

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

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PRINTED: 02/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 01/18/2012
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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE Division of Health Care SOURCES, INC. Branch HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314
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F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY17520) was conducted on 12/27/11. The complaint was substantiated with deficient practice cited at "D" level. After supervisory review the complaint was reopened on 01/17-18/12. Immediate Jeopardy was identified to exist from 11/24/11 to 12/05/11.</p> <p>On 11/16/11 unsafe items (knives and tools) were found in Resident #1's room after the resident had threatened to harm self. The facility failed to plan and implement interventions to ensure Resident #1 did not have access to unsafe items. Resident #1 displayed mental/psychosocial adjustment difficulty and attempted to harm self by cutting his/her wrist with a butter knife on 11/24/11, at 12:30 PM. Although the resident was placed on 15-minute monitoring checks, the facility failed to adequately supervise the resident and ensure the resident did not have access to unsafe items. On 11/24/11, at 4:15 PM, Resident #1 cut him/her self with a razor the resident had stored in his/her room. A search of the resident room after this incident on 11/24/11, revealed the following items were discovered: a container of approximately 20 to 30 razors, a dark-handled lock blade pocket knife four to four and one-half inches long, and a half bottle of Aspirin.</p> <p>It was determined the facility had completed corrective actions prior to the visit on 12/27/11, thus resulting in the determination of Past Jeopardy. It was determined the Immediate Jeopardy was removed on 12/06/11.</p>	F 000		
F 152 SS=D	<p>483.10(a)(3)&(4) RIGHTS EXERCISED BY REPRESENTATIVE</p> <p>In the case of a resident adjudged incompetent.</p>	F 152		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Quincy Perry</i>	TITLE <i>Administrator</i>	(X6) DATE <i>02/10/2012</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 152	<p>Continued From page 1</p> <p>under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf.</p> <p>In the case of a resident who has not been judged incompetent by the State court, any legal surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, it was determined the facility failed to ensure the rights of one of four sampled residents (Resident #1), who had been adjudged incompetent, were exercised by the person appointed under state law to act on the resident's behalf. Resident #1 was allowed to leave the facility without Resident #1's appointed guardian's knowledge or approval on a total of twenty-six occasions from July 2011 to November 2011.</p> <p>The findings include:</p> <p>A review of the facility policy entitled "Residents Leaving The Facility" (dated 09/16/06) revealed residents were to sign out upon leaving the facility and sign back in upon returning to the facility. The policy further indicated residents who were cognitively impaired based on the Resident Assessment Instrument (RAI) must be accompanied by a family member or responsible party when leaving the facility. However, the policy did not address residents who had not been assessed to be cognitively impaired and</p>	F 152	<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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F 152	<p>Continued From page 2</p> <p>had court-appointed guardians or restrictions placed on the resident leaving the facility.</p> <p>A review of the admission Minimum Data Set (MDS) assessment completed on 05/14/11 and a quarterly MDS assessment completed on 10/12/11 for Resident #1 revealed the facility had assessed the resident as alert and oriented. Additional review of the medical record revealed the resident had diagnoses which included Anxiety, Depression, Alcohol Abuse, Cirrhosis of the Liver, and a history of threatening to harm self. Further review of the record revealed Resident #1 had been adjudged incompetent and a guardian was appointed on 08/20/09 to make all decisions and manage the resident's affairs, both health and financial.</p> <p>Continued review of the medical record revealed the facility's Social Worker noted on 08/04/10 the resident's guardian requested Resident #1 leave the facility only for Physician appointments and/or court hearings. The note was placed in the front of the resident's medical record and directed staff to call the guardian if there were any questions.</p> <p>A review of the document entitled "Release of Responsibility For Leave of Absence Forms" for Resident #1 dated July 2011 to November 2011 revealed the resident signed out and left the facility on a total of twenty-six (26) occasions. There was no documented evidence the resident's guardian was notified nor permission obtained from the guardian for the resident to leave the facility.</p> <p>An interview conducted on 12/27/11 at 9:50 AM, with the guardian for Resident #1 revealed the</p>	F 152	<p><u>F152 Rights Exercised by Representative</u></p> <p>Targeted Resident Resident #1's Guardian is being notified and permission is obtained from the Guardian prior to this resident leaving the facility.</p> <p>Identification of Other Residents The medical records of all residents with court-appointed guardians were reviewed to ensure the guardians are being notified and approval obtained if or when the resident leaves the facility.</p> <p>Systemic Changes The facility policy entitled "Residents Leaving the Facility" was updated to include specific instructions on notification and obtaining permission of</p>		

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F 152	<p>Continued From page 3</p> <p>facility allowed Resident #1 to leave the facility with members of the resident's family that the guardian had not approved. Further interview revealed the facility failed to notify the resident's guardian or obtain permission from the guardian for the resident to leave the facility with the family members.</p> <p>An interview conducted with Registered Nurse (RN) #2 on 12/27/11 at 1:35 PM, revealed RN #2 was not aware that Resident #1 could not sign out of the facility without guardian consent until the guardian voiced a concern in November 2011. According to RN #2, Resident #1 would sign out of the facility to attend a day treatment program and would sign out of the facility and leave with his/her family.</p> <p>An interview conducted with the West Hall Unit Manager (UM) on 12/27/11 at 6:30 PM, revealed if a resident had a guardian, nurses were responsible to call and obtain permission from the guardian for the resident to leave the facility. According to the UM, the nurses did not understand that even though Resident #1 was alert and oriented, the resident's guardian had been appointed by the Courts to make decisions related to Resident #1's care, and was to be the only one to make decisions.</p> <p>An interview conducted with the Director of Nursing (DON) on 12/27/11 at 6:40 PM, revealed the facility did not have a policy related to residents who had court-appointed guardians being allowed to leave the facility without the approval of the guardian. The DON stated she was aware of the guardian's concern related to Resident #1 being permitted by facility staff to</p>	F 152	<p>court-appointed guardians when residents with court-appointed guardians leave the facility.</p> <p>In-servicing has been completed on the updated policy with the Licensed Nurses on 12/16/11 and 12/17/11. In-services were completed by the DON and Staff Development Coordinator.</p> <p>A listing of residents with court-appointed guardians has been compiled and is available at each nurse's station. The listing includes the guardian's name and contact information.</p> <p>Monitoring The Social Service Director is responsible for placing the guardianship court documents in the resident's clinical record. The Quality Assurance (QA) Nurse will audit the medical records of the residents with court-</p>		

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F 152	Continued From page 4 leave the building without the guardian's consent. The DON stated she initiated in-service training to nursing staff on 12/16/11 related to residents with guardians; however, the in-service training was completed for all of the nurses. According to the DON, the facility was not always aware of where Resident #1 went or with whom the resident left the facility with during the timeframe of July 2011 to November 2011.	F 152	appointed guardians weekly for 4 weeks and monthly thereafter to ensure notification and permission is completed when/if the resident leaves the facility. Date of Completion	02-17-12	
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, it was determined the facility	F 280	Past noncompliance: no plan of correction required.		

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F 280	<p>Continued From page 5</p> <p>failed to ensure the Comprehensive Care Plan for one of four sampled residents (Resident #1) was periodically reviewed and revised by a team of qualified persons after each comprehensive assessment. The facility readmitted Resident #1 on 11/16/11 after the resident was hospitalized for psychiatric treatment. Resident #1 displayed unstable behaviors and unsafe items (knives and tools) were found in the resident's room on 11/16/11. The facility failed to revise Resident #1's plan of care to ensure the resident had appropriate supervision to prevent the resident from harming self. On 11/24/11 Resident #1 became depressed because the resident's guardian would not allow the resident to leave the facility. The resident cut his/her wrist with a butter knife at 12:30 PM, and a razor at 4:15 PM, which the resident had stored in his/her room. The failure of the facility to review/revise Resident #1's plan of care to include appropriate interventions related to supervision caused or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. The Immediate Jeopardy was identified to exist on 11/24/11 through 12/05/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation, and as a result, Past Jeopardy was determined. The Immediate Jeopardy was determined to be corrected on 12/06/11.</p> <p>The findings include:</p> <p>A review of the facility policy entitled "Behavior Management" (undated) revealed facility staff was to monitor and manage resident behaviors. According to the policy, if it was determined a resident needed a behavior management care</p>	F 280		

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F 280	<p>Continued From page 6</p> <p>plan the Interdisciplinary Team would develop a plan based on the resident's behaviors and overall condition. Further review of the policy revealed the resident would be monitored at least quarterly and as needed for care plan effectiveness and the plan would be revised as indicated. There was no evidence the Behavior Management policy outlined staff duties when a resident's behavior was monitored.</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on 05/14/11. The resident's diagnoses included Anxiety, Depression, Alcohol Abuse, and Cirrhosis of the Liver. In addition, the resident had a history of suicide attempts and threats to harm self. A review of Resident #1's Minimum Data Set (MDS) comprehensive assessment dated 05/14/11 and the quarterly MDS assessment dated 10/12/11 revealed the facility assessed the resident as alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15. Further review of the medical record revealed Resident #1 was appointed a guardian by the state on 06/23/09. A review of documentation revealed staff developed a comprehensive plan of care on 10/19/11 to address Resident #1's behavior related to mood and anxiety.</p> <p>Review of the medical record revealed on 11/09/11 Resident #1's guardian informed the facility that Resident #1 was not to leave the facility with anyone other than the guardian or an approved family member. Continued review of the medical record revealed the resident became depressed related to the restrictions placed by the guardian on visits outside of the facility. On 11/16/11 the resident voiced a desire to harm</p>	F 280		

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F 280	<p>Continued From page 7</p> <p>himself a search of the resident's room revealed unsafe items (knives and tools).</p> <p>Review of Resident #1's comprehensive care plan revealed the care plan was updated on 11/16/11 to include every 15-minute checks, in a response to the resident's expressed desire to harm self. However, the facility failed to revise the plan of care with interventions to address unsafe items found in the resident's room.</p> <p>Review of the resident's medical record revealed on 11/24/11 Resident #1 became depressed because the resident's guardian would not allow the resident to leave the facility. The resident cut his/her wrist with a butter knife at 12:30 PM, and a razor at 4:15 PM, which the resident had stored in his/her room. An order was received from the resident's physician on 11/24/11 at 12:45 PM, to transfer the resident to the psychiatric hospital and Resident #1 was transferred from the facility at 6:55 PM.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 01/17/12 at 12:20 PM, revealed the resident's care plan was revised to include 15-minute checks on 11/16/11 after the resident voiced a desire to harm himself. According to LPN #1 the intervention was for staff to monitor the resident every 15 minutes. However, the LPN stated she did not revise the care plan to include what staff was to monitor when they conducted 15-minute observations or what actions facility staff was to take to ensure the resident did not harm his/her self.</p> <p>An interview conducted with the Minimum Data Set (MDS) Nurse on 01/18/12 at 4:30 PM,</p>	F 280		

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F 280	<p>Continued From page 8</p> <p>revealed the MDS Nurse had not revised the resident's plan of care related to the resident's behaviors due to limitations placed on his/her visits being restricted by the guardian. In addition, the nurse stated she was not aware Resident #1 had become upset, voiced disagreement, or exhibited behaviors as a result of the restrictions the resident's guardian had placed on his/her visits outside of the facility. The MDS nurse stated no other interventions were developed or considered for Resident #1 other than monitoring the resident every 15 minutes when the resident had attempted to harm him/her self.</p> <p>*The facility implemented the following actions to correct the deficiency:</p> <ul style="list-style-type: none"> - The facility placed Resident #1 on one to one supervision on 11/24/11 at 4:15 PM, till the resident was transferred from the facility at 6:55 PM. Resident #1's plan of care was reviewed and revised to include interventions of one to one supervision when the resident was readmitted to the facility on 12/09/11 and is ongoing. - The facility developed a new policy/procedure entitled "Suicide Prevention" with procedures to remove the resident from any threat of immediate danger and to implement one to one monitoring when this level of supervision was determined to be safest for the resident. In addition, according to facility policy, if a resident is at high risk for injuring self or others the resident will be transferred immediately to an acute care facility. - Facility staff was in-serviced on the "Suicide Prevention" policy and administered a post test 	F 280			

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F 280	<p>Continued From page 9</p> <p>for competency by the facility staff development nurse. In-servicing was initiated on 11/28/11 and completed on 12/05/11.</p> <p>- Resident #1's supervision was documented every 15 minutes by the staff providing one to one supervision; documentation reviewed daily by the Unit Manager and the Director of Nursing; and is ongoing.</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observations, interviews, and record reviews conducted on 01/17-18/12 revealed Resident #1 was provided one to one supervision by facility staff when the resident was readmitted to the facility on 12/09/11, and is ongoing. Interview conducted with the MDS Nurse on 01/18/12 at 4:30 PM, revealed staff had updated Resident #1's care plan to include the resident's supervision level and the resident was currently undergoing a significant change assessment related to hospice care. A review of Resident #1's medical record confirmed facility staff had updated the resident's care plan to include the one to one supervision.</p> <p>A review of the in-service training records revealed all staff currently employed by the facility was trained on the policy and the employees were tested for competency/knowledge of the policy after the training was completed on 12/05/11. Interviews with CNAs and Nurses on 01/17-18/12 revealed the staff had been trained and was knowledgeable of the policy.</p> <p>An interview conducted with the Director on</p>	F 280			

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F 280	Continued From page 10 Nursing (DON) on 01/17/12 at 5:30 PM, revealed Resident #1 was monitored each shift by nurses. In addition the DON stated facility staff discussed Resident #1 and reviewed the resident's care each day to ensure the resident continued to remain safe.	F 280			
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies it was determined the facility failed to ensure one of four residents (Resident #1) received adequate supervision to prevent accidents. On 11/16/11 unsafe items (knives and tools) were found in Resident #1's room after the resident had threatened to harm self. The facility failed to provide adequate supervision to ensure Resident #1 did not have access to unsafe items. Resident #1 displayed mental/psychosocial adjustment difficulty and attempted to harm self by cutting his/her wrist with a butter knife on 11/24/11 at 12:30 PM, after the resident's guardian denied the resident a family home visit. Resident #1 was placed on 15-minute monitoring at that time and at 4:15 PM on the same day, 11/24/11, Resident #1 cut his/her wrist again with	F 323	Past noncompliance: no plan of correction required.		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165273	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED C 01/18/2012
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314		
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F 323	<p>Continued From page 11</p> <p>a razor blade which the resident had stored in his/her room. The failure of the facility to provide adequate supervision to Resident #1 caused or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. The Immediate Jeopardy with substandard quality of care was identified to exist on 11/24/11 through 12/05/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation, thus it was determined Past Jeopardy. The Immediate Jeopardy was determined to be corrected on 12/06/11.</p> <p>The findings include:</p> <p>A review of the facility's policy entitled "Increased Resident Monitoring Policy" (undated) revealed the policy of the facility was to provide observation as deemed appropriate for situations or circumstances that may warrant additional monitoring for any resident who stated intent to harm or kill themselves. Further review of the policy revealed interventions could include, but were not limited to, timed safety checks and (up to) one to one observation of the resident.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident to the facility on 05/14/11. The resident's diagnoses included Anxiety, Depression, Cirrhosis of the Liver, Bipolar Disorder, and a History of Suicide Attempts and Threatening to Harm Self. A review of the resident's Minimum Data Set (MDS) comprehensive assessment dated 05/14/11 and the quarterly MDS assessment dated 10/12/11 revealed the facility assessed the resident as alert and oriented with a Brief Interview for Mental Status (BIMS) score of 15.</p>	F 323			

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F 323	<p>Continued From page 12</p> <p>Review of the medical record revealed on 11/16/11 Resident #1 expressed intent to harm self upon returning from an inpatient psychiatric hospital admission. The resident displayed unstable behavior and a search of the resident's room revealed unsafe items (knives and tools). The resident's physician was notified and the resident was referred for further psychiatric treatment. However, the facility failed to plan/implement adequate interventions to prevent the resident from harming self with unsafe items.</p> <p>A review of nurse's notes for Resident #1 revealed on 11/24/11 at 12:30 PM, the resident returned to the nursing unit from the main dining room and stated to Licensed Practical Nurse (LPN) #1 that he/she needed to go to the community mental health center. According to documentation in the medical record, at that time, the resident then went into his/her room and cut his/her wrist with a butter knife and sustained an open area to the inner wrist seven centimeters (7 cm) long that was "weeping" clear fluids. The resident's physician was contacted at 12:45 PM, and orders were received to send the resident to the hospital for a psychiatric evaluation. However, the hospital informed the facility staff the resident could not be admitted without a court order because the resident had a guardian. Resident #1 was placed on a 15-minute monitoring schedule until arrangements could be made for the resident's transfer.</p> <p>Further review of the nursing notes revealed at 12:45 PM on 11/24/11, the resident reported to LPN #1 he/she had pocket knives in the room and upon entering the resident's room, the</p>	F 323			

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F 323	<p>Continued From page 13</p> <p>resident informed the nurses the knives were in a locked box in the facility's front office. However, there was no documented evidence a search was conducted of the resident's room to determine if there were knives in the resident's room. At 4:00 PM, when staff performed a 15-minute assessment, the resident informed LPN #1 "if the facility wasn't going to do anything he/she would." Documentation in the medical record revealed at 4:15 PM, Resident #1 cut his/her wrist again with a safety razor blade which the resident had stored in his/her room. Facility staff provided first aid, bandaged the resident's wrist, and at that time Resident #1 was placed on one to one supervision. At the request of the Director of Nursing, nursing staff conducted an initial search of Resident #1's room and according to documentation, nursing staff discovered a bag of razors, a pocket knife, assorted tools, and a bottle of (unidentified) pills. Resident #1 was transferred from the facility to the hospital on 11/24/11 at 6:55 PM.</p> <p>An interview conducted with Resident #1 on 01/17/12 at 11:45 AM, revealed the resident was depressed on 11/24/11 and had tried to draw attention to him/her self. According to Resident #1, the resident had not tried to "kill" him/her self and had only "scratched" his/her arm with a butter knife.</p> <p>An interview conducted with State Registered Nurse Aide (SRNA) #1 on 01/17/12 at 1:40 PM, revealed when he arrived to work at 3:00 PM on 11/24/11, staff was observing Resident #1 every 15 minutes because of the resident's attempt to harm self. According to SRNA #1, Resident #1 informed him at approximately 4:15 PM, that the</p>	F 323			

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F 323	<p>Continued From page 14</p> <p>resident had cut his/her wrist with a razor. SRNA #1 stated he immediately informed the nurse. The SRNA stated the nurse provided treatment to the resident's wound and placed the resident on one to one supervision. Continued interview with SRNA #1 revealed after the resident cut himself/herself, the nurses searched the resident's room and found an unknown amount of razors and a knife that was approximately three inches long.</p> <p>An interview conducted with LPN #1 on 01/17/12 at 12:20 PM, revealed she was assigned to provide nursing services for Resident #1 on 11/24/11. According to the LPN, Resident #1 informed LPN #1 that he/she wanted to go to the community crisis center because the resident was upset due to the guardian's restrictions on his/her visits outside of the facility. The LPN stated Resident #1 reported to her that he/she had cut his/her wrist with a butter knife. LPN #1 stated the resident was assessed to have a small scratch on his/her wrist, was placed on 15-minute observations and the resident's physician was notified of the incident. The interview revealed at 12:45 PM, the resident's physician requested Resident #1 be transferred to the hospital for psychiatric evaluation. According to the LPN, Resident #1 required a court order for admission to the hospital's psychiatric unit and the LPN contacted the facility's Administrator because the LPN was not aware of how to obtain a court order for the resident. The LPN stated she was not aware if the facility had a policy/procedure related to a resident's threat to harm himself/herself. According to LPN #1, it was standard practice at the facility to place the resident on 15-minute observations for 24 to 72 hours if a resident</p>	F 323		

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F 323	<p>Continued From page 15</p> <p>threatened harm to him/her self. Further interview with LPN #1 revealed at 4:15 PM on 11/24/11, Resident #1 cut him/her self with a razor while awaiting transfer to the hospital. The LPN stated the resident was placed on one to one supervision and the Director of Nursing (DON) instructed the LPN to search the resident's room to ensure the resident's safety. The LPN stated a search of the room was conducted and staff discovered a container of approximately 20 to 30 razors, a dark-handled lock blade pocket knife four to four and one-half inches long, and a half bottle of Aspirin. Further interview with the LPN revealed the resident was under constant one to one supervision until the resident was transferred from the facility to the hospital on 11/24/11 at 6:55 PM.</p> <p>An interview with the Director of Nursing (DON) on 01/17/12 at 2:40 PM, revealed the DON was not aware LPN #1 was not knowledgeable in the implementation of facility policy or how to ensure residents who had threatened to harm themselves were protected and appropriate interventions implemented. According to the DON, 15-minute observations of Resident #1 was not appropriate due to the resident's threat to harm himself/herself and the 15-minute observations would not ensure the resident's safety. According to the DON, Resident #1 should have been placed on one to one supervision after the first attempt to harm him/her self and until the resident could be transferred from the facility.</p> <p>*The facility implemented the following actions to correct the deficiency:</p>	F 323			

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F 323	<p>Continued From page 16</p> <ul style="list-style-type: none"> - The facility placed Resident #1 on one to one supervision on 11/24/11 at 4:15 PM, till the resident was transferred from the facility at 6:55 PM. Resident #1's plan of care was reviewed and revised to include interventions of one to one supervision when the resident was readmitted to the facility on 12/09/11 and is ongoing. - The facility developed a new policy/procedure entitled "Suicide Prevention" with procedures to remove the resident from any threat of immediate danger and to implement one to one monitoring when this level of supervision was determined to be safest for the resident. In addition, according to facility policy, if a resident is at high risk for injuring self or others the resident will be transferred immediately to an acute care facility. - Facility staff was in-serviced on the "Suicide Prevention" policy and administered a post test for competency by the facility staff development nurse. The in-service was initiated on 11/28/11 and completed on 12/05/11. - Resident #1's supervision was documented every 15 minutes by the staff providing one to one supervision; documentation was reviewed daily by the Unit Manager and the Director of Nursing; and is ongoing. <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observations, interviews, and record reviews conducted on 01/17-18/12 revealed Resident #1 was provided one to one supervision by facility staff when the resident was readmitted to the facility on 12/09/11, and is ongoing. Interview</p>	F 323			

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F 323	Continued From page 17 conducted with the MDS Nurse on 01/18/12 at 4:30 PM, revealed staff had updated Resident #1's care plan to include the resident's supervision level and the resident was currently undergoing a significant change assessment related to hospice care. A review of Resident #1's medical record confirmed facility staff had updated the resident's care plan to include the one to one supervision. A review of in-service training records revealed all staff currently employed by the facility was trained on the policy and the employees had been tested for competency/knowledge of the policy after the training was completed on 12/05/11. Interviews with CNAs and Nurses on 01/17-18/12 revealed the staff had been trained and was knowledgeable of the policy. An interview conducted with the Director on Nursing (DON) on 01/17/12 at 5:30 PM, revealed Resident #1 was monitored each shift by nurses. In addition the DON stated facility staff discussed Resident #1 and reviewed the resident's care each day to ensure the resident continued to remain safe. An interview conducted with the Administrator on 01/18/12 at 5:30 PM, revealed as part of the new policy and procedure the Administrator is notified if a resident threatens to harm self to ensure the resident is provided appropriate interventions to ensure the resident's safety.	F 323			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and	F 490			

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F 490	Continued From page 18 efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to be administered in a manner which enabled resources to be used effectively and efficiently for one (Resident #1) of four sampled residents to ensure the resident's highest practicable physical, mental, and psychosocial well-being was attained or maintained. The facility failed to ensure policies and procedures were implemented to provide supervision to Resident #1 when the resident expressed a desire to harm him/her self on 11/16/11 and after the resident cut him/her self with a knife and razor on 11/24/11. The failure of the facility to have an effective system to provide appropriate interventions and supervision for residents caused or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. The Immediate Jeopardy was identified to exist on 11/24/11 through 12/05/11. The facility implemented corrective actions which were completed prior to the State Agency's investigation, and as a result, Past Jeopardy was determined. The Immediate Jeopardy was determined to be corrected on 12/06/11. The findings include: A review of the facility's policy entitled "Increased Resident Monitoring Policy" (undated) revealed the policy of the facility was to provide	F 490	Past noncompliance; no plan of correction required.		

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F 490	<p>Continued From page 19</p> <p>observation as deemed appropriate for situations or circumstances that may warrant additional monitoring for any resident who stated intent to harm or kill themselves. Further review of the policy revealed interventions could include, but were not limited to, timed safety checks and (up to) one to one observation of the resident.</p> <p>The facility admitted Resident #1 on 05/14/11 with diagnoses of Anxiety, Depression, Cirrhosis of the Liver, Bipolar Disorder, and a History of Suicide Attempts and Threatening to Harm Self. On 11/16/11 unsafe items (knives and tools) were found in Resident #1's room after the resident had threatened to harm self. The facility failed to implement interventions to ensure Resident #1 did not have access to unsafe items. Documentation in the medical record revealed on 11/24/11 at 12:30 PM, Resident #1 injured his/her wrist with a butter knife. There was no documented evidence a search was conducted of the resident's room to determine if there were knives in the resident's room. Resident #1 was placed on 15-minute monitoring at that time and at 4:15 PM on the same day Resident #1 cut his/her wrist again with a razor blade which the resident had stored in his/her room. A search of the resident's room after the second attempt to harm self revealed a bag of razors, a pocket knife, assorted tools, and a bottle of (unidentified) pills.</p> <p>An interview conducted with LPN #1 on 01/17/12 at 12:20 PM, revealed she was not aware if the facility had a policy/procedure related to a resident's threat to harm himself/herself. According to LPN #1, it was standard practice at the facility to place the resident on 15-minute</p>	F 490			

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F 490	<p>Continued From page 20</p> <p>observations for 24 to 72 hours if a resident threatened harm to him/her self.</p> <p>An interview with the Director of Nursing (DON) on 01/17/12 at 2:40 PM, revealed the DON was not aware LPN #1 was not knowledgeable in the implementation of facility policy or how to ensure residents who had threatened to harm themselves were protected and appropriate interventions implemented. Per interview, Resident #1 should have been placed on one to one supervision after the first attempt to harm himself/herself and until the resident could be transferred from the facility. The DON stated 15-minute observations of Resident #1 were not appropriate due to the resident's threat to harm himself/herself and the 15-minute observations would not ensure the resident's safety.</p> <p>An interview conducted with the Administrator on 01/18/12 at 5:30 PM, revealed the Administrator was made aware of Resident #1's behaviors on 11/24/11 and came to the facility to assist with obtaining a court order required by the psychiatric hospital to have the resident involuntarily admitted to the hospital's psychiatric unit. According to the Administrator, she was not aware the facility policy was not effective in providing supervision to residents who had made attempts to harm self or to address/define unsafe items. Additional interview revealed the Administrator realized the facility was not able to meet the resident's needs and had started the discharge procedure to give the resident a 30-day discharge notice. The Administrator stated Resident #1 would remain on one to one supervision until discharged to another facility to ensure the resident's safety.</p>	F 490		

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F 490	Continued From page 21 *The facility implemented the following actions to correct the deficiency: - The facility placed Resident #1 on one to one supervision on 11/24/11 at 4:15 PM, till the resident was transferred from the facility at 6:55 PM. Resident #1's plan of care was reviewed and revised to include interventions of one to one supervision when the resident was readmitted to the facility on 12/09/11 and is ongoing. Resident #1 was issued a written discharge notice on 12/16/11 because the facility was unable to meet the needs of Resident #1 related to suicidal behaviors. - The facility developed a new policy/procedure entitled "Suicide Prevention" with procedures to remove the resident from any threat to immediate danger and to implement one to one monitoring when this level of supervision was determined to be safest for the resident. In addition, according to facility policy, if a resident is at high risk for injuring self or others the resident will be transferred immediately to an acute care facility. - Facility staff was in-serviced on the "Suicide Prevention" policy and administered a post test for competency by the facility staff development nurse. The in-service was initiated on 11/28/11 and completed on 12/05/11. - Resident #1's supervision was documented every 15 minutes by the staff providing one to one supervision with Resident #1; reviewed daily by the Unit Manager and the Director of Nursing; and is ongoing.	F 490			

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F 490	<p>Continued From page 22</p> <p>**The surveyor validated the corrective action taken by the facility as follows:</p> <p>Observations, interviews, and record reviews conducted on 01/17-18/12 revealed Resident #1 was provided one to one supervision by facility staff when the resident was readmitted to the facility on 12/09/11, and is ongoing. Interview conducted with the MDS Nurse on 01/18/12 at 4:30 PM, revealed staff had updated Resident #1's care plan to include the resident's supervision level and the resident was currently undergoing a significant change assessment related to hospice care. A review of Resident #1's medical record confirmed facility staff had updated the resident's care plan to include the one to one supervision.</p> <p>A review of the 30-day discharge notice for Resident #1 revealed the notice was issued on 12/16/11 due to the facility not being able to meet the needs of Resident #1. Interview with the facility Social Worker and the Administrator on 01/18/12 revealed Resident #1 in the process of being discharged to another facility to better meet the resident's needs.</p> <p>A review of in-service training records revealed all staff currently employed by the facility was trained on the policy and the employees had been tested for competency/knowledge of the policy after the training was completed on 12/05/11. Interviews with CNAs and Nurses on 01/17-18/12 revealed the staff had been trained and was knowledgeable of the policy.</p> <p>An interview conducted with the Director on Nursing (DON) on 01/17/12 at 5:30 PM, revealed</p>	F 490			

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 01/18/2012
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 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 490	Continued From page 23 Resident #1 was monitored each shift by nurses. In addition the DON stated facility staff discussed Resident #1 and reviewed the resident's care each day to ensure the resident continued to remain safe. An interview conducted with the Administrator on 01/18/12 at 5:30 PM, revealed as part of the new policy and procedure the Administrator is notified if a resident threatens to harm self to ensure the resident is provided appropriate interventions to ensure the resident's safety.	F 490			