

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

PRINTED: 05/03/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/19/2013
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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000 INITIAL COMMENTS

A Recertification Survey was conducted 04/16/13 through 04/19/13. Deficiencies were cited with the highest Scope and Severity of an "F".

F 224 483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATE

SS=D 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 it was determined the facility failed to implement the facility's policy that prohibits against misappropriation of resident property for one (1) of eighteen (18) sampled residents. Resident #18 notified the facility of an allegation of misappropriation and there was no documented evidence of an investigation or of notification to state agencies in accordance with state law.

The findings include:
Review of the facility "Misappropriation of Resident Property Investigation" Policy, undated, revealed when an incident of misappropriation of resident property was reported, the Administrator would appoint a representative to investigate the incident. The investigation would consist of: an

F 000

F 224

1. Resident #18 had money as she reported missing, replaced by the facility. The resident had no noted adverse effects from lack of reporting noted.
2. All residents have the right to be protected from mistreatment, neglect, and abuse of residents and misappropriation of resident's property. All residents have the potential to be affected by this practice.
3. Misappropriation of Resident Property Policy and Concern and Consent Program was reviewed and staff education on Policy and Program will be completed by the Staff Development Coordinator on May 14, 2013.
4. Concern and Consent Program concerns log will be maintained by the Social Services Director and reviewed weekly X 4 weeks, then

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: INTERIM EXECUTIVE DIRECTOR DATE: 5/10/13

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 224 Continued From page 1

interview with the person reporting the incident, interviews with any witnesses to the incident, an interview with the resident, an interview with the alleged employee, a review of the resident's personal inventory record, interviews with staff members on all shifts that had 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 a review of all circumstances surrounding the incident. Further review of the policy revealed when an allegation of suspected or actual misappropriation of resident property had occurred the facility administrator or his/her designee would notify the State Licensing and Certification Agency.

Review of Resident #18's medical record revealed diagnoses which included Diabetes Mellitus and Depressive Disorder. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/04/12, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of fifteen (15) indicating the resident had no cognitive impairment.

Interview with Resident #18, on 04/17/13 at 10:00 AM, during a Group Interview revealed he/she had a change purse come up missing which contained \$15.59. The resident stated he/she kept the change purse under his/her pillow and it was noted to be missing about four (4) months ago. Further interview revealed she had notified the Social Worker who gave him/her a lock box to use in the future. Resident #18 stated the change purse with money was not found and he/she did not remember his/her room being searched or the Administration getting back with

F 224

monthly X 3 months by the Executive Director to ensure reportable concerns are investigated and reported to appropriate agencies. Results of these audits will be reported to the Performance Improvement committee.

5. Completion Date: May 30, 2013

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him/him related to the results of the investigation.

F 224

Interview, on 04/18/13 at 4:00 PM, with the Social Worker revealed he remembered Resident #18 complaining of having a change purse with money missing. He stated he did not complete any paper work related to the allegation and did not remember if the resident's room was searched or if an investigation was completed. He stated he remembered reporting the incident to the previous Administrator. Continued interview revealed allegations of misappropriation were to be reported to state agencies by the Administrator.

Interview, on 04/19/13 at 8:45 AM, with the Director of Nursing (DON) revealed she was unable to find any investigation related to Resident #18's allegation of misappropriation and stated she did not remember the resident complaining of a missing change purse containing money. She stated, if an allegation of misappropriation was made, staff were to interview the resident involved and other residents on the hall as well as any staff who was working with the resident at the time the item came up missing. She further stated the resident's room should have been searched and if the missing money was not found it would need to be reported to state agencies. Continued interview revealed if there was an allegation of misappropriation it was discussed in the morning meeting and an investigation form would be initiated immediately. She further stated if the Social Worker was made aware of this allegation he should have followed through with notifying her and the Administrator to follow through with an investigation.

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F 224	Continued From page 3 Interview, on 04/19/13 at 11:55 AM, with the Administrator revealed he started at the facility on 03/11/13. He stated the Administrator was to be notified of all allegations of misappropriation and it would be discussed in the morning meeting. He further stated this allegation should have been investigated and reported to state agencies.	F 224			
F 241	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy it was determined the facility failed to promote care for all resident's in a manner and in an environment which maintained or enhanced each resident's dignity and respect in full recognition of their individuality for one (1) of eighteen (18) sampled residents (Resident #1). Licensed Practical Nurse (LPN) #3 failed to have the privacy curtain pulled around Resident #1 while she conducted a full body skin assessment. In addition, two (2) staff failed to wait for permission before opening the door during the skin assessment. The findings include:	F 241	1. Resident # 1 is cared for in a manner and in an environment which maintains her dignity and respect in full recognition of her own individuality. The Director of Nursing educated Nurse #3 and the 2 staff members upon notification from the surveyors concerning pulling privacy curtains when providing care and to wait to be invited into a resident room before entering the room if the door is closed. 2. All residents have the right to be cared for in a manner and in an environment which maintains their dignity and respect in full recognition of their own individuality. All residents have the potential to be affected by this practice.		

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F 241	Continued From page 4 Review of the facility's policy titled "General Resident Rights Guidelines", not dated, revealed staff were to knock on the resident's door and wait for a response and identify themselves before entering the room. Further review of the guidelines revealed when provided care they were to have the resident screened and draped to provide maximum privacy. Observation, on 04/17/13 at 3:40 PM, revealed the privacy curtain for Resident #1 was not pulled while LPN #3 conducted a skin assessment of Resident #1. Further observation revealed Certified Nursing Assistant (CNA) #5 knocked on the door; however, she did not wait for permission before she opened the door, exposing Resident #1. Continued observation revealed an unidentified staff member opened Resident #1's door, without knocking, again exposing Resident #1. Interview with CNA #5, on 04/18/13 at 2:30 PM, revealed she should have waited for permission before opening the door to Resident #1's room. Interview with LPN #3, on 04/18/13 at 2:40 PM, revealed she should have pulled the privacy curtain around Resident #1's bed before she started the skin assessment. She further stated staff were to wait for permission to enter a resident's room before they opened the door. Interview with the DON, on 04/19/13 at 11:00 AM, revealed staff were to always pull the privacy curtain around a resident's bed prior to providing care for the resident. She further stated staff were to wait for permission before they entered a	F 241	3. Policy "General Resident Rights Guidelines" was reviewed and education regarding Resident Rights including maintaining privacy will be completed by the Staff Development Coordinator on May 14, 2013. 4. Observation Audits to include monitoring of privacy curtains and awaiting approval to enter rooms will be conducted weekly X 4, then monthly X 3, by the Director of Nursing or Assistant Director of Nursing. Results of audits will be reported to the Performance Improvement Committee monthly. 5. Completion Date: May 30, 2013		

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F 241 Continued From page 5
resident's room. Further interview revealed Resident #1's privacy curtain should have been pulled before the skin assessment was started and the staff should have waited for permission before they opened Resident #1's door.

F 241

F 252 483.15(h)(1)
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

F 252

1. The identified area of clutter in the Sunroom was resolved on the evening of April 16, 2013 upon notification by surveyors.
2. All areas of the facility are to be maintained to ensure a safe, clean, comfortable and homelike environment. All residents have the potential to be affected by this practice.
3. Staff education regarding maintaining a safe, clean, comfortable, and homelike environment will be completed by the Staff Development Coordinator on May 14, 2013. An assessment of available storage areas was completed on April 25, 2013, by the Executive Director, and reassignment of equipment storage will be completed by May 30, 2013.

This REQUIREMENT is not met as evidenced by:
Based on observation and interview it was determined the facility failed to ensure a safe, clean, comfortable and homelike environment. Observation, on 04/16/13, revealed the Sunroom on the South Unit was cluttered with an electric floor cleaner, an electric floor buffer, a soiled popcorn machine, a wheelchair, and a mechanical lift.

The findings include:
Observation, on 04/16/13 at 2:45 PM, revealed the Sunroom on the South Unit was cluttered with items which included an electric floor cleaner, an electric floor buffer, a wheelchair, and a mechanical lift. Further observation revealed there was a popcorn machine which had been stored with a brown build up on the pot.

During a Resident Group Interview, conducted on

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F 252	Continued From page 6 04/17/13 at 10:00 AM, eight (8) residents who the facility had assessed to be alert and oriented revealed it was sometimes difficult to get to the table and chairs in the Sunroom on the South Unit because items were stored in the way. Interview, on 04/19/13 at 10:30 AM, with the Director of Nursing (DON), revealed she could see where it was a concern to have the clutter of equipment in the Sunroom. She stated there had been an activity in the Sunroom where the popcorn machine had been utilized and it must not have been cleaned. Interview, on 04/19/13 at 11:55 AM, with the Administrator revealed he was looking into better options for storage of equipment and agreed the clutter in the Sunroom could make it difficult for the residents to use the room.	F 252	4. Environmental rounds audits will be completed daily for 30 days, then weekly X 4 weeks, then monthly X 2 months by Department Managers to ensure a safe, clean, comfortable, homelike environment. Results of these audits will be reported to the Performance Improvement Committee. 5. Completion Date: May 30, 2013		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, Interview and review of facility policy it was determined the facility failed to ensure housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation, on 04/16/13, revealed resident care equipment including toothbrushes, denture cups, hair brushes, and combs were unlabeled at	F 253	1. Room 103: Denture cup, brush and comb were labeled, bagged and stored in the bedside table on April 16, 2013, upon notification by surveyors. Room 102: Denture cup and toothbrush were labeled, bagged, and stored in the bedside table on April 16, 2013, upon notification by surveyors. Room 107: Denture cup and comb were labeled, bagged and stored in the bedside table on April 16, 2013, upon notification by surveyors. Room 109 wash basin was labeled, bagged and stored in the bedside table on April 16, 2013, upon notification by surveyors.		

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F 253	Continued From page 7 resident sinks. There was also unlabeled and unbagged wash basins and graduated cylinders in resident bathroom floors. The findings include: Review of the facility Oral Hygiene Policy, undated, revealed after oral hygiene, clean the equipment and return to the designated storage area, bedside stand, or bathroom. Further review of the policy revealed to make sure the resident's denture container was clearly marked with the resident's name and room number. Review of the facility Hair and Nails Policy, undated, revealed staff should only use the resident's brush and comb and not borrow from another resident. Observations, on 04/16/13 from 2:45 PM until 3:30 PM, revealed: Room 103- denture cup, and brush and comb, all unlabeled at the sink. Room 102- denture cup and toothbrush unlabeled at the sink Room 107- denture cup and comb unlabeled at the sink Room 109- wash basin unlabeled and unbagged in the bathroom floor Room 111- graduated cylinder unbagged and unlabeled in the bathroom floor Room 113 bathroom- two (2) wash pans unlabeled and unbagged stored on top of the paper towel holder Interview, on 04/16/13 at 5:30 PM, with the Director of Nursing (DON) revealed denture cups, toothbrushes, brushes and combs were to be	F 253	Room 111: Graduated cylinder was labeled, bagged and stored in the bedside table on April 16, 2013, upon notification by surveyors. Room 113: Wash pans were discarded and replaced, labeled, bagged, and stored in the bedside table on April 16, 2013, upon notification by surveyors. 2. All residents are to be provided with housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. 3. Policies related to storage of personal care items to maintain a sanitary, orderly, and comfortable interior were reviewed by the ED, DON, SDC, Housekeeping Supervisor, and Maintenance Director on April 29 and staff education will be completed regarding maintaining sanitary, orderly, and comfortable interior related to storage of personal care items by the Staff Development Coordinator on May 14, 2013.		

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F 253	Continued From page 8 labeled with the resident's name and bagged and placed in a drawer. She further stated the graduated cylinders were used to empty urinary catheters and were to be labeled with the residents name and bagged. Continued interview revealed the wash basins were used for partial baths and were to be labeled and stored in the bedside table.	F 253	4. Environmental rounds audits will be conducted by the Department managers including monitoring for proper labeling and storage of personal care items daily X 30 days, then weekly X 4 weeks, to ensure a sanitary, orderly, and comfortable interior for all residents. Results of monitoring audits will be reported to the Performance Improvement Committee monthly.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, Interview, record review and review of facility's policy it was determined the facility failed to ensure a Comprehensive Plan	F 279	5. Completion Date: May 30, 2013		

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F 279	Continued From page 9 of Care was developed for each resident to meet the resident's medical needs that was identified in the comprehensive assessment for one (1) of eighteen (18) sampled residents (Resident #6). Although Resident #6 was assessed to have dysphagia with recommendations from speech therapy for supervision while eating, there was no documented evidence of a Plan of Care to address this resident's risk for aspiration and choking. The findings include: Review of Resident #6's medical record revealed diagnoses which included Dementia, Chronic Renal Disease, Dysphagia and Hypertension. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/28/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15) which indicated the resident had cognitive impairment. Further review revealed the resident was assessed as requiring supervision for eating, and as having a mechanically altered diet. Review of the Care Area Assessment Summary (CAAS), dated 03/03/13, revealed the resident was receiving a dysphagia level diet related to a history of swallowing problems. Review of the monthly Physician's Orders, dated 04/10, revealed the resident was ordered a Dysphagia Diet. Review of the Speech Plan of Treatment, dated 08/24/10, revealed Resident #6 needed to be	F 279	1. Resident # 6 careplan was revised to include needed supervision with meals on May 6, 2013, after reevaluation by the Speech Therapist. Resident had no noted adverse effects. 2. A audit of all resident careplans will be reviewed by nurse management by May 30, 2013 to ensure careplans are based on the comprehensive assessment, which includes measurable objectives and individualized interventions to meet residents needs. 3. Education will be provided to the MDS coordinator, Social Service Director, Dietary Manager, Activities Director and Licensed Nurses by the Director of Nursing by May 14, 2013. 4. Careplans will be audited by the Director of Nursing or Assistant Director of Nursing to ensure they are based on the resident's comprehensive assessment, which includes measurable objectives and individualized interventions to meet residents needs weekly X 4 weeks, then monthly X 3. Results of audits will be reported to the Performance Improvement Committee monthly. 5. Complete Date: May 30, 2013		

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F 279 Continued From page 10
supervised in dining room due to impulsivity and impaired cognition. Further review of the plan revealed Resident #6 had swallowed his/her bottom dentures during a meal and experienced a severe choking episode. The Speech Therapy Discharge Summary, dated 08/26/10, recommend removing dentures, continue with mechanical soft diet and thin liquids and to provide supervision in dining room for meals.

Observation, on 04/17/13 at 11:50 AM, revealed Resident #6 was in bed in his/her room feeding self a dysphagia regular diet, unsupervised.

Interview, on 04/19/13 at 10:00 AM, with the Speech Therapist who wrote the above note revealed she did not remember completing a recent speech evaluation on Resident #6; however, stated she was aware he/she ate fast with large bites and she was aware he/she was not being supervised when he/she was eating in his/her room. She stated once the speech evaluations were done, the rehab supervisor takes the information to the MDS Coordinator to be care planned. She confirmed Resident #6 did need supervision while eating.

Interview, on 04/19/13 at 10:45 AM, with the Director of Nursing (DON), revealed the resident probably needed supervision while eating after reviewing the Speech Therapist notes.

Review of the Comprehensive Plan of Care, dated 03/12/13, revealed a problem stating the resident required extensive assistance with Activities of Daily Living (ADLs) related to a CVA in the past with approaches to attempt to get the resident up for all meals and no dentures were to

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NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD	STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351
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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
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F 279	Continued From page 11 be worn. Further review of the Comprehensive Plan of Care revealed there was no care plan in place to address this resident's dysphagia and need for supervision while eating. Interview, on 04/19/13 at 11:00 AM, with the MDS Coordinator Assistant revealed she had completed Resident #6's last MDS and Care Plan. She stated she did not necessarily check the speech therapy notes when developing the care plan because if there was a problem she would receive a referral from speech therapy or other therapies. She stated she was aware the resident was not to have dentures due to a choking episode in the past related to the dentures and she had care planned that; however, she was unaware of the need for a care plan related to dysphagia and the need for supervision while eating.	F 279		
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 interview, record review and review of facility policy it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one (1) of eighteen (18) sampled residents (Resident #7). Physician's Orders were received for Macrobid (antibiotic medication) for recurrent Urinary Tract	F 281	1. Resident # 7 completed antibiotic therapy as ordered on 4/17/13 with a maintenance dose started on 4/18/13. Resident did not have any adverse effects noted from starting the antibiotic on 4/11/13 in place of 4/10/13. 2. Physician orders written in the last 14 days were reviewed by the Director of Nursing on May 7, 2013, to ensure prompt implementation of orders, with no additional issues identified.	

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F 281 Continued From page 12
Infections (UTI) for Resident #7 on 04/10/13; however, there was no documented evidence the medication was started until 04/11/13.

The findings include:

1. Review of Resident #7's medical record revealed diagnoses which included Alzheimer's Disease and a History of Urinary Tract Infections (UTIs). Review of the Admission Minimum Data Set (MDS) Assessment, dated 03/21/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of three (3) out of fifteen (15). Further review revealed the facility assessed the resident as having frequent incontinence of bowel and bladder and as having a UTI in the past thirty (30) days.

Review of the Comprehensive Plan of Care, dated 04/10/13, revealed the resident had a UTI with an approach for the antibiotic to be administered as ordered.

Review of the Physician's Orders, dated 04/10/13 revealed orders for Macrobid twice a day for seven (7) days, then daily for twenty-eight (28) days.

Review of the Medication Administration Record (MAR), dated 04/10, revealed the medication was not started until 04/11/13 at 8:00 AM.

Interview, on 04/19/13 at 9:00 AM, with Licensed Practical Nurse (LPN) #4 revealed she had obtained the Physician's Order for the Macrobid on 04/10/13. She checked the emergency box and stated she could have pulled the medication

F 281 3. Education for the Licensed Nurses regarding following physician orders promptly will be completed by the Staff Development Coordinator on May 14, 2013.

4. An audit of new physician orders will be completed by the Director of Nursing or Assistant Director of Nursing to ensure physician orders were promptly implemented as written daily X one month, then monthly X 3. Results of these audits will be reported to the Performance Improvement Committee.

5. Completion Date: May 30, 2013

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F 281	Continued From page 13 from the emergency box because Macrobid was kept in the emergency box. She stated she thought the medication could be started the next day. Interview, on 04/19/13 at 9:15 AM, with the Director of Nursing revealed it was her expectation that antibiotics were to be started as soon as they were prescribed. She stated the Macrobid could have been pulled from the emergency box.	F 281		
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 interview and record review it was determined the facility failed to ensure services were provided by the facility in accordance with each resident's written Plan of Care for one (1) of eighteen (18) sampled residents (Resident #6). Although Resident #6 was receiving two (2) anti-hypertensive medications, there was no documented evidence the resident's vital signs were routinely being obtained and monitored as per the Plan of Care. The findings include:	F 282	1. Resident # 6 receives weekly vital sign assessments related to his use of anti-hypertensive medications. This resident did not have any adverse effects to blood pressure not being obtained. 2. All residents have the potential to be affected by this practice. An 100% audit of all resident charting will be completed by the Nursing Management to ensure timely implementation of careplan interventions, and concerns identified addressed, by May 30, 2013. 3. All Licensed Staff will be educated regarding ensuring services are provided in accordance with each resident's written plan of care and assessment and charting requirements	

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F 282 Continued From page 14

1. Review of Resident #6's medical record revealed diagnoses which included Dementia, Chronic Renal Disease, and Hypertension. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 03/28/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of three (3) out of fifteen (15) indicating the resident had cognitive impairment.

Review of the Comprehensive Plan of Care, dated 03/28/13, revealed Resident #6 was at risk for alteration cardiac status due to diagnoses of Hypertension, Hypertlipidemia, Congestive Heart Failure, and a History of Cerebral Vascular Accident (CVA) in the past. The approaches included; observe for signs and symptoms of hypotension, observe for cardiac distress, vital signs as needed, medications as ordered, and notify Physician of any cardiac issues and treat as ordered.

Review of the monthly Physician's Orders, dated 04/13, revealed medications ordered for Hypertension including Lisinopril 10 milligrams (mg's) every day, and Lopressor 25 mg's every day.

Interview with Licensed Practical Nurse (LPN) #5, on 04/18/13 at 9:30 AM, who was assigned to the resident revealed the last vital signs obtained on the resident was 03/08/13. She stated vital signs were to be obtained weekly and documented on the weekly assessment for all residents and there was a schedule the nurses went by to ensure this was done.

Interview, on 04/19/13 at 10:45 AM, with the

F 282

by the Staff Development Coordinator on May 14, 2013.

4. Careplan interventions will be audited by the Director of Nursing, Assistant Director of Nursing, and Staff Development Coordinator to ensure interventions are implemented as written daily X 4 weeks, then monthly X 3 months. Results of audits will be reported to the Performance Improvement Committee.

5. Completion Date: May 30, 2013

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F 282 Continued From page 15
Director of Nursing revealed vital signs were to be obtained weekly for all residents and documented in the weekly notes. She stated she did not realize this was not being done because she had a set schedule the nurses were to check to see which residents were scheduled for vital signs and a weekly assessment during their shift.

F 282

F 431 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS

F 431

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 labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

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.

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

1. Medication Rooms and Medications
Carts were cleaned and organized to ensure medications and biological were stored in accordance with state and federal laws and policy on April 16, 2013, upon notification by surveyors.

2. All Medication and Biological storage areas were assessed to ensure proper storage of medication and biological product on April 16, 2013, upon notification by surveyors.

3. Medication Storage and Biological storage policies were reviewed and staff education will be provided by the Staff Development Coordinator by May 14, 2013. Cleaning Schedule for Medication Carts and Rooms were implemented on April 22, 2013.

4. Audits to ensure proper medication and biological storage including,

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F 431	<p>Continued From page 16</p> <p>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, interview and review of the facility policy it was determined the facility failed to ensure medications and biological used in the facility were stored in accordance with state and federal laws and per the facility policy. Observations, on 04/16/13, revealed the temperature logs for the medication refrigerators were not maintained for three (3) of the six (6) medication carts. Further observation revealed dried liquid in the drawers and on the outer wall of the cart, food items and medications were found stored together and with chemicals, the emergency medication boxes were found without the plastic zip tie locks in place, water was dripping onto medications stored in the medication refrigerator on the South Unit, and a bag of Intravenous (IV) fluids and tubing was found stored on the floor of the medication room.</p> <p>The findings include:</p> <p>Review of the facility Medication Storage and Security, dated 06/06, revealed medications and biologicals was to be stored safely and securely. Further review revealed orally administered medications were to be kept separate from externally used medications (e.g., suppositories, liquids, lotions, and tablets), and was also not to be stored in the same area as food items. Further review revealed potentially harmful</p>	F 431	<p>cleanliness of medication carts, temperatures of refrigerators, proper organization of Medication rooms will be conducted by the Director of Nursing, Assistant Director of Nursing, or Staff Development Coordinator daily for 30 days, then weekly X 4. Results of audits will be reported to the Performance Improvement committee.</p> <p>5. Completion Date: May 30, 2013</p>	

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F 431 Continued From page 17

substances, (e.g. household poisons, cleaning supplies, and disinfectants) was to be clearly identified and stored in a locked area separately from medications and other biologics. Further review revealed medications requiring refrigeration was to be kept in a refrigerator with a thermometer, which allowed for the temperature to be monitored.

1. Observation of the medication room on the West unit, on 04/16/13 at 4:30 PM, revealed four (4) emergency boxes without the plastic zip tie lock in place, a bag of soft peppermints, and a package of peanut butter and crackers on the same shelf as a box of Lidoderm patches. Further observation revealed twelve (12) boxes of oral medications on a different shelf, three (3) open containers of super-sani wipes on the same shelf as a case of canned sodas and a box of swiss roles. Further observation on the West unit revealed medication cart A had a bottle of liquid medication in the same drawer as oral tablet and capsule medications, an orange colored dried substance on the bottom of one of the drawers, and yellow beads loose in the bottom of a drawer with a dried brown substance throughout the bottom of the drawer. Further observation revealed medication cart B had a dried thick white substance in one of the drawers as well as down the side of the medication cart; a bottle of liquid medication in the same drawer as oral tablet and capsule medications and a package which contained a capsule with brown liquid on the outside of the package.

Interview with Licensed Practical Nurse (LPN) #6, on 04/16/13 at 4:40 PM, revealed he did not know who was responsible for cleaning the medication

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F 431 Continued From page 18

cars. He further stated liquid medications should not be stored in the same drawer as oral tablet and capsule medications and the spilled liquids should have been cleaned as soon as they were spilled. He further stated he should have replaced the plastic zip tie locks on the emergency medication boxes after removing medications for a resident. Further interview revealed the yellow beads in the drawer came out of a broken medication capsule and should have been cleaned out of the medication cart as soon as the capsule broke. He further stated the food items in the medication room should not be stored with medications or chemicals.

2. Observation of the medication room on the North unit, on 04/16/13 at 5:40 PM, revealed two (2) bottles of Virex TB solution on the same shelf as a resident's box of saltine crackers and twenty-four (24) pack of canned sodas. Additional observation revealed three (3) emergency medication boxes without a zip tie lock in place.

Interview with LPN #7, on 04/16/13 at 5:40 PM, revealed food items should not be stored with medications or chemicals. Further interview revealed after a medication was taken out of the emergency medication box, the plastic zip tie lock should always be replaced.

3. Observation of the medication room on the South unit, on 04/16/13 at 6:00 PM, revealed a bag of IV fluids and tubing on the floor in the medication room; water dripping on the medication labels in the medication refrigerator; a plastic spray bottle of Comet Bleach cleaner on the same shelf as boxes of ostomy supplies and

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F 431 Continued From page 19
a box of resident swiss rotes and two (2) large bags with in house stock Bisacodyl suppositories sitting on top of plastic bags of loose tobacco; and a package of peeps sitting on top of the emergency medication box.

Interview with LPN #8, on 04/16/12 at 6:00 PM, revealed the IV fluids and tubing should not have been stored on the floor of the medication room. Further interview revealed the medications in the medication refrigerator should have been stored in a manner which would have protected them from the dripping water. She further stated food items and medications should not be stored together and neither item should ever be stored on the same shelf as a chemical.

Interview with the DON, on 04/17/13 at 10:00 AM, revealed third shift was to document the temperatures of the medication refrigerators every night. She further stated the medications in the refrigerator on the South Unit should have been stored in a manner which protected them from the dripping water. Further interview revealed third shift was to clean the medication carts every week; however, if a nurse spilled something in or on the medication cart it was their responsibility to clean the cart. Further interview revealed food items and medications were to never be stored together on the same shelf, and was never be stored on the same shelf as a chemical. She further stated medication was to never be stored on the floor of the medication room. Further interview revealed after a nurse took the plastic zip tie lock off of an emergency medication box that they should replace the plastic zip tie lock immediately after removing a medication.

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K 000 INITIAL COMMENTS

K 000

CFR: 42 CFR 483.70(a)

Building: 01

Survey under: NFPA 101 (2000 Edition)

Plan approval: 1967, 1970

Facility type: SNF/NF

Type of structure: Type III (211) Protected

Smoke Compartment: Eight (8)

Fire Alarm: Complete fire alarm with heat and smoke detectors in corridors and resident rooms on North and South Wings, all corridors on East and West Wing (software upgrade: 2011)

Sprinkler System: Complete sprinkler system (dry)

Generator: Type II powered by Natural Gas with Propane backup.

A Life Safety Code survey was conducted on 04/18/13 with no deficiencies cited.

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

INTERIM EXECUTIVE DIRECTOR

TITLE

5/19/13

(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.