urinary incontinence with the completion of the last Quarterly MDS assessment.</p> <p>Further review of the Quarterly MDS dated 11/30/10 revealed the resident required extensive assistance for transfers and ambulation. Review of the Resident Assessment Protocol Summary (RAPS) dated 05/20/10 revealed the resident was at risk for falls due to unsteadiness on his/her feet and the resident attempted unassisted transfers.</p>			

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F 280	Continued From page 17  Observation of Resident #4 on 12/01/10 at 11:40 AM revealed the resident was in the dining room sitting in a wheelchair with a tab alarm clipped to his/her shirt.  Review of the Comprehensive Plan of Care dated 06/19/08, revealed the resident was at risk for falls; had a fall with a fracture in the past, and had a shuffled gait due to Parkinson's Disease. There were several fall interventions in place; however, there was no intervention noted on the Plan related to the use of a chair alarm.	F 280		
	Review of the Incident/Accident Data Questionnaire revealed the resident sustained a fall on 10/28/10 at 11:50 AM. According to the Incident Report, the resident was sitting in front of the wheelchair on his/her buttocks and the chair alarm was sounding.  Review of the Incident/Accident Data Questionnaire 11/26/10 revealed the resident sustained a fall on 11/26/10 at 1:30 PM. According to the Incident Report, the resident leaned over and slid to the floor in front of the wheelchair. The report further stated the chair alarm was in place; however, the report did not state if the chair alarm was functioning.  Interview on 12/02/10 at 6:15 PM with RN #2/MDS Coordinator revealed the intervention for the tab alarm should have been on the Plan of Care. She reviewed the medical record and stated the tab alarm may have been missed on the Plan of Care because there was no Physician's Order for the alarm. She further stated there was to be Physician's Orders for all alarms.			

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F 280	Continued From page 18  2. Review of Resident #7's medical record revealed diagnoses which included Mental Retardation, History of a Pressure Ulcer, and Coronary Artery Disease. Review of the Quarterly Minimum Data Set (MDS) dated 11/04/10, revealed the facility assessed the resident as having cognitive impairment, as requiring total assistance with transfers, as being unable to ambulate, and as sustaining a fall. Review of the Resident Assessment Protocol Summary dated 07/28/10 revealed the resident had a history of falls and tried to get up unassisted.	F 280		
	Observation of the resident's bed on 11/30/10 at 3:30 PM revealed there was a bed alarm in place.  Review of the Comprehensive Plan of Care dated 10/12/09, revealed the resident was at risk for falls and injuries and had a history of falls. Further review revealed there was no intervention related to the use of a bed alarm.  Review of the Incident/Accident Data Questionnaire revealed the resident sustained a fall on 01/23/10 at 7:10 PM and was noted to be sitting on the floor by the bed. The Incident Report did not indicate if the resident had a bed alarm in place at the time of the fall or if the alarm was working.  Further review of the Quarterly MDS dated 11/04/10, revealed the facility assessed the resident as having a Pressure Ulcer. Review of the RAPS dated 07/28/10 revealed the resident had a Stage II area to the heel and had a pressure reduction mattress in place.  Observation of the resident's bed on 11/30/10 at			

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F 280	<p>Continued From page 19</p> <p>3:30 PM revealed there was an air mattress on the bed.</p> <p>Review of the Comprehensive Plan of Care dated 09/27/10 revealed the resident was at risk for skin breakdown related to decreased mobility. There were several interventions noted; however, there was no intervention related to the use of an air mattress.</p> <p>Further review of the medical record revealed Physician's Orders dated 11/10 for Plavix (antiplatelet medication) seventy-five milligrams (75 mgs) daily for a diagnosis of Coronary Artery Disease.</p>	F 280		
	<p>Review of the Comprehensive Plan of Care dated 05/26/08, revealed the resident had an alteration in cardiac status and was diagnosed with Hypertension and Atrial Fibrillation. Review of the interventions, revealed the Plan of Care failed to address the risks associated with the antiplatelet medication.</p> <p>Interview on 12/02/10 with Licensed Practical Nurse (LPN) #8/MDS Coordinator revealed she did not go to the resident's room when she completed the MDS, she interviewed the resident in the hallway. Therefore, she stated, she did not observe the bed alarm or the air mattress on the bed. She further stated the interventions for the bed alarm and the air mattress should have been on the Plan of Care. Further interview revealed she should have had addressed the risks associated with the Plavix medication on the Plan of Care.</p> <p>Interview on 12/02/10 at 9:40 AM with the Director of Nursing (DON) revealed the Charge Nurses on</p>			

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>
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F 280	<p>Continued From page 20</p> <p>the floor were to complete acute care plans for acute illnesses. She further stated the Physician's Orders were copied by medical records and a copy was sent to the daily morning meeting where the Director of Nursing (DON) and Assistant Director of Nursing (ADON) checked to ensure the Care Plans were updated from the Physician's Orders. Continued interview, revealed the MDS Coordinators developed Care Plans with the Admission, Significant Change, and Annual MDSs and revised the care plans with the Quarterly MDS. She stated she was aware there was still a problem with Care Plan revisions.</p>	F 280		
	<p>3. Review of Resident #8's record revealed diagnoses which included Cerebrovascular Accident (CVA), Depressive Disorder, Senility without Psychosis, Late Effective Hemiplegia Side, Abnormal Posture, Dysphagia and Urinary Incontinence.</p> <p>Review of the Comprehensive Care Plan with the goal and target date of 02/15/11 revealed the facility noted the resident required assistance with Activities of Daily Living (ADL) due to his/her CVA with hemiplegia. An intervention noted on the Plan of Care included the resident would be up daily to the Broda chair and the resident required his/her meals to be set up in dining room for self feeding and drinks in bowls for easier access.</p> <p>Observations throughout the survey revealed the resident was not observed at any time to be in a Broda chair or in the dining room (for self feeding). The resident was observed to receive enteral feeding and no food by mouth.</p> <p>Review of the Physician's orders for the month of November stated no food by mouth, the resident</p>			

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F 280	<p>Continued From page 21</p> <p>was ordered to have Glucerna 1.2 at seventy (70) milliliters per hour for twenty (20) hours during the day.</p> <p>Interview with CNA #1 on 12/02/10 at 9:00 AM revealed Resident #8 was not gotten out of bed to a chair very often. This CNA indicated the resident was up to the chair last week. She stated the resident did not eat anything by mouth because he/she had a gastrostomy tube.</p> <p>Interview with CNA #2 on 12/02/10 at 9:10 AM revealed Resident #8 was gotten up and transferred to chair on shower days, approximately ten (10) days each month. She further indicated the resident did not eat anything by mouth secondary to he/she has a gastrostomy tube.</p>	F 280		
	<p>Interview with the Director of Nursing on 12/02/10 at 10:30 AM revealed the Comprehensive Care Plan should have been changed at the resident's last annual review in November related to the resident sitting in Broda chair daily and eating in the dining room.</p> <p>4. Record review revealed Resident #3 was admitted to the facility on 03/21/07 with diagnoses which included Dementia, Colon Cancer, and Anemia. Further record review revealed the facility noted a weight loss in September 2010.</p> <p>Review of the Physician's Orders for November 2010 revealed an order on 09/30/10 that the resident could stay in bed for breakfast and to get the resident up to a wheelchair for lunch and dinner.</p> <p>Review of the Comprehensive Care Plan dated</p>			

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F 280	<p>Continued From page 22</p> <p>01/29/09 revealed a problem of at risk for weight loss due to terminal illness. Further review revealed interventions added to the plan on 9/21/10, 9/29/10, and 10/04/10 to address the weight loss however there was no evidence the Care Plan had been revised to include the intervention to get Resident #3 up in a wheelchair for lunch and dinner.</p> <p>Observation of the dinner meals on 12/01/10 and 12/2/10 revealed Resident #3 was served the dinner meal in bed. Interview on 12/01/10 at 5:30 PM, with GNA #10, who was assigned to Resident #3 on 12/01/10, revealed the resident usually ate dinner in the bed. Interview on 12/02/10 at 4:50 PM, with CNA #7, who was assigned to Resident #3 on 12/02/10, revealed sometimes the resident didn't want to get up for dinner.</p> <p>Interview on 12/01/10 at 5:45 PM with Licensed Practical Nurse (LPN) #7, who worked on Resident #3's unit, revealed the nurse signing off the order was to revise the Care Plan. Interview with the Director of Nursing on 12/02/10 revealed, the order should have been added to the Care Plan as an intervention.</p> <p>5. Review of Resident #5's clinical record revealed he/she was admitted on 06/16/08 with diagnoses which included Generalized Pain, Left Below Knee Amputation, Kidney Disease- Stage IV and Status Post Right Hip Fracture.</p> <p>Review of the Comprehensive Care Plan dated 04/01/10, with goal and target date of 01/25/11 revealed a problem documented as a recently healed Stage IV stasis ulcer to the right heel with Osteomyelitis. The goal was noted as "will have no signs or symptoms of reopening over the next</p>	F 280		

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F 280	<p>Continued From page 23 ninety (90) days." An intervention included the use of a heel boot, as ordered.</p> <p>Review of Physician's orders for November 2010 and December 2010 revealed an order for the "Posey" heel cushion/boot to be worn on the right foot twenty- two (22) hours a day except for cleaning/grooming to prevent further breakdown.</p> <p>Review of the Treatment Administration Record (TAR) for October, November and December 2010 revealed Resident #5 was to be checked once per shift to ensure the resident was wearing the heel boot. Further review revealed the TAR was initiated once per shift for all three months except for 10/22/10 and 11/18/10 which had no initials for any shift to indicate the heel boot was checked.</p> <p>Interview with CNA #5 on 12/01/10 at 10:40 AM revealed CNAs use their daily care guide to care for residents. She stated Resident #5 had the heel boot on last week but had not seen it on him/her in the last few days. CNA #5 was unaware the heel boot intervention was on the CNA care guide. Review of the daily care guide with CNA #5 revealed an intervention which stated, "heel cushion to be worn on right foot 22 hours daily."</p> <p>Interview with CNA #6 on 12/01/10 at 10:45 AM revealed he did not know about the heel boot and, had never seen it on Resident #5. CNA #6 was unaware the intervention was on the CNA care guide. Review of the care guide with CNA #6 revealed the heel cushion was to be worn on the right foot twenty-two (22) hours per day.</p> <p>Resident #5 stated on 12/01/10 at 3:40 PM,</p>	F 280		

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F 280	Continued From page 24 during a skin assessment that he/she had not worn the boot for a long time. Observations through out the survey revealed at no time was Resident #5 wearing the "Posey" heel boot as ordered.  Interview with Licensed Practical Nurse (LPN) #5 on 12/01/10 at 2:55 PM revealed the CNAs were suppose to know what was on their care guides. LPN #5 was unaware as to why the CNAs did not know this was on the care guide. LPN #5 indicated she was aware Resident #5 had the order for the heel boot, but did not know the location of the boot. However, this LPN had indicated on the November TAR that the boot was on the resident.	F 280	<b>F281 Services provided meet professional standards</b>  1.) Resident #5 physican was notified and heel boots were discontinued on 12/1/2010 per his order.  Resident #3' s physician was notified on 12/3/2010. Continue	
F 281 SS=E	Interview with the Assistant Director of Nursing (ADON) on 12/01/10 at 4:00 PM revealed if a treatment block was initialed on the TAR, it indicated the treatment was done. The ADON was not aware why the heel boot checks were marked as done when the boot could not be found. Further interview with the ADON revealed it was all nursing staff's responsibility to make sure the Aides were aware of what the resident care guides had listed as interventions. <b>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  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 physicians orders were	F 281	current order for resident to be out of bed in chair for lunch and dinner.  Resident #6's physician was notified on 12/3/2010 and an order received to continue current order to elevate heels.  Resident # 9's physician was notified and an order was received for the UA and C&S to be discontinued on 12/1/2010.  Resident #10's physician was notified and an order to discontinue the Rocephin on 12/3/2010.  Resident #10 Darvocet order was discontinued on 10/5/2010.	

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F 281	<p>Continued From page 25</p> <p>implemented/followed for five (5) of twenty-one (21) sampled residents (Resident #5, #3, #6, #9 and #10). The following residents had Physician orders which were not implemented: Resident #5 was to have heel boot at all times; Resident #3 was to be up in a wheelchair for lunch and dinner; Resident #6 was to have his/her heels floated; Resident #9 had an order to obtain a urine culture and sensitivity and Resident #10 ordered medications which was not provided.</p> <p>The findings include:</p>	F 281	<p>2.) Review of physician orders written in past 14 days was reviewed by the Director of Nursing on 12/28/2010 to ensure physician orders were implemented/followed.</p>	
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	<p>1. Review of Resident #5's clinical record revealed an admission date of 06/16/08. The resident's diagnoses included Generalized Pain, Left Below the Knee Amputation, Stage IV Renal Disease and Status Post Right Hip Fracture.</p> <p>Review of Physician's orders for November and December 2010 revealed an order for Resident #5 to have a "Posey" heel boot/cushion on twenty- two (22) hours a day. The Physician noted the resident was allowed to have it off for cleaning and grooming.</p> <p>Review of the Comprehensive Care Plan dated 04/01/10 revealed a problem of a recently healed Stage IV stasis ulcer to heel with Osteomyelitis. The goal was for the resident not to have signs/symptoms of reopening (of the ulcer) over the next ninety (90) days. An intervention noted the heel boot was to be worn as ordered.</p> <p>Interview with CNS #5 (Resident #5's usual care giver), on 12/01/10 at 10:40 AM revealed CNAs had a care guide to let them know the resident's needs. This Aide stated she had seen the boot on Resident #5 last week but not in the last few</p>		<p>3.) Licensed nursing staff will be inserviced by the Director of Nursing or designee regarding implementation and following of Physician orders on 1/8/2011.</p> <p>4.) An audit of new physician orders will be completed by the Director of Nursing or designee to ensure physician orders were implemented/followed as written daily X one month, then monthly X 3, and results reviewed in PI meeting.</p> <p>5.) DATE OF COMPLIANCE: 1/12/2011.</p>	
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F 281	Continued From page 26 days. She indicated she was not aware the heel boot was on the care guide for Resident #5, and must have overlooked that intervention.  Interview with CNA #6 (a part time care giver on Resident #5's unit), on 12/01/10 at 10:45 AM revealed he was unaware of the intervention, related to the use of the heel boot being on the care guide. He indicated he had never seen the boot on Resident #5 and did not know the location of the heel boot.  Interview with Licensed Practical Nurse (LPN) #5 on 12/01/10 at 2:55 PM revealed she knew about the order for the heel boot but did not know the location of the boot. LPN #5 stated she did not know why the CNAs did not know this was on the care guide or why the nursing staff (including herself) had been initialing the Treatment Administration Record (TAR) that the boot was on when no one knew the location of the heel boot. She further stated she did not know if the boot information had been passed along to the CNAs but they should be using their care guides.  Interview with the Assistant Director of Nursing (ADON) on 12/01/10 at 4:00 PM revealed it was ultimately the unit nurses responsibility to make sure the residents received the care ordered for them.  Observation of Resident #5 throughout the survey revealed at no time was the ordered "Posey" heel boot on the resident's right foot.  Observation of a skin assessment on 12/01/10 at 3:10 PM by LPN #5 revealed the resident had no broken skin areas and/or no red or mushy areas on his/her right foot.	F 281		

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F 281	Continued From page 27  Interview with Resident #5 during this skin assessment revealed he/she had not worn the right heel boot "for a long time."  2. Record review revealed Resident #3 was admitted to the facility on 03/21/07 with diagnoses which included Dementia, Colon Cancer, and Anemia. Further record review revealed the facility noted a weight loss in September 2010.  Review of the Physician's Orders for November 2010 revealed an order on 09/30/10, which stated the resident could stay in bed for breakfast and to get the resident up to a wheelchair for lunch and dinner.  Review of the Daily Care Guide for Resident #3 revealed an intervention to leave the resident in bed for breakfast but no intervention to get the resident up to a wheelchair for lunch and dinner.  Observation of the dinner meals on 12/01/10 and 12/2/10 revealed Resident #3 was served the dinner meal in bed. Interview on 12/01/10 at 5:30 PM, with CNA #10, who was assigned to Resident #3 on 12/01/10, revealed the resident usually ate dinner in the bed. Interview on 12/02/10 at 4:50 PM, with CNA #7, who was assigned to Resident #3 on 12/02/10, revealed sometimes the resident doesn't want to get up for dinner.  3. Review of the clinical record revealed Resident #6 was readmitted to the facility on 11/21/10, after a hospital stay, with diagnoses which included Hypertension, Depression, and End Stage Renal Disease.	F 281		

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F 281	Continued From page 28 Review of the Weekly Skin Integrity Data Collection dated 11/21/10 revealed Resident #6 returned from the hospital with a red and open areas to the coccyx, a reddened right heel, and a seeping wound to the left arm.  Review of the Physician Admission Orders dated 11/21/10 revealed an order to "Position heels off bed." Continued review revealed Resident #6 was to have to have the left arm wound cleansed with normal saline, packed with Nugauze, and wrapped with Kerlix gauze twice a day.	F 281		
	Observation of Resident #6 during the initial tour on 11/30/10 at 11:00 AM revealed the resident's heels were on the bed. Observation on 12/01/10 at 10:00 AM revealed a pillow under the resident's lower extremities was ineffective, as the resident's heels were on the bed. Observation on 12/01/10 at 10:45 AM revealed Resident #6 had been dressed for a dialysis appointment. The resident was wearing socks, but no shoes. The heels were on the bed. Continued observation revealed ring pillows, designed to be worn on the ankles to keep the heels "floating" were on the resident's bedside table.  Interview with CNA #2 on 12/01/10 at 10:55 AM revealed she was not aware the resident heels were to be kept off the bed. She stated she was not familiar with the ring pillows and didn't use them. She further stated "my care plan doesn't say to float heels."  Interview with Licensed Practical Nurse (LPN) #4 on 12/02/10 at 8:40 PM revealed the resident did not return to the facility after dialysis on 12/01/10. The resident was taken to the hospital from the dialysis center and remained in the hospital. Due			

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F 281	<p>Continued From page 29</p> <p>to the resident's absence, a skin assessment could not be performed.</p> <p>Review of the Treatment Administration Record (TAR) revealed Resident #6 was to have the wound on the left arm cleansed with normal saline, packed with Nugauze, and wrapped with Kerlix twice a day. Continued review revealed the dressing changes were scheduled for 6:00 AM and 6:00 PM every day. Further review revealed no documented evidence the dressing change was done at 6:00 AM on 11/24, 11/25, 11/26, 11/27, 11/29 or 11/30. Interview with LPN #4 on 12/02/10 at 10:50 AM revealed she did not believe the dressing was always changed twice a day, especially on days the resident went out for dialysis. She stated it was possible the dressing was changed, but the nurse failed to document it on the TAR.</p> <p>4. Review of Resident #9's clinical record revealed diagnoses which included Acute and Chronic Urinary Tract Infections, Diabetes Mellitus and Urinary Retention.</p> <p>Review of the Physician's Progress Notes, dated 09/20/10 stated that he would check a urinalysis every two ( 2) months related to the resident's history of recurrent urinary tract infections leading to sepsis.</p> <p>Review of the Physician November Orders, dated 11/17/10 revealed an order to catheterize Resident #9 to obtain a urine specimen for a Urinalysis with Culture and Sensitivity.</p> <p>Review of November Medication and Treatment Records for the resident revealed the catheterized urine specimen for Urinalysis with Culture and</p>	F 281		

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F 281	Continued From page 30 Sensitivity was not obtained until 11/19/10.  Interview with Licensed Practical Nurse (LPN) #2 on 12/01/10 at 3:20 PM revealed the staff person who charted the urine was not obtained on 11/19/10 should have listed the reason and initiated the Physician notification.  Interview with the Director of Nursing (DON) on 12/01/10 at 3:30 PM revealed the facility had failed to follow the Physician's order related to obtaining the urine specimen for the resident's as well as ensuring the Physician was notified.	F 281		
	5. Review of the clinical record revealed Resident #10 was admitted on 04/06/10 with diagnoses which included End Stage Alzheimer's, Generalized Pain, Osteoarthritis and Constipation.  Review of the September 2010 Physician orders revealed an order for Darvocet-N-100 (narcotic for mild to moderate pain relief) tablet to be given at 6:00 AM, 12:00 PM and 8:00 PM, for generalized pain.  The Medication Administration Record for September 2010 was reviewed and revealed that two periods during September the resident went twenty-four hours without receiving the Darvocet, as ordered. On 09/06/10, the resident received the 12:00 PM medication dose as scheduled but did not receive the 8:00 PM dose on 09/06/10 or the 6:00 AM dose on 09/07/10. On 09/27/10, the resident received the 6:00 AM dose but did not receive the scheduled 12:00 PM or 8:00 PM dose. Further review of the records revealed only one entry regarding the missed doses, dated 09/27/10 stating out of medication awaiting back			

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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40361		
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F 281	Continued From page 31 order.  Interview with LPN #2 on 12/01/10 at 3:20 PM she stated she was the nurse that did not give the medication on 09/27/10. She indicated the medication was not available in the medication cart and had notified the pharmacy. She also stated that she may have notified the pharmacy a second time that evening when the medication was still not available even though she could find no record in the resident's chart of that communication.	F 281		
	Interview with the DON on 12/02/10 at 2:45 PM revealed when the Darvocet N-100 was not given the nurse should have charted the reason in Resident #10's chart. Continued interview revealed the medication should have been ordered STAT (needed immediately) and the pharmacy would have delivered the medication to the facility within two (2) hours. She also stated the physician or Hospice should have been notified.  In addition Resident #10's November 2010 Monthly Physician Orders revealed an order on 11/17/10 for a one time injection of Rocephin one (1) gram to be administered intramuscularly. Review of the November 2010 Medication Administration Record revealed no evidence that the injection of Rocephin (bacterial antibiotic) was administered as ordered.  Interview with the DON on 12/01/10 at 3:30 PM revealed she had recently spoken with the nurse that had received the order and she had not given the medication because she did not have Lidocaine (analgesic that can be used to decrease Rocephin injection pain) available.			



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F 282	Continued From page 33  Review of Physician's orders revealed an order for Resident #5 to have a "Posey" heel boot/cushion on twenty- two (22) hours a day. The Physician noted the resident was allowed to have it off for cleaning and grooming.  Review of the Comprehensive Plan of Care, dated 04/01/10, revealed Resident #5 had a recently healed Stage IV Stasis ulcer right heel with Osteomyelitis. An intervention noted on the Plan of Care included the use of a heel boot.	F 282	5.) DATE OF COMPLIANCE: 1/12/2011.	
	Interview with CNA #5 ( a usual care giver for Resident #5) on 12/01/10 at 10:40 AM revealed she had seen the boot on the resident last week but had not seen it on for a few days. She further stated Aides were supposed to use a care guide to tell them what the resident's care needs were and indicated she did not know the heel boot was on the care guide. CNA #5 stated, "I must have overlooked it."  Interview with CNA #6, (a part time care giver for Resident #5), on 12/01/10 at 10:45 AM revealed he did not know about the heel cushion and had never seen it on Resident #5. This CNA stated he generally did not look at it; he had no answer when asked why he does not use it.  Interview with LPN #5/Charge Nurse on Resident #5's unit, on 12/01/10 at 2:55 PM revealed she was aware of the Care Plan related to the heel boot, but did not know where the boot was. The heel boot was not found after a search of Resident #5's room by LPN #5. Further interview revealed the nurses were responsible for making sure the CNAs were doing their jobs according to the care guide. LPN #5 was unable to answer			

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F 282	<p>Continued From page 34</p> <p>why she did not check the CNAs work to make sure it had been done.</p> <p>Interview with Assistant Director of Nursing on 12/01/10 at 4:00 PM revealed it was all staff's responsibility to make sure residents were taken care of according to the Plans of Care. She was unable to answer why the SRNA's were not using the care guides or why the nurses were not monitoring the care given.</p> <p>2. Review of Resident # 6's clinical record revealed Resident #6 was readmitted to the facility on 11/21/10, after a hospital stay, with diagnoses which included Depression, Hypertension, and End Stage Renal Disease. Continued review revealed the resident was status post Cardiovascular Accident (CVA).</p> <p>Review of the Comprehensive Care Plan dated 05/28/10 revealed it was active until 02/15/10. Interventions included staff were to dress the resident in street clothing daily and the resident was to be up to chair daily.</p> <p>Observations of Resident #6 on 11/30/10 at 11:00 AM, 3:30 PM, 4:30 PM, 5:10 PM, 5:45 PM, and 6:15 PM revealed the resident was dressed in a facility gown throughout the day. In addition, the resident was lying in bed at every observation.</p> <p>Interview with CNA #2 on 12/01/10 at 10:55 AM revealed the resident was not dressed except on dialysis days. She stated the resident got up in the chair "sometimes".</p> <p>There was no documented evidence the Care Plan was updated to reflect resident desires or refusals related to dressing and getting out of bed</p>	F 282		

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F 282  F 309 SS=E	Continued From page 35 daily. <b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b>  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.	F 282  F 309	<b>F309 Provide care/services for highest well being</b>  1.) Resident #7's physician was notified and an order received on 12/2/2010.	
	This REQUIREMENT is not met as evidenced by: Based on observation, interview and record 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 one (2) of twenty-one (21) sampled residents (Residents #5 and #7). Resident #7 was noted to have redness to the penis, scrotum, and bilateral groin areas. There was no Physician's Orders for treatment to the areas. In addition, staff was using Calmoseptine Ointment to the areas without a Physician's Order for the medication. Resident #5 had an order for a narcotic pain medication which was un-available for a fourteen (14) day period.  The findings include:  1. Review of Resident #7's medical record revealed diagnoses which included Mental Retardation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/04/10, revealed the facility assessed the resident as having cognitive impairment, and requiring		Resident #5's physician was notified on 12/1/2010 and an order was received to schedule the narcotic. Narcotic was given as ordered.  2.) A 100% audit of physician orders written in past 14 days was reviewed by nurse management on 12/28/2010 to ensure physician orders were implemented and followed.  24 hour reports will be audited for the last 14 days by nursing management to ensure physician notification of changes in condition.	

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F 309	<p>Continued From page 36 extensive to total assistance with Activities of Daily Living (ADLs).</p> <p>Review of the Resident Assessment Protocol Summary dated 07/28/10, revealed the resident was at risk for skin issues related to his/her overall health status, and staff were to observe for skin issues during daily care and per weekly assessments.</p> <p>Review of the Comprehensive Plan of Care with an onset date of 09/27/06, revealed the resident was at risk for skin breakdown and staff were to notify the Physician of any skin issues and treat as ordered.</p>	F 309	<p>3.) Licensed nursing staff will be inserviced by the Director of Nursing or Staff Development coordinator on 1/8/2011 regarding implementation and following of Physician Orders.</p>	
	<p>Observation of a skin assessment performed by Licensed Practical Nurse (LPN) #6 on 12/01/10 at 10:00 AM for Resident #7, revealed the resident's penis, scrotum, and groin area was red.</p> <p>Interview with LPN #6 at the time of the skin assessment revealed she was aware the resident had redness to the areas, and the resident was receiving Calmoseptine Ointment to the areas which she applied.</p> <p>Review of the Weekly Skin Integrity Data Collection dated 11/24/10 revealed there was no documented evidence of the redness of the penis, scrotum, and groin.</p> <p>Review of the Physician's Orders dated 12/01/10 revealed there was no Physician's Orders for a treatment to the penis, scrotum, and groin.</p> <p>Further interview with LPN #6 on 12/02/10 at 5:00 PM revealed she had just notified the Physician of the resident's redness of the genitalia and groin</p>		<p>Licensed Nursing staff will be inserviced by the Director of Nursing or Staff Development Coordinator on 1/8/2011 regarding Physician notification of changes in resident condition.</p> <p>4.) A 100% audit of new physician orders will be completed by nursing management to ensure physician orders were implemented and followed as written daily, Monday through Friday X 4 weeks, then monthly X 3, and results reviewed in PI meeting.</p> <p>Change in conditions will be</p>	

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F 309	Continued From page 37 areas and had received new orders. She further stated she should have notified the Physician after the skin assessment on 12/01/10; however, she thought all residents could be treated with Calmoseptine without a Physician's Order since the facility had the medication "in stock".  Review of the Physician's Orders dated 12/02/10 revealed orders for Calmoseptine to the buttocks, groin area, penis, and abdominal folds twice a day and as needed.	F 309	audited by nursing management to ensure physician notification daily, Monday through Friday X 4 weeks, then monthly X 3, and results reviewed in the PI meeting.  5.) DATE OF COMPLIANCE: 1/12/2010.		
	2. Review of Resident #5's clinical record revealed diagnoses which included Hypertension, Diabetes, and Generalized Pain. Review of the Physician Orders dated 10/04/10 revealed the resident was to receive Lortab (pain medication), one (1) or two (2) tablets, every four (4) to six (6) hours as needed.  Review of the Quarterly Minimum Data Set Assessment dated 09/22/10, revealed Resident #5 experienced moderate pain on a daily basis. Review of the Comprehensive Care Plan dated 04/09/09 revealed the plan was active until 01/23/11. An interventions included to provide medications as ordered, and to "monitor for effectiveness of pain meds."  Review of the Medication Administration Record for October 2010 revealed Resident #6 received the Lortab on sixteen (16) occasions between 10/04/10 and 10/15/10. On each occasion, the medication was documented as being effective. Between 10/15/10 and 10/30/10, there was no documented evidence Resident #5 was provided the Lortab.  Interview with the Social Services Director (SSD)				

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F 309	<p>Continued From page 38</p> <p>on 12/02/10 at 6:45 PM revealed he had been approached by the Ombudsman (date unknown) for assistance regarding the unavailable medication. He stated he went to the West Wing, where the resident resided, and confirmed the medication was unavailable. He further stated the pharmacy had to have an original prescription before they would fill a controlled substance, including Lortab. Continued interview revealed the SSD called the physician's office himself and spoke to a nurse who stated she would have the doctor send the prescription "the next day." The SSD stated he did not know why Resident #5 was out of medication so long without anyone following up.</p> <p>Interview with LPN #5 on 12/02/10 at 7:15 PM revealed Resident #5 had been out of pain medication for about two (2) weeks. She stated if the Pharmacy did not have a prescription, they would not send the controlled drug. LPN #5 stated she had attempted to call the Physician at his office on several occasions, and had spoken to his Physician Assistants (PAs) at the facility, to request a prescription for the Pharmacy. Continued interview revealed the PAs told LPN #5 they would tell the physician when they returned to the office.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 12/02/10 at 7:30 PM revealed the Pharmacy would not deliver a controlled substance without a prescription. The ADON confirmed Resident #5 had not received the pain medication between 10/15/10 and 10/30/10. She stated the West Wing nurses had tried to contact the Physician at his office several times.</p> <p>Attempts were made to interview the resident</p>	F 309		

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F 309 F 314 SS=D	Continued From page 39 however, the resident refused. 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  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.  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 had pressure sores receives necessary treatment and services to promote healing for one (1) of twenty-one (21) sampled residents (Resident #7). A new area was observed on the heel of Resident #7 on 12/01/10 and the facility failed to obtain a treatment order until 12/02/10.  The findings include:  Review of Resident #7's clinical record revealed diagnoses which included Mental Retardation. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 11/04/10, revealed the facility assessed the resident as having cognitive impairment, as requiring extensive to total assistance with Activities of Daily Living (ADLs), and as having a pressure ulcer.  Review of the Resident Assessment Protocol	F 309 F 314	<b>F314 Treatment to prevent/heal pressure sores</b>  1.) Resident #7 had treatment orders in progress and MD was notified of change in status on 12/2/10. New orders were obtained, careplanned and implemented.  2.) All residents with treatments in progress were evaluated nursing management on 12/9/2010 for changes in status to ensure MD notification of any changes.  On 12/28/2010 a 100% audit of all residents was conducted by nursing management to identify anyone with changes in skin conditions.  3.) Nursing staff will be inserviced regarding MD notification of any		

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F 314	Continued From page 40 Summary dated 07/28/10, revealed the resident was at risk for skin issues and had a Stage II area to the heel. Further review revealed staff was to observe for skin issues during daily care and per weekly assessment.  Review of the Comprehensive Plan of Care with an onset date of 09/27/06, revealed the resident was at risk for skin breakdown related to decreased mobility. Interventions included notifying the Physician of any skin issues and treat as ordered.	F 314	changes in the status of pressure areas, prevention of pressure areas as well as notification of change in skin condition by the Director of Nursing or designee on 1/8/2011.  4.) An audit of residents with treatments in progress as well as	
	Review of the Braden Scale for Predicting Pressure Sore Risk dated 10/20/10, revealed the facility assessed the resident as being at risk for developing a pressure sore related to being "chair fast", and having very limited mobility.  Observation, on 12/01/10 at 10:00 AM, of a skin assessment performed by LPN #6, revealed there was an area on the resident's right heel which measured one and a half centimeters (1.5 cm) x one (1 cm) and appeared purple in color. The nurse described the area as a new "darker area." Interview with LPN #6, at the time of the skin assessment, revealed the resident was receiving a treatment to the heel of Mediplex every three days; however, the darker area on the heel was new, since the dressing was last changed.  Review of the Physician's Orders dated 12/10 revealed Orders for Allewyn dressing with Kerlex every three (3) days and as needed to the right heel.  Review of the Weekly Pressure Sore Tracking Report dated 11/19/10, completed by the wound nurse, revealed the area to the resident's right		residents with weekly skin assessments will be evaluated by nursing management to ensure MD notification of changes in status weekly X4, then monthly X 3, and results reviewed in PI meeting.  5.) DATE OF COMPLIANCE: 1/12/2011	

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F 314	<p>Continued From page 41</p> <p>heel was closed. Review of the Weekly Skin Integrity Data Collection dated 11/24/10 revealed there was no documented evidence of skin breakdown on the right heel.</p> <p>Further review of the clinical record on 12/02/10 revealed there was no documented evidence the Physician had been notified of the dark purple area on the resident's right heel which was identified on 12/01/10 by LPN #6. In addition, there was no documented evidence the new area of skin breakdown in the Nurses' Notes, in the Weekly Pressure Sore Tracking Report, or in the Weekly Skin Integrity Data Collection.</p> <p>Interview on 12/02/10 at 4:15 PM with the Director of Nursing (DON), revealed the nurse who identified the skin breakdown for Resident #7 should have notified the Physician "right away for treatment orders".</p> <p>Interview on 12/02/10 at 5:00 PM with LPN #6, revealed the dark spot on the resident's right heel could be tissue damage. She further stated, the Physician should have been notified when she identified the area, and the information should have been documented in the Nurses' Notes.</p> <p>Interview on 12/02/10 at 5:20 PM, with the wound nurse, revealed she had not done measurements or wound assessments on the resident's heel for a few weeks because the wound had healed. Observation of the resident's right heel at the time of the interview revealed staff was using the wrong dressing. The wound nurse stated staff was using Mediplex and should have been using Allevyn. She further stated, the area on the resident's right heel was purple and was unstageable. Continued interview, revealed if</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/02/2010
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD			STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351	
(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 42 staff identified new wounds they were to notify the Physician, notify her, and document the measurement and the description of the wound in the Nurses' Notes. She further stated she had not been notified of any change in the resident's right heel.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  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 is incontinent of bladder received appropriate treatment and services to prevent Urinary Tract Infections (UTIs) for one (1) of twenty-one (21) sampled residents (Resident #13).  The findings include:  Review of Resident #13's medical record revealed diagnoses which included Polyneuritis, Urinary Retention, and a History of Urinary Tract Infections (UTIs). Review of the Quarterly Minimum Data Set (MDS) Assessment dated 09/14/10, revealed the facility assessed the	F 315	<b>F315 no catheter, prevent uti, restore bladder</b>  1.) Resident # 13 has had no further urinary-tract-infections noted and receives appropriate treatment and services to prevent infections .  2.) All residents with foley catheters were evaluated by nursing management on 12/9/2010 for symptoms of infection and appropriate treatment and services to prevent infections. Also on 12/9/2010, appropriate catheter usage and assesment for possible restoration of bladder function was audited by nursing management.  3.) Nursing staff will be inserviced by Director of Nursing or designee	

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F 315	Continued From page 43 resident as having moderate impairment related to cognitive skills, requiring extensive to total assistance with Activities of Daily Living, having an indwelling catheter, and as having a UTI in the past thirty (30) days.  Review of the Physician's Orders dated 09/20/10 revealed orders for Augmentin (antibiotic medication) 875 milligrams twice a day for fourteen (14) days related to an UTI. Further review revealed Physician's Orders dated 11/17/10 for Doxycycline (antibiotic medication) 100 milligrams twice a day for 14 days and Clpro (antibiotic medication) 500 milligrams twice a day for 14 days for a UTI.  Observation of Indwelling catheter care on 12/02/10 at 10:00 AM revealed CNA #7 cleaned the "Foley" indwelling catheter tubing wiping from the catheter tubing towards the meatus.  Interview on 12/02/10 at 10:20 AM with CNA #7 revealed he did not realize he had wiped the wrong direction when cleaning the "Foley" indwelling catheter tubing. He further stated he did not remember having an inservice at the facility related to "Foley" indwelling catheter care.	F 315	on 1/8/2011 regarding appropriate treatment and services to prevent infections with catheter usage.  4.) Nursing staff performance of foley catheter care will be evaluated daily X 1 week, weekly X 4, then monthly X 3 by the Director of Nursing or designee. In addition, a monthly audit will be completed for residents currently using catheters for appropriate usage of catheter, assesment of possible restoration and review of infection organisms.		
F 323 SS=E	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.	F 323	5.) DATE OF COMPLIANCE: 1/12/2011.		

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F 323	<p>Continued From page 44</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 each resident received adequate supervision and assistance devices to prevent accidents for one (1) of twenty-one (21) sampled residents (Resident #9). Resident #9 was observed to utilize a fall mat which slid when stepped on creating a fall hazard.</p> <p>The findings include:</p>	F 323	<p><b>F323 Free of accident hazards/supervision devices</b></p> <p>1.) Resident #9 had floor mats removed on 12/2/2010.</p> <p>2.) All fall mats were evaluated for fall hazards Executive Director and</p>	
	<p>Record review revealed Resident #9 was admitted with diagnoses which included Dementia, Joint Pain, Osteoporosis, and Muscle Weakness.</p> <p>Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 11/09/10 revealed the facility assessed the resident as being moderately cognitive impaired and at risk for falls.</p> <p>Review of the resident's Comprehensive Plan of Care revealed an intervention for the use of fall mats, related to potential for falls and fractures.</p> <p>Observation on 12/02/10 revealed a fall mat in the resident's room which slid when the resident stepped on the mat. Observation and interview with the Corporate Registered Nurse, (RN), on 12/02/10 at 3:30 PM confirmed the mat was a hazard and she immediately removed the mat for disposal and informed nursing staff to obtain a different fall mat for the resident's room.</p> <p>Observation and interview with the Assistant Director of Nursing, (ADON), 12/02/10 at 8:00 PM confirmed the original mats located in Resident</p>		<p>Director of Maintenance on 12/2/2010. No other mats were identified as being a hazzard.</p> <p>On 12/2/2010, a walk through of the facility was conducted by the management team to ensure the enviroment remains as free of accidental hazards as possible and that residents utilized appropriate equipment to reduce the risk of accidents.</p> <p>3.) Nursing Staff will be inserviced by Director of Nursing or designee on 1/8/2011 regarding supervision and assistance devices in an attempt to reduce accidents.</p>	

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F 323	Continued From page 45	F 323		
F 328 SS=D	<p>#9's room had been disposed of and the replacement mats did not slide.</p> <p><b>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</b></p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses.</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 residents receive proper treatment and care for special services related to oxygen usage signs not located on two (2) of thirteen (13) resident's rooms who had oxygen located in their rooms. The facility failed to have an effective system in place to ensure residents receiving enteral feeding, specifically Resident #8, were provided the necessary monitoring.</p> <p>The findings include:</p> <p>1. Observation during tour on 12/02/10 revealed 2 unsampled resident rooms that did not have the proper signage posted regarding use of oxygen in those rooms.</p> <p>Review of Life Care Centers of America's General</p>	F 328	<p>In addition, all staff was inserviced on 1/8/2011 regarding identifying and reporting any hazards that may contribute to resident accidents.</p> <p>4.) Resident rooms will be assessed with daily rounds by department managers and licensed nursing staff to ensure facility is free of safety hazards to ensure appropriate supervision is provided and to ensure staff utilizing assistance devices appropriately. Results will be reported to the PI meeting.</p> <p>5.) DATE OF COMPLIANCE: 1/12/2011.</p>	

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F 328	<p>Continued From page 46</p> <p>Oxygen Use Policy, dated 10/2004, stated that No Smoking and Oxygen In Use signs must be posted on the outside of a room entrance where oxygen therapy is administered.</p> <p>Observation and interview with the Assistant Director of Nursing (ADON)-on 12/02/10 at 8:10 PM confirmed the facility failed to post No Smoking and Oxygen in Use signage on the outside of rooms 102 and 304. The ADON informed a staff person assigned down each of the halls to post the signage immediately.</p>	F 328	<p><b>F 328 Treatment/care for special needs</b></p> <p>1.) All rooms containing Oxygen have Oxygen signage.</p>	
	<p>2. Record review for Resident #8 revealed diagnoses which included Cerebrovascular Accident (CVA), Diabetes Mellitus, Senility, Hemiplegia, and Dysphagia.</p> <p>Review of the Physician orders for the month of November revealed Resident #8 was to receive Glucerna 1.2 at seventy (70) milliliters (ml) per hour for twenty (20) hours each day. In terms of the volume of feeding ordered, the resident was to receive fourteen hundred (1400) ml each day.</p> <p>Review of the Medication Administration Record (MAR) for the month of November 2010 revealed the documented twenty-four (24) hour totals of enteral feeding received by Resident #8 failed to indicate the resident was receiving 1400 ml per day, as orders. Review of the MAR revealed such totals as 11/01/10 two thousand one-hundred sixty (2160) ml; on 11/04/10 five hundred (500) ml; on 11/15/10 eight hundred forty (840) ml; on 11/23/10 forty (40) ml; and, on 11/30/10 five hundred sixty (560) ml.</p> <p>Interview with Licensed Practical Nurse (LPN) #9 on 11/30/10 at 6:40 PM revealed enteral feeding</p>		<p>Resident #8 tube feeding orders were clarified on 12/20/2010 to determine hours of down time and the MAR identifies accurate amounts of formula administered.</p> <p>2.) All rooms containing Oxygen were audited by nursing management to ensure Oxygen signage on 12/3/2010.</p> <p>All residents receiving tube feedings will be reviewed by nursing management 12/27/2010 to ensure proper tube feeding monitoring is in place.</p> <p>Residents receiving colostomy care, injections and special foot care were assessed on 12/28/2010 for proper treatment.</p>	

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F 328	Continued From page 47 was stopped when resident was cleaned, which is every two (2) hours. She further indicated there were no initials on the enteral feeding bottle identifying who provided the feeding. She also stated the resident's enteral feeding was stopped four (4) hours each day with no set time in place. She further indicated there was no system for documentation when enteral feeding was held for assisting the resident with Activities of Daily Living (ADL's) or the Physicians every twenty (20) hours order.	F 328	We have no residents requiring the use of a trach.  3.) Nursing Staff and Department managers will be inserviced by the Director of Nursing or designee regarding Oxygen usage signage will be completed on 1/8/2011.		
	Interview with Registered Nurse (RN) #1 on 12/01/10 at 5:10 PM revealed the resident's enteral feeding was turned off for four (4) hours each day and it depended on if the blood sugar was "good." She indicated, on the day of the survey, that it was good, one hundred fifty-eight (158) this morning and one hundred fifty-four (154) this evening so she turned the feeding off at 3:00 PM and it would be turned back on at 7:00 PM by the night shift nurse. She indicated the facility does not determine a set time when enteral feeding was stopped stating it could be different times on different days and it was not required to be documented when the feeding was stopped. She stated she was unsure why the MAR was inconsistently documented, each shift was supposed to document the amount of enteral feeding infused and the facility had no process for documenting when enteral feeding was held.  Further interview with RN #1 on 12/01/10 at 5:10 PM revealed the staff determine how much enteral feeding the resident had received by reading the amount of volume infused off of the machine, which pumps the feeding from the bottle to the gastrostomy tube and delivers the feeding to the resident. The amount on the machine		Nursing staff will be inserviced by Director of Nursing or designee regarding monitoring and documentation of tube feeding on 1/8/2011. In addition, nursing staff will be inserviced regarding colostomy care, injections and special foot care.  4.) An audit of all rooms containing Oxygen will be completed by the Director of Nursing or designee daily, Monday through Friday X 4 weeks, then Monthly X 3, and results reviewed in PI meeting.		

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F 328	<p>Continued From page 48</p> <p>digital readout is documented and then reset each shift, however sometimes it was not reset depending on if the Nurse gets busy and forgets.</p> <p>Interview with RN #3 on 12/02/10 at 8:50 AM revealed she had changed the enteral feeding the previous night and she did not document the time at which she changed the bottle. She then removed the bottle of Glucerna 1.2 which revealed two hundred (200) ml remained and the bottle was hung on 12/01/10 at 8:30 PM. The bottle observed to be distributing enteral feeding to the resident at that present time was noted to be dated 12/01/10 and timed as being started at 7:00 AM with no initials of what staff member placed the feeding. RN #1 indicated staff rely on the feeding pump digital read out to determine how much feeding a resident has received. She stated she was unaware of the facility's policy on enteral feeding relating to monitoring and distribution. She stated if the machine was not functioning properly then and the alarm will sound and the machine will be sent to Biomed for repairs. The facility was unable to define what would happen if the alarm did not sound if a machine malfunctions. She further indicated there was not a set time for enteral feeding to be turned off during the day.</p> <p>Interview with the Director of Nursing (DON) on 12/02/10 at 10:30 AM revealed the digital readout on the enteral feeding pump machines were what tells the nurses how much feeding the residents, who have this as their source of nutrients, had received. She indicated if the bottle was changed twice during the shift the pump keeps track of how much is given from the previous bottle. She stated if staff set the digital read out to volume feed the machine tells them how much enteral</p>	F 328	<p>An audit of monitoring and documentation of tube feeding will be completed by the Director of Nursing or designee weekly X 4, then monthly X 3 and results reviewed in PI meeting.</p> <p>Colostomy care, injections and special foot care will be audited monthly x 3 months. Results will be reviewed in the PI meeting.</p> <p>5.) DATE OF COMPLIANCE: 1/12/2011</p>	

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F 328	Continued From page 49 feeding has been infused. She further stated staff were supposed to document the amount of enteral feeding infused and reset the volume feeding readout on the pump for the next shift. She also indicated there was not a set time for the enteral feeding to be stopped during the 24 hour period to ensure the feeding infused for 20 hours as ordered.  Interview with the Registered Dietitian (RD) on 12/02/10 at 6:14 PM revealed she was responsible for calculating the resident's nutritional needs and calculating the amount of enteral feeding necessary to meet those needs, but she was not responsible for monitoring the amount of enteral feeding the resident received.  Review of Tube Feeding Policy provided by the facility revealed the policy failed to address how feedings should be administered on a regular basis, only in relationship to medication administration. It does not address any process for monitoring the amount of enteral feeding infused nor did it address monitoring to ensure the enteral feeding was infused per Physician's orders.	F 328	<b>F333 Residents free of significant med errors</b>  1.) Unsampled Resident was notified of error and no new orders obtained. Resident is receiving Norvasc as ordered.	
F 333 SS=D	<b>483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</b>  The facility must ensure that residents are free of any significant medication errors.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure residents were free of significant medication errors for one (1) unsampled resident	F 333	2.) Medication Pass observations will be conducted by the Staff Development Coordinator for all licensed nurses by 1/8/2011 to ensure residents are free from significant medication errors.  3.) All licensed nursing staff will be inserviced by the Staff Development by 1/8/2011 or designee regarding medication administration.  4.) Medication pass observations will be conducted by the Director of Nursing or designee to ensure residents are free of significant medication errors daily X 4 weeks, then monthly X 3 and results reviewed in PI meeting.	

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F 333	Continued From page 50 (Resident #22) related to the failure to administer an ordered medication.  The findings include:  Observation of the medication pass on 12/01/10 at 9:00 AM, revealed Licensed Practical Nurse (LPN) #6 administered medications to unsampled Resident #22.  Upon reconciliation of the medications administered with the Physician's Orders, it was noted the nurse failed to administer Norvasc (medication used for the treatment of hypertension) two and a half milligrams (2.5 mg's) which was ordered daily. Review of the Medication Administration Record revealed the medication was signed out by LPN #6 as administered.  Interview with LPN #6 on 12/01/10 at 10:00 AM revealed she signed out the medication on the MAR as though it was administered, and thought she had administered the medication.  Review of the facility's "Policies for Medication Administration" Chapter 12, Section 13, revealed staff were to "Initial each medication in the correct box on the MAR (Medication Administration Record) after the medication is given."	F 333	5.) DATE OF COMPLIANCE: 1/12/2011  <b>F365 Food in form to meet individual needs</b>	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS  Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365	1.) Resident #3's physician was notified of resident receiving chicken on the bone. No New orders were obtained. Resident #3 is receiving her diet as ordered.  <b>Please note resident did not have any adverse effect from being served chicken on the bone.</b>  2.) 100% audit of all diet orders and accuracy of meal cards as well meal pass observation was completed by Director of Dietary Services on 12/28/2010 to ensure residents receive correct diet and prepared recommendation.	

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F 365	Continued From page 51 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure one (1) of twenty-one (21) sampled residents (Resident #3) received food prepared in a form to meet the resident's individual needs.  The findings include:  Record review revealed Resident #3 was admitted to the facility on 03/21/07 with diagnoses which included Dementia, Colon Cancer, and Anemia.  Review of the Quarterly Minimum Data Set (MDS) assessment dated 09/14/10, revealed the facility assessed the resident as being independent in eating with minimal set up required.  Review of the meal card for Resident #3 on 12/01/10 at 11:30 AM revealed instruction to "De-bone all meats before sending". Observation of the noon meal revealed Resident #3 was served chicken with the bone in it. Observation further revealed Resident #3 was independently eating his/her lunch meal.  Interview with the Dietary Manager on 12/01/10 at 11:45 AM revealed it was the responsibility of the kitchen staff to check the meal tray against the meal card before sending the meal tray out of the kitchen. She further stated the Aide should also check the meal card against the actual meal on the tray when setting it up for the resident. The Dietary Manager stated Resident #3 should have received de-boned meat.	F 365	3.) Dietary and Nursing staff will be inserviced by the Director of Dietary Services and the Director of Nursing on reading dietary cards to ensure the food is prepared and served per MD direction to meet resident individual needs by 1/8/2011.  4.) Audits will be conducted by the Director of Dietary Services to ensure diets are served and prepared per MD orders to meet residents individual needs daily Mon – Fri X 4 weeks, weekly x 4 then monthly x 3 and results reviewed in PI meeting.  5.) DATE OF COMPLIANCE: 1/12/2011	
F 368 SS=E	483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME	F 368		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/02/2010
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NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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F 368	<p>Continued From page 52</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p>	F 368	<p><b>F 368: Frequency of Meals</b></p> <p>1. The meal times were changed on 12/28/2010 to reflect a maximum of 14 hours between a substantial evening meal and breakfast the next day.</p>	
	<p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</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 there were no more than fourteen (14) hours between a substantial evening meal and breakfast the following day, except when a nourishing snack was provided at bedtime. As evidenced by fifteen (15) hours between the evening meal and the breakfast meal. Review of the list of residents receiving 8:00 PM snacks revealed only thirty-one (31) of ninety (90) total residents received evening snacks.</p> <p>The findings include:</p> <p>Review of facility's scheduled meal times revealed breakfast was served at 6:45 AM, lunch at 10:45 AM to resident rooms and 11:00 AM in</p>		<p>2. Meal times for the evening meal will be changed to a later time frame to reflect a maximum of 14 hours between a substantial evening meal and breakfast the next day.</p> <p>3. New meal times will be posted throughout the facility and reviewed with the residents at resident council meeting.</p> <p>4. The Dietary Manager will audit the new times daily x 4 weeks to ensure compliance with the time requirement. Results will be brought to the PI meeting</p> <p>5. COMPLIANCE DATE: 1/12/2011</p>	

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40361</b>	
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F 368	Continued From page 53 the lobby and dinner was served at 3:45 PM. This calculates to fifteen (15) hours between the evening meal and the breakfast meal the following morning.  Interview with Cook #6 on 11/30/10 at 4:28 PM revealed some residents received a bedtime snacks which included sandwiches, or nutritional shakes, or ice cream, depending on the resident's likes or dislikes.  Interview with the Dietary Manager on 12/02/10 at 6:35 PM revealed there were only thirty-one (31) residents who received bedtime snacks. She further indicated a bedtime snack was provided if it was ordered or requested. The Dietary Manager stated that not all residents received an evening/bedtime snack and all residents used to be offered snacks but were not at the current time.	F 368		
F 371 SS=E	Review of the list of residents receiving snacks titled, "Nourishment Listing by time" printed 12/02/10, revealed only thirty-one (31) residents were receiving a snack between the evening meal and breakfast. <b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b>  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	<b>F371: Food Procure, Store/Prepare/Serve</b>  1. The freezer was checked and found to be operating correctly by the Maintenance Director on 12/3/2010. The ice build up in the freezer was thawed and removed on 12/3/2010 by the Maintenance Director. Any boxes with ice build up were discarded. The two hotel pans were washed, dried appropriately and placed back into storage on 11/30/2010. The juice spouts were cleaned on 12/2/2010. The metal vents were removed and cleaned by the maintenance director on 12/2/2010. In addition, the Dietary Manager conducted a departmental meeting on 12/2/2010 discussing food temp policies, microwaving food and appropriate handwashing.  2. The kitchen was inspected on 12/10/2010 to ensure food is stored, prepared and distributed	

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F 371	Continued From page 54  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to prepare, distribute and store food under sanitary conditions. As evidenced by ice build up on food boxes in the freezer, pans stored wet and dirty, heavily soiled juice dispenser spouts and dirty ceiling vents, lack of temperature measurements on tray line food items and improper hand washing and usage of gloves.	F 371	appropriately by the management team. The kitchen was deep cleaned on 12/11/2010. All vents were checked and cleaned as needed. All stored dishes were examined and cleaned as needed. All juice spouts were checked and cleaned as necessary. Any boxes with ice build up were discarded immediately. Temperature logs were reviewed and found to be accurate and complete. A daily cleaning schedule was completed by the Dietary Manager for cleaning the juice machine.		
	The findings include:  1. Observation of the freezer on 11/30/10 at 10:40 AM revealed approximately four (4) inches of ice buildup on the ceiling and sides of the condenser unit and ice buildup was noted to be approximately two (2) inches thick and approximately twelve (12) inches in length and six (6) inches wide on the floor underneath the condensing unit in the freezer. Ice buildup was also noted on food boxes which included a box of Danishes and chocolate ice cream stored under the condenser in the freezer.  Interview with Dietary Aide #7 on 11/30/10 at 10:40 AM revealed she was not sure why the freezer had ice buildup on the ceiling and floor. She indicated staff scraped off the ice and it usually didn't "get as bad" as it was at that time.  Observation on 12/02/10 at 9:42 AM revealed the ice buildup in the freezer has decreased by approximately half an inch and the ice buildup remained on the box of Danishes and chocolate ice cream.		3. An inservice was conducted on 12/2/2010 and again on 12/8/2010 by the Dietary Manager, reviewing the facility's policies regarding storing, preparing, distributing and serving food. More specifically, food temperatures, proper storing of dishes, cleaning schedule of the juice machine and proper hand washing techniques. The Executive Director reviewed with the Maintenance Director the preventative maintenance schedule		

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F 371	<p>Continued From page 55</p> <p>Interview with the Dietary Manager on 12/02/10 at 9:42 AM revealed she had never had any of the staff notify her there was ice build up on food boxes. She indicated she hoped the staff would not use food items with ice build up on them.</p> <p>Interview with Dietary Aide #7 on 12/02/10 at 9:45 AM revealed the kitchen staff do not throw any food away if the ice is just on top of the boxes. She further indicated they still use the food and just scrape the ice off of the top of the boxes.</p>	F 371	<p>to include the cleaning of the metal vents when changing out filters. The cleaning schedule was reviewed by the Executive Director and the Dietary Manager and revisions made as necessary.</p>	
	<p>2. Observation on 11/30/10 at 11:10 AM revealed two (2) half size hotel pans stored wet and one (1) deep full size hotel pan stored wet with a yellow food substance caked onto the bottom of the pan.</p> <p>Interview with the Dietary Manager on 11/30/10 at 11:10 AM revealed pans should be air dried and checked to make sure they are cleaned before storing secondary to bacteria growth.</p> <p>3. Observation on 11/30/10 at 11:00 AM revealed a thick residue buildup on all four juice nozzles located on the automatic juice dispenser, located near the window into the dining area.</p> <p>Observation on 11/30/10 at 3:20 PM revealed the juice spouts remained with thick residue buildup.</p> <p>Observation on 12/02/10 at 9:48 AM revealed the juice dispensers remained with thick residue buildup.</p> <p>Interview with Dietary Aide #23 on 12/02/10 at 9:48 AM revealed the spouts were supposed to go through the dishwasher every night.</p>		<p>4. A complete inspection of the kitchen will be conducted monthly. The freezer will be audited weekly x 4 then monthly X 3 by the Dietary Manager for ice build up. The metal vents will be audited weekly x 4 then monthly x 3 by the Maintenance Director. Temperature logs will be audited daily by the Dietary Manager to ensure accuracy. The juice spouts and dish storage will be audited daily X 4 weeks, weekly x 4 then monthly x 3 by the Dietary Manager for cleanliness. The results of these audits will be brought to the PI meeting for review.</p> <p>5. DATE OF COMPLIANCE: 1/12/2011</p>	

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F 371	<p>Continued From page 56</p> <p>4. Observation on 11/30/10 at 3:15 PM revealed the two (2) ceiling vents near the walk-in refrigerator had a significant buildup of dust.</p> <p>Interview with the Dietary Manager on 12/02/10 at 9:54 AM revealed Maintenance was responsible for the cleaning of these vents.</p> <p>Interview with the Maintenance Director on 12/02/10 at 9:54 AM revealed they were on a monthly maintenance program. He further indicated he changed the filters approximately two (2) weeks ago but he did not take the metal vent covers down to clean them. He stated the vents did need to be taken down and cleaned.</p> <p>5. Observation on 11/30/10 at 3:40 PM revealed Cook #6 took temperatures of food items which were to be served to residents for the evening meal. Further observation revealed Cook #6 failed to take temperatures of the ground meat and fortified mashed potatoes. During the meal observation it was noted both of these food items were served to residents.</p> <p>Interview on 11/30/10 at 5:30 PM with Cook #6 revealed she should have taken the temperatures of all the food items on the resident tray line to ensure all foods were at the proper temperatures.</p> <p>Observation on 11/30/10 at 5:25 PM revealed Dietary Aide #5 heated tomato soup in the microwave in a glass bowl. This Aide was observed to remove the bowl from the microwave, remarked how hot it was and set the bowl back down on the table top while obtaining aluminum foil to cover the bowl. The Aide was observed to use pot holders to transport the bowl to the window to the dining room for the Nursing</p>	F 371		

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F 371	<p>Continued From page 57</p> <p>Aide to transport to the resident's room on the resident's tray.</p> <p>Observation on 11/30/10 at 5:35 PM revealed the soup, which was heated in the microwave, sitting on the resident's tray along with the rest of the resident's meal. A CNA was observed to enter the resident's room to feed the resident. Intervention was initiated when the CNA removed the aluminum foil from the bowl of soup and the soup was removed from the resident's room by this surveyor and taken back to the kitchen.</p>	F 371		
	<p>Interview with Dietary Aide #5 revealed he was unaware if the facility had a policy on the usage of the microwave in heating resident food and drinks. He stated the temperature should have been taken before the soup was sent out to the resident.</p> <p>Interview with the Dietary Manager on 11/30/10 at 5:50 PM revealed the facility did not have a policy on microwave usage for heating resident food and drinks.</p> <p>Review of the facility's policy, which was provided in reference to temperature measurements of food, titled "Cooking Meats" (and was not dated) revealed it was important to cook and hold hot items to a temperature above one hundred forty (140) degrees Fahrenheit or hold below forty (40) degrees Fahrenheit. The policy indicated bacteria that cause foodborne illnesses grow quickly and make foods unsafe between the temperatures of forty (40) degrees Fahrenheit and one hundred forty (140) degrees Fahrenheit.</p> <p>6. Observation on 11/30/10 at 4:25 PM revealed Dietary Aide #4 left the resident tray line to obtain</p>			

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F 371	<p>Continued From page 58.</p> <p>drinks from the refrigerator. She was observed to open the door with her bare hands and return to tray line after putting on new gloves without washing her hands prior to replacing her gloves.</p> <p>During observation on 11/30/10 at 4:50 PM, Cook #6 was observed to remove her gloves, move a resident tray cart, replace her gloves and return to the tray line without washing her hands prior to putting on new gloves.</p> <p>Observation on 11/30/10 at 5:05 PM revealed Dietary Aide #3 entering the refrigerator to obtain</p>	F 371	<p><b>F 441: Infection Control</b></p> <p>1. LPN # 7 was re-educated on 11/30/2010 by the Director of Nursing regarding the handling of medications and proper handwashing techniques.</p>	
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F 441 SS=E	<p>Dietary Aide #3 entering the refrigerator to obtain drinks using her bare hands to open the refrigerator door. Dietary Aide #3 did not wash her hands prior to returning to the tray line to assemble resident trays.</p> <p>Interview on 11/30/10 at 5:30 PM with Dietary Aide #4, Cook #6 and Dietary Aide #3 revealed hands should be washed after touching the refrigerator door, resident carts, phone or any task away from the tray line. They also indicated hands should be washed after taking gloves off and before putting on new gloves.</p> <p>Review of facility's policy titled "Hand Washing," dated 01/01/2007 revealed guidelines for when hands should be washed which included before donning gloves for working with food and after engaging in other activities that contaminate the hands.</p> <p><b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b></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</p>	F 441	<p>LPN # 6 was re-educated on 12/3/2010 by the Director of Nursing regarding infection control while providing wound care to residents.</p> <p>The wound nurse was re-educated on 12/20/2010 by the Director of Nursing regarding proper handwashing techniques will performing wound care.</p> <p>The medical equipment was removed from resident #6's room on 12/2/2010.</p> <p>The visitor witnessed assisting residents with clothing protectors was asked not to do so due because of infection control.</p>	
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F 441	<p>Continued From page 59 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>	F 441	<p>The resident witnessed clearing dirty food trays and used clothing protectors then passing out desserts to other residents was informed she was not allowed to do this. This resident is care planned to assist cleaning in the dining room only. Resident was instructed not to pass food or drinks to other residents.</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 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.</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 effective infection control program in</p>		<p>Ice scoop was removed from the ice cooler, cleaned and placed back into the proper container.</p> <p>LPN # 5 was re-educated on 12/3/2010 by the Director of Nursing regarding wearing gloves and proper hand washing techniques while performing wound assessments.</p> <p>2. All residents were assessed for signs and symptoms of infection on 12/28/2010 by nurse management.</p> <p>3. An in-service was conducted on 1/8/2011 for all staff regarding the facility's infection control program</p>	

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F 441	Continued From page 60 order to prevent the development and transmission of disease and infection within the facility.  The findings include:  1. Observation of the medication pass on 11/30/10 at 4:25 PM, revealed LPN #7 touched pills with his bare hands after removing the medication from the package for Unsampled Resident #23. LPN #7 then placed the medication in a cup with applesauce and spoon fed the medication to the resident.  Further observation, revealed LPN #7 then left Unsampled Resident #23's room, set up medications, and administered medications to Unsampled Resident #24. There was no evidence LPN #7 washed or sanitized his hands after administering medication to Unsampled Resident #23, and before administering medications to Unsampled Resident #24.  Interview on 11/30/10 at 4:38 PM with LPN #7 revealed he should not have touched medications with his bare hands. He further stated he should have washed or sanitized his hands after the administration of medication to Unsampled Resident #23, and prior to setting up medications for Unsampled Resident #24 "due to infection control issues."  Review of the facility's "Policies for Medication Administration" revealed hand hygiene protocol should be followed before and after each administration of medication.  2. Observation of a dressing change on 12/01/10 at 10:00 AM for Resident #7 revealed LPN #6	F 441	that is designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  4. Infection control audits will be conducted by department managers weekly x 4 then monthly x 3 to ensure compliance with the regulation. Wound care audits related to infection control will be conducted by nursing management weekly x 4 then monthly x 3. Results of these audits will be brought to the monthly PI meeting for review and further recommendations.  5. DATE OF COMPLIANCE: 1/12/2011.	

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F 441	<p>Continued From page 61</p> <p>placed the wound measuring device on the floor next to the resident's foot while she removed the soiled dressing from the resident's right heel/ankle wound, while the resident was sitting in the wheelchair. The nurse then picked up the measuring device from the floor and placed the device next to the resident's right heel/ankle wound in order to measure the wound. She then placed a new Mediplex dressing on the resident's right heel/ankle wound, without cleaning the wound. When the nurse was interviewed by the surveyor as to why the wound was not cleansed prior to placing a new dressing on the wound, she removed the new dressing from the wound. LPN #6 then removed her gloves and exited the resident's room to obtain more supplies. There was no evidence the nurse washed her hands after removing her gloves, and prior to opening the resident's door. LPN #6 then returned and cleansed the resident's wound with wound cleanser, and applied another dressing.</p> <p>Interview on 12/01/10 at 10:15 AM, with LPN #6 revealed she knew she had placed the wound measuring device on the floor before using it; however, she was unaware she had touched the wound with the wound measuring device while measuring the wound. Further interview revealed she did not think she needed to clean the wound prior to the dressing change since she had just done the dressing change the day before.</p> <p>3. Observation on 12/02/10 at 5:20 PM revealed the Wound Nurse examined and palpated Resident #7's wound on the right heel, removed her gloves, and walked out of the resident's room without washing or sanitizing her hands. Interview with the Wound Nurse, immediately afterward, revealed she should have washed her</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  <b>LIFE CARE CENTER OF MOREHEAD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351</b>		
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F 441	<p>Continued From page 62 hands after removing the soiled gloves.</p> <p>4. Record review revealed Resident #6 was readmitted to the hospital on 11/21/10 after a three (3) day hospital stay. Diagnoses included Hypertension, Depression, and End Stage Renal Disease.</p> <p>Observation during the initial tour, on 11/30/10 at 11:00 AM revealed Resident #6 was in a semi-private room, but did not have a roommate. Continued observation revealed medical equipment was stored in the resident's closet, including an oxygen concentrator, a portable suction unit, a nebulizer for respiratory treatments, a positioning wedge, and a walker. Continued observation revealed clothes and shoes were stored in the same location as the equipment.</p> <p>Observation on 12/01/10 at 8:45 AM, 10:00 AM, and 10:45 AM revealed the equipment remained in the closet.</p> <p>Interview with CNA #2 on 12/01/10 at 10:55 AM revealed the resident's roommate had expired, but she wasn't sure when. She stated the equipment belonged to the roommate, and the clothes and the shoes belonged to Resident #6. She further stated the walker should be returned to the Therapy Department and the other items placed in the storage room. Continued interview revealed CNA #2 believed housekeeping was responsible for cleaning and storing the equipment after a resident was discharged from the facility.</p> <p>Interview with the housekeeping staff on 12/01/10 at 11:05 AM revealed the equipment in the closet</p>	F 441			

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F 441	<p>Continued From page 63</p> <p>belonged to the resident's roommate. She stated she sometimes removed equipment herself, or told the nurse about it. She further stated she told the nurse "yesterday" the equipment was there. Continued interview revealed she did not know whose responsibility it was, but it should be cleaned before placing in the storage room.</p> <p>Observation on 12/02/10 at 9:00 AM and 10:55 AM revealed the equipment remained stored in the closet with the items belonging to Resident #6.</p>	F 441		
	<p>Interview with LPN #4 on 12/02/10 at 9:40 AM revealed the positioning wedge, the clothes and the shoes belonged to Resident #6 and should not be stored with equipment belonging to someone else. She stated it was a nursing responsibility to clean the equipment but she did not know whose responsibility it was to remove the equipment when a resident was discharged from the facility. The nurse expressed surprise the equipment was still there. She agreed it should have been cleaned and stored when the room was cleaned after the roommate expired.</p> <p>Interview with the Director of Nursing on 12/02/10 at 11:00 AM revealed it was a nursing responsibility to clean and store medical equipment after a resident was discharged from the facility.</p> <p>5. Observation in the Dining Room on 12/01/10 at 11:10 AM revealed a visitor assisting residents with clothing protectors without washing hands between dirty and clean contacts.</p> <p>Interview with LPN #8 on 12/02/10 at 11:25 AM revealed it was the staff members' responsibility</p>			

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F 441	Continued From page 64 to assist residents with clothing protectors. She stated that if a resident has a guest with them then it would be appropriate for the guest to assist only that one resident. She also stated that she was not aware of any training regarding infection control or handwashing which was provided to visitors.  Interview with the Administrator on 12/02/10 at 11:40 AM confirmed that the facility failed to provide a sanitary environment by allowing a visitor to apply clothing protectors to residents without providing education on hand hygiene.	F 441		
	6. Observation of the lunch meal on 12/01/10 revealed an unsampled resident was assisting with clearing the dirty food trays and used clothing protectors. Observation revealed the unsampled resident to handle dirty food trays and used clothing protectors and then proceed to the desert tray and pass out deserts to residents in the dining room. Observation revealed the unsampled resident failed to wash hands between the dirty and clean.  Interview with the Dietary Manager on 21/01/10 at 11:50 AM revealed it was part of the resident's care plan to assist in the dining room and and the resident received education on the task, however the resident would require education about handwashing and going from dirty to clean.  7. Observation on 11/30/10 during the lunch meal and on 11/30/10 during the evening meal, as well as 12/01/10 at the lunch meal revealed the ice scoop was stored in the ice cooler located in the main dining room.  Interview with the Dietary Manager on 12/01/10 at			

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F 441	<p>Continued From page 65</p> <p>11:55 AM revealed the ice scoop should be stored in the compartment attached to the cooler and staff would require re-education on the proper storage of the ice scoop. She further stated this was an infection control hazard.</p> <p>Review of the Infection Control Policy revealed support services will implement specific policies and procedures to ensure an infection-free environment and cross-contamination.</p> <p>8. Observation on 11/30/10 at 4:50 PM revealed CNA #4 took a dirty tray from a resident's room and placed it in the tray cart over trays that had not yet been passed to residents. Interview with CNA #4 on 11/30/10 at 4:58 PM revealed she should not have put the dirty tray in with the clean meal trays. She stated it should have not been put into the cart until all trays were passed because it could spread bacteria and residents could become sick.</p> <p>9. Review of Resident #5's clinical record revealed he/she was admitted on 06/16/08 with diagnoses which included Left Below the Knee Amputation and Status Post Right Hip Fracture.</p> <p>Observation of a skin assessment on 12/01/10 at 3:10 PM with LPN #5 revealed she failed to wash/sanitize her hands when she entered the resident's room,. LPN #5 failed to put gloves on to conduct the skin assessment and failed to wash/sanitize hands after the skin assessment was completed.</p> <p>Interview with LPN #5, after the assessment, revealed the facility's hand washing policy stated hands need to be washed before and after each resident contact. Further interview revealed she</p>	F 441		

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F 441	Continued From page 66 should have washed her hands and worn gloves to perform the skin assessment.	F 441		
F 465 SS=F	<b>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</b>  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public.  The findings include:  Observation during the initial tour on 11/30/10 at 11:00 AM revealed the following: door facings throughout the building were scuffed and in need of paint; air conditioning units in rooms 317, 318, 319 and 325 had dust build up; the shower room on the 100 hall had two (2) missing tiles and a black substance built up along the base of the shower walls. The West Hall shower room had three (3) missing tiles and a black and green substance on the floor and on the shower walls; a shared bathroom for rooms 324 and 322 and the bathroom as well as the bedroom area in room 325 had holes in the walls; the toilets in rooms 201, 206, 311 and 314 had rusty bolts sticking up approximately one inch from the base of the toilets. Further observation revealed a build up of dirt and dust along the base boards in all the hallways; stool was found on the back of the toilet	F 465	<b>F 465: Safe/Functional Environment</b>  1. Door faces were placed on a schedule to be repainted  A/C units in rooms 317, 318, 319 and 325 were cleaned on 12/1/2010.  The shower rooms on West wing and on the South wing were cleaned on 12/1/2010 and tiles repaired on 12/5/2010.  Holes identified in room 325 and in the bathroom wall between rooms 322 and 324 were repaired on 12/1/2010.  Bolts were cleaned or replaced if needed in room 201, 206, 311 and 314.  Baseboards were cleaned throughout the facility on 12/1/2010.	

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F 465	Continued From page 67 and on the wall in the bathrooms of rooms 315 and 325; a dirty bed pan was on the bathroom floor of room 317 and 325; the bed pans were not labeled; day light was visible around the air condition unit in room 319; a soiled bed pan was in the wheel chair in room 323, the bed pan was not labeled; the air mattress cord in room 213 was stretched from the outlet to the head of the bed in a manner that created a safety hazard along the side of the bed.  Interview with the Housekeeping Supervisor on 12/01/10 at 11:10-AM revealed all room and bathrooms were cleaned daily. She stated the Head Housekeeper was responsible for going behind the housekeepers and checking for cleanliness daily. Interview further revealed the tile floor and base boards needed to be replaced because they were too old to get clean. She stated staff work hard to clean the facility but it didn't look clean. She stated the dirt and dust build up in the hallways should not have been there and stated the wheelchairs, walkers, and equipment in the hallways and clutter throughout the facility made it hard to clean.  Interview with the Maintenance Supervisor on 12/02/10 at 4:00 PM revealed he was responsible for repairs at the facility, and he had only been in the position for two (2) months. He stated he realized there was a lot to do. During further interview he stated he was aware there were several air conditioning units in residents' rooms that were not properly sealed to prevent air from outside. He agreed that the cord in room 213 posed a safety hazard and that he needed to be more critical in how he looked at potential risks. He indicated the walls should be free of holes, there were missing tiles, and the base boards and	F 465	The bathrooms in rooms 315 and 325 were cleaned thoroughly.  The bedpans were discarded and new pans given.  The opening around the AC unit in room 319 repaired on 12/1/2010.	
			The air mattress cord in room 213 was relocated on 11/30/2010.  2. The Executive Director and Director of Maintenance conducted a walk through of the facility on 12/3/2010 to identify any areas failed to provide a safe, functional, sanitary and comfortable environment. Any areas identified were corrected or scheduled to be corrected.  3. The facility's preventive maintenance program (TELS) was reviewed with the Director of Maintenance by the Executive Director on 12/3/2010.	

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F 465  F 520 SS=F	Continued From page 68 door facings throughout the facility needed to be painted. He further stated he did not realize the rusty toilet bolts were a hazard to residents. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.	F 465  F 520	The facility's cleaning schedule was reviewed with the Housekeeping supervisor by the Executive Director on 12/3/2010 to discuss concerns and any changes needed.  Department managers were inserviced on conducting daily facility rounds and how to report any areas of concern on 1/8/2011 by the Executive Director.  4. Environmental audits will be conducted weekly x 4 then monthly x 3 by the department managers to ensure compliance with the regulation. Areas of concern will be brought to the facility's Performance Improvement meeting for review and further recommendations.  5. DATE OF COMPLIANCE: 1/12/2011	
	The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.  A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.  Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain a Quality Assessment and Assurance Program that developed and implemented appropriate plans of action to correct quality			

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F 520	<p>Continued From page 69</p> <p>deficiencies. This was evidenced by repeated deficiencies related to the infection control program and the facility's failure to implement an effective system to ensure changes in skin condition for residents were recognized, evaluated, and addressed appropriately.</p> <p>The findings include:</p> <p>1. Based on observation, interview, and record review, it was determined the facility failed to maintain an effective infection control program in order to prevent the development and transmission of disease and infection within the facility. This was a repeat deficiency for the facility which was cited 05/21/10 for deficiencies related to failure to wash hands during wound care.</p>	F 520	<p><b>F 520: Quality Assurance Committee</b></p> <p>1. The Performance Improvement minutes from previous meetings were reviewed by the Committee on 12/27/2010 to identify any other areas of concern.</p>	
	<p>Review of the facility's plan of correction, with a 07/01/10 compliance date, revealed the nursing management would conduct inservices for all licensed nurses to include infection control practices during wound care. In addition all licensed nurses were to complete a wound care competency. The facility alleged audits would be completed by nursing management weekly for four (4) weeks and monthly for three (3) months to assess infection control measures during wound care. Record review revealed the facility implemented it's plan of correction, however there was no documented evidence the facility monitored the entire infection control program to ensure over all compliance. Review of the facility's audits revealed on going infection control problems were not identified.</p> <p>Observations during the survey revealed a dressing change and a skin assessment were</p>		<p>2. The Regional Director of Clinical Services reviewed the previous three months of Performance Improvement minutes on 12/28/2010 to identify any other areas of concern.</p> <p>3. The Performance Improvement committee members were inserviced by the Regional Director of Clinical Services on 12/28/2010 regarding the Quality Assurance program to ensure appropriate plans of action are developed and implemented to correct quality deficiencies.</p>	

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F 520	<p>Continued From page 70.</p> <p>performed using poor aseptic technique and lack of hand washing and improper use of gloves. Further observation of a medication administration revealed the nurse failed to wash hands between multiple residents and touched medications with ungloved hands prior to administration of the medications.</p> <p>Observation further revealed facility staff placed dirty meal trays in the cart with unserved residents' meals. Observations revealed improper storage of the ice scoop in the dining room and visitors and an unsampled resident assisting in the dining room during meals without washing hands between dirty and clean contact with residents and food.</p>	F 520	<p>4. Plans of action developed in the Performance Improvement meeting will be reviewed monthly in the Medical Director Oversight meeting to ensure that appropriate plans of action have been implemented accurately to correct any quality issues.</p>	
	<p>Interview with the Staff Development Coordinator on 12/02/10 at 5:30 PM revealed the facility had implemented wound care competencies for staff; however, these competencies were not incorporated into the new hire orientation.</p> <p>Interview with the Assistant Director of Nursing on 12/02/10 at 7:15 PM revealed she was responsible for the infection control program as it related to tracking and trending resident infections and antibiotic therapy. However, she was not involved in staff training related to infection control measures, wound care, or hand washing.</p> <p>Refer to F441 (Infection Control)</p> <p>2. Based on observation, interview and record review it was determined the facility failed to have an effective system in place to ensure changes in skin conditions were recognized, evaluated, reported and addressed in a timely and appropriate manner as cited on the 05/21/10</p>		<p>5. DATE OF COMPLIANCE: 1/12/2011</p>	

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F 520	Continued From page 71 survey and again on the 12/02/10 survey.  Review of the facility's plan of correction with a compliance date of 07/01/10 revealed nursing management would conduct inservices for all licensed nurses to include accurate skin assessments with appropriate recording, reporting and timely intervention. Further review revealed nurse competencies for wound care would be completed by all licensed staff. Record review revealed the facility completed competencies and audits to ensure compliance.	F 520			
	However, the facility failed to ensure treatment was provided for one resident. Observation during a skin assessment on 12/01/10 revealed a new purple area to the resident's right heel that was unidentified by the facility prior to the assessment. There was no indication the Physician was notified until 12/02/10 and interview revealed the Wound Nurse was not notified of the new area.  Further, during a skin assessment on 12/02/10, a resident was noted to have excoriated areas on the buttocks that the facility had not identified and had failed to notify the Physician and obtain a treatment order for the area. Also, during a skin assessment for a resident on 12/01/10 revealed reddened genitalia and record review on 12/02/10 revealed the facility had failed to notify the Physician and obtain a treatment order.  Interview on 12/02/10 at 5:20 PM, with the wound nurse, revealed if staff identified new wounds they were to notify the Physician, notify her, and document the measurement and the description of the wound in the Nurse's Notes.				

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F 520	<p>Continued From page 72</p> <p>Interview on 12/02/10 at 5:30 PM, with the Administrator and Director of Nursing (DON) revealed monitoring of the provision of care and services was on going through daily rounds by department managers. Interview revealed the facility looked at pressure through the quality assurance program, however they were unaware there was a problem with identification of changes in skin conditions or infection control practices.</p> <p>Interviews with licensed staff revealed they were aware of the facility's Quality Assurance Program but were not aware of ongoing monitoring related to infection control or wound care management by quality assurance committee.</p> <p>Refer to F309 and F314</p>	F 520			