

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 22</p> <p>Interview with LPN #4, on 03/26/14 at 6:27 PM, revealed she was in Resident #15's room with RN #1 and LPN #1. She stated RN #1 asked her to remove a Fentanyl Patch from the resident because he/she had become lethargic. She stated she removed the patch from the right side of the chest and did not see any other patches on the resident.</p> <p>Interview with LPN #1, on 03/28/14 at 10:17 AM, revealed she was in Resident #15's room with RN #1 and LPN #4 and they stated the resident was unresponsive. RN #1 asked LPN #4 to remove a Fentanyl Patch. Additionally, she stated the resident was rolled several times in the process of getting him/her ready for discharge and she did not notice another patch on the resident.</p> <p>Review of the Hospital History and Physical from the Intensive Care Unit, dated 01/18/14, revealed the resident was admitted with a chief complaint of Acute Altered Mental Status and was responding only to painful stimuli. The resident was not verbally responsive at the time of admission. All of the resident's pain medication was discontinued and the response was monitored. Review of the Hospital Discharge Summary, dated 01/23/14, revealed Resident #15 was brought to the emergency room on 01/18/14 for confusion and was found to have a Fentanyl Patch and it was removed at the hospital. The resident was given Narcan and immediately started to arouse and was able to tell the nurse his/her name.</p> <p>Review of a hospital Laboratory Report, dated 01/18/14, revealed a urine drug screen was completed and the urine tested negative for Opiates. Interview with the Hospital Pharmacist</p>	F 333	<p>and removal, when unable to determine date of application and as ordered by physician.</p> <p>4. Notification of DON/ADON upon receipt of new fentanyl patch orders received.</p> <ul style="list-style-type: none"> <li>All licensed nurses received the above training beginning on 04/03/14 by DON/SDC/ADON or MDS nurse. Education included quiz with required score of 100% to validate competency. This education was complete on 100% of licensed staff prior to midnight 04/04/14.</li> <li>DON, Staff Development Coordinator (SDC) and MDS Nurse provided education to the Certified Nurse Aides to observe for patches during ADL care and notify nurse if more than one patch is identified as being present on a resident. Education was initiated 04/04/14 and completed prior to midnight for any staff on duty. Staff not receiving education prior to midnight 04/04/14 will receive prior to beginning their next scheduled shift.</li> <li>Beginning 04/04/14, licensed nurses are to notify the DON/ADON at the time of receiving a new order for fentanyl to ensure order is correct, documentation of site, and two (2)</li> </ul>		

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

PRINTED: 08/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42066	
(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 333	<p>Continued From page 23</p> <p>Manager, on 04/02/14 at 11:10 AM, revealed If a Fentanyl Patch was left in place and another applied the resident would not be at a full dose but would be receiving between fifty (50) and one hundred (100) mcg related to Fentanyl being a residual drug. Additionally, she stated a urine test for opiate detection could show negative results even if the resident had an excess amount of the drug in the system because Fentanyl was a synthetic drug and would not show up in a urine drug test.</p> <p>Interview with the Intensive Care Unit RN #7, on 04/02/14 at 11:22 AM, revealed he was the Admission Nurse on 01/19/14, when Resident #15 was admitted to the Intensive Care Unit from the Emergency Room. He stated his documentation revealed he was informed the resident had a Fentanyl Patch removed in the emergency room, but he could not specifically remember being told.</p> <p>Review of the facility's investigation, (no date), revealed on 01/18/14 (no time), Resident #15 had decreased level of consciousness and nursing staff removed a Fentanyl Patch, applied oxygen, and performed an accu-check (test blood sugar level). The resident was discharged to the Emergency Room on 01/18/14 (no time) and was admitted to the hospital on 01/19/14. The Discharge Summary from the Emergency Room to the Intensive Care Unit revealed Emergency Room staff removed a Fentanyl Patch and administered Narcan. In addition, review of interviews conducted by the facility's Administration, on 01/23/14, revealed RN #1 stated a verbal report received from the hospital nursing staff on 01/23/14 to LPN #1, prior to Resident #15 returning to the facility, revealed the</p>	F 333	<p>nurses monitoring application, removal and disposal.</p> <ul style="list-style-type: none"> <li>On 04/04/14, SDC provided education to all licensed nurses regarding notification of DON of any new order/admission with an order for fentanyl patch. Also included was additional education of ensuring that order is correct, documentation of site, two (2) nurses witnessing removal and destruction and one (1) licensed nurse is monitoring patch placement every shift.</li> <li>On 04/04/14, RDCS provided additional education to Certified Nursing Assistants (CNA) regarding documenting and reporting to the licensed nurse if two (2) patches of any kind are found on the resident.</li> <li>On 04/10/14, DON additional education provided to licensed nurses regarding transdermal patches. Content included transdermal patch application and two (2) nurses to apply and remove on MAR and to contact DON/ED immediately if patch is ordered and not present.</li> <li>On 04/15/14, RDCS additional education was provided to licensed nurses regarding what information is to be documented on MAR, and what Nurse #2 is validating on the MAR. Nurse #2 is validating</li> </ul>	

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

PRINTED: 08/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 24 resident had a Fentanyl Patch in place on admission to the hospital.</p> <p>Interview with the Director of Nursing (DON), on 03/28/14 at 3:00 PM, revealed nursing staff should perform a head to toe assessment on new admissions and when a resident was sent out to the hospital an assessment should be completed related to the issue of concern. The DON stated she would expect the nursing staff to know if a resident had a patch on and would expect them to document it in the Nurse's Notes, or on the MAR.</p> <p>Interview with the facility's Medical Director, on 03/28/14 at 3:15 PM, revealed he would have expected nursing staff to look at all of the resident's medications on admission and if the list included a Fentanyl Patch, he would have expected the nurse to assess the resident to see if the patch was administered in the hospital prior to coming to the nursing home. Additionally, he stated he could not say whether or not the dose of Fentanyl the resident had received was life threatening as he did not assess the resident.</p> <p>Interview with the facility's Executive Director, on 04/03/14 at 10:45 AM, revealed she did not initiate an investigation because she did not feel there was a medication error made even after she was aware of Resident #15 being admitted to the hospital Intensive Care Unit with a Fentanyl overdose. The Executive Director stated the facility received ten (10) Fentanyl patches from the pharmacy when the Resident #15 was admitted. She revealed one (1) patch was administered to the resident and one patch was removed from the resident prior to the resident going to the hospital. She stated there were nine</p>	F 333	<p>application, location, removal and disposal with Nurse #1.</p> <ul style="list-style-type: none"> <li>On 04/14/14, 04/15/14 and 04/16/14 the RDCS additional education provided to licensed nurses regarding therapeutic interchange; reading MARs; ensuring orders match MAR; transdermal patch orders, specifically MAR to order vs written order; medications administration; and the 5 rights of medication administration.</li> <li>On 04/17/14, RDCS completed additional education regarding transcribing order as soon as medication order received, new MARs each month must be compared to prior month MAR.</li> </ul> <p>4. <u>Monitoring to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> <li>On 4/03/14 the medical director and resident's attending physician were notified by the Executive Director of jeopardy and action plan. Both were in agreement with action plan.</li> <li>The PI committee met on 04/04/14 to review action plan, validate education completed, and update Medical Director on the additional documentation for new admission on the initial data collection tool and to validate monitoring is in place.</li> </ul>		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 25</p> <p>(9) patches left which meant the count was correct so she did not feel they had made a medication error.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 03/15/14, Resident #15 was discharged home with family and no longer resides at the center.</p> <p>The facility initiated an internal investigation at the time the resident was readmitted on 01/23/14 and was identified as having an accidental narcotic overdose. The DON, ADON, SDC, and Regional Director of Clinical Services (RDCS) conducted a medication pass audit which included administration, rotation, and patch presence on 02/01/14 and 02/06/14. No discrepancies were identified and the audits were on-going.</p> <p>On 04/07/14, the DON and RDCS completed a validation to ensure that all nine (9) residents with any type of transdermal patch had the location of the patch on the resident documented on the MAR and that all medications were being administered per physician's orders.</p> <p>On 01/24/14, two (2) additional residents were identified as receiving Fentanyl patches to treat pain. The DON verified the physician's orders for the patches, reviewed the MAR to assure the patches were being administered correctly, and documentation and verification the residents received the patches as ordered.</p> <p>Fentanyl patches were audited by the DON on 01/24/14 for all residents with orders to verify the patch count was accurately reflective of the narcotic count sheet.</p>	F 333	<ul style="list-style-type: none"> <li>The PI committee will continue to meet weekly for 30 days, then 2x monthly for 30 days, then monthly to review all audit findings and make revisions to the action plan as indicated.</li> <li>At least quarterly, the PI committee will review medication errors and actions taken.</li> <li>Beginning 04/04/14 for fentanyl patches and 4/07/14 for all other transdermal patches, the DON/ADON/SDC/Unit Manager or MDS nurse will validate that all patch orders are correct, administration and removal is recorded on the MAR and site applied location is documented on MAR. In addition, for new patient admissions, the validation will include observation and documentation of patches applied by the hospital on the initial data collection tool. This process will occur 7 days a week for 30 days, then will be completed 4 times a week for 30 days, then 1 x week for 4 months. Findings will be addressed in PI meetings as indicated.</li> <li>DON/ADON/SDC or Unit Manager to monitor next 5 admissions beginning 04/05/14 with fentanyl patch orders to ensure that the fentanyl patch order is recorded on</li> </ul>		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 26</p> <p>On 04/03/14, the RDCS and the DON reviewed the documentation of the residents with Fentanyl patches (two residents from 01/23-02/06/14, two (2) residents from 02/06-02/07/14, three (3) residents from 02/07/14-present). The Fentanyl patch orders and January to present MARs reflected the resident's patches were applied per physician's orders. The site for the patch was documented and monitoring was documented on the MAR throughout the month.</p> <p>Residents who had an order for a Fentanyl patch were seen by a physician in the center on 04/03/14 with no concerns with dosage or documentation noted.</p> <p>The Pharmacist conducted a review of all current Fentanyl patch orders and counts were correct on 02/04/14. She also reviewed the documentation of the location of the patch on the MARs and verified each shift placement check.</p> <p>On 01/31-02/02/14, all licensed nurses were provided education on medication administration including Fentanyl patches. This education was completed by the DON and the Staff Development Coordinator (SDC) and was provided for 100% of the licensed nurses before midnight on 02/02/14.</p> <p>On 04/03/14, the RDCS completed education for the Executive Director, DON, Assistant Director of Nursing (ADON), SDC, and the Minimum Data Set Coordinator (MDSC) which included:</p> <p>Transdermal patch administration/removal policy and procedure Required documentation of the Fentanyl patch</p>	F 333	<p>the MAR correctly, that the location is documented on the MAR and on the initial data collection tool and that the location of the fentanyl patch is verified on the resident where the MAR indicates. This process will occur 7 days a week for 30 days, then 4 times a week for 30 days, 1 x weekly for 4 months. Findings will be addressed in PI meetings as indicated.</p> <ul style="list-style-type: none"> <li>DON, ADON, SDC, MDS nurse, Unit manager or RDCS to monitor nurses during medication administration to validate the preparing and giving medication in the prescribed dose, route, frequency and removal of patches (when indicated) for five residents, 5 x weekly x 30 days beginning 04/18/14, then 3 x week x 30 days, then 1 x weekly for 4 months to ensure professional standards of care and that medications are given per MD order. Findings will be addressed in PI meetings as indicated.</li> </ul> <p>5. F333 Completion Date: 04/19/2014</p>		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056	
(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 333	<p>Continued From page 27</p> <p>removal and application, including anatomical location of patch to be on the MAR. Admission documentation in admission assessment/notes to include Fentanyl patches present and the location. Notification of DON or ADON upon receipt of new Fentanyl patch orders received.</p> <p>All licensed nurses received the above training beginning on 04/03/14. Education was completed by the DON, ADON, or MDS Nurse. Education included a quiz which required a score of 100% to validate competency. This education was completed with 100% of licensed staff on 04/04/14. Any licensed nurse who did not receive the above training would not be allowed to work until the training was completed.</p> <p>The DON, ADON, MDS Nurse, and SDC provided education to the Certified Nursing Assistants (CNAs) to include observing for transdermal patches during activity of daily living (ADL) care and to notify the Charge Nurse if more than one (1) patch was identified on the resident. Education was initiated on 04/04/14 and was completed prior to midnight to all staff on duty. Any staff who did not receive the training prior to midnight on 04/04/14 was to receive the training prior to beginning his/her next working shift.</p> <p>Nursing will notify the DON or ADON at the time of all new Fentanyl patch orders received.</p> <p>On 04/03/14, the DON and ADON completed audits of residents' records who were receiving a Fentanyl patch for documentation of placement on the MAR and verified the patch was located on the resident in accordance to the assessed, documented site. The DON, ADON, and RCDS</p>	F 333		

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

PRINTED: 08/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 8TH ST. LA CENTER, KY 42066		
(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 333	<p>Continued From page 28</p> <p>reviewed resident records who currently had Fentanyl patches to validate the physician's order matched the MAR.</p> <p>Beginning 04/04/14, the DON, ADON, SDC, Unit Manager, MDS Nurse and/or RDCS will validate the transdermal patches orders are correct, recorded on the MAR, location will be documented on the MAR, and verify the patch is located on the resident in accordance with the assessed, documented site. The process was to occur seven (7) days a week for thirty (30) days, then would be completed four (4) times a week for thirty (30) days. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>The DON, ADON, SDC, or Unit Manager will monitor the next five (5) admissions with a transdermal patch order beginning on 04/05/14, and again on 04/07/14 to ensure transdermal patch orders were recorded on the MAR correctly, the location was documented on the MAR and on the initial data collection tool. They will verify the patch was on the resident as the MAR indicated. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>All audit and monitoring outcomes would be presented to and reviewed by the Performance Improvement (PI) Committee for revision or plan recommendations. Audits would be completed seven (7) days a week, for the next thirty (30) days, then at a rate of four (4) times per week for</p>	F 333			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42058	
(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 333	<p>Continued From page 29</p> <p>thirty (30) days. The PI Committee would meet weekly over the next thirty (30) days, then bi-weekly for thirty (30) days to review results.</p> <p>PI meetings were held on 02/05, 02/06, 02/12, 02/19, 02/26, 03/05, 03/07, 03/09, and 03/19/14. Review of education provided in regard to medication administration as well as full review of completed medication administration audits were conducted at each PI meeting.</p> <p>On 04/03/14, the Medical Director and the resident's attending physician were notified of Immediate Jeopardy and the facility's action plan and both agreed with the action plan.</p> <p>The PI Committee met on 04/04/14 to review the action plan, validate education as completed, and to update the Medical Director on the additional documentation for new admissions on the initial data collection tool and to validate monitoring was in place.</p> <p>The PI Committee consists of the Executive Director, DON, ADON, SDC, MDS Nurse, Social Services, and Activity Director. The PI Committee was to meet weekly for thirty (30) days to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. The PI Committee was to meet two (2) times a month for thirty (30) days, then monthly to review all audit findings and make revisions as needed to the action plan based on audit findings.</p> <p>**The State Survey Agency validated the</p>	F 333		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 30 corrective action taken by the facility as follows:</p> <p>Record review revealed Resident #15 was discharged home with family on 03/15/14.</p> <p>Review of Medication Pass Audits, dated 02/01/14 and 02/06/14 revealed the DON, ADON, SDC, and RDCS conducted a medication pass audit and monitored the entire medication pass including the administration of medication patches to include ensuring the rotation of sites for the patches, patches were dated and timed, as well as documented on the MAR for placement and removal of the old patch. Random patch audits were ongoing and continued to be performed three (3) times a week.</p> <p>Review of the MAR audit list, dated 04/07/14, revealed the DON and RCDS completed observations of the nine (9) residents with any type of transdermal patch to ensure the patch was located at the same site as was documented on the MAR. In addition, they reviewed the physician's orders to ensure the staff was following the physician's order for the patch.</p> <p>Review of the Physician's Progress Notes, dated 04/03/14, for Resident #10 and Resident #3 revealed both residents were assessed and received Fentanyl patches with no adverse side effects noted.</p> <p>Review of a Medication Audit form, dated 04/04/14, revealed the pharmacists reviewed the MARs for Resident #3 and Resident #10 for correct documentation for placement, checks, application, removal, and disposal of Fentanyl patches with no concerns noted.</p>	F 333			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 31</p> <p>Review of the inservice log, dated 01/31/14-02/02/14, revealed 100% of licensed staff was inserviced and a post test was completed to verify competency of transdermal patch administration by the DON and SDC.</p> <p>Review of training, dated 04/03/14, revealed 100% of licensed staff to include RN #8 was inserviced on the procedure for Admssion/Readmission of residents utilizing Fentanyl patches by the DON, ADON, SDC, and MDS Coordinator. The training included transdermal patch administration and removal policy and procedure; the required documentation of patch removal and application, including location of the patch; the documentation on Admission Assessments and Notes should include if any patches present and the location of the patches; and Notification of the DON and/or ADON upon receipt of new patch orders. A competency exam was given to verify the understanding of the training. 100% of licensed staff was inserviced and new hires will receive the same training.</p> <p>Review of the CNA training log, dated 04/04/14, revealed a phone training was completed by the Regional Nurse Consultant on 04/04/14 which included to observe for patches during care and to utilize a "stop and watch" tool to report areas to the charge nurse.</p> <p>Interviews with RN #2, RN #4, RN #10, RN #11, LPN #1, LPN #5, LPN #6, LPN #7, LPN #8, and LPN #10, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were trained on the disposal process for transdermal patches, documentation of the site of the patch on the resident, physician notification if more than one</p>	F 333			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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 333	<p>Continued From page 32</p> <p>(1) patch was found on a resident, and the process of documenting patches on new admissions. Additionally, RN #2, RN #4, RN#10 and RN #11 were educated on the notification of the Director of Nursing and/or the Assistant Director of Nursing of new orders for Fentanyl patches, the admission process for transdermal patches documentation, placement checking of the patch and to complete a complete body audit if the patch was not where it was supposed to be and conduct an investigation, and the disposal process for the patches which includes two (2) licensed nursing staff to witness and destroy the patch by folding it and placing it in a Sharp's container.</p> <p>Interviews with CNA #1, CNA #2, CNA #3, and CNA #4, on 04/09/14 between 10:15 AM and 10:45 AM, revealed they were inserviced on reporting to the Charge Nurse if while performing care to a resident, two (2) patches were found to be present on the resident. They stated they would fill out a "Stop and Watch" form and turn it in to the Charge Nurse.</p> <p>Review of the Transdermal Patch Audits, on 04/08/14 and 04/09/14 revealed all new transdermal patch orders were reported to the DON and/or ADON. The DON and ADON completed audits of residents who were currently on a transdermal patch of any kind with the last audit completed on 04/08/14 and to continue every day for seven (7) days. The facility did not have any new admissions on transdermal patches at this time.</p> <p>On 04/03/14, the Medical Director was notified of the AoC and agreed with the plan with a verified signature. Review of the Quality Assurance</p>	F 333			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 282 W. 5TH ST. LA CENTER, KY 42056		
(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 333	Continued From page 33 meeting notes, dated 01/01/14, revealed the AoC was discussed via a phone call between the Medical Director and the Executive Director.  Review of the PI Committee meeting documentation, dated 01/01/14 through 03/19/14 revealed meetings were held weekly to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being.  Interviews conducted with the ADON, DON, and the Executive Director, on 04/09/14, revealed medication administration was discussed in the PI meetings as stated in the AoC and training was provided to licensed nursing staff as well as the CNAs related to identifying multiple patches on residents or a patch on a resident on initial admission to the facility.	F 333	In addition to the prior abatement submitted and accepted on 04/08/2014, the facility also submits the following plan of correction:  F 490 Effective Administration/Resident Well Being. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.		
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 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, review of the Executive Director's (ED) job description, and review of the facility's policy and procedure and Plan of Correction for the 02/11/14 Abbreviated Survey, it	F 490	1. <u>Resident(s) affected by alleged deficient practice:</u> • Resident was discharged home on 03/15/14 with family and no longer resides at the center.  2. <u>Residents with potential to be affected by alleged deficient practice:</u> • All new admissions, readmissions and other residents who have a new order for transdermal patches will be reviewed daily during morning meeting. This discussion will include but not be limited to: 1. Type of transdermal medication ordered, 2. Compliance to policy regarding the presence of transdermal patch documentation in clinical record and MAR, 3. Any other medication related concerns.		

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

PRINTED: 08/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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	<p>Continued From page 34</p> <p>was determined the facility failed to have an effective system to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one (1) of fifteen (15) sampled residents (Resident #15).</p> <p>During an Abbreviated Survey concluded on 02/11/14, Immediate Jeopardy was identified at 483.20 Resident Assessment F-281 Services Meet Professional Standards; and 483.25 Quality of Care, F-333 Free of Significant Medication Error. The facility submitted a Plan of Correction for the 02/11/14 survey; however, additional investigation during the Standard Recertification, Revisit and Abbreviated Survey concluded on 04/09/14 revealed the residents continued to be at risk for significant medication errors. Immediate Jeopardy was identified at 482.20 Resident Assessment, F-281; 485.25 Quality of Care, F-333 Free of Significant Medication Error; and, 483.75 Administration, F-490 Administration and F-520 Quality Assessment and Assurance.</p> <p>The facility failed to have an effective system in place to monitor the placement and removal of medication transdermal patches and failed to identify if transdermal patches were in place on admission to ensure the medication was administered at the right dose for one (1) of fifteen (15) sampled residents (Resident #16). In addition, the facility failed to ensure education provided to licensed staff was effective. Per the facility's Plan of Correction, for the survey dated 02/11/14, all licensed nurses received education on two (2) occasions on the five (5) rights (right resident, right time, right medication, right dose, and right route) of medication administration.</p>	F 490	<p>4. Actions taken to resolve/correct.</p> <ul style="list-style-type: none"> <li>Beginning 4/03/14 times 8 weeks, the Executive Director to notify RDCS and RVP of any non-compliance to transdermal patch policies, medication errors, and corrective actions taken, at the time of finding.</li> </ul> <p>3. <u>Systems to ensure alleged deficient practice does not recur:</u></p> <ul style="list-style-type: none"> <li>On 4/08/14, the Executive Director was provided additional education by the RVP, regarding job description, prompt notification to the RVP/RDCS of issues and medication errors, and how to review the entire plan of correction and monitor.</li> <li>Beginning week of 04/12/14, Executive Director to meet with DON weekly to validate all plan of correction education and audits are completed as indicated, medication errors are identified and action taken if indicated.</li> <li>RVP/RDCS and Executive Director to discuss clinical and plan of correction oversight weekly x 8 weeks, beginning week of 04/12/14, then as PI committee recommends.</li> </ul> <p>4. <u>Monitoring to ensure alleged deficient practice does not recur:</u></p>	

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42050	
(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	<p>Continued From page 35</p> <p>However, a licensed nurse failed to remove a Fentanyl patch prior to the application of a new patch to ensure the resident received the right dose of medication for one (1) of fifteen (15) sampled residents (Resident #15).</p> <p>On 01/14/14, Resident #15 was readmitted to the facility with a Fentanyl patch in place and a physician's order for a fifty (50) microgram (mcg) Fentanyl Patch (opiate pain medication) every seventy-two (72) hours. On 01/17/14, the facility applied a Fentanyl patch; however, there was no documented evidence the facility removed the old patch prior to applying the new one. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli. A Fentanyl Patch was removed and the resident was sent to the Emergency Room. Review of hospital documentation revealed a Fentanyl Patch was removed in the Emergency Room also. The resident was administered a dose of Narcan (Opiate drug reversal drug) 0.4 milligrams (mg) via IV piggyback and the resident woke up and stated his/her name to the Emergency Room Nurse. Resident #15 was admitted to the Intensive Care Unit (ICU), on 01/19/14 at 12:03 AM, with a primary diagnosis of Encephalopathy secondary to a Fentanyl Patch and a secondary diagnosis of Accidental Narcotic Overdose.</p> <p>The facility's failure to have an effective system to ensure it was administered in a manner that enabled it to use its resources effectively and efficiently has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/03/14 and was determined to exist on 01/17/14. The facility was notified of the Immediate Jeopardy on 04/03/14.</p>	F 490	<ul style="list-style-type: none"> <li>On 4/03/14 the medical director and resident's attending physician were notified by the Executive Director of jeopardy and action plan. Both were in agreement with action plan.</li> <li>The PI committee met on 04/04/14 to review action plan, validate education completed, and update Medical Director on the additional documentation for new admission on the initial data collection tool and to validate monitoring is in place.</li> <li>The PI committee will continue to meet weekly for 30 days, then 2x monthly for 30 days, then monthly to review all audit findings and make revisions to the action plan as indicated.</li> <li>At least quarterly, the PI committee will review medication errors and actions taken.</li> <li>RDCS/RVP to attend all PI committee meetings either in person or by phone, to identify quality issues which includes medication errors, trends and assist in plan of correction implementation and development of action plans to correct any issue identified. Beginning week of 04/03/14 x 8 weeks, and on-going until PI committee and RVP recommend change in frequency.</li> <li>Executive Director to meet with clinical team 5 x week, x 8 weeks</li> </ul>	

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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	<p>Continued From page 36</p> <p>An acceptable Allegation of Compliance was received on 04/08/14, alleging the removal of the Immediate Jeopardy on 04/08/14. The State Survey Agency validated, on 04/09/14, the Immediate Jeopardy was removed on 04/08/14, as alleged. The Scope and Severity was lowered to a "D" at 42 CFR 483.20 Resident Assessment F-281; 42 CFR 483.25 Quality of Care F-333; and, 42 CFR 483.75 Administration, F-490 and F-520 while the facility develops and implements the Plan of Correction (POC) and the facility's Quality Assurance (QA) monitors the effectiveness of the systemic changes.</p> <p>The findings include:</p> <p>Review of the Executive Director's (ED) job description, revised 04/18/13, revealed the Position Summary as follows: "The ED provides leadership and direction for overall facility operations to provide quality resident care in accordance with all laws and regulations." Further review of the Essential Functions revealed "Must ensure the residents receive high quality care."</p> <p>Review of the Administrative General Policies, (no date), revealed "The ED will be responsible for implementing facility policies and formulating departmental policies with advice and counsel from the consultants, medical staff, and departmental staff. The ED will administer and conduct all aspects of the policies and programs within the framework provided."</p> <p>Review of the facility's Plan of Correction (POC), for the survey dated 02/11/14, revealed all licensed staff was educated on the five (5) rights</p>	F 490	<p>beginning week of 04/03/14 to ensure all clinical issues addressed and plan of correction followed. This audit will continue at least 3 x weekly x 3 months, then as recommended by PI Committee.</p> <p>5. Completion Date: 04/19/2014</p>		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 5TH ST. LA CENTER, KY 42056		
(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	<p>Continued From page 37</p> <p>of medication administration and a post competency test related to medication administration was given on two (2) occasions. The five (5) rights of medication administration are: 1.) Right Resident, 2.) Right Drug, 3.) Right Dose, 4.) Right Time and, 5.) Right Route. However, the facility failed to have an effective system in place to monitor the placement and removal of medication transdermal patches and identify if transdermal patches were in place on admission to ensure the medication was administered at the right dose.</p> <p>Interview and record review revealed Resident #15 was readmitted to the facility, on 01/14/14, with a Fentanyl patch in place. On 01/17/14, the facility applied a Fentanyl patch; however, there was no documented evidence the facility removed the old patch prior to applying the new one. On 01/18/14, Resident #15 was found staring blankly and with minimal response to verbal stimuli and was diagnosed with Accidental Narcotic Overdose.</p> <p>Interview with the Facility's ED, on 04/03/14 at 10:45 AM, revealed she did not initiate an investigation into the incident with Resident #15 because she did not feel there was a medication error made even after she was made aware of hospital documentation that Resident #15 was admitted to the hospital Intensive Care Unit with a Fentanyl overdose and had a Fentanyl patch on upon arrival at the hospital. The Executive Director stated the facility received ten (10) Fentanyl patches from the pharmacy when Resident #1 was admitted. She revealed one (1) patch was administered and one patch was removed prior to the resident going to the</p>	F 490			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LA CENTER, KY 42056		
(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	<p>Continued From page 38</p> <p>hospital. She stated there were nine (9) patches left which meant the count was correct so she did not feel they had made a medication error. However, review of the Hospital Discharge Documentation revealed Resident #15 had a Fentanyl patch applied at the hospital prior to being admitted to the facility. Additionally, she stated, the Medication Administration policy revealed two (2) staff was to monitor the removal and destruction of any used Fentanyl patches. However, on 01/17/14, there was no documented evidence the staff witnessed the removal and destruction of Resident #15's Fentanyl patch that the resident received at the hospital.</p> <p>Further interview with the ED, on 05/09/14 at 2:00 PM, revealed audits were conducted related to medication administration and the five (5) rights of medication administration, and continue to be ongoing monthly. She stated there was no failure identified related to the facility's policy, which would have led to a second significant medication administration error, nor was there a failure related to the training provided after the first significant medication error. Therefore, she did not feel there was a second significant medication error made.</p> <p>Further interview with the ED revealed 100% of all staff was inserviced related to the five rights of medication administration. The ED reiterated, based on the facility's policy on medication administration, there were no failures identified related to the Admitting Nurse's assessment of Resident #15 on 01/14/14.</p> <p>A Post Survey interview with the Director of Nursing (DON), on 05/20/14 at 1:45 PM, revealed</p>	F 490			

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

PRINTED: 08/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056	
(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	<p>Continued From page 39</p> <p>the licensed staff should remove the old transdermal patch prior to applying a new patch to ensure the right dose of medication was administered per physician's order.</p> <p><b>**The facility implemented the following actions to remove the Immediate Jeopardy:</b></p> <p>On 03/15/14, Resident #15 was discharged home with family and no longer resides at the center.</p> <p>The facility initiated an internal investigation at the time the resident was readmitted on 01/23/14 and was identified as having an accidental narcotic overdose. The DON, ADON, SDC, and Regional Director of Clinical Services (RDCS) conducted a medication pass audit which included administration, rotation, and patch presence on 02/01/14 and 02/06/14. No discrepancies were identified and the audits were on-going.</p> <p>On 04/07/14, the DON and RDCS completed a validation to ensure that all nine (9) residents with any type of transdermal patch had the location of the patch on the resident documented on the MAR and that all medications were being administered per physician's orders.</p> <p>On 01/24/14, two (2) additional residents were identified as receiving Fentanyl patches to treat pain. The DON verified the physician's orders for the patches, reviewed the MAR to assure the patches were being administered correctly, and documentation and verification the residents received the patches as ordered.</p> <p>Fentanyl patches were audited by the DON on 01/24/14 for all residents with orders to verify the patch count was accurately reflective of the</p>	F 490		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 252 W. 6TH ST. LACENTER, KY 42066		
(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	<p>Continued From page 40 narcotic count sheet.</p> <p>On 04/03/14, the RDCS and the DON reviewed the documentation of the residents with Fentanyl patches (two residents from 01/23-02/06/14, two (2) residents from 02/06-02/07/14, three (3) residents from 02/07/14-present). The Fentanyl patch orders and January to present MARs reflected the resident's patches were applied per physician's orders. The site for the patch was documented and monitoring was documented on the MAR throughout the month.</p> <p>Residents who had an order for a Fentanyl patch were seen by a physician in the center on 04/03/14 with no concerns with dosage or documentation noted.</p> <p>The Pharmacist conducted a review of all current Fentanyl patch orders and counts were correct on 02/04/14. She also reviewed the documentation of the location of the patch on the MARs and verified each shift placement check.</p> <p>On 01/31-02/02/14, all licensed nurses were provided education on medication administration including Fentanyl patches. This education was completed by the DON and the Staff Development Coordinator (SDC) and was provided for 100% of the licensed nurses before midnight on 02/02/14.</p> <p>On 04/03/14, the RDCS completed education for the Executive Director, DON, Assistant Director of Nursing (ADON), SDC, and the Minimum Data Set Coordinator (MDSC) which included:</p> <p>Transdermal patch administration/removal policy and procedure</p>	F 490			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42056		
(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	<p>Continued From page 41</p> <p>Required documentation of the Fentanyl patch removal and application, including anatomical location of patch to be on the MAR. Admission documentation in admission assessment/notes to include Fentanyl patches present and the location. Notification of DON or ADON upon receipt of new Fentanyl patch orders received. All licensed nurses received the above training beginning on 04/03/14. Education was completed by the DON, ADON, or MDS Nurse. Education included a quiz which required a score of 100% to validate competency. This education was completed with 100% of licensed staff on 04/04/14. Any licensed nurse who did not receive the above training would not be allowed to work until the training was completed.</p> <p>The DON, ADON, MDS Nurse, and SDC provided education to the Certified Nursing Assistants (CNAs) to include observing for transdermal patches during activity of daily living (ADL) care and to notify the Charge Nurse if more than one (1) patch was identified on the resident. Education was initiated on 04/04/14 and was completed prior to midnight to all staff on duty. Any staff who did not receive the training prior to midnight on 04/04/14 was to receive the training prior to beginning his/her next working shift.</p> <p>Nursing will notify the DON or ADON at the time of all new Fentanyl patch orders received.</p> <p>On 04/03/14, the DON and ADON completed audits of residents' records who were receiving a Fentanyl patch for documentation of placement on the MAR and verified the patch was located on the resident in accordance to the assessed, documented site. The DON, ADON, and RCDS</p>	F 490			

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2014	
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 6TH ST. LA CENTER, KY 42058		
(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	<p>Continued From page 42</p> <p>reviewed resident records who currently had Fentanyl patches to validate the physician's order matched the MAR.</p> <p>Beginning 04/04/14, the DON, ADON, SDC, Unit Manager, MDS Nurse and/or RDCS will validate the transdermal patches orders are correct, recorded on the MAR, location will be documented on the MAR, and verify the patch is located on the resident in accordance with the assessed, documented site. The process was to occur seven (7) days a week for thirty (30) days, then would be completed four (4) times a week for thirty (30) days. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>The DON, ADON, SDC, or Unit Manager will monitor the next five (5) admissions with a transdermal patch order beginning on 04/05/14, and again on 04/07/14 to ensure transdermal patch orders were recorded on the MAR correctly, the location was documented on the MAR and on the Initial data collection tool. They will verify the patch was on the resident as the MAR indicated. If a discrepancy was identified, the nurses involved would not be allowed to administer medications until they were retrained and deemed to be competent in medication administration.</p> <p>All audit and monitoring outcomes would be presented to and reviewed by the Performance Improvement (PI) Committee for revision or plan recommendations. Audits would be completed seven (7) days a week, for the next thirty (30) days, then at a rate of four (4) times per week for</p>	F 490		

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

PRINTED: 06/02/2014  
FORM APPROVED  
OMB NO. 0938-0301

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185320	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/09/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF LACENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 262 W. 5TH ST. LA CENTER, KY 42056		
(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	<p>Continued From page 43</p> <p>thirty (30) days. The PI Committee would meet weekly over the next thirty (30) days, then bi-weekly for thirty (30) days to review results.</p> <p>PI meetings were held on 02/05, 02/06, 02/12, 02/19, 02/26, 03/05, 03/07, 03/09, and 03/19/14. Review of education provided in regard to medication administration as well as full review of completed medication administration audits were conducted at each PI meeting.</p> <p>On 04/03/14, the Medical Director and the resident's attending physician were notified of Immediate Jeopardy and the facility's action plan and both agreed with the action plan.</p> <p>The PI Committee met on 04/04/14 to review the action plan, validate education as completed, and to update the Medical Director on the additional documentation for new admissions on the initial data collection tool and to validate monitoring was in place.</p> <p>The PI Committee consists of the Executive Director, DON, ADON, SDC, MDS Nurse, Social Services, and Activity Director. The PI Committee was to meet weekly for thirty (30) days to review all audits, new admissions with transdermal patches, and revise the care plans to ensure resident's individual needs were met and residents were receiving care to meet the highest practicable well being. The PI Committee was to meet two (2) times a month for thirty (30) days, then monthly to review all audit findings and make revisions as needed to the action plan based on audit findings.</p> <p><b>**The State Survey Agency validated the</b></p>	F 490			