

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

PRINTED: 06/22/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185258	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 04/20/2012
NAME OF PROVIDER OR SUPPLIER LAKE WAY NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 2607 MAIN STREET HWY 644 SOUTH BENTON, KY 42025		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS AMENDED 06/22/12 F153 - information changed due to IDR An abbreviated survey (KY #18139) was conducted on 04/16/12 through 04/20/12 to determine the facility's compliance with Federal requirements. KY #18139 was substantiated with deficiencies cited at the highest S/S of a "D." F 153 SS=D 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 review of the facility's policy/procedures, it was determined the facility failed to ensure one resident's (#1's) Power of Attorney (POA), in the selected sample of three residents, was provided copies of the resident's clinical records. Findings include: A review of the facility's policy/procedure, "Medical Records," dated October 2007, revealed the private health information for a resident who	F 000	<u>RESPONSE PREFACE</u> Lake Way Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The Plan of Correction is submitted as a written allegation of compliance. Lake Way Nursing and Rehabilitation Center's response the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Lake Way Nursing and Rehabilitation Center reserves the right to refute any of the stated deficiencies of this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any administrative or legal proceeding.		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Alexa Buzyn

TITLE

Administrative

(X6) DATE

6/29/2012

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 153	Continued From page 1 is still living will only be released to the resident or the resident's POA. An interview with Resident #1's POA, on 04/16/12 at 1:54 PM, revealed she requested a copy of the resident's medical record, on 03/22/12, when the resident was sent to the hospital and the POA was allowed to look at the physician's progress notes; however, further interview with the POA, on 04/23/12 at 9:45 AM, revealed the POA still had not received the copies of Resident #1's clinical record. An interview with the Administrator, on 04/17/12 at 10:10 AM, revealed, on 03/22/12, the day the resident was sent to the hospital, the POA requested to see the medical records and she "showed her the progress notes."	F 153	Resident #1 is no longer a resident of the facility. 100% audit of all current residents was completed by Medical Records on 5/09/2012 for requests per the resident or legal representative for chart reviews and/or a copy of the medical record. None were identified. Review for requests by the residents and/or legal representative will be completed daily (Monday thru Friday) by the Administrative Staff (to include Activities Director, Social Worker, Medical Records, AR Bookkeeper, Dietary Manager, Housekeeping Director, and Maintenance Director) in morning meetings. Any requests identified will be followed up on immediately by the Administrator, DON or ADON.	
F 280 SS=D	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	F 280	A QI audit will be completed by the QI Nurse on the daily (Monday thru Friday) reviews for follow-up per the Federal Regulation and Facility Policy for release of information to the resident and/or legal representative weekly X4, then	

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F 280	<p>Continued From page 2 each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident's care plan was revised for one resident (#1), in the selected sample of three residents.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Resident Care Plan," revised 09/19/11, revealed "modification of the care plan would be done at least quarterly and as needed for residents under the direction of the RN Coordinator/designee."</p> <p>A record review revealed the facility admitted Resident #1 on 04/27/11 with diagnoses to include Senile Dementia with Delirium, Angina Pectoris, a Pacemaker and Chronic Heart Failure (CHF).</p> <p>A review of the significant change Minimum Data Set (MDS) assessment, dated 03/12/12, revealed the facility identified Resident #1 as severely cognitively impaired.</p> <p>A review of the resident's care plan, "Pacemaker- At risk for potential complications due to Pacemaker malfunction," dated 05/04/11, revealed an intervention for routine pacemaker checks, as ordered by the physician, dated 05/04/11. There was no indication how often this</p>	F 280	<p>monthly X4. Any concerns will be reported to the Administrator or DON immediately. Findings will be reviewed in the Executive QI Meeting quarterly.</p> <p>Resident #1 is no longer a resident of the facility.</p> <p>Resident's currently in the facility with pacemakers cardiology groups were contacted about the recommended timeframes for each resident's pacemaker check by 05/14/12 per the DON. The care plans of all residents with pacemakers were revised to include the cardiologist group, time check, recommendations, and the responsible discipline by 05/14/12 by the MDS Nurses. A tracking tool of all current residents with pacemakers will be reviewed by the DON or ADON each month to include the attending physician, cardiology group, when last pacemaker check was done, when next check will be due, and follow up of function. Any</p>	05/18/12	

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F 280	Continued From page 3 was to occur, who was responsible to ensure the process had been followed, who was the ordering physician or when the next reading would occur. An interview with Resident #1's Power of Attorney (POA), on 04/02/12 at 9:40 AM, revealed she requested the facility have the resident's pacemaker function checked, and she had not received a response about completion of this request. An interview with the Director of Nursing (DON), on 04/17/12 at 10:07 AM, revealed she interviewed the POA about the pacemaker, which was implanted in June 2010. She revealed she did not want to put the resident though another surgery if anything was to happen to the pacemaker, and the family stopped checking the pacemaker function "a long time ago." However, the POA changed her mind in February 2012 and decided to have the pacemaker function checked. The cardiologist's office was notified and stated they could not check it over the phone and they would have to come to the facility to evaluate the device. At this time, the DON was unable to determine if the device was ever tested. Further interview with the DON, on 04/19/12 at 12:20 PM, after she reviewed the paperwork and notified the cardiologist's office, revealed the technician was at the facility to check the device on 02/03/12. She stated there was no set plan about how often the pacemakers needed to be checked, as there were several residents with different types of pacemakers and several cardiologists involved with different orders regarding the checks. Resident #1 had not had the pacemaker checked, until 02/03/12, when the POA changed her mind. The care plan was not updated to	F 280	new admissions with pacemakers or current residents with new implants will be added to the listing for review. Attending physician and cardiology group will be notified of any concerns. A QI audit will be completed monthly by the QI Nurse reviewing the listing of residents with pacemakers, timeliness of pacemaker checks, and care plan reviews. Any concerns will be reported to the Administrator and DON. Findings will be reviewed at the Executive QI Meeting quarterly.	05/18/12	

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F 280	Continued From page 4 reflect this or to monitor the outcome of the test or when the next test was due.	F 280			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility identified ten residents with implanted pacemaker devices; however, the facility failed to have a system in place to monitor residents with implanted pacemaker devices, as well as the required testing for the optimum performance of these devices for one resident (#1), in the selected sample of three residents, and seven unsampled residents. On 04/16/12, the facility census was 90 residents. Findings include: A review of the pacemaker list provided by the facility revealed there were ten residents with pacemakers. A review of each resident's (#1, #2, #3, #4, #5, #6, #7, #8, #9, and #10) care plan, "Pacemaker- At risk for potential complications due to Pacemaker malfunction," revealed an intervention for "routine pacemaker checks, as ordered by the physician." There was no indication of how often the pacemaker checks	F 309	Resident #1 is no longer a resident of the facility. Orders were obtained from attending physicians to follow the recommendations of the cardiology groups on frequency of pacemaker checks for residents #2, #3, #4, #5, #6, #7, #8, #9 and #10 by 05/14/12 per the DON. The care plans for residents with pacemakers were revised to include the cardiology group, time check recommendations and the responsible discipline by 05/14/12 by MDS nurses. Licensed Nurses were in-serviced regarding importance of pacemaker checks, the frequency of pacemaker checks per recommendations of the cardiology groups, what cardiology group oversees each individual resident with a pacemaker, and follow-up of function of pacemaker with the test group by 05/14/12 per the DON and ADON. Any licensed nurses unable to attend will be retrained prior to returning to work.		

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F 309	<p>Continued From page 5</p> <p>were to occur, who was responsible to ensure the process was followed, who was the ordering physician, or when the next reading was suppose to occur. There were no manufacturer's recommendations about testing of the device, as well as no policy/procedure or tracking tools to ensure routine testing of the devices was completed, or how often they were to be tested and the results of the testing.</p> <p>A record review revealed the facility admitted Resident #1 on 04/27/11 with diagnoses to include Senile Dementia with Delirium, Angina Pectoris, a Pacemaker and Chronic Heart Failure. A review of the significant change Minimum Data Set (MDS) assessment, dated 03/12/12, revealed the facility identified Resident #1 as severely cognitively impaired.</p> <p>A review of the cardiologist's report, dated 06/10/10 and 02/02/12, revealed the facility contacted the cardiologist's office, on 02/02/12, for a pacemaker check on Resident #1's device. A review of the report revealed a technician went to the facility to check the pacemaker, on 02/03/12, and brought the report back to the office. A review of the "Wrap-up Overview," dated 02/03/12, revealed a copy of the report, left at the facility by the technician contained technical jargon and was unclear if the pacemaker functioned properly.</p> <p>A review of the list of the residents with pacemakers (#2 through #10) revealed these residents had recent pacemaker checks completed or were scheduled to have the testing completed.</p>	F 309	<p>A tracking tool of all current residents with pacemakers will be reviewed by the DON or ADON each month to include the attending physician, cardiology group, when last pacemaker check was done, when next check will be due, and follow-up of function of pacemaker with test group. Any new residents with pacemakers will be added to the tracking tool for review. Attending physician and cardiology group will be notified of any concerns.</p> <p>A QI audit will be completed by the QI Nurse to review the listing of resident with pacemakers, timeliness of pacemaker checks, care plan revisions, and follow-up of function of pacemaker after each check with cardiology group who completed the testing. Any concerns will be reported to the Administrator and DON. Findings will be reviewed at the Executive QI Meeting quarterly.</p>	05/18/12	

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F 309	<p>Continued From page 6</p> <p>Interviews with Residents #2 through #10, on 04/17/12 through 04/19/12, revealed that Residents #4, #5 and #10 denied having an implanted pacemaker and were marked on the facility's Roster/Matrix as cognitively impaired. Residents #2, #3, #6, #7 and #9 revealed they had the devices and had routine pacemaker checks completed with no concerns. Resident #8 stated he/she had the device implanted "four to five years ago," but was unable to recall if the routine checks were completed at the facility.</p> <p>An interview with the Director of Nursing (DON), on 04/17/12 at 10:07 AM, and on 04/19/12 at 12:20 PM and 4:00 PM, revealed there was no policy/procedure for the monitoring of pacemakers. However, the DON maintained a list of residents with pacemakers, the dates that the pacemakers were implanted and were last checked, the cardiologist who placed the device, and the next testing due date of the device. The DON stated the list was started when any resident was admitted with a pacemaker. The DON revealed Resident #1's pacemaker was not tested, as the family did not want to pursue testing until 02/02/12. The device was tested on 02/03/12, when a technician came to the facility, and left a copy of the test results, which the DON was unable to interpret. The DON did not notify the cardiologist to ensure the device was working properly. Additionally, she stated there was no set plan about how often the pacemakers needed to be checked, as there were several residents with different types of pacemakers and several cardiologists involved with different orders regarding the checks. Furthermore, the DON stated the results of the testing were sent to the cardiologist's office, and unless the cardiologist</p>	F 309			

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F 309	Continued From page 7 office contacted the facility, it was assumed the results were favorable. Resident #1's pacemaker was not checked, until 02/03/12, when the POA changed her mind about having the pacemaker checked. The care plan was not updated to reflect this information or to monitor the outcome of the test or when the next test was due. The facility did not notify the cardiologist's office to confirm the findings or to receive further orders. An interview with the Administrator, on 04/19/12 at 11:55 AM, revealed the facility did not have a policy/procedure to monitor the required pacemaker testing, and the facility completed the testing upon request of the resident's cardiologist. Any paperwork or contact to or from the resident's cardiologist was maintained by the DON.	F 309			