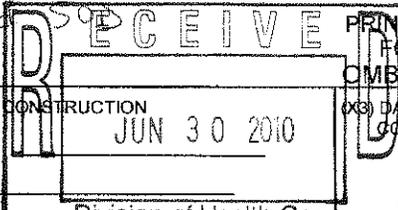


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

Second



PRINTED: 06/24/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185293	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  5/21/2010
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NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER	STREET ADDRESS 1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p><b>Plan of Correction Disclaimer for Laurel Creek Health Care Center</b></p> <p>Please accept this Plan of Correction as our credible allegation of compliance. Preparation and/or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and/or executed solely because of State and Federal requirement.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Clara C. Benz</i>	TITLE <i>Director</i>	(X6) DATE 06-28-10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and record reviews, it was determined that the facility failed to inform the resident's attending physician and the resident's legal representative for two (2) of twenty-one (21) sampled residents when residents #9 and #13 experienced a change in condition.</p> <p>The findings include:</p> <p>1. Resident #9 was observed on May 19, 2010, at 11:40 a.m., to have a large dark purple bruise to the upper right forearm. A skin assessment conducted on May 20, 2010, at 4:00 p.m., with facility staff revealed resident #9 was further observed to have several fading bruises on the left forearm and the top of the left hand. In addition, the resident was observed to have a dark purple bruise between the first and second finger of the left hand, a fading bruise on the left elbow, and small fading bruises on the posterior right forearm. Resident #9 was unable to verbalize how these bruises had occurred.</p> <p>A review of the comprehensive care plan dated September 11, 2009, revealed the facility had identified resident #9 to be at risk for bruising related to routine administration of Plavix. Interventions included to conduct weekly skin assessments, administer medications as ordered, and to use a draw sheet for transfers. There was no evidence the facility addressed the individual bruising in the resident's plan of care.</p> <p>A review of the weekly skin assessment conducted on March 30, 2010, by facility staff</p>	F 157	<p>1.)Resident #9 and resident #13's R/P and Physician were notified of discoloration areas to bilateral upper extremities. No new orders by the Physicians at this time.</p> <p>2.) The review of the change in condition audit tool will be completed by 06/10/10 to ensure new orders; changes in condition and incidents dated 05/01/10 through 05/21/10 were properly communicated to the Physicians and the R/P.</p> <p>3.) The Staff Development Coordinator completed an inservice on 05/28/10 for nursing personnel for notification of new treatments, new orders, and changes in condition.</p> <p>continued</p>	

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F 157	<p>Continued From page 2</p> <p>revealed resident #9's skin was intact; no bruising was documented. The weekly skin assessment conducted on April 6, 2010, noted the resident's skin was intact and bruising was indicated on the form; however, the documentation did not include the site or assessment of the bruise. Further review of the weekly skin assessments conducted on April 13, 2010, April 20, 2010, and on April 27, 2010, revealed resident #9 continued to have bruising; however, the site or staging of the bruises was not identified. The weekly skin assessment dated May 4, 2010, revealed the resident's skin was intact with no bruising indicated. On May 11, 2010, the weekly skin assessment identified resident #9 had bruising of both arms and the forearm/wrist areas were circled on the document.</p> <p>On May 20, 2010, at 4:15 p.m., an interview was conducted with the Licensed Practical Nurse (LPN) who conducted the above identified weekly skin assessments. The LPN stated bruises were required to be documented on the weekly skin assessments and in the nurse's notes. The LPN stated the resident's attending physician and responsible party (R/P) were to be notified immediately when a resident was assessed to have a bruise or any injury. The LPN stated the R/P and the physician had not been notified when resident #9 was assessed to have bruises since the resident received Plavix and was easily bruised.</p> <p>A review of the facility's policy/procedure related to notification of the resident's attending physician and responsible party revealed staff was required to notify the resident's attending physician and responsible party when a change in the resident's condition was noted. The policy/procedure</p>	F 157	<p>3.) (Continued) Any Nursing Personnel who did not receive this inservice by the 28<sup>th</sup> will be required to do so prior to working their next scheduled shift.</p> <p>4.) Nursing Administration will audit all new orders, changes in conditions and incidents during the change in condition meeting to ensure they have been properly communicated to the Physician, Responsible party, or legal representative weekly for 4 weeks, then monthly for 3 months. The results of the audits will be reviewed at the monthly Performance Improvement meeting. Systems will be updated as indicated. Audits will be continued until committee determines compliance.</p>	06-30-10	

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F 157	<p>Continued From page 3</p> <p>identified changes to include "an accident/incident which results in injury."</p> <p>2. Resident #13 was observed on May 21, 2010, at 10:15 a.m., to have a dark purple fading bruise on the top of the left hand, a large dark purple bruise on the right elbow, and a fading purple bruise on the upper right forearm. Resident #13 stated the bruise on the right elbow was caused from "staff bumping it on the doors."</p> <p>A review of the weekly skin assessments conducted on May 10, 2010 and May 17, 2010, revealed resident #13's skin was assessed to be intact and no bruises were indicated on the skin assessment form.</p> <p>A review of the nurse's notes dated March 15, 2010, at 12:00 p.m., revealed facility staff had assessed resident #13 to have a purplish bruise on the left eyelid. According to the nurse's notes, the resident stated the bruise was caused from accidentally bumping the eye with the sling. However, there was no documentation that the resident's attending physician or R/P was informed of the bruise of the resident's left eyelid. Further review of the nurse's notes revealed there was no evidence the facility had identified/assessed the bruising on the resident's left hand, right elbow, and upper right forearm. In addition, there was no evidence the facility had notified the resident's attending physician or R/P of these bruises.</p> <p>An attempt was made to interview the facility staff responsible for conducting the skin assessments on May 10 and May 17, 2010. However, the nurse was not available for interview.</p>	F 157			

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F 157	Continued From page 4 An interview conducted with the Unit Manager (UM) on May 21, 2010, at 1:15 p.m., revealed facility staff was responsible to notify the resident's attending physician and R/P when the resident was assessed to have bruising or injury.	F 157			
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and	F 225			

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F 225	<p>Continued From page 5</p> <p>certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure that all allegations of abuse, including injuries of unknown source, were investigated and reported to the appropriate state agencies timely. Observations conducted for residents #9 and #13 on May 20, 2010 and on May 21, 2010, revealed the residents to have several unidentified bruises of the hands and bilateral upper extremities. However, there was no evidence the facility had conducted an investigation to determine the etiology of the bruises and no evidence the appropriate state agencies had been notified regarding injuries of unknown source for residents #9 and #13.</p> <p>The findings include:</p> <p>1. A review of the medical record revealed resident #9 was admitted to the facility on September 5, 2008, with diagnoses of Alzheimer's Dementia, Coronary Artery Vessel Graft, and Hypertension. A review of the current physician's orders dated April 2010 revealed the resident had physician's orders to receive Plavix 75 mg (milligrams) and Aspirin 81 mg daily. A review of the comprehensive care plan dated September 11, 2009, revealed the facility had identified resident #9 to be at risk for bruising related to routine administration of Plavix. Interventions included to conduct weekly skin</p>	F 225	<p>1.) Once the facility was informed that resident #9 and resident #13 had several unidentified bruises of the hands and bilateral upper extremities, DON and ADON spoke with resident #13 who was alert and oriented, stated the bruise on her right elbow and right forearm was related to her right arm being humped on the doorway of her room during transfer to shower. The DON and ADON reviewed resident #13's chart for lab sticks and found that resident #13 had a CMP Lipid Panel, TSH, and a Renal Function Panel drawn on 5-6-10 from the top of the left hand. Resident #13 confirmed that the nurses use her hands to draw her blood. DON and ADON interviewed resident #13 and the staff caring for her on 3-15-10 related to the bruise to the left eye lid noted in the medical record date 3-15-10. Resident #13 confirmed that the bruise on the left eye lid was caused by the sling accidentally hitting her when the mechanical lift was being used for transfer. DON and ADON interviewed the nurse who made the nurse's note on 3-15-10 and she stated she was called to resident #13's room on 3-15-10 related to the sling on the mechanical lift had hit the resident's left eye by accident.</p> <p>Continued</p>		

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F 225	<p>Continued From page 6</p> <p>assessments, administer medications as ordered, and to use a draw sheet for transfers.</p> <p>Resident #9 was observed on May 19, 2010, at 11:40 a.m., to have a large dark purple bruise of the upper right forearm. A skin assessment conducted on May 20, 2010, at 4:00 p.m., with facility staff revealed resident #9 was further observed to have several fading bruises on the left forearm and the top of the left hand. In addition, the resident was observed to have a dark purple bruise between the first and second finger of the left hand, a fading bruise on the left elbow, and small fading bruises on the posterior right forearm. Resident #9 was unable to verbalize how these bruises had occurred.</p> <p>A review of the weekly skin assessment conducted on March 30, 2010, by facility staff revealed resident #9's skin was intact; no bruising was documented. The weekly skin assessment conducted on April 6, 2010, noted the resident's skin was intact and bruising was indicated on the form; however, the documentation did not include the site or assessment of the bruise. Further review of the weekly skin assessments conducted on April 13, 2010, April 20, 2010, and on April 27, 2010, revealed resident #9 continued to have bruising; however, the site or staging of the bruises was not identified. The weekly skin assessment dated May 4, 2010, revealed the resident's skin was intact with no bruising indicated. On May 11, 2010, the weekly skin assessment identified resident #9 had bruising of both arms, and the forearm/wrist areas were circled on the document. However, there was no evidence the facility had conducted an investigation regarding the bruises/injuries documented on the weekly skin assessments and</p>	F 225	<p>Continued from page 6</p> <p>The DON and ADON assessed resident #9 and noted bruising to the right upper and lower forearm, left forearm, elbow, hand, and a bruise between the 2<sup>nd</sup> and 3<sup>rd</sup> finger on the left hand. Resident #9 was unable to verbalize the cause of the bruising. The DON and ADON spoke with resident responsible party and she verbalized her father had bruised easily ever since he had been on blood thinners. He bruised easily when he was at home. She verbalized that Dr. Cornett had discussed with her that she was decreasing his Plavix to 75 mg. twice a week related to his risk of bleeding and bruising. The DON and ADON reviewed resident #9's medical record and found that the resident receives Plavix 75 mg. p o twice weekly, which increases the risk for bruising. Resident #9 receives a lab draw for a CBC and CMP monthly. The DON and ADON consulted with the primary physician, Dr. Cornett, related to the bilateral bruising on upper extremities of resident #9 and she stated his skin is very thin, fragile, and will bruise easily with routine care despite the Plavix being ordered twice weekly.</p> <p>Continued</p>		

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F 225	<p>Continued From page 7</p> <p>no evidence the facility had reported these injuries of unknown source to the appropriate state agencies.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #1 on May 20, 2010, at 4:15 p.m., revealed the nurses were required to assess and document any changes in the resident's condition, including bruises or injury of unknown source. LPN #1 stated the nurse should question the nurse aides to attempt to determine the etiology of a bruise. LPN #1 stated the LPN "assumed" the bruises identified on resident #9's forearm was caused by the resident hitting the side rails; however, no investigation had been completed/documented.</p> <p>An interview conducted with the Director of Nurses (DON) on May 20, 2010, at 5:15 p.m., revealed the staff nurses were required to report incidents of bruising to the Unit Manager (UM) or the DON. The DON stated the DON or UM was responsible to conduct an internal investigation to determine the etiology of the bruise/injury. The DON stated either the Facility Administrator or the DON was responsible to report any injury of unknown source to the appropriate state agencies. The DON stated no investigations had been conducted into the bruises for resident #9 since the resident routinely received Plavix and Aspirin and no incidents had been reported to the state agencies.</p> <p>A review of the facility's policy/procedure related to abuse revealed facility staff was required to complete an incident report when a resident was assessed to have "suspicious" bruising and the Facility Executive Director would be required to proceed with an investigation. The</p>	F 225	<p>Continued from page 7</p> <p>Resident #9 and resident #13's responsible party and physician were notified of discoloration areas to bilateral upper extremities. No new orders by the physicians at this time.</p> <p>2.) All residents have the potential to be affected. A head to toe skin assessment was completed on all residents on 5-24-10 by the nurse management team and no other residents were identified to have any discolored areas of unknown origin.</p> <p>3.) All licensed associates was inserviced on 5-28-10 by the SDC related to documenting bruises ie: location, size and cause. Nursing staff will continue observing size and progress with weekly skin assessments until resolved. Nursing staff must start an investigation immediately to determine cause of bruising. The DON, ED, or ADON must be notified immediately of any bruising of unknown origin. The ED/DON or designee will report it to the appropriate state agencies. All licensed nursing staff was inserviced 05/28/10 on documenting all successful and unsuccessful lab sticks in the medical record.</p> <p>4.) The Director of Nursing or designee will audit the 24-hour report sheet daily Monday through Friday for 4 weeks, then twice weekly for 1 month, to identify any incidents that may require further follow up or reporting.</p> <p>Continued</p>	

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F 225	<p>Continued From page 8</p> <p>policy/procedure further directed the Facility Executive Director was responsible to report any reports of possible abuse to the appropriate state agencies.</p> <p>2. Resident #13 was admitted to the facility on May 20, 2003, with diagnoses of Hypertension, Paraplegia, Depression, Hyperlipidemia, and Chronic Bronchitis.</p> <p>Resident #13 was observed on May 21, 2010, at 10:15 a.m., to have a dark purple fading bruise on the top of the left hand, a large dark purple bruise on the right elbow, and a fading purple bruise on the upper right forearm. Resident #13 stated the bruise on the right elbow was caused from "staff bumping it on the doors."</p> <p>A review of the weekly skin assessments conducted on May 10, 2010 and May 17, 2010, revealed resident #13's skin was assessed to be intact and no bruises were indicated on the skin assessment form.</p> <p>A review of the nurse's notes dated March 15, 2010, at 12:00 p.m., revealed facility staff had assessed resident #13 to have a purplish bruise on the left eyelid. According to the nurse's notes, the resident stated the bruise was caused from accidentally bumping the eye with the sling. However, there was no evidence the facility had conducted an investigation to determine the etiology of the bruise of the resident's eyelid and no evidence the facility had reported the bruising of the resident's eyelid to the appropriate state agencies when the bruise was identified on March 15, 2010.</p> <p>An interview conducted with the Unit Manager</p>	F 225	<p>Continued from page 8</p> <p>The Unit Managers or designee will be assigned to perform a head to toe skin assessment on 5 residents weekly for one month, then every other week for 4 weeks to assure accuracy of the weekly skin assessments. Performance Improvement Committee will review audits monthly. Revisions will be made to the systems as indicated. Audits will continue until the committee determines compliance.</p>	6-30-10

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F 225	Continued From page 9 (UM) on May 21, 2010, at 1:15 p.m., revealed the UM was not aware of the bruises on the resident's arms. The UM stated an incident report was not completed unless the bruise was "big." The UM stated if the etiology could not be determined, the nurse should document the injury was a result of unknown source in the nurse's notes.	F 225		
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 interview and record review, the facility failed to develop and implement written policies and procedures for the identification, investigation, and reporting of injuries of unknown source as possible abuse/neglect.  The findings include:  A review of the facility's policy revealed facility staff was required to complete an incident report when a resident was assessed to have "suspicious" bruising and the Facility Executive Director would be required to proceed with an	F 226	1.) Once facility was informed that the facility Abuse Mistreatment Neglect Policy did not address reporting and investigating injuries of unknown source, the policy was amended to include this information to meet the regulation requirements.  2.) All residents had the potential to be affected.  3.) Staff was inserviced by the Staff Development Coordinator on 5-28-10 on the amended Abuse Mistreatment Neglect Policy which addresses reporting and investigating of unknown source.	

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F 226	Continued From page 10 investigation. The policy/procedure further directed the Facility Executive Director was responsible to report any reports of possible abuse to the appropriate state agencies. Review of the policy revealed no further guidance to identify, report, and investigate injuries of unknown source as required.  An interview conducted with the Facility Administrator on May 21, 2010, at 3:45 p.m., revealed the facility policy had not changed for several years. Further interview revealed that the facility would report bruising if abuse was suspected and that bruising for residents #9 and #13 was discussed with the physician, was not suspicious in nature, and was not considered an injury of unknown source. Further interview revealed the Administrator was not aware the facility policy did not address reporting and investigating injuries of unknown source.	F 226			
F 257 SS=D	Reference F225. 483.15(h)(6) COMFORTABLE & SAFE TEMPERATURE LEVELS  The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 - 81° F  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide comfortable temperature levels for residents; during the lunch meal services the temperature of the main dining room was observed to be sixty-six (66) degrees Fahrenheit on May 19, 2010.	F 257			

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F 257	Continued From page 11  The findings include:  Observations conducted during the lunch meal on May 19, 2010, at 12:10 p.m., revealed seven of the 24 residents seated in the dining room were observed to eat lunch while wearing coats or long-sleeved attire. Additional observations revealed the temperature of the dining room was 66 degrees Fahrenheit.  Interviews conducted with residents #22, #23, and #24 on May 19, 2010, at 12:30 p.m., revealed the residents were wearing long-sleeved attire because the dining room was often cold and the residents became chilled when eating in the dining room.  An interview conducted with the Maintenance Director on May 19, 2010, at 12:20 p.m., revealed the Maintenance Director checked the facility air temperatures daily and the weather had been cool for the last couple of days. However the Maintenance Director was not aware the dining room temperature was 66 degrees Fahrenheit.	F 257			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280	1.) Immediately upon identifying the temperatures in the dining room the Maintenance Director made adjustments to the air conditioning system to get the temperatures to comply with the regulations. A thermometer was placed in the dining room.  2.) All Residents in the dining room had the potential to be affected by the low temperatures. The air temperature was checked in other common areas i.e. Activity Room, East, West and Front Lounge. These air temperatures met regulation.  3.) A Resident Council meeting was conducted on June 14, 2010 with all Residents that have a potential to be affected by the dining rooms temperatures being too low. There were no concerns expressed.  4.) Maintenance Director or designee will audit dining room temperatures daily for 2 weeks, then randomly for 2 weeks. Findings will be presented to the Performance Improvement Committee. Temperature audits will continue as determined by the Performance Improvement Committee.	06-30-10	

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F 280	<p>Continued From page 12</p> <p>for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to revise the care plan for one (1) of twenty-one (21) sampled residents (resident #3) to reflect the resident's current medical status. Resident #3 was placed on comfort measures only on January 19, 2010, by the attending physician. However, there was no care plan revision to reflect comfort measures only.</p> <p>The findings include:</p> <p>Review of the medical record for resident #3 revealed the resident was admitted to the facility on October 19, 2009, with diagnoses that included Alzheimer's Disease, Gastroesophageal Reflux, Hypothyroidism, Hypertension, Cardiac Dysrhythmia, Osteoporosis, Anxiety, Depression, and Behaviors with Mood Disorders. Review of a physician's order dated January 19, 2010, revealed the physician documented that the family of resident #3 was requesting comfort measures only because the resident did not want intravenous fluids/artificial feeding and the physician agreed with honoring the resident's wishes due to the resident having poor prognosis.</p>	F 280	<p>1.) Resident #3's Care Plan was updated on 05/21/10 to reflect the current condition and interventions as appropriate.</p> <p>2.) An audit of all Resident Care Plans will be completed by 06/21/10 to assure any changes in condition are revised accordingly on the Care Plan by Nursing Administration.</p>	06-30-10

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F 280	Continued From page 13  A review of the current comprehensive care plan for resident #3 revealed the care plan had been reviewed on March 10, 2010. However, there was no evidence that the facility revised and implemented a care plan for resident #3 regarding the physician's order and the family's wishes for comfort measures only. The only identified problem/need on the current care plan for resident #3 was that the resident had an advanced directive, and the documented approach for the problem was Do Not Resuscitate (DNR).  Review of the Minimum Data Set (MDS) quarterly assessment dated March 7, 2010, revealed resident #3 continued to have a gradual decline in physical functioning status and continued to have a significant weight loss of nine percent within 90 days.  An interview was conducted with the MDS Coordinator at 4:50 p.m. on May 21, 2010. The MDS Coordinator stated that the care plan had not been revised in regards to comfort measures for resident #3 prior to May 21, 2010 (last day of survey).	F 280	Continued from Page 13  3.) The MDS team was inserviced on 05/28/10 regarding care plan revision by the Director of Nursing.  4.) Orders and changes in condition will be audited by the Director of Nursing or designee during the change in condition meeting Monday through Friday. This audit will be conducted Monday through Friday for 4 weeks, then monthly for 3 months to assure compliance with the RAI process. The results of the audits will be reviewed monthly in the Performance Improvement meeting. Revisions to the systems will be updated as indicated. Audits will continue until committee determines compliance.	06-30-10	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 282			

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F 282	<p>Continued From page 14</p> <p>review, it was determined that the facility failed to ensure services were provided in accordance with the written plan of care for one (1) of twenty-one (21) sampled residents. Resident #10 had interventions for the call light to be available and answered properly to prevent falls. However, observation of resident #10 on May 19, 2010, at 11:38 a.m., revealed that the call light was not within resident's reach.</p> <p>The findings include:</p> <p>An observation of resident #10 on May 19, 2010, at 11:38 a.m., and 4:30 p.m., revealed the call light was found hanging over the back of the resident's bed. On May 20, 2010, at 9:25 a.m., 11:00 a.m., and 12:05 p.m., observation revealed the call light hanging on the arm of resident #10's chair and not within the resident's reach. On May 20, 2010, at 2:25 p.m., the call light was found lying on the chair beside resident #10's bed and not within resident reach. On May 20, 2010, at 2:45 p.m., the call light was found to be tied to the chair of resident #10 and lying on the floor and not within the resident's reach. On May 21, 2010, at 10:25 a.m., resident #10 was lying in bed with the call light tied to the chair beside the bed and not within the resident's reach.</p> <p>A review of resident #10's medical record revealed that resident #10 was assessed to be at risk for falls, and an intervention placed on the care plan was for the call light to be available and answered promptly.</p> <p>An interview was conducted on May 20, 2010, at 2:45 p.m., with the CNA assigned to care for resident #10 on May 19, 2010 and May 20, 2010. The CNA stated that resident #10 knows how to</p>	F 282	<ol style="list-style-type: none"> <li>1.) Residents #10's call light was clipped to the bed cover within reach immediately.</li> <li>2.) A 100% review of resident rooms was completed and all call lights were found within reach of the residents. New clips were applied as needed.</li> <li>3.) The Staff Development Coordinator completed an inservice on 05/28/10 for all nursing staff related to call lights being placed within resident's reach.</li> <li>4.) Audits will be completed on 10 random rooms Monday through Friday for 4 weeks for call lights being in reach of resident, then bi-weekly on 10 rooms for 4 weeks, then monthly on 10 rooms for 3 months. All audits will be reviewed in the monthly Performance Improvement meeting. Audits will continue until the Performance Improvement committee determines compliance.</li> </ol>	06-30-10

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F 282	<p>Continued From page 15</p> <p>use the call light, and that the resident is checked more often due to the resident being at risk for falls. The CNA stated that the call light being tied to a chair and in the floor is a "no-no." The CNA further stated that the CNAs are responsible for making sure that the call light is within the resident's reach. The CNA placed the call light on resident #10's bed within reach before leaving the resident's room.</p> <p>An interview conducted on May 21, 2010, at 10:25 a.m., with the CNA responsible for resident #10's care that day revealed resident #10 pushes the call light if the resident requires staff assistance. The CNA further states that it is the responsibility of the CNA to make sure the resident has a call light within reach. The CNA states he/she goes into resident #10's room three to four times during every shift.</p> <p>An observation of resident #10 on May 21, 2010, at 10:25 a.m., revealed resident #10 was lying in bed and the call light was found tied to a chair and not within the resident's reach. The CNA untied the call light and placed it beside the resident before leaving the resident's room.</p> <p>An interview was conducted on May 21, 2010, at 10:45 a.m., with the Licensed Practical Nurse (LPN) assigned to care for resident #10. The LPN stated if the resident required staff assistance, the resident would push the call light. The LPN further stated it is the CNA's responsibility to check the residents every two hours or more often if needed, and to make sure that the call light is within the resident's reach. The LPN stated this is monitored by the Charge Nurse by making walking rounds on the residents to check to be sure call lights are within resident</p>	F 282			

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F 282	Continued From page 16 reach. The LPN was informed of the dates and times that the call light was found not to be within the reach of resident #10.	F 282			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure one (1) of twenty-one (21) sampled residents received appropriate treatment and services to prevent a decrease in range of motion. Resident #9 was assessed to require a knee-positioning device to be utilized when the resident was in bed to prevent contracture development of both knees. However, observations conducted on May 19-21, 2010, revealed the knee-positioning device was not applied for resident #9.  The findings include:  A review of the medical record revealed resident #9 was admitted to the facility on September 5, 2008, with diagnoses of Alzheimer's Dementia, Malignant Neoplasm of the Prostate, Anemia, and Malaise. A review of the significant change comprehensive assessment completed on September 14, 2009, revealed resident #9 was	F 318	1.) Resident #9's knee positioning device was applied on 05/21/10. A therapy screen request was given to therapy to evaluate for continued use.  Continued on page 18		

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F 318	<p>Continued From page 17</p> <p>assessed to require extensive to total assistance with bed mobility and transfers, and to be non-ambulatory. Resident #9 was further assessed to have no limitation in range of motion and to be receiving occupational and physical therapy services. A quarterly assessment completed on March 15, 2010, revealed resident #9 continued to be assessed to have no limitation in range of motion and no therapy services were provided during the assessment reference period.</p> <p>A review of the physician's orders dated April 2010 revealed resident #9 had a physician's order to wear a knee-positioning device while in bed.</p> <p>A review of the Certified Nurse Aide (CNA) Daily Care Guide dated May 12, 2010, revealed the CNAs were responsible to apply a knee-positioning device to resident #9's knees when the resident was in bed.</p> <p>Observation of resident #9 conducted on May 19, 2010, at 11:40 a.m., 12:20 p.m., 2:55 p.m., 3:45 p.m., and 5:00 p.m., revealed the resident was lying on the bed and had been repositioned appropriately. However, there was no evidence the knee-positioning device was utilized for the resident during the observations conducted on May 19, 2010. Further observations conducted on May 20, 2010, at 9:25 a.m., 11:00 a.m., 12:00 p.m., 2:50 p.m., and 4:00 p.m., revealed resident #9 was in bed with a pillow in place under the resident's knees and there was no evidence the knee-positioning device was being used for resident #9 on May 20, 2010.</p> <p>An interview conducted with the Physical Therapist (PT) on May 21, 2010, at 11:30 a.m., revealed resident #9 had been discharged from</p>	F 318	<p>Continued from Page 17</p> <p>2.) All residents with orders for positioning devices were reviewed to assure positioning device was available and applied.</p> <p>3.) The Staff Development Coordinator completed an inservice on 06/02/10 with all nursing staff related to residents with orders for positioning devices and a review of passive and active range of motion. Therapy screen indicated continued use for positioning device for Resident # 9.</p> <p>4.) Each resident will be assessed for range of motion issues per nursing / therapy on admission, quarterly, annually, and any re-admission from the hospital. Nursing administration and RSM will audit all resident orders for positioning devices weekly times 4 weeks, then monthly times 3 months. DON/ADON or designee will audit the application of the positioning devices weekly x 4 then monthly x 3 months. All audits will be reviewed in the monthly Performance Improvement meeting. Systems will be updated as indicated. Audits will continue until committee determines compliance.</p>	06-30-10	

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F 318	Continued From page 18 PT in July 2009 and the knee-positioning device was recommended to prevent further contractures of the resident's knees.  An interview was conducted with CNA #1 on May 21, 2010, at 10:15 a.m. CNA #1 stated the knee-positioning device had not been placed on resident #9. When questioned where the knee-positioning device was kept, the CNA located the device in the resident's closet and placed the device between the resident's knees.  An interview conducted with CNA #2 on May 21, 2010, at 10:50 a.m., revealed the knee-positioning device was to be placed on resident #9's knees when the resident was in bed to prevent contractures. CNA #2 stated the CNA had placed pillows under the resident's knees and had not seen the knee-positioning device.  An interview conducted with the UM on May 21, 2010, at 2:30 p.m., revealed the staff nurses were responsible to conduct resident rounds at random to monitor for resident care needs. The UM stated the CNAs were responsible to apply the knee-positioning device for resident #9.	F 318			
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 323			

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F 323	<p>Continued From page 19</p> <p>by: Based on observation, interview, and record review, the facility failed to ensure the resident environment remained as free of accident hazards as possible. The facility hot water temperature to resident rooms and shower rooms was observed to be one hundred eighteen (118) degrees Fahrenheit. In addition, drain covers in the facility hallways were observed to be loose and above the level of the floor. The floor at the door of the East wing dining room was uneven due to a missing threshold.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observations of hot water temperatures conducted on May 20, 2010, at 9:15 a.m., revealed the water temperatures for rooms 116, 117, 122, 126, 132, the East wing shower room, and the West wing shower room were at 118 degrees Fahrenheit.</li> </ol> <p>Observations conducted on May 20, 2010, at 10:00 a.m., of thermometers mounted on the East and West wing hot water heaters revealed the thermometers indicated the hot water temperatures were 110 degrees Fahrenheit.</p> <p>A group interview conducted with alert and oriented residents on May 19, 2010, at 3:30 p.m., revealed the residents had no concerns with facility water temperatures or with bathing.</p> <p>An interview conducted with the Maintenance Director on May 20, 2010, at 10:00 a.m., revealed that the Maintenance Director monitored the facility water temperatures each week and completed a water temperature monitoring log. Additional interview revealed new mixing valves</p>	F 323	<ol style="list-style-type: none"> <li>1.) Once the water temperatures was identified as being too hot, the Maintenance Director immediately began adjustments to bring the water temperatures down. All staff was inserviced on 5-19-10 to not use the water, baths and showers were put on hold. New thermometers were put in place immediately once facility was notified that drain covers of the hallways on East and West wing were loose and protruded above the level of the floor, the Maintenance Director began the process to purchase new drain covers. Once made aware of the uneven floor and missing threshold at the East Wing dining room, the Maintenance Director made staff, etc. aware the threshold was ordered and would be installed immediately when received.</li> <li>2.) All residents had the potential to be affected.</li> <li>3.) All staff was inserviced on 05/25/10 to be alert to water temperatures and report if indicated to high a temperature as well as to be alert to loose protruding facility drain covers in the hallways on East and West wings and at the East Wing dining room door. Staff were inserviced on reporting and completing Maintenance Request forms.</li> </ol> <p>continued on page 21</p>		

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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL CREEK HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962</b>		
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F 323	<p>Continued From page 20</p> <p>and thermometers were installed on the hot water heaters in March 2010. Further interview with the Maintenance Director revealed the thermometer primarily used to monitor water temperatures had broken and the backup thermometer was difficult to read accurately. The Maintenance Director stated he primarily relied on the thermometers on the hot water heaters to monitor the facility hot water temperatures, however, was not aware that the thermometers on the East and West wing hot water heaters were indicating a hot water temperature lower than the actual temperature of the hot water for both the East and West wings.</p> <p>A review of the weekly hot water temperature monitoring logs from March 22 to May 14, 2010, revealed the facility hot water temperatures were consistently documented to be 108 degrees Fahrenheit.</p> <p>A review of the facility water temperature inspection policy revealed the hot water temperatures were to be monitored weekly and were required to be within a range of 100 to 110 degrees Fahrenheit.</p> <p>2. Observations conducted during an environmental tour with the Facility Maintenance Director on May 21, 2010, at 11:00 a.m., revealed facility drain covers in the center of the hallways on both the East and West wings were loose and protruded above the level of the floor. Additional observations revealed an area of uneven floor and a missing threshold at the door of the East wing dining room.</p> <p>An interview conducted with the Maintenance Director during the tour on May 21, 2010, at 11:00 a.m., revealed the East wing dining room floor</p>	F 323	<p>Continued from page 20</p> <p>4.) Executive Director, Maintenance Director and/or designee will audit the water temperatures, facility floor drain covers and thresholds 3 times a day for 2 weeks, then 1 time per day for 2 weeks. Findings will be presented to the Performance Improvement committee. Water temperature audits will continue as determined by the Performance Improvement Committee.</p>	06-30-10	

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F 323	Continued From page 21 had been recently replaced and the threshold was ordered but had not been delivered. Further interview revealed the Maintenance Director was not aware of the loose drain covers in the hallway nor had the Maintenance Director considered the loose and protruding drain covers or the missing threshold an accident hazard.	F 323		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION  The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census.  The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors.  The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.	F 356		

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F 356	Continued From page 22  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post current staffing as required. On May 19, 2010, at 9:15 a.m., facility staffing was posted for May 17, 2010.  The findings include:  Observations of facility posted staffing conducted upon entry to the facility on May 19, 2010, at 9:15 a.m., revealed the facility staffing board had the facility staffing posted for May 17, 2010, and had not been updated.  An interview conducted with the Business Office Manager on May 21, 2010, at 3:30 p.m., revealed the staffing was required to be posted daily and that the receptionist retrieves the staffing hours from the time clock to post the facility staffing, however, the time clock malfunctioned on May 17, 2010, and the receptionist was not able to obtain the correct hours to post the facility staffing for May 19, 2010.	F 356			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be	F 431	1.) Once the facility was informed the staffing board was out of compliance it was corrected immediately.  2.) Nurse staffing data must be posted daily at the beginning of each shift. The data is for public review.  3.) Business Office Staff was inserviced on the regulation on May 20, 2010.  4.) Executive Director, Business Office Manager, or designee will audit the board 1 time per day for 30 days to assure correct information. Findings will be presented to the Performance Improvement committee and audits will continue as determined by the findings of the Performance Improvement committee.	06-30-10	

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F 431	<p>Continued From page 23</p> <p>labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to store and label all drugs and biologicals in accordance with currently accepted professional principles. Four (4) boxes of Xopenex was stored at improper temperature, one hundred seven (107) BD vacutainers were expired and available for resident use, five (5) tubes of ointments/creams did not contain proper labeling, and two (2) vials of Influenza Vaccine and one (1) vial of Tuberculin skin test serum were not dated when opened and remained available for use.</p>	F 431			

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F 431	<p>Continued From page 24</p> <p>The findings include:</p> <p>Observation of the facility's medication rooms and medication carts on May 21, 2010, at 1:55 p.m., revealed four boxes of Xopenex stored in a cabinet in the West Wing Skilled Unit medication room. The manufacturer's label stated to store the medication at a temperature of 68 to 77 degrees Fahrenheit. Observation on May 21, 2010, at 2:20 p.m., revealed the room temperature in the medication room was 80 degrees Fahrenheit.</p> <p>Review of the Medication Room Daily Temperature Log revealed the temperature of the West Wing Skilled Unit medication room for the month of May 2010 was recorded above 77 degrees Fahrenheit every day except for two days. Review of the April 2010 Medication Room Daily Temperature Log revealed the temperature readings were above 77 degrees Fahrenheit every day except for 4 days.</p> <p>Further observation revealed 107 tiger top BD vacutainers (vials used to obtain blood for laboratory analysis) had an expiration date of April 2010 and remained available for use.</p> <p>Nystatin 100,000 units, 30 grams (g), Triamcinolone Acetonide cream 1%, 80 g, allergy cream 2%, 1 ounce, Mometasone Furoate cream 0.1%, 45 g, Biafine Topical Emulsion 45 g, topical ointments/creams were observed in a zipper-lock storage bag in a cabinet in the West Wing Skilled Unit medication room. The medications did not contain proper labeling as to the resident's name or instructions for use of the topical medications.</p> <p>Further observation of the East Wing medication</p>	F 431	<ol style="list-style-type: none"> <li>1.) All items with no label, expired, or not dated when opened were discarded immediately, and new medications and treatments were reordered from the pharmacy at the facilities expense. Four (4) boxes of Xopenex were moved to the East Wing Medication room. The Director of Maintenance notified an electrician on 05/21/10 related to medication room temperatures being too warm. The electrician serviced the air units in all the medication rooms and all temperatures are being maintained between 59-77 degrees.</li> <li>2.) Nursing Administration performed a complete audit of each medication room on east and west wings and no other items were found to be not labeled, expired, or not dated. Nursing staff is recording medication room temperatures daily, and administrative staff is monitoring temperatures for compliance Monday through Friday.</li> </ol> <p>continued on page 26</p>		

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F 431	Continued From page 25 room revealed two vials of Influenza Vaccine and one vial of Tuberculin skin test serum opened and available for use; however, the vials were not dated to indicate the date the vial was opened.  Interview on May 21, 2010, at 3:00 p.m., with the Unit Supervisor (US) revealed the medication room temperature should not be over 80 degrees Fahrenheit. The US stated the medication room temperatures were checked by the medication nurse every morning and recorded on the temperature log. The US stated the medication nurse should fill out a maintenance slip any time the room temperature was over 80 degrees Fahrenheit. The US stated the weekend nurse was assigned to check the medication rooms, medication carts, and laboratory supplies, for expired items or unnecessary medications. The US stated all multi-dose vials should be dated when opened and discarded after 30 days except insulin, which should be discarded after 28 days.  Review of the facility's policy revealed medication room temperatures should be maintained at 59 to 77 degrees Fahrenheit. A Refrigeration Policy dated February 22, 2007, revealed the night shift nurses were assigned to clean out the medication refrigerators every Wednesday. The facility's pharmacy recommendation for storage of medication dated March 29, 2010, revealed Influenza Vaccine vials should be dated when opened and discarded after 28 days.	F 431	Continued from page 25  3.) Staff Development Coordinator completed an inservice on 05/28/10 on medication storage, labeling, expirations, and dating vials when opened. She reviewed monitoring and recording temperatures for the medication rooms and the required temperatures of the medication rooms 59-77 degrees. They were educated to report any temperature greater than 77 degrees to the Executive Director, Director of Maintenance, Director of Nursing, and Assistant Director of Nursing. Pharmacy does a quarterly review of each medication room to assess medication room storage, labeling, and dating vials.  4.) Medication room audits will be performed by the Director of Nursing or designee Monday through Friday for 4 weeks for unlabeled, expired, or not dated medications when opened and medication room temperatures. The Director of Nursing or designee will perform these audits monthly for 3 months. These audits will be reviewed in the Performance Improvement Meeting monthly. Systems will be updated as indicated. Audits will continue until committee determines compliance. The nursing staff will continue to monitor and record medication room temperatures daily per regulation.		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		6-30-10	

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F 465	Continued From page 26  This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. On May 21, 2010, commode bolts were observed to be rusted and unsightly with missing bolt covers. A resident's bedside table was observed to be chipped and splintered, and a footboard to a resident's bed was chipped and unsightly.  The findings include:  Observations conducted during an environmental tour conducted with the Facility Maintenance Director on May 21, 2010, at 11:00 a.m., revealed commode anchor bolts were rusty and missing covers in resident rooms 116, 117, 126, #128, 132, and 139. Additional observations revealed a chipped and splintered bedside table in resident room 126, and a chipped footboard on a bed in resident room 163.  An interview conducted on May 21, 2010, at 11:00 a.m., with the Facility Maintenance Director revealed the Maintenance Director was notified of items needing repair by receiving maintenance requests and being told by staff while making daily rounds. Further interview revealed the Maintenance Director had no maintenance requests for the identified items nor was aware the items were in need of repair.	F 465	1.) Once the commode anchor bolts were reported to be rusty with missing covers in rooms numbers 116, 117, 126, 128, 132, and 139 the Director of Maintenance purchased the parts to repair. Upon being informed that a bedside table was chipped and splintered and a footboard was chipped, facility made arrangements to replace.  2.) Executive Director, Maintenance Director and Housekeeping/Laundry Supervisor conducted audits throughout resident rooms to identify problems with rusty, missing anchor bolt covers and chipped or splintered bedside tables and chipped footboards. Identified problems will be repaired and/or replaced.  3.) All staff was inserviced on June 3, 2010 on reporting maintenance issues in need of attention and completing Maintenance Repair Request forms.  4.) Executive Director and Maintenance Director or designee will audit room commode anchor bolts, bedside tables and footboards 2 x per week for 4 weeks then 1 x per week for 4 weeks to assure there are no maintenance issues. Findings will be presented to the Performance Improvement Committee and audits will be determined by the findings of the Performance Improvement Committee.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE	F 514		06-30-10	

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F 514	<p>Continued From page 27</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain accurate clinical records for one (1) of twenty-one (21) sampled residents. The physician wrote an order on January 19, 2010, for resident #3 to be given comfort measures only. However, the order for comfort measures that the physician had written had not been transferred to the current physician's orders for resident #3.</p> <p>The findings include:</p> <p>Review of the medical record for resident #1 revealed the resident was admitted to the facility on October 19, 2009, with diagnoses that included Alzheimer's Disease, Gastroesophageal Reflux, Hypothyroidism, Hypertension, Cardiac Dysrhythmia, Osteoporosis, Anxiety, Depression, and Behaviors with Mood Disorders.</p> <p>Review of the advance directive for resident #3 revealed the family requested to maintain the resident as comfortably as reasonably possible,</p>	F 514	<p>1.) On review of resident #3's medical record the order for comfort measures per family request was found on page number 3 out of 5 located just under turn and reposition every 2 hours and as needed.</p> <p>Continued on page 29</p>	

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F 514	<p>Continued From page 28</p> <p>Do Not Resuscitate (DNR), and in regards to a feeding tube it was handwritten on the advance directive to ask the family when the need arose.</p> <p>Review of a physician's order dated January 19, 2010, revealed the physician documented that the family of resident #3 was requesting comfort measures only because the resident's wishes were for no intravenous fluids/artificial feeding and the physician agreed with honoring the resident's wishes due to the resident having poor prognosis.</p> <p>An interview was conducted with a licensed nurse (charge nurse for resident #3) at 4:00 p.m. on May 21, 2010. The nurse stated that any time a physician writes an order, it should be carried over to the current physician's orders. The nurse was unable to locate the chart to check the order. The Director of Nursing (DON) was unable to locate any documentation in the medical record that the physician's order for comfort measures had been transferred to the current physician's orders. The Administrator stated at 4:20 p.m. on May 21, 2010, if staff was unable to locate any documentation regarding the comfort measures on the current physician's orders by this time, the surveyor could assume the documentation was not there.</p>	F 514	<p>Continued from Page 28</p> <p>2.) A Review of the medical record for any resident with a comfort measure order was completed. All medical records reviewed were found in compliance with a physician order current.</p> <p>3.) The Staff Development Coordinator completed an inservice on 05/27/10 with the Health Information Manager related to physicians order entry. The Staff Development Coordinator completed an inservice on 05/28/10 with all licensed staff on monthly order change over.</p> <p>4.) The Director of Nursing or Designee will audit all medical records of residents with a comfort measures order monthly for 12 months to assure the order is on the current months physicians orders. The audit will be reviewed in the monthly Performance Improvement Committee meeting. Revisions will be made to the systems as indicated. Audits will continue until Performance Improvement Committee determines compliance.</p>	06-30-10	

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NAME OF PROVIDER OR SUPPLIER  LAUREL CREEK HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1033 NORTH HIGHWAY 1 MANCHESTER, KY 40962	
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K 000	INITIAL COMMENTS  A life safety code survey was initiated and concluded on May 25, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	<p><b>Plan of Correction Disclaimer For Lanrel Creek Health Care Center</b></p> <p>Please accept this Plan of Correction as our credible allegation of compliance. Preparation and / or execution of this Plan of Correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth on the statement of deficiencies. This Plan of Correction is prepared and / or executed solely because of State and Federal requirement.</p>	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4.  This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to utilize proper access doors in the fire/smoke wall assembly in the attic area. This deficient practice affected four (4) of seven (7) smoke compartments, staff, and approximately eighty (80) residents. The facility has the capacity for 107 beds with a census of 98 on the day of survey.  The findings include:  During the Life Safety Code survey on May 25,	K 025		1.) Once the facility was informed that it failed to utilize proper access doors in the fire / smoke wall assembly in the attic above the cross corridor doors next to resident room 114 and in the attic above cross corridor doors next to resident rooms 121 and 140 – 4 of 7 smoke compartments. Facility contacted a company to install access doors to meet approved design and rating.

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

*Clara E. Benz*

TITLE

*Executive Director 06-16-10*

(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.

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>186293</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>05/25/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>LAUREL CREEK HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1033 NORTH HIGHWAY 11 MANCHESTER, KY 40962</b>	
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K 025	<p>Continued From page 1</p> <p>2010, at 11:20 a.m., with the Director of Maintenance, the attic above the cross corridor doors next to resident room 14 was noted to have an unapproved makeshift door in the fire/smoke barrier wall. This door had been left open. This type of access door is required to be of an approved design and rating to help prevent fire/smoke from spreading to other areas of the building in a fire situation. An interview revealed the Director of Maintenance was going to go through the building and seal these types of unapproved doors and provide a proper access to the attic from the floor below. During the survey unapproved makeshift doors were noted to be located in the attic above cross corridor doors next to resident rooms 121 and 140.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>8.2.3.2.1 Door assemblies in fire barriers shall be of an approved type with the appropriate fire protection rating for the location in which they are installed and shall comply with the following.</p> <p>(a) * Fire doors shall be installed in accordance with NFPA 80, Standard for Fire Doors and Fire Windows. Fire doors shall be of a design that has been tested to meet the conditions of acceptance of NFPA 252, Standard Methods of Fire Tests of Door Assemblies.</p> <p>Reference: NFPA 80 (1999 Edition).</p> <p>11-1.2 Components. An access door shall be an integral unit including the door, frame, hinges, latch, and closing device (where required) bearing a label that reads "Frame and Fire Door Assembly."</p>	K 025	<p>2.) Audits were conducted by Maintenance to assure remaining access doors were in compliance with code. No other problems were identified.</p> <p>3.) Maintenance Director inserviced staff on the regulation and informed them the problem would be corrected.</p> <p>4.) Maintenance Director and / or designee will audit daily until repaired. Findings will be presented to Performance Improvement Committee for further direction.</p>	6/30/10

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K 025	Continued From page 2 Exception: A vertical access door shall be permitted to have hinges that are not part of the labeled assembly, provided the hinges conform to Table 2-4.3.1. 11-1.2.1 Access doors shall be self-closing. 11-1.2.2 Access doors shall be self-latching. Exception: A horizontal access door that does not open downward and that remains in place when an upward force of 1 psf (48 N/m <sup>2</sup> ) is applied over the entire exposed surface of the door shall not be required to be self-latching.  11-1.2.3 Self-closing access doors that are intended to be used to allow a person to enter the concealed space behind the door completely shall be operable from the inside without the use of a key or tool. 11-1.2.4 Access doors shall be installed in accordance with their listing. 11-2 Types of Doors. 11-2.1 Horizontal Access Doors. 11-2.1.1 Door assemblies used in fire-rated floors or floor-ceiling or roof-ceiling assemblies shall be tested in the horizontal position in accordance with the procedures described in NFPA 251, Standard Methods of Tests of Fire Endurance of Building Construction and Materials, and shall be labeled as horizontal access doors. 11-2.1.2 A horizontal access door shall bear a label that includes the additional wording "For Horizontal Installation." 11-2.1.3 A horizontal access door shall be used in a	K 025			

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K 025	Continued From page 3 fire-rated floor or floor-ceiling or roof-ceiling assembly only where it has been tested and listed for use as a component of the assembly. 11-2.1.4 Horizontal access doors shall not be required to be subject to the hose stream test. 11-2.2 Vertical Access Doors. 11-2.2.1 Vertical access doors shall have a fire protection rating of 3/4 hour, 1 hour, or 1 1/2 hours. (See Appendix F.)  Reference: NFPA 101 (2000 Edition).  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025		
K 046	NFPA 101 LIFE SAFETY CODE STANDARD	K 046		

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K 046 SS=E	<p>Continued From page 4</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all exterior exits contained emergency lighting serviced by the emergency generator as required. This deficient practice had the potential to affect two (2) of seven (7) smoke compartments, staff, and approximately 45 residents. The facility has the capacity for 107 beds with a census of 98 on the day of survey.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code survey on May 25, 2010, at 12:00 p.m., with the Director of Maintenance, revealed no light fixture at the rear of the East wing exit. Exits must be illuminated to the public way and be connected to the emergency generator. An interview revealed the Director of Maintenance was not aware the light fixture was missing. During the survey a light fixture was also noted to be missing at the rear of the West wing exit.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7</p>	K 046	<p>1.) Once the facility was informed that the rear East Wing exit and the rear West Wing exit were required emergency exit lighting serviced by the emergency generator an electrician was called. Emergency lighting serviced by the emergency generator will be installed at both identified exits.</p> <p>2.) Audits were conducted by the Maintenance Director at all other exits to assure compliance with the regulation. No other problem was identified.</p>		

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K 046	<p>Continued From page 5</p> <p>(3) High-rise buildings as required by other sections of this Code</p> <p>(4) Doors equipped with delayed egress locks</p> <p>(5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply</p> <p>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p>	K 046	<p>3.) Maintenance Director inserviced staff on the regulation and informed them the problem would be corrected.</p> <p>4.) Maintenance Director and / or Designee will audit daily until repaired. Findings will be presented to the Performance Improvement Committee for further direction.</p>	6/30/10	