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

PRINTED: 07/06/2012
FORM APPROVED
OMB NO. 0938-0391

RECEIVED JUL 19 2012 Division of Health Care Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED
	185337		06/21/2012

NAME OF PROVIDER OR SUPPLIER
LEE COUNTY CARE & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
246 EAST MAIN STREET
BEATTYVILLE, KY 41311

(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 A standard health survey was conducted on 06/19-21/12. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	Lee County Care and Rehabilitation Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers it response, credible allegations or compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 174 SS=B	483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure that reasonable access to the use of a telephone where residents could place calls without being overheard by facility residents and staff was provided for four of nine residents that were observed and/or interviewed. A group interview conducted on 06/19/12, with six alert and oriented residents revealed two of the residents (Residents #5 and #22) revealed the facility provided cordless telephones for resident use. However, according to Residents #5 and #22, the cordless telephones did not have reception to the residents/resident rooms located at the end of the A/B Halls. According to the residents, because there was no telephone reception in that area, the residents did not have access to a telephone for private conversations. In addition, interview with Resident #24 on 06/20/12, at 2:35 PM, and observation of Resident #26 on 06/20/12, at 1:30 PM, revealed the residents did not have access to the use of a telephone where calls could not be overheard. The findings include:	F 174		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature], LPNA
TITLE: Administrator
(X6) DATE: 07/18/2012

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

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F 174	Continued From page 1 The facility's policy, Telephone, Resident use of, dated June 2007, stated residents would have easy access to telephones. The policy noted designated telephones would be available to residents to make and receive private telephone calls and would be located in areas that offer privacy and would accommodate the hearing impaired and wheelchair bound residents. During the group interview conducted on 06/19/12, with six alert and oriented residents, Resident #5 and Resident #22 revealed the cordless portable telephones provided for resident use did not have reception in the resident rooms located at the end of the resident halls and as a result, the telephones could not be used privately in the resident rooms. The interview revealed residents were required to use the nurses' cordless telephone located at the nurses' station and the resident conversations could be overheard by facility staff and other visitors. An interview was conducted with Resident #22 on 06/20/12, at 2:30 PM. Resident #22 stated he/she was unable to place calls privately from the room and reported staff assisted him/her to the desk located at the nurses' station in order for the resident to talk with family members by telephone. An interview was conducted with Resident #24 on 06/20/12, at 2:35 PM. Resident #24 stated he/she had a telephone in his/her resident room but the reception was not always good and the resident could not hear all the conversation(s).	F 174	**F 174** 1. New cordless phones were installed by the Home Office IT Department on 6/21/2012 at each nurse's station for resident use. R5, R22, R24, R25 and R26 were informed by the Social Service Director of the phone installation. 2. Alert and orientated residents were notified on 07/19/2012 by the Quality of Life Director, Housekeeping Director and Administrator that cordless phones are available at each nursing station for resident use. 3. Dedicated phone lines were installed on 06/21/2012 by the Home Office IT Department at each nurse's station for the new cordless phones that are for resident use. Staff will be educated by the Director of Nursing, Assistant Director of Nursing, Quality Assurance Nurse or Administrator on the location of the newly installed phones and that	

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F 174	Continued From page 2 An observation conducted on 06/20/12, at 1:30 PM, revealed staff assisted Resident #26 to place a telephone call from the nursing unit with staff present. Staff was observed to place a corded telephone on top of the counter and within the resident's reach. Staff acknowledged the resident could have access to the cordless telephone but they had failed to offer the phone for the resident's use. An interview was conducted on 06/21/12, at 3:00 PM, with the Facility Maintenance Supervisor. The Maintenance Supervisor thought residents were allowed to use the cordless telephone kept on the medicine cart. An interview was conducted on 06/21/12, at 3:00 PM, with the Licensed Practical Nurse (LPN) that had offered assistance to Resident #26. The LPN stated the residents had a separate line for resident use but could also use the nurses' cordless telephone. An attempt was made by the LPN and Maintenance staff on 06/21/12, at 3:00 PM, to place a telephone call from a cordless telephone located at the end of the A Hall for testing purposes. However, the call was unsuccessful due to poor reception. An interview was conducted with the Facility Administrator on 06/20/12, at 1:00 PM. The Facility Administrator stated he was unaware of the problem with the cordless telephone reception.	F 174	phones are for resident use. The new phones will be discussed by the Quality of Life Director and/or Administrator with Residents during the Resident Council Meeting on July 27, 2012. The Social Services Director, Administrator or Housekeeping Director will interview seven residents weekly for four weeks and monthly for two months to ensure phone privacy is provided. 4. All information or issues will be presented to the QA committee monthly for two quarters for recommendations. 5. Completion Date:	8/1/12
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE	F 250		

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F 250	Continued From page 3 The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the Social Services Director job description, the facility failed to provide medically related social services for one of twenty-six sampled residents (Resident #11). Resident #11's family member expired on 05/26/12, however, there was no evidence social services had been provided for grief counseling for the resident. The findings include: Interview with the Interim Director of Nurses on 06/20/12, at 4:40 PM, revealed the facility did not have a policy related to the provision of social services for the residents. A review of the job description for the Social Services Director (SSD), dated December 2011, revealed the SSD was responsible to assist residents and families with social, emotional, and family issues and to maintain progress notes for each resident indicating response to the treatment plan and adjustment to life in the facility. A review of the medical record revealed the facility admitted Resident #11 on 06/05/08, with diagnoses to include Hypertension, Congestive Heart Failure, Lumbosacral Spondylosis, and	F 250	**F250** 1. R11 was interviewed by the Social Service Director and grief counseling was offered. 2. All residents have the potential to be affected by the alleged deficient practice. Alert and oriented residents were interviewed by the ADON, MDS Coordinator and Social Service Director on 06/20/12 and 06/21/2012 and no other issues were identified. 3. Education was provided to the Social Service Director by the DON regarding grief counseling on 06/20/2012 and that this is to be provided per resident need. Staff will be educated by the DON, Administrator or QA Nurse by 08/01/2012 to report any noted issues to the Social Service Director, DON or Administrator and to note any reported resident needs on the 24-Hour Report sheet. The 24-Hour Report Sheet will be reviewed 5 days	

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F 250	Continued From page 4 Chronic Anxiety. A review of the annual comprehensive assessment with a reference date of 06/05/12, revealed the facility assessed Resident #11 to have mood symptoms of "feeling down, depressed, or hopeless" for two to six days during the reference period and to feel tired or have little energy for seven to eleven days during the reference period. The comprehensive assessment identified Resident #11 to have a "Brief Interview for Mental Status (BIMS)" score of 15 which indicated the resident's cognitive status was intact. A review of a comprehensive care plan dated 06/13/12, revealed facility staff identified Resident #11 to have mood and/or /behavior problems, and indicated staff was to observe for changes in the resident's mood/behaviors, notify the physician of changes, provide SSD visit to the resident as needed, and to obtain a psychiatric consultation, as needed, for the resident. A review of the nurse's notes dated 05/26/12, at 10:00 PM, revealed Resident #11 verbalized to the nurse that the resident's "baby" sibling had "died yesterday." The nurse documented the attending physician was notified and new orders were received to administer 5 mg of Valium (anti-anxiety drug) four times a day for three days to Resident #11. A review of the SSD progress notes revealed the most recent note was dated 03/12/12 (75 days prior to the death of the resident's sibling). The progress note identified the resident had good familial support and was friendly and talkative.	F 250	per week by the DON, MDS Coordinator or ADON in the morning clinical meeting. 4. An audit of the 24-Hour Report will be completed daily by the Social Service Director, DON or Administrator to determine any resident needs for four weeks and monthly for one month. All findings will be discussed in the monthly Quality Assurance Meeting . The QA Committee will make recommendations as needed. 5. Completion Date:	8/1/12

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F 250	Continued From page 5 The social services note further indicated one to one visits would be done as needed; however, there was no documentation the SSD had provided grief counseling related to the death of the resident's sibling on 05/26/12. Interview conducted with Resident #11 on 06/20/12, at 4:30 PM, revealed the resident's sibling expired approximately four weeks prior to the interview. The resident stated he/she had talked with the nurses and nurse aides about his/her sibling's death and, even though Resident #11 stated he/she knew who the SSD was, stated the SSD had not talked with the resident about the death of the resident's sibling. Interview conducted with Licensed Practical Nurse (LPN) #1 on 06/20/12, at 5:25 PM, revealed the LPN had documented the death of Resident #11's sibling on the 24-hour shift report log. The LPN stated the administrative staff reviewed the report log during the daily meetings to review for any resident concerns. Interview conducted with the SSD on 06/20/12, at 5:00 PM, revealed resident concerns should be reported to her during the daily administrative meetings. The SSD stated she believed the death of Resident #11's sibling had been mentioned during the daily meeting but stated she had not talked with the resident about the effect the death of the resident's sibling had on the resident. The SSD acknowledged she should have talked with the resident and offered grief counseling to the resident.	F 250		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES	F 253		

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F 253	Continued From page 6 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 and interview, it was determined the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary, comfortable interior. Several wheelchairs in use by residents were observed to have ragged, torn arms. The shower on C Wing was out of order and there was a foul odor from the toilet in resident rooms C3-5. The findings include: An interview with the Maintenance Supervisor (MS) on 06/21/12 at 1:00 PM, revealed the facility did not have a maintenance policy. Observations during the environmental tour on 06/21/12, at 1:00 PM, revealed the following areas were in need of maintenance services: -Wheelchairs in resident rooms 101-A, B2-B, B8-A, B12-B, C5, and C6-B were observed to have torn, ragged arms. The wheelchair in resident room C16-B was observed to have the arms wrapped with kling bandage. -The shower on C Wing had a sign on the shower stall, "DO NOT USE." Further observation revealed the hose to the handheld shower head was not connected to the water supply pipe.	F 253	**F253** 1. Wheelchairs in resident rooms 101-A, B2-B, B8-A, B12-B, C5, C6-B and C16-B were noted and identified for needed repairs by the Plant Operations Director and Plant Operations Assistant. The arms on the wheelchairs will be repaired or replaced by the Plant Operations Director, Plant Operations Assistant or Rehab Services Manager by 08/01/2012. The urine odor in the bathroom between resident rooms C3-C5 was cleaned by the Housekeeper assigned to this hall upon being notified of the issue on 06/20/2012. It was determined that the source of the odor was identified as being under the new flooring that had just been installed by the Home Office Construction Department. The flooring will be removed and replaced by the Plant Operations Director or Plant Operations Assistant by 08/01/2012.	

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F 253		F 253	The shower heads on C-Wing will be replaced by the Plant Operations Director or Plant Operations Assistant 08/01/2012 to ensure proper function. 2. Resident wheelchairs will be assessed by Plant Operations Director, Plant Operations Assistant or Rehab Services Manager by 07/25/2012. Residents that have wheelchairs with noted issues will be identified and repaired and/or replaced by the Plant Operations Director, Plant Operations Assistant or Rehab Services Manager by 08/01/2012. The Housekeeping Director conducted a full round of the building to identify other rooms that may have odors present 6/20/2012. Any rooms that had odors present were cleaned by the Housekeeping Assistant assigned to that particular area. 3. The Plant Operations Director or Plant Operations Assistant will utilize the monthly Preventative	

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F 253	Continued From page 6 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 and interview, it was determined the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary, comfortable interior. Several wheelchairs in use by residents were observed to have ragged, torn arms. The shower on C Wing was out of order and there was a foul odor from the toilet in resident rooms C3-5. The findings include: An interview with the Maintenance Supervisor (MS) on 06/21/12 at 1:00 PM, revealed the facility did not have a maintenance policy. Observations during the environmental tour on 06/21/12, at 1:00 PM, revealed the following areas were in need of maintenance services: -Wheelchairs in resident rooms 101-A, B2-B, B8-A, B12-B, C5, and C6-B were observed to have torn, ragged arms. The wheelchair in resident room C16-B was observed to have the arms wrapped with kling bandage. -The shower on C Wing had a sign on the shower stall, "DO NOT USE." Further observation revealed the hose to the handheld shower head was not connected to the water supply pipe.	F 253	Maintenance Tool for wheelchairs. Any noted issues will be repaired and/or scheduled for replacement at that time. The Regional Plant Operations Director or Administrator will be the wheelchair Preventative Maintenance Program to ensure compliance. Staff will be educated by the DON, Plant Operations Director or Administrator by 08/01/2012 on visually looking for wheelchairs that need repairs. This education will reiterate the process of when a wheelchair is noted to need repairs; a work order needs to be completed. Education will be provided by the Plant Operations Director or Plant Operations Assistant of the process of completing a work order upon identifying a wheelchair that needs repairs by 08/01/2012. The Housekeeping Director or appointed Housekeeper will conduct an audit of each bathroom five times per week	

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F 253	Continued From page 7 -Observations on 06/19/12, at 10:45 AM and 12:00 PM, revealed there was a strong urine odor in the toilet between resident rooms C3-C5. The housekeeper was observed mopping the floor just prior to the 12:00 PM observation, however, the smell did not improve. Observations on 06/20/12, at 9:00 AM and 11:00 AM, revealed the strong odor continued. According to the MS, the procedure was for staff to complete a maintenance request, place it in the maintenance box at the nurses' stations and then a Maintenance employee would pick it up daily. The MS stated he was unaware that wheelchairs were ragged and torn and he had not been notified the shower on C Wing was out of order. The MS further stated he had replaced the flooring in the C3-5 toilet in an attempt to prevent the urine odor, but it had not improved.	F 253	for four weeks then monthly to identify any odors. Any odors identified will be addressed at that time. Staff will be educated by the Housekeeping Director, Plant Operations Director or Plant Operations Assistant regarding use of maintenance request forms and locations of housekeeping supplies for any incidents that occur when housekeeping staff are not in the building. 4. The Administrator or DON will audit the Maintenance Request log and the bathroom audits weekly for four weeks and then monthly for two months. The audits will be reviewed monthly by the Quality Assurance meeting for recommendations.	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician's orders for one of twenty-two sampled residents (Resident #7). Resident #7 had physician's orders to utilize a hand splint for eight to ten hours during the day, however, observations conducted during the day on 06/20/12 and 06/21/12, revealed no evidence of a hand splint in use for Resident #7.	F 281	5. Completion Date: **F281** 1. Hand splint was placed on the hand of R7 by the assigned RN. R7 was assessed by the assigned RN and there wasn't any change in status.	8/1/12

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F 281	Continued From page 8 The findings include: An interview with the facility's Director of Nursing (DON) on 06/25/12, at 3:00 PM, revealed the facility does not have a policy regarding following physician's orders. A review of the medical record for Resident #7 revealed the facility admitted the resident on 07/10/11, with diagnoses that included Cerebrovascular Accident, Dementia, Seizure Disorder, and Hypertension. The comprehensive admission Minimum Data Set (MDS) assessment revealed Resident #7 had limited range of motion in the left upper extremity. A review of the physician's order, dated 08/11/11, revealed Resident #7 was "to wear a left palm protector eight to ten hours daily. Nursing staff to apply/remove and monitor for redness, edema and skin breakdown." Observations on 06/19/12, at 12:20 PM, 2:20 PM, 4:45 PM, and 5:50 PM, revealed no hand splint was in use for Resident #7. Observations on 06/20/12, at 9:20 AM, 1:30 PM, 2:45 PM, 4:45 PM, and 7:15 PM, revealed no hand splint was in use. Observations on 06/21/12, at 9:05 AM, revealed no hand splint was in use for Resident #7. An interview with State Registered Nurse Aide (SRNA) #1 on 06/21/12, at 9:30 AM, revealed SRNA #1 assumed the Restorative Aides (RAs) were responsible for the placement/monitoring of splints and was unaware Resident #7 was not utilizing a splint.	F 281	2. All residents that require splint application have the potential to be affected by the alleged deficient practice. Residents that have splints were checked by the DON, ADON and MDS Coordinator on 06/21/2012 and no other issues were identified. 3. Education will be provided by the QA Nurse, ADON or DON to nursing staff by 08/01/2012 regarding following physician's orders for splint applications. A 100% audit of splint application will be conducted by the Director of Nursing, ADON or QA Nurse weekly for four weeks and then monthly for two months to ensure appropriate splint application. 4. All audits will be reviewed by the Quality Assurance committee monthly for three months for recommendations. 5. Completion Date:	8/1/12

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F 281	Continued From page 9 An interview with SRNA #3, who was the RA on 06/21/12, at 9:55 AM, revealed Resident #7 was not on the Restorative caseload to apply/remove a hand splint. An interview with Registered Nurse (RN) #1 on 06/21/12, at 10:30 AM, revealed she was responsible to monitor Resident #7's use of a hand splint. According to RN #1, she "thought" she saw it on Resident #7's hand and had initialed the treatment record to indicate it was there. RN #1 further stated she guessed she "was mistaken."	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one of twenty-six sampled residents (Resident #11). Resident #11 verbalized thoughts of suicide to a facility staff nurse on 04/30/12; however, there was no evidence the facility had provided care and services to meet the mental and	F 309	**F309** 1. Upon notification R11 was placed on 1:1 supervision by direct care staff, interviewed by Social Service Director and a Psychiatric consult was initiated. 2. All residents have the potential to be affected by the alleged deficient practice. Alert and oriented residents were interviewed by the Social Service Director for any signs and symptoms of depression on 06/20/12 and 06/21/2012. No other issues were noted.	

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	185337		06/21/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY CARE & REHABILITATION CENTER	246 EAST MAIN STREET BEATTYVILLE, KY 41311

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F 309	Continued From page 10 psychosocial needs of the resident and to ensure the safety of the resident. The findings include: A review of the facility Suicide Monitoring policy (dated June 2007) revealed facility staff would continually monitor residents for indicators of acute depression and/or suicidality and provide immediate intervention to ensure the safety of the resident. The policy noted the resident would not be left unattended and an assessment of the resident's current behavior and emotional status would be completed and communicated to the physician when a resident exhibited signs/symptoms of suicidality. The policy further noted the resident would be evaluated by a physician, psychiatrist, or psychotherapist "as soon as possible" to determine the supervision, treatment, or emergency hospitalization required by the resident's condition. In addition, the policy noted a room and body search would be ordered and conducted immediately to remove any potential dangerous objects. A review of the medical record revealed the facility admitted Resident #11 on 06/05/08, with diagnoses to include Hypertension, Congestive Heart Failure, Lumbosacral Spondylosis, Depression, and Chronic Anxiety. A review of the annual comprehensive assessment with a reference date of 06/05/12, revealed the facility assessed Resident #11 to have mood symptoms of "feeling down, depressed, or hopeless" for two to six days during the reference period and to feel tired or have little energy for seven to eleven days during the	F 309	3. Education was provided to the Social Service Director by the DON 06/20/2012 regarding the Suicide Monitoring Policy. Staff will be educated by the DON and QA Nurse regarding the Suicide Monitoring Policy on 06/20/2012 and 06/21/2012 to report any verbalization of potential suicide risk to the Social Service Director, DON or Administrator immediately. Staff will be educated by the DON, ADON or QA Nurse to note any signs of potential suicidal behavior on the 24-Hour Report by 08/01/2012. The 24-Hour Report sheet will be reviewed five days per week in the morning clinical meeting by the DON, ADON, MDS Coordinator or QA Nurse. An audit of the 24-Hour Report will be completed daily by the Social Service Director, DON, ADON or QA Director to determine any resident needs for four	

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F 309	Continued From page 11 reference period. The comprehensive assessment identified Resident #11 to have a Brief Interview for Mental Status (BIMS) score of 15 which indicated the resident's cognitive status was intact. A review of the comprehensive care plan dated 06/13/12, revealed the facility addressed Resident #11's mood/behavior problems and noted the resident had episodes of tearfulness and/or crying related to the resident's children, deceased spouse, and health status. The care plan noted the resident preferred to stay in bed most of the time. In addition, the care plan noted Resident #11 had a past history of suicidal thoughts prior to admission. Interventions included to observe the resident for changes in mood/behavior, notify the physician of changes, provide a psychiatric consultation as needed, provide medications as ordered, and for the Social Services Director (SSD) to provide visits with the resident as needed. A review of the nurse's notes dated 04/30/12, at 1:30 AM, revealed Resident #11 voiced to the nurse he/she was "worried about family, was sad, and wanted to end his/her life." The nurse's note revealed the nurse sat and talked with the resident and the resident further stated he/she "hurt so bad" and that sometimes he/she "wanted God to take [him/her] on." The nurse documented she continued to talk with Resident #11 and the resident calmed. However, there was no documentation that the nurse reported the incident to the resident's attending physician or that the nurse implemented the established policy/procedure related to Suicide Monitoring in an effort to protect Resident #11.	F 309	weeks. Then weekly for four weeks and monthly for one month. 4. All findings will be discussed in the Quality Assurance Meeting monthly. The QA Committee will make recommendations as needed. 5. Completion Date:	8/1/12

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F 309	Continued From page 12 Resident #11 was observed on 06/19/12, at 2:10 PM and 3:15 PM, to be lying in bed with his/her eyes closed. Resident #11 was also observed on 06/20/12, lying on the bed at 10:30 AM, at 1:30 PM, at 3:15 PM, and at 4:30 PM. In addition, the resident was observed to eat both the lunch and dinner meals in the room on 06/19/12 and 06/20/12, and was not observed to be out of bed or out of the room on 06/19/12, from 12:25 PM to 5:20 PM, and from 10:30 AM to 4:30 PM on 06/20/12. Interview conducted with Resident #11 on 06/20/12, at 4:30 PM, revealed the resident stated he/she had thought about "harming myself." The resident stated although he/she had six children, only two maintained a relationship with the resident, and the resident dealt with depression. Resident #11 stated he/she "knew better than to harm myself; would go to hell." Licensed Practical Nurse (LPN) #1 confirmed in an interview conducted on 06/20/12, at 5:25 PM, Resident #11 had verbalized on 04/30/12, that he/she wanted to end his/her life. The LPN stated she took the resident's statement seriously and counseled and monitored the resident hourly during the rest of her shift. LPN #1 stated she was required to contact the resident's physician and to call the SSD when a resident made any type of suicidal threat; however, she stated she believed the resident was calmer and did not contact either the physician or the SSD. The LPN acknowledged she should have implemented the suicide precautions identified in the facility's policy.	F 309		

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F 309	Continued From page 13 Interview conducted with the SSD on 06/20/12, at 5:00 PM, revealed the SSD was not aware of the suicidal comments made by Resident #11. Interview conducted with the Facility Administrator on 06/20/12, at 6:15 PM, revealed he also was not aware of the suicidal comments made by Resident #11 on 04/30/12.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to provide care and services to promote healing and prevent the development of pressure sores for one of twenty-two sampled residents (Resident #1). The air mattress in use for Resident #1 was observed to be turned off and, as a result, was not functioning. The findings include: A review of the facility's pressure sore policy, dated December 2010, revealed the facility would implement a preventive program to prevent	F 314	**F314** 1. The air mattress for R1 was immediately turned by the assigned RN upon being reported to be off on 06/20/2012. R1 was assessed by the assigned RN for new skin issues and none were noted. 2. All other residents that have an air mattress were checked by the DON and ADON to ensure they were in the on position and functioning properly on 06/20/2012. No other issues were noted. 3. Audits will be conducted daily by the Director of Nursing, ADON or QA Nurse for four weeks to ensure air mattresses are on and functioning properly.	

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F 314	Continued From page 14 additional new areas from developing and ensure all preventive measures were listed on the care plan and flow sheets. A review of the medical record for Resident #1 revealed the facility admitted Resident #1 on 01/12/11, with diagnoses that included Dementia, Diabetes, Osteoarthritis, and Hypertension. A comprehensive Minimum Data Set (MDS) assessment dated 04/23/12, revealed the resident had a Stage 2 pressure sore and was at risk for pressure sore development. A review of the plan of care dated 05/01/12, for Resident #1 revealed the resident had pressure sores to the coccyx and left heel upon admission and were now healed/resolved but monitored per staff for reoccurrence. A review of physician's orders for Resident #1 revealed a physician's order dated 03/25/11, for a "Stat 4" air mattress to the bed at all times. Observation of Resident #1 during a change of a DuoDerm dressing to the resident's coccyx on 06/20/12, at 1:40 PM, revealed the air mattress was not in use. The mattress was in place on the bed; however, the switch was in the off position. In an interview with State Registered Nurse Aide (SRNA) #4, the SRNA stated, "I guess we didn't turn it back on." An interview with Registered Nurse (RN) #1 at 1:40 PM on 06/20/12, revealed the mattress should have been turned on and that she had failed to observe Resident #1's air mattress was off.	F 314	Education will be provided to staff by the DON, QA Nurse or ADON to ensure mattresses are checked for proper functioning. The education will include that if a mattress is discovered to not be functioning properly; it will immediately be reported to the assigned nurse and noted on the 24 Hour Report. The 24-Hour Report will be checked in the daily clinical meeting by the DON, ADON, MDS Coordinator or QA Nurse and any issues with air mattresses will be addressed. 4. The audits will be discussed monthly during the Quality Assurance Committee Meeting. The QA Committee will make any needed recommendations. 5. Completion Date:	8/1/12

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F 314	Continued From page 15 An interview with RN #2 on 06/21/12, at 4:50 PM, revealed the air mattresses were set up and the settings adjusted by the person who delivers them and that the delivery person checked the settings weekly. RN #2 stated she did not know what the settings were supposed to be, that she just monitored that mattresses were turned on. An interview with SRNA #4 at 4:58 PM on 06/21/12, related to the use of air mattresses revealed he did "not touch them," the nurses do that. An interview with the Assistant Director of Nursing (ADON) on 06/21/12, at 5:00 PM, revealed the facility had not conducted any in-service education related to the air mattresses since "sometime last Fall." The ADON further stated the facility did not monitor the air mattress pressure settings to ensure the mattresses were on and/or functioning.	F 314		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure foods/liquids were palatable and at the proper temperature during the evening meal on	F 364	F364 1. A new tray was prepared by the Dietary Department for the resident to replace the test tray. The Dietary Manager interviewed R11 to identify any issues. No other issues identified. 2. All other residents have the potential to be affected by the alleged deficient	

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F 364	Continued From page 16 the Seasons Unit on 06/19/12. The findings include: A review of the Food Presentation policy, dated October 2009, revealed foods would be served to residents at the proper temperatures; hot foods served hot and cold foods served cold. The policy did not include specific timeframes for the resident meal trays to be distributed. Observation conducted of the evening meal service on 06/19/12, revealed trays were transported in a closed meal cart from the kitchen to the Seasons Unit at 5:00 PM. The closed food cart was observed to contain the hot foods and the cold foods were observed to be transported in a cooler on a separate cart. Residents in the dining room were observed to be served first from the food cart. The Assistant Director of Nurses (ADON) was observed to deliver the remaining trays to the residents' rooms on the unit. The last tray was removed from the cart at 5:34 PM (34 minutes after the meal cart arrived to the dining room), and a test tray was obtained for food temperatures and palatability. Palatability testing revealed the macaroni with tomatoes tasted warm and bland, the green beans tasted cold, and the fish tasted tepid. A review of the Food Temperature Chart revealed dietary staff had obtained food temperatures after prepared food items were placed on the steam table prior to tray preparation and tray delivery to the units of the facility. The fish was recorded to be at 140 degrees, the macaroni with tomatoes was at 180 degrees, and the green beans were at 180 degrees. The Food Temperature Chart	F 364	practice. Alert and oriented residents on the Seasons Unit were interviewed by the Dietary Manager on 6/20/2012 for any issues related to food temperatures. No other issues noted. 3. Staff educated by the DON, Dietary Manager or Administrator on ensuring trays are passed as soon as they are brought to the unit. Staff educated by the DON, Dietary Manager or Administrator on ensuring trays are not taken out of the food cart and loaded onto a utility cart for delivery. Facility Managers have a rotation schedule in order to provide additional dining room coverage for all three meals. The Dining Room Manager scheduled rotation has been revised by the Administrator to provide more assistance in the dining room, so staff can pass room trays more efficiently. This	

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F 364	Continued From page 17 identified the desired temperature was 140-165 degrees for the fish, macaroni with tomatoes, and green beans. Interview with LPN #2 on 06/19/12, at 5:45 PM, revealed the meal tray delivery usually took more than 30 minutes to complete. Interview with Resident #11 on 06/20/12, at 4:30 PM, revealed the resident ate all meals in the resident's room on the Seasons Unit. The resident stated hot food items were sometimes cold when received. Interview with the ADON on 06/21/12, at 1:10 PM, revealed she helped during meal times where she was needed. The ADON stated she did not know the length of time it usually took for staff to deliver trays to residents that eat in their rooms. The ADON further stated she was not aware of a specific time allotted to complete the tray delivery, but trays should be delivered as quickly as possible. An interview conducted with the Dietary Manager (DM) on 06/21/12, at 1:30 PM, revealed temperatures were monitored on the tray line at the beginning of each meal and also during the meal. The DM stated the temperatures obtained from the steam table were found to be acceptable. The DM stated she was not aware of a specific time for trays to be delivered to the residents' rooms after being delivered from the kitchen. The DM stated test trays for temperature and palatability were conducted at least weekly for all three meals on each unit of the facility and no problems had been identified.	F 364	will ensure that food is at correct temperature and palatable. The Dietary Services Manager, Assistant Dietary Manager or Registered Dietitian will conduct temperature audits at point of service weekly to ensure food is served at a palatable temperature. The Dietary Services Manager, Assistant Dietary Manager or Dietitian will randomly audit the room tray meal service for temperatures at point of service and ensuring trays are delivered timely. These audits will be conducted randomly for all three meals two times per week for one month. 4. Findings will be discussed monthly with the Quality Assurance Committee. The QA Committee will make recommendations as needed. 5. Completion Date:	8/1/12

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

PRINTED: 07/06/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	B. BUILDING 01 - MAIN BUILDING 01 B. WING	06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY CARE & REHABILITATION CENTER	246 EAST MAIN STREET BEATTYVILLE, KY 41311

RECEIVED
JUL 19 2012
Division of Health Care
Southern Enforcement Branch

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K 000	INITIAL COMMENTS	K 000		
	CFR: 42 CFR 483.70(a)			
	BUILDING: 01			
	PLAN APPROVAL: 1993			
	SURVEY UNDER: 2000 Existing			
	FACILITY TYPE: SNF/NF			
	TYPE OF STRUCTURE: One story, Type III (200)			
	SMOKE COMPARTMENTS: 6			
	FIRE ALARM: Complete automatic fire alarm system.			
	SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.			
	GENERATOR: Type II natural gas generator.			
	A life safety code survey was initiated and concluded on 06/20/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.			
	Deficiencies were cited with the highest deficiency identified at "F" level.			
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		
	Smoke barriers are constructed to provide at			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	Administrator	07/18/2012

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

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	185337	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	06/20/2012

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K 025	Continued From page 1 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, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. This deficient practice affected two of six smoke compartments, staff, and twenty-nine residents. The facility has the capacity for 109 beds with a census of 92 on the day of the survey. The findings include: During the Life Safety Code survey on 06/20/12, at 9:50 AM, with the Director of Maintenance (DOM), an unsealed penetration of electrical conduit and water piping was observed in the attic area above the fire/smoke barrier doors in the B Wing of the facility. In a fire situation, unsealed penetrations of smoke barriers aid in the spread of smoke and fire to other parts of the building. An interview with the DOM on 06/20/12, at 9:50 AM, revealed the DOM was aware fire/smoke barriers needed to be properly sealed. The DOM stated he was not aware this wall needed to be repaired.	K 025	**K025** 1. No residents were directly listed on the report 2. All residents have the potential to be affected by the alleged deficient 3. The unsealed penetration of electrical conduit and water piping above the fire/smoke barrier doors in the B Wing will be filled with be filled with material that is capable of maintaining the smoke resistance of the smoke barrier. An audit will be conducted by the Plant Operations Director and/or Designee of areas that have penetrations. This will be conducted monthly for three months. 4. Audits and/or updates will be discussed in the Quality Assurance Committee Meetings. The QA Committee will review and make recommendations when necessary. 5. Completion Date:	08/01/2012

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K 025	Continued From page 2 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. 19.1.1.3 Total Concept. All health care facilities shall be designed, constructed, maintained, and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. Because the safety of health care occupants cannot be ensured adequately by dependence on evacuation of the building, their protection from fire shall be provided by appropriate arrangement of facilities, adequate staffing, and development	K 025		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185337	A. BUILDING 01 - MAIN BUILDING 01 B. WING	06/20/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LEE COUNTY CARE & REHABILITATION CENTER	246 EAST MAIN STREET BEATTYVILLE, KY 41311

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K 025	Continued From page 3 of operating and maintenance procedures composed of the following: (1) Design, construction, and compartmentation (2) Provision for detection, alarm, and extinguishment (3) Fire prevention and the planning, training, and drilling programs for the isolation of fire, transfer of occupants to areas of refuge, or evacuation of the building	K 025		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the generator set by NFPA standards. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 109 beds with a census of 92 on the day of the survey. The findings include: During the Life Safety Code survey on 06/20/12, at 11:30 AM, an interview with the Director of Maintenance (DOM) during a record review revealed the DOM was not aware the generator	K 144	**K144** 1. No residents were directly identified in the report 2. All residents have the potential to be affected by the alleged deficient practice. 3. The generator transfer switch will be exercised and logged once a month by the Plant Operations Director and/or Designee. The Plant Operations Director will submit a copy to the Administrator and/or designee at the end of each month as evidence of this procedure being conducted. 4. The procedure will be discussed in the Quality Assurance Committee Meetings. The QA Committee will make	

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K 144	Continued From page 4 transfer switch should be exercised and logged once a month. This test helps ensure the generator transfer switch is operating properly. Reference: NFPA 110 (1999 Edition). 6-4.5 Level 1 and Level 2 transfer switches shall be operated monthly. The monthly test of a transfer switch shall consist of electrically operating the transfer switch from the standard position to the alternate position and then a return to the standard position.	K 144	recommendations as necessary. 5. Completion Date:	08/01/2012