

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

PRINTED: 02/17/2011
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 01/28/2011
--	--	--	--

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 000	INITIAL COMMENTS AMENDED A recertification survey was conducted, on 01/25/11 through 01/28/11, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "E". Additionally, an abbreviated surveys KY #14864, KY #14786, and KY #15100 were conducted. KY #14864 was found unsubstantiated. KY #14786 was found unsubstantiated. KY #15100 was found substantiated with deficiencies cited.	F 000	"The preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of Federal and State Laws."	
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to implement written policies and procedures that prohibit mistreatment, neglect and abuse for one resident (#15), in the selected sample of 15. On 06/09/10, Registered Nurse (RN) #1 overheard Certified Nursing Assistant (CNA) #1 yell at Resident #15 and reported the incident to Licensed Practical Nurse (LPN) #1; however, CNA #1 continued to provide direct care, after the report. Findings include: Resident #15 was admitted to the facility with	F 226	F 226 The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of residents and misappropriation of resident property. 1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> Resident #15 no longer resides at the facility. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> Facility incident reports for the past 3 months, were reviewed to determine any incidents of unknown origin that had not been investigated. None were found. Resident and staff interviews were completed by the ED, to determine any unreported allegations of abuse. Resident Council minutes for the past 3 months were reviewed for any reports of abuse or neglect. None were found. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Dinger Atkins* TITLE *Executive Director* (X6) DATE *03-15-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

PRINTED: 02/17/2011
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 01/28/2011
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 226	<p>Continued From page 1</p> <p>diagnoses to include Senile Dementia, Anxiety, Depressive Disorder, Congestive Heart Failure, and personal history of a fall. Closed record review revealed Resident #15 was transferred to an acute care hospital, on 08/10/10, after the facility assessed and identified the resident had low oxygen saturation and the resident expired at the hospital, on 08/19/10.</p> <p>A review of the facility policy entitled, "Protection of Residents: Reducing the Threat of Abuse and Neglect" dated 02/09, revealed all alleged or suspected violations involving mistreatment, abuse, neglect, injuries of unknown origin would be promptly reported to the Administrator and/or Director of Nursing (DON). The charge nurse would complete and sign the Incident Report and notify the physician and resident's responsible party of the occurrence. The incident would be reported immediately to the Administrator or his designated representative and the DON. The charge nurse would immediately assess the resident and offer medical attention, if necessary. Findings of the assessment and any treatment provided would be documented in the resident's medical record. When an incident of resident abuse was suspected, the incident must be reported to the supervisor regardless of the time lapse, since the incident occurred. The supervisor notified the DON and the Executive Director of the alleged incident. The investigation shall include an interview with the resident if appropriate, interviews with staff members on all shifts having contact with the resident at the time of the incident, interviews with the resident's roommate, family and/or visitors who may have information regarding the incident, and an interview with other residents who received care or services from the alleged perpetrator.</p>	F 226	<p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • Staff members involved in deficient practice of 06/08/10, received re-education from the Executive Director upon notification of the allegation and initiation of an investigation. • Executive Director provided education to Department Directors February 18, 2011 on facility policy related to reporting and investigating allegations of abuse. • Executive Director provided the following education: February 22, 2011- staff inservice on facility policy and procedures related to reporting and investigation of allegations of abuse and neglect. Education to include providing safety for residents, documenting any incidents, and initiating investigations. • Upon any reports of allegation of abuse or neglect, ED or designee will immediately initiate safety measures for any resident involved as well as an investigation. • Executive Director provided education on abuse and neglect prevention and reporting to Resident Council on March 2, 2011. Education will be completed monthly by ED or designee. • All noted education will be completed at General Orientation, quarterly, and as needed. 		

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

PRINTED: 02/17/2011
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 01/28/2011
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 226	Continued From page 2 A review of the facility investigation revealed the Administrator initiated an investigation, on 06/09/10, regarding the allegation of verbal abuse of Resident #15, perpetrated by CNA #1. The Administrator notified the appropriate agencies on 06/09/10; however, further review of the investigation revealed no interview was conducted with the resident, other staff members who worked with CNA #1 or the resident residing in the room with Resident #15. An interview with RN #3, on 01/26/11 at 11:21 AM, revealed she was Resident #15's daughter and Power of Attorney (POA). RN #1 stated she worked the midnight shift, the night of the alleged verbal abuse occurred. She stated she received a report from LPN #1 which indicated two nurses had witnessed an incident of verbal abuse directed at Resident #15. She stated she monitored the resident for any unusual behavior throughout the night and the Administrator initiated an investigation of the incident the following day. She stated, "I actually did not realize at the time, but when CNA #1 was not working anymore, (Resident #15) was much more relaxed and willing to do activities". An interview with RN #1, on 01/27/11 at 9:13 AM, revealed she overheard CNA #1 hollering at Resident #15, as she was walked down the hall. She stated that CNA #1 was "hateful" towards the resident. She heard CNA #1 state, "Do you wanna fall again or sit your ass in the floor!". The resident began crying, saying "No". RN #1 reported she went to the nurse's desk and reported the incident to LPN #1, who was the charge nurse. LPN #1 went to the resident's room and stood outside, listening to CNA #1. RN	F 226	4. Monitoring to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> 24 hour report sheet will be reviewed daily by Administrative team, Monday-Friday. Executive Director or designee will be responsible to ensure procedures are implemented and investigations are completed and documented for any potential allegations of abuse. Resident Council minutes will be reviewed monthly by the Executive Director for any allegations of abuse or neglect that may not have been reported. Results of all investigations will be reported to Regional Vice President or Regional Director of Clinical Services to ensure policy and procedure was followed and a thorough investigation has been completed. 	03-14-11	

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

PRINTED: 02/17/2011
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 01/28/2011
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 226	<p>Continued From page 3</p> <p>#1 stated she left the facility, after reporting the incident to LPN #1, as she had completed her assigned shift. As she drove, she felt she had not responded appropriately to the situation and she called the Director of Nursing (DON) and left a voice mail. RN #1 stated whenever she received an allegation of abuse, she was expected to remove the person from the resident's room. She was expected to ensure the residents were safe and report to her supervisor, immediately. RN #1 stated she did not report the allegation immediately and looking back, she should have entered the resident's room, removed CNA #1 at that time and should have sent the CNA home. Afterwards, she should have completed an incident report and made the DON aware.</p> <p>An interview, with CNA #1, on 01/27/11 at 9:30 AM, revealed she assisted Resident #15 to the bathroom and the resident started to sit down on the commode before she was positioned close enough. She stated she raised her voice, because she was trying to hold the resident up. CNA #1 stated she told the resident, "Come on let's do it" and the resident stated, "No I can't". She stated she told the resident, "(He/She) had done this before and we're not going to have a pity party". The CNA stated the next thing she knew, LPN #1 came down to the room and "hollered" at her, and left the room, without assisting her with the resident. CNA #1 stated she assisted the resident back to bed his/her bed, assisted two other residents and took a break around 8:30 PM. LPN #1 did not say anything to her upon her return from the break. CNA #1 revealed she completed her last bed check, pulled trash, completed her paperwork, reported to the on-coming shift, and clocked out around</p>	F 226			

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

PRINTED: 02/17/2011
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 01/28/2011
--	--	--	--

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 226	<p>Continued From page 4</p> <p>10:30 PM. The next day (06/09/10), when she arrived to the work, the Administrator called her into her office and asked if there was any trouble the previous night and she explained about Resident #15. She stated the Administrator asked her if she had cursed at the resident and she stated, "No". The Administrator asked if she had stated, "Pity party" and she informed her she had stated those words in the interaction with Resident #15. CNA #1 stated she was informed she was placed on a three day suspension, related to an allegation of verbal abuse and the week later, she was terminated.</p> <p>An interview, with LPN #1, on 01/27/11 at 2:16 PM, revealed she was the charge nurse on duty on 06/08/10. She and another nurse had reported CNA #1 had yelled at Resident #15. LPN #1 went to the resident's room and heard CNA #1 yell at the resident. She knocked on the door, entered the room and asked if CNA #1 needed help. She stated CNA #1 stated, "I'm trying to keep him/her from sitting his/her ass in the floor". LPN #1 informed CNA #1 she did not need to talk to the resident in that manner. After exiting the room, LPN #1 stated she stood outside and listened to CNA #1 and then stated she was calling the Administrator. LPN #1 wrote the DON a letter and placed it underneath her office door. She did not send CNA #1 home that night, after she received the report of verbal abuse, because she was unsure she could rely on her judgement to make that decision. The following day, the Administrator called her to the office regarding the incident and informed her she should have sent the employee home immediately. LPN #1 stated with an allegation of abuse, they were expected to send the person home, do an assessment of the resident, complete an incident report, document</p>	F 226		
-------	---	-------	--	--

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

PRINTED: 02/17/2011
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 01/28/2011
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 226	Continued From page 5 in the nurse's notes, and contact the Administrator and DON. She revealed she did not remove the employee, document in the nurse's notes or contact the Administrator. An interview, with the DON, on 01/26/11 at 2:57 PM and 01/27/11 at 10:34 AM, revealed she was not on duty at the time of the incident and the Administrator completed the investigation. She did not recall who contacted her, however, she received two phone calls regarding the incident. The DON informed the staff to follow-up with the Administrator and ensure the resident was not harmed. She called or sent a text message to the Administrator regarding the incident. Additionally, she expected the staff to make sure the person alleged to have committed the abuse, to be sent home and an investigation initiated. An interview, with the Administrator, on 01/27/11 at 2:51 PM, revealed she became aware of the allegation of abuse, on 06/09/10. She did not receive any calls or text messages from any staff on 06/08/10. The Administrator stated she did not interview any other staff, because she had two witnesses to the incident and there were no other staff members to interview and she did not interview any other residents on the unit.	F 226	F 281 The services provided or arranged by the facility must meet professional standards of quality. 1. Resident(s) affected by alleged deficient practice <ul style="list-style-type: none"> Resident #12 was assessed by nursing administration to have no adverse reactions from the family member administration of her medications. Nursing administration provided LPN #1 education on the proper process of medication administration on 01/25/2011. 2. Residents with potential to be affected by alleged deficient practice: <ul style="list-style-type: none"> Nursing administration will notify family members/ responsible parties in writing of facility policy on medication administration. 3. Systems to ensure alleged deficient practice does not recur: <ul style="list-style-type: none"> Nursing Administration provided education to nurses on the proper procedure of medication administration. Education was completed on February 22, 2011. Medication administration policy will be taught to all new nurses during general orientation. 		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 281			

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

PRINTED: 02/17/2011
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 01/28/2011
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 281	<p>Continued From page 6</p> <p>ensure services were provided or arranged to meet professional standards of quality for one resident (#12), in the selected sample of 15. On 01/25/11 at 5:18 PM, Licensed Practical Nurse (LPN) #1 provided medication to Resident #12's family member and allowed the family member to administer the medication. LPN #1 continued the medication pass and failed to ensure administration of the medication, per physician's order.</p> <p>Findings include:</p> <p>Resident #12 was admitted to the facility with diagnoses to include Hypertension, Atrial Fibrillation, Senile Dementia, and Hypothyroidism.</p> <p>A review of the policy entitled, "Medication Administration" dated 10/04 revealed, "All medication is administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis. Only licensed personnel administer medications. Remain with the resident to ensure that medication is swallowed".</p> <p>Observation, on 01/25/11 at 5:15 PM, revealed Resident #12's family member approached LPN #1, at the medication cart, and requested the resident's medication. LPN #1 was observed to place Keflex (antibiotic) 500 milligrams (mg) tablet and Tylenol PM (pain medication/sleep aide) tablet into a paper souffle cup and hand the medication to Resident #12's family member. She also gave the family member a bottle of Dorzolamide 2% (anti-glaucoma medication) eye drop and Travatan Z .004% (lowers the intraocular pressure related to glaucoma) eye drop. Observation revealed Resident #12's family member entered the resident's room and</p>	F 281	<p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • DON or designee will audit 3 nurses a week for medication administration technique x 4 weeks. • Nursing Administration will provide on-going education as indicated for non-compliance. • Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	03-14-11

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

PRINTED: 02/17/2011
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 01/28/2011
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 281	<p>Continued From page 7</p> <p>administered the Keflex tablet to the resident and placed the Dorzolamide 2% eye drop in each eye, at 5:18 PM. The family member placed the two bottles of eye drops on the bedside table along with the Tylenol PM tablet in the souffle cup. She stated she would give the Tylenol PM to the resident after he/she had supper. LPN #1 continued her medication pass and did not observe the resident taking his/her medications.</p> <p>A review of the physician's orders, dated January 2011, revealed Travatan Z .004% eye drop at bedtime (7 PM), Dorzolamide HCL 2% eye drops instill one drop in each eye two times a day (9 AM and 4 PM), Pain Reliever PM caplet give one tablet at bedtime (7 PM), and on 01/22/11 the resident was prescribed Keflex 500 mg one tab by mouth three times a day (8 AM, 1 PM, & 5 PM).</p> <p>An interview, with LPN #1, on 01/27/11 at 2:16 PM, revealed she gave the medication to Resident #12's family member for administration. She did not see the resident take his/her medication (Keflex and Dorzolamide eye drops) when the family member gave them to the resident. She stated, "I realized I messed up by giving the medication to his/her (family) and allowing her to give them to the resident. I went and told the Director of Nursing and she completed a self-administration form. LPN #1 stated she did not ensure the resident took his/her medication and now realized she did not comply with the facility policy regarding the licensed staff administering the medication.</p> <p>An interview, with the DON, on 01/28/11 at 10:30 AM, revealed LPN #1 came to her regarding the medicine given to the family member to</p>	F 281		

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

PRINTED: 02/17/2011
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 01/28/2011
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 281	Continued From page 8 administer to Resident #12. She stated Resident #12 was confused and could not administer his/her own medication. She stated the nurse was responsible for making sure the resident took his/her medication.	F 281	<p>F 329 Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>1. Resident(s) affected by alleged deficient practice:</p> <ul style="list-style-type: none"> • Nursing Administration provided education to nursing staff on 01/28/2011 for administration of PRN pain medication. Education content included assessment of pain utilizing the pain flow sheet as well as documentation of results of PRN medications. • Nursing Administration provided education to nursing staff on 02/15/2011 for administration of PRN medications. Education content included non-pharmaceutical approaches attempted prior to administration of PRN medication, documentation of administration of PRN medications, documentation of results of PRN medications, notification of physician for PRN medications being given routinely, and avoidance of multiple PRN medications given simultaneously, including the need to assess for 	
F 329 SS=D	<p>483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, it was determined the facility failed to ensure the drug regimen for one Resident (#8), in</p>	F 329		

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

PRINTED: 02/17/2011
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 01/28/2011
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 329	<p>Continued From page 9</p> <p>the selected sample of 15, remained free of unnecessary drugs.</p> <p>The facility administered a scheduled Fentanyl 25 micrograms (mcg) transdermal patch every 72 hours to Resident #8. Resident #8 had an order for Norco 10/325 milligrams (mg), one or two tablets as dependent on pain severity, every six hours as needed. Resident #8 had an order for Ativan (anti-anxiety) 1 mg by mouth every six hours, as needed for restlessness. The drugs were administered simultaneously, without an assessment to determine the need for the medication and an evaluation of the potential adverse effects related to the combined use of the drugs.</p> <p>Findings include:</p> <p>Record review revealed Resident #8 was admitted to the facility, on 12/07/2010, with diagnoses which included Urinary Tract Infection, a history of Falls, Hypertension, Convulsions and Dementia.</p> <p>Observations on 01/25/11 at 5:15 PM, on 01/26/11 at 8:55 AM, on 01/27/11 at 9:30 AM, at 11:02 AM and at 12:20 PM and on 01/28/11 at 9:30 AM, revealed Resident #8 was in the wheelchair or the broda chair sleeping.</p> <p>Observations on 01/25/11 at 3:50 PM and at 5:15 PM, on 01/26/11 at 4:23 PM and on 01/28/11 at 9:30 AM, revealed Resident #8 was lethargic and not easily aroused.</p> <p>Observations on 01/26/11 at 8:55 AM, and on 01/27/11 at 12:20 PM, revealed Resident #8 was in the broda chair sleeping and did not respond to verbal stimulus.</p>	F 329	<p>appropriateness. In addition, licensed nurses received education in regard to behavior flow sheets for scheduled and PRN psychotropic medications, which addresses alternative measures prior to medicating, possible side effects, and appropriate indications for use of the medication.</p> <ul style="list-style-type: none"> Resident #8 had medications reviewed by her attending physician on 02/01/2011, no new orders noted. A medication regimen review for Resident #8 was conducted by the Consultant Pharmacist on 02/22/11, with recommendations made to the physician for reduction of Ativan 1mg every 6 hours as needed, to 0.5 mg every 6 hours as needed. Physician orders were received to reduce Ativan to 0.5 mg every 6 hours as needed anxiety and/or restlessness. <p>2. Residents with potential to be affected by alleged deficient practice:</p> <ul style="list-style-type: none"> On 02/22/11, Consultant Pharmacist completed drug regimen reviews of all 62 in-house residents for unnecessary drugs. 15 recommendations were made: 9 drugs to be discontinued for non-use; 6 drugs for dose reduction. Out of these 15, 11 were complied with. The 4 recommendations not complied with were reviewed by the physician for reduction and/or therapeutic indication. The 4 	

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

PRINTED: 02/17/2011
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 01/28/2011
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 329	<p>Continued From page 10</p> <p>A review of the admission Minimum Data Set (MDS), dated 12/20/10, revealed the facility identified Resident #8 as cognitively impaired and on a scheduled pain medication regimen.</p> <p>A review of the Physician Order, dated 12/07/10, revealed an order for Norco (a combination of a narcotic pain medication, hydrocodone and acetaminophen) 10/325 mg, one or two tabs dependent on severity, as needed for pain every six hours and Ativan (anti-anxiety) 1 mg, every six hours, as needed for restlessness.</p> <p>A review of Medication Administration Record (MAR) and Narcotic Sign-Out Sheet revealed the facility administered Ambien 5 mg (sleep aid), Norco 10/325 mg two tablets, and Ativan (anti-anxiety agent) 1 mg to the resident, on 12/16/10 at 7:30 PM and on 12/17/10 at 9:00 PM and the facility administered Ambien 5 mg, Norco 10/325 mg one tablet, and Ativan 1 mg to the resident, on 01/08/11 at 10:00 PM. Record review revealed no documented evidence of behaviors related to anxiety, pain, insomnia, restlessness prior to administration of the multiple medications, on 12/17/10 and on 01/08/11.</p> <p>Record review revealed, on 12/26/10 at 10:45 PM, on 01/17/11 at 9:00 PM, on 01/18/11 at 9:00 PM and on 01/19/11 at 9:00 PM, the facility administered Norco 10/325 mg and Ativan 1 mg simultaneously for Resident #8. On 12/15/10 at 11:00 PM, the facility administered Ambien 5 mg and Ativan 1 mg simultaneously to Resident #8. A review of Nurse's Medication Notes, dated 12/16/10 at 8:00 AM, revealed Resident #8 was unable to be aroused enough for safe administration of morning medicines.</p>	F 329	<p>recommendations will be continued at this time as ordered by the physician, and will continue to have monthly pharmacy review for further recommendations. Licensed nurses will continue to monitor for appropriateness, alternative interventions, and indications for use.</p> <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • Nursing administration educated nurses on the proper administration and documentation of PRN medication on 01/28/11. • Nursing administration provided education to nurses on the expectation to assess residents prior to the administration of PRN medication and the use of non-pharmacological interventions prior to the administration of PRN medications. Education completed 02/22/11. • Nursing administration provided educate to nurses on administering PRN medication for the appropriate reason. Education completed 02/22/11. • Nursing administration will educate new nurses on attempting non-pharmaceutical approaches prior to administration of PRN medication, documentation of administration of PRN medications, documentation of results of PRN medications, notification of physician for PRN 		

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

PRINTED: 02/17/2011
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 01/28/2011
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 329	Continued From page 11 A review of the Nurse's Notes, dated 12/17/10 at 2:30 AM, revealed the resident received a combination of Ambien, Ativan, and Norco related to anxious behavior exhibited related to the resident attempt to exit a chair unassisted. There was no documentation, in the nurse's notes, regarding any other behaviors or evidence of an assessment to determine a need to administer the multiple medications simultaneously, on 12/15/10, 01/17/11, 01/18/11 and 01/19/11. An interview with Registered Nurse #2, on 01/28/11 at 3:08 PM, revealed Resident #8 was increasingly confused and was restless at night, and the resident would get "In a tizzy," and had the "days/nights mixed up." She administered the Norco and Ativan simultaneously to Resident #8, in an attempt to help the resident to sleep. She stated she understood the resident's family administered the medications at the same time at home. RN #2 acknowledged her awareness that the Norco was ordered for pain and Ativan was ordered for anxiety, however, she never consulted with the resident's physician regarding symptoms of insomnia. An interview with the Director of Nursing (DON), on 01/28/11 at 10:42 AM, revealed she believed the resident received the Norco and Ativan on a long term basis. She believed the resident's family provided information to the facility, regarding how the medications were administered in the home, prior to admission. The DON stated she could understand why staff administered the medications simultaneously, based on the resident's medication history. She stated she expected staff to assess the resident and document the effectiveness of the medication and	F 329	medications being given routinely, and avoidance of multiple PRN medications given simultaneously, including the need to assess for appropriateness. • Ongoing education will be provided in nursing orientation and as indicated for non-compliance by Nursing Administration. 4. Monitoring to ensure alleged deficient practice does not recur: • DON or designee will audit behavior documentation, pain documentation and PRN drug administration for proper drug use daily, Monday-Friday, for 1 month, then 3 times a week for 1 month, then weekly for 1 month. • Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed.	03/14/11

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

PRINTED: 02/17/2011
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 01/28/2011
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 329	Continued From page 12 she expected staff to administer medications per the order and based on the intended use. She stated the pain medications should be given for pain and anxiety medications for anxiety. An interview with Resident #8's, family/Power of Attorney (POA), 01/28/11 at 2:08 PM, revealed Resident #8 had never had a problem with anxiety and had not received Ativan prior to a fall and subsequent hospitalization, on 11/24/10. The family member stated that prior to the fall, Resident #8 had taken Lortab (pain medication), Keppra (antiepileptic) and Mobic (for arthritis). Ativan had been ordered during the hospital stay after a fall, which occurred prior to admission. An interview with Resident #8's physician, on 01/28/11 at 4:45 PM, revealed he expected staff to administer pain medication in response to pain and anxiety medication in response to anxiety.	F 329	F332 The facility must ensure that it is free of medication error rates of five percent or greater. 1. Resident(s) affected by alleged deficient practice: <ul style="list-style-type: none"> Noted medication errors resulted from time discrepancy only, no inaccurate medications were administered. Resident #2 was observed by nursing and found to be asymptomatic for signs/symptoms of hypo, hyperglycemia resulting from the late administration of Metformin (administered 27 minutes outside the facility's established time frame). No adverse reaction was noted by the Licensed Nurse. Family and Physician notification of the error was made, with no further physician orders noted. Notification was made on 02/16/11, when facility was made aware of the error. Resident #6 was assessed by nursing staff and found to be asymptomatic for changes in mood or behavior as a result of the late administration of Haldol and Depakote (administered 16 minutes outside the facility's established time frames). Family and Physician notification of the error was made, with no further physician orders noted. Notification was made on 02/16/11. 	
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to ensure that it was free of medication error rates of 5% or greater. A total of 41 opportunities were observed with four (4) medication errors, which affected three residents (#2, #6, & #12), in the selected sample of 15. The facility's medication error rate was 9%. Findings include:	F 332		

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

PRINTED: 02/17/2011
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 01/28/2011
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 332	<p>Continued From page 13</p> <p>A review of the policy entitled, "Medication Administration" dated 10/04 revealed "All medication are administered safely and appropriately to help residents overcome illness, relieve/prevent symptoms, and help in diagnosis. Only licensed personnel administer medications. Remain with the resident to ensure that medication is swallowed".</p> <p>1. Resident #2 was admitted to the facility with diagnoses to include Senile Dementia, Hypertension, and Altered Mental Status.</p> <p>A review of physician's orders, dated January 2011, revealed an order for Metformin HCL (medication for lowering blood sugars) 500 milligrams (mg) two times a day at 9:00 AM and 4:00 PM.</p> <p>An observation during the medication pass, on 01/25/11 at 5:27 PM, revealed Licensed Practical Nurse (LPN) #1 administered Metformin 500 mg tablet. The medication was administered outside of the facilities established time-frame for medication administration.</p> <p>2. Resident #6 was admitted with diagnoses to include Diabetes Mellitus, Hypertension, and Psychosis Not Otherwise Specified (NOS).</p> <p>A review of the physician's order, dated January 2011, revealed Haloperidol (anti-psychotic) 5 milligrams (mg) give 1/2 tablet (2.5 mg) by mouth two times a day at 9:00 AM and 7:00 PM and Depakote 500 mg tab one every evening with supper for Obsessive-Compulsive Disorder.</p> <p>An observation during a medication pass, on</p>	F 332	<p>when the facility was made aware of the error.</p> <ul style="list-style-type: none"> Resident #12 received eye drop medication 18 minutes after the established facility time frames. No adverse effects were noted by the licensed nurse. Family and Physician notification of the error was made, with no further physician orders noted. Notification was made on 02/16/11 when the facility was made aware of the error. Director of Nursing educated LPN #1 on the established medication time frames and appropriate medication administration and observation on 01/25/11. <p>2. Residents with potential to be affected by alleged deficient practice:</p> <ul style="list-style-type: none"> All residents benefit from proper medication administration. Nursing Administration provided education to nurses on proper procedures of medication administration. Education included proper medication administration, as well as identification and reporting of medication errors, and assessment of residents for adverse reactions resulting from medication errors. Education was completed on 02/22/11. 		

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

PRINTED: 02/17/2011
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 01/28/2011
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 332	<p>Continued From page 14</p> <p>01/25/11 at 5:16 PM, revealed LPN #1 administered Haloperidol (anti-psychotic) 5 milligrams (mg) 1/2 tablet (2.5 mg) by mouth and a Depakote 500 mg tablet. These medications were administered outside of the facilities established time-frame for medication administration.</p> <p>3. Resident #12 was admitted to the facility with diagnoses to include Hypothyroidism, Hypertension, Senile Dementia, and Atrial Fibrillation.</p> <p>A review of the physician's orders, dated January 2011, revealed Dorzolamide HCL 2% eye drops instill one drop in each eye two times a day (9 AM and 4 PM).</p> <p>An observation during the medication pass, on 01/25/11 at 5:18 PM AM, revealed LPN #1 did not administer the Dorzolamide HCL eye drops for the resident. The nurse handed the medication to the resident's family member, to administer for the resident and the eye drops were administered outside of the facility's established time-frame for administration.</p> <p>An interview with LPN #1, on 01/27/11 at 2:16 PM, revealed she had one hour before or after the scheduled time to administer the medication to the residents. She did not realize she was out of compliance regarding the time-frame to administer the medications. She was expected to administer the residents' medications, as ordered by physician. Additionally, she stated she was "wrong" to pass Resident #12's medication to the resident's family for administration.</p> <p>An interview, with the Director of Nursing, on</p>	F 332	<p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Nursing administration educated nurses on the proper procedure of medication administration. Education was completed 02/22/11. Nursing administration will educate new nurses on the policy of medication administration in orientation and as needed. <p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> DON or designee will audit 3 nurses a week for medication administration technique for 1 month to ensure the medication administration policy is followed then 3 nurses a month for 1 month then 3 nurses quarterly for 2 quarters. Nursing administration will provide ongoing education for non-compliance. Results of audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed. 	03/14/11

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

PRINTED: 02/17/2011
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 01/28/2011
--	--	--	--

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 332 F 371 SS=E	<p>Continued From page 15 01/28/11 at 10:30 AM, revealed staff had an hour before or after the time scheduled to administer the medication. She expected staff to administer medication as ordered.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to store prepare, distribute and serve food under sanitary conditions. Observation, on 01/25/11 at 11:47 AM, revealed the cook placed pureed bread on the residents' plates, without changing gloves. The facility had a census of 58 and five of the 58 residents received a pureed diet. Findings include:</p> <p>A review of the policy entitled, "Handwashing" dated 01/01/07, revealed staff washed hands to remove contamination and after handling soiled utensils or equipment and engaging in other activities that contaminate the hands.</p> <p>The policy entitled, "Use of Disposable Gloves for Food Handling" dated 01/01/07, revealed disposable gloves were used appropriately by all</p>	F 332 F 371	<p>F371 The facility must (1)Procure considered satisfactory by Federal, State or Local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions.</p> <p>1 / 2. Residents affected / potential to be affected by alleged deficient practice.</p> <ul style="list-style-type: none"> • Dietary Services Manager provided immediate education to the dietary staff member on proper food handling. • All residents benefit from sanitary food storage and preparation. No residents were affected by alleged deficient practice. <p>3. Systems to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> • An inservice was provided to the dietary staff on 02/11/11 by the Food Service Director related to handwashing and sanitary preparation and distribution of / food. 	

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

PRINTED: 02/17/2011
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 01/28/2011
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 371	<p>Continued From page 16</p> <p>associates in order to prevent the contamination of food. The gloves were discarded when damaged or soiled or when interruptions occur. Gloves were not worn outside of the work area i.e. in hallways or to and from resident rooms, nourishment storage areas and dining areas.</p> <p>Observation on 01/25/11 at 11:37 AM, revealed the cook touched the serving utensils, plates and a container of parmesan cheese, after the cheese had been in the dining room for resident use and then placed pureed bread on plates, without changing her gloves, during the trayline service.</p> <p>An interview with the cook, on 01/28/11 at 3:35 PM, revealed she "did not think" when she placed the pureed bread on the residents' plate. She usually used a pair of tongs to place the food item (pureed bread) on the plates. She provided no explanation why she placed the pureed bread on the plates with her gloved hands after touching the serving utensils, plates and a container of parmesan cheese.</p> <p>An interview with the Dietary Manager, on 01/28/11 at 3:50 PM revealed she expected the staff to use utensils to place food on the plates. If the food item was placed on the plate with a gloved hand, then she should have washed her hands and changed gloves.</p>	F 371	<p>4. Monitoring to ensure alleged deficient practice does not recur:</p> <ul style="list-style-type: none"> Weekly sanitation audits will be conducted by the dietary manager, with a monthly audit being completed by the Consultant RD. Audit will include visual observation of food service technique. Ongoing. Results of all audits will be brought to the monthly Performance Improvement Committee to determine the need for further monitoring and updating the plan as needed. Appropriate action plans will be reviewed and revised as needed 	03-14-11

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

PRINTED: 01/31/2011
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/25/2011
--	--	--	--

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
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 01/25/11, to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.