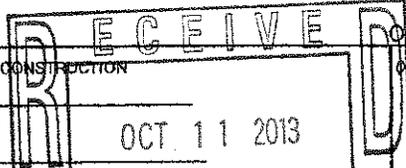


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/03/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/19/2013
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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41304 Division of Health Care Enforcement Branch
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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<p>F 000</p> <p>F 282 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY20735) was conducted on 09/19/13. The complaint was substantiated with deficient practice identified at 'D' level.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility policy review, it was determined the facility failed to provide care in accordance with the written Plan of Care for one of three sampled residents (Resident #1). Resident #1's Plan of Care stated staff was not to leave the resident unattended when the resident was in the bathroom. However, on 09/15/13, at 3:00 PM, Resident #1 was found on the floor of the locked shower room and was noted to have a 0.5 centimeter diameter skin tear to the right ankle. Based on interview and a review of documentation, facility staff left Resident #1 unattended in the bathroom at the time of the resident's fall on 09/15/13.</p> <p>The findings include: Review of the facility's undated policy entitled "Activities of Daily Living" revealed all residents would be assessed for level of assistance required to safely complete each activity of daily</p>	<p>F 000</p> <p>F 282</p>	<p>Preparation and execution of this plan of correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared and executed solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Whitney Spouts* TITLE: *A. Administrator* (X6) DATE: *10-11-2013*

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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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 1</p> <p>living (ADL). According to the policy, resident care plans, including the Comprehensive Care Plan and the nursing assistant care plan were to reflect the resident's degree of independence and include interventions that were specific to the resident based on the resident's preferences, needs, and abilities.</p> <p>Review of the facility's undated policy entitled "Individual and Interdisciplinary Plan of Care" revealed the facility would maintain an up-to-date plan of care on each resident. The plan of care was to be comprehensive/reasonable and contain approaches to care that would reflect and benefit the needs of the resident. The plan of care was also to have a resident-focused approach for favorable outcomes in consideration of each resident's characteristics, severity of condition, strengths, needs, abilities, disabilities, disease, impairment, and other significant factors.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 12/26/12, with diagnoses including Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, and Cerebral Vascular Accident. The record revealed Resident #1 had severely impaired cognition.</p> <p>Review of Resident #1's current Comprehensive Plan of Care (04/12/13) revealed two staff members were to provide assistance to the resident with all transfers and/or toileting needs. Continued review of the Comprehensive Plan of Care also revealed staff was not to leave the resident unattended in the bathroom.</p> <p>Interview on 09/19/13, at 2:25 PM with State Registered Nursing Assistant (SRNA) #2 revealed Resident #1 could verbally request assistance to</p>	F 282	<p><u>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>Resident #1 was transported to the hospital and evaluated on 9/15/2013 and has no side effects from the incident. The staff involved in this incident with Resident #1 is no longer employed by the facility.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents' Comprehensive Care Plans were reviewed to include degree of independence and interventions specific to the resident's preferences, needs, and abilities. These Comprehensive Care Plans were compared to the SRNA Care Plans. Care Plans were revised and updated as needed on 9.17.2013.</p>	

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F 282	<p>Continued From page 2</p> <p>go to the bathroom but never used a call light for assistance. SRNA #2 revealed at the end of her shift on 09/15/13, at approximately 3:00 PM, the SRNA went to the shower room to wash her hands and entered the four-digit code on the shower room door in order to open the door. The SRNA stated when she opened the door, she observed a wheelchair in the middle of the floor facing the shower stalls and Resident #1's legs extended out of the shower stall. SRNA #2 stated the resident was alone in the shower room. According to the SRNA, Resident #1 was alert and the SRNA stepped outside of the shower room to obtain help. SRNA #2 stated she and LPN #1 had to re-enter the door code to enter the shower room. SRNA #2 stated Resident #1 did not have the cognition to remember or enter a four-digit code and enter the shower room independently.</p> <p>Interview on 09/19/13, at 1:50 PM with Licensed Practical Nurse (LPN) #1 revealed Resident #1 was "pleasantly confused," required assistance with transfers and toileting, and sat up in a wheelchair most of the day. The interview revealed on 09/15/13, SRNA #1 came to work at approximately 2:00 PM and was at the nurses' station having a discussion with LPN #1. During the conversation, Resident #1 voiced a need to go to the restroom and LPN #1 asked SRNA #1 to assist the resident to the bathroom. According to LPN #1, SRNA #1 assisted Resident #1 away from the nurses' station. LPN #1 stated at approximately 3:00 PM, she heard SRNA #2 call for assistance due to a resident being found on the floor. According to LPN #1, she responded to the SRNA's call for help, went to the shower room, and observed Resident #1 lying on the floor. LPN #1 stated the resident reported that</p>	F 282	<p>Measures Put in Place or Systemic Changes</p> <p>On 9.16.2013 through 9.20.2013 the DON provided in-servicing for all nursing staff on following the resident's individual care plans, including resident transfers and toileting. Nursing staff were also in-serviced by the Occupational Therapist on transfer techniques on 10.8.2013. Nursing staff completed post-test following all in-services to ensure comprehension of the education.</p> <p>The Director of Nursing developed a monitoring system that will be utilized by the Unit Managers to compare the care plans to the care being provided to the residents. These audits will be completed weekly on five percent of nursing staff members.</p> <p>Monitoring of Performance for Sustainment</p> <p>The Director of Nursing will present results of the monitoring system with The Quality Assurance Committee that meets monthly for their recommendations and follow-up.</p>	10/15/2013	

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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER, INC			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11 BOONEVILLE, KY 41314		
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F 282	Continued From page 3 he/she had hit the back of his/her head as a result of the fall. LPN #1 assessed the resident and observed a small skin tear to the resident's right ankle. The LPN notified the physician and the resident was transported to the hospital for further evaluation. The interview revealed the resident remained alert following the fall, and a Computerized Tomography (CT) scan obtained at the hospital revealed normal results. Interviews on 09/19/13, at 4:00 PM with the Director of Nursing (DON) and the Administrator revealed staff notified them on Sunday, 09/15/13, at approximately 3:15 PM that staff had found Resident #1 alone in the shower room and lying on the floor. According to the DON and the Administrator, statements were obtained from the staff that had worked during the timeframe Resident #1 was found on the bathroom floor, and none of the staff reported having assisted Resident #1 to the shower room. The facility initiated an investigation and on Monday morning (09/16/13) the Administrator and DON reviewed the video footage for 09/15/13 and observed SRNA #1 taking Resident #1 into the shower room at 2:12 PM. According to interview, the video revealed SRNA #1 left the shower room within a minute without the resident, and SRNA #2 entered the shower room at 2:58 PM. The Administrator stated Resident #1 was left unattended in the shower room for 46 minutes. The interview revealed SRNA #1's employment at the facility was terminated on Tuesday, 09/17/13. The DON acknowledged staff failed to provide care in accordance with Resident #1's Plan of Care.	F 282			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			

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F 323	<p>Continued From page 4</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and facility policy review, it was determined the facility failed to ensure each resident received adequate supervision to prevent accidents for one of three sampled residents (Resident #1). A review of the medical record, including the Comprehensive Plan of Care, revealed Resident #1 required the assistance of two staff members for transfers and toileting, and was not to be left alone in the bathroom. However, interview revealed on 09/15/13, one staff member assisted the resident to the shower room and left the resident unattended. According to interviews and a review of documentation, Resident #1 fell to the floor from the wheelchair while in the shower room unattended and sustained a skin tear to the right ankle.</p> <p>The findings include: Review of the facility's undated policy entitled "Fall Management Program," revealed each resident would be thoroughly assessed to establish fall risks and care planning and implementation of appropriate interventions to minimize falls and injuries in an effort to ensure</p>	F 323	<p><u>F323 483.25 (h) FREE OF CCIDENT HAZARDS/SUPERVISION/DEVICES</u></p> <p><i>Residents Found to Have Been Affected</i> Resident #1 was transported to the hospital and evaluated on 9/15/2013 and has no side effects from the incident. The staff involved in this incident with Resident #1 is no longer employed by the facility.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 323 regarding accident hazards and supervision. Systemic and Monitoring actions listed below will include all residents who have the potential to be affected.</p> <p><i>Measures Put in Place or Systemic Changes</i> On 9.16.2013 through 9.20.2013 the DON provided in-servicing for all nursing staff on following the resident's individual care plans, including resident transfers and toileting, safety factors and the</p>	

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F 323	<p>Continued From page 5 the resident's safety.</p> <p>Review of the facility's job description for "Nursing Assistant" revealed the nursing assistant would perform resident care activities necessary in caring for the personal needs, safety, and comfort of the residents as assigned. The job description further stated the nursing assistants were required to implement the resident care plan.</p> <p>Medical record review for Resident #1 revealed the facility admitted the resident on 12/26/12, with diagnoses of Chronic Obstructive Pulmonary Disease, Alzheimer's Dementia, and Cerebral Vascular Accident. The medical record revealed Resident #1's cognition was severely impaired.</p> <p>Comprehensive Plan of Care review for Resident #1 revealed interventions implemented on 04/12/13, for two staff members to assist the resident with all transfers/toileting and for staff not to leave the resident unattended in the bathroom.</p> <p>Interview on 09/19/13, at 2:25 PM with State Registered Nursing Assistant (SRNA) #2 revealed on 09/15/13, at approximately 3:00 PM the SRNA entered the four-digit code to unlock the door to the shower room, entered, observed a wheelchair in the middle of the floor facing the shower stalls, and saw Resident #1's legs extended out and on the floor of the shower room stall. SRNA #2 stated the resident was alert and had a small skin tear on the right ankle. According to SRNA #2, she left the room to call for help, and she and Licensed Practical Nurse (LPN) #1 re-entered the shower room to assess and offer assistance to Resident #1.</p> <p>Interview on 09/19/13, at 1:50 PM with LPN #1</p>	F 323	<p>importance of supervision. Nursing staff were also in-serviced by the Occupational Therapist on transfer techniques on 10.8.2013 to ensure safety. Nursing staff completed post-test following all in-services to ensure comprehension of the education.</p> <p>The Director of Nursing developed a monitoring system that will be utilized by the Unit Managers to check safety and supervision when delivering care to the residents. These audits will be completed weekly on five percent of nursing staff members.</p> <p>Monitoring of Performance for Sustainment</p> <p>The Director of Nursing will present results of the monitoring system with The Quality Assurance Committee that meets monthly for their recommendations and follow-up.</p> <p>Compliance Date 10/15/2013</p>	

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F 323	<p>Continued From page 6</p> <p>revealed on 09/15/13, Resident #1 propelled his/her self in a wheelchair to the nurses' station and voiced the need to go to the bathroom. LPN #1 stated she asked SRNA #1 to assist the resident and the SRNA assisted the resident away from the nurses' station. According to LPN #1, at approximately 3:00 PM, she heard SRNA #2 call for assistance due to a resident found on the floor. The interview revealed the LPN went to the shower room and observed Resident #1 alone and lying on the floor. According to LPN #1, the resident reported hitting the back of the resident's head during the fall. LPN #1 assessed the resident and noted a small skin tear to the resident's right ankle. The LPN notified the physician and the resident was transported to the local hospital for evaluation due to the fall. LPN #1 also stated she notified the Administrator of the incident.</p> <p>Interviews on 09/19/13, at 4:00 PM with the Director of Nursing (DON) and the Administrator, revealed on Sunday, 09/15/13, at approximately 3:15 PM, staff called the Administrator and reported Resident #1 was found alone on the shower room floor. Interviews revealed an investigation was initiated and on Monday morning the Administrator and the DON reviewed the video footage for 09/15/13 and observed SRNA #1 taking Resident #1 into the shower room at 2:12 PM. According to interviews, SRNA #1 left the shower room "within a minute" without Resident #1. According to the Administrator, the video footage revealed SRNA #2 entered the shower room at 2:58 PM and found Resident #1. The video footage revealed Resident #1 was left unattended in the shower room for 46 minutes. The interview revealed SRNA #1 was terminated from employment at the facility on 09/17/13 as a</p>	F 323			

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F 323	Continued From page 7 result of the incident.	F 323			