

Acceptable POC  
8/2/14 - date

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

PRINTED: 07/18/2014  
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  C 07/03/2014
NAME OF PROVIDER OR SUPPLIER  LIFE CARE CENTER OF MOREHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351	
(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)

F 000 INITIAL COMMENTS

The Abbreviated Survey to investigate KY #00021854 was initiated on 07/01/14 and concluded on 07/03/14. The allegation was unsubstantiated. However, deficient practice was identified and cited.

F 226 483.13(c) DEVELOP/IMPLMENT SS=D ABUSE/NEGLECT, ETC POLICIES

The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

This REQUIREMENT is not met as evidenced by:  
Based on record review, interview and review of the facility's policy, it was determined the facility failed to implement its written policy related to conducting a thorough investigation after an injury of unknown origin was identified, for one (1) of four (4) sampled residents. Review of the State Agency Intake Form revealed the facility reported the identification of an injury of unknown origin for Resident #1. The facility's investigation did not include interviews with staff who cared for Resident #1 at the time the injury was identified.

In addition, an educational offering related to preventing injury to Resident #1 during the provision of care was attended by only twenty-five (25) of the fifty (50) direct care staff employed by the facility.

The findings include:

F 000: F 226

#1 Resident #1 bruise has resolved without any concerns. The Executive Director informed the family of investigation findings verbally on 7/24/2014.

F 226: During the investigation process, the C.N.A.'s providing care at that time were interviewed by the charge nurse verbally prior to the MDS nurse being notified that the bruises were of unknown origin. All residents have the potential to be affected.

#2. All abuse/neglect allegations were reviewed within a 60 day look back from 5/15/2014 thru 7/20/2014 to identify the following:

- A. Were written statements obtained including the employees that were caring for the identified residents
- B. Upon investigation conclusion was the identified resident's family notified of investigation conclusion.

Were any changes to plan of care related to investigation outcome relayed to staff by updating the C.N.A. sheet care directive to ensure all staff are aware by using the

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: ED (X6) DATE: 7/25/14

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 226 Continued From page 1

Review of the facility's policy, titled "Protection of Residents: Reducing the Threat of Abuse and Neglect" (no date), revealed all reports of abuse would be promptly and thoroughly investigated, and the resident and/or the resident's representative would be kept informed of the progress of the investigation. Further review revealed the investigation would include a written summary of interviews with the person(s) reporting the incident, any witnesses to the incident, the resident and the resident's roommate, and family and/or visitors who may have information regarding the circumstances surrounding the incident. Continued review revealed the following policy statement: "Residents have the right to be treated by caring and compassionate staff who have adequate knowledge to appropriately respond to residents with diverse behaviors and dependencies, facilitating a protective environment for both residents and staff".

1. Review of the State Agency Intake Form, dated 06/19/14, revealed it included the facility's final report of an injury of unknown origin for Resident #1 which was identified on 06/15/14. Continued review revealed the resident's daughter, on 06/15/14, reported two (2) bruises located on Resident #1's right inner leg directly above the ankle.

Review of the Daily Staffing Sheet for 06/15/14 (the day the bruises were identified) revealed Licensed Practical Nurse (LPN) #5, State Registered Nursing Assistant (SRNA) #2, SRNA #6 and SRNA #7 were assigned to the unit where Resident #1 resided.

Review of the facility's investigation file related to

F 226

C.N.A. care directives. Any issue identified will be immediately corrected with physician and family notification, completed by 7/25/2014.

Social Service Director interviewed all residents with BIMS of 10 to 15 regarding abuse and neglect, this was completed by 7/25/2014. Any issue identified will be reported to all agencies, physician and family. All skin assessments completed for residents with BIMS less than 10 will be reviewed by the Director of Nursing for a look back period of 6/1/2014 thru 7/20/2014 to identify any possible injury/bruise that would require investigation. An audit of all care directives to identify that all care directives are reflective of the current resident plan of care will be completed by Director of Nursing, Assistant Director of Nursing, Social Service Director, MDS, Staff Development Coordinator. Date of completion: 7/31/2014. Any issue identified will be reported to physician and family and any agency required immediately.

#3. Education provided by Regional Director of Clinical Services to the Executive Director, Director of Nursing, MDS nurse, Assistant Director of Nursing, and Staff Development Coordinator regarding reporting and

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F 226	Continued From page 2 Resident #1's bruises of unknown origin revealed a total of three (3) written statements were obtained from staff. Continued review revealed no statements were given by LPN #5 or SRNAs #2, #6 and #7. In addition, there was no documented evidence of an interview and/or written statement obtained from the resident's daughter, who first identified the bruises.  Interview with Resident #1's daughter, on 07/01/14 at 9:24 AM, revealed she was the responsible party for the resident. She stated she was not notified of the outcome of the facility's investigation.  Interview with SRNA #2, on 07/02/14 at 10:50 AM, revealed on 06/15/14 she reported the daughter's concern about Resident #1's bruises to LPN #5 and they discussed how they might have occurred. She stated no administrative staff ever interviewed her, and she was not asked to provide a written statement.  Interview with SRNA #6, on 07/02/14 at 4:48 PM, revealed she, along with SRNA #2, reported Resident #1's bruises to LPN #5 on 06/15/14. She stated she was not interviewed by any facility staff and was not asked to provide a written statement.  Interview with SRNA #7, on 07/02/14 at 5:12 PM, revealed she worked on the unit where Resident #1 resided on 06/15/14, but was not assigned to her care that day. She stated she was not interviewed by any facility staff, nor asked to provide a written statement related to any knowledge she may have had regarding Resident #1's bruises.	F 226	investigating abuse and neglect, reporting findings to family, appropriate follow up and investigation procedure, completed on 7/25/2014. Staff Development Coordinator/Executive Director/Director of Nursing to reeducate all staff regarding the abuse and neglect and investigation procedures with appropriate follow up completed by 8/1/2014. The Executive Director/Director of Nursing will notify the Regional Director of Clinical Services/Regional Vice President by phone of any abuse/neglect/misappropriation when an allegation is made x 30 days to ensure policy is followed and investigation is completed and timely, to begin on 7/22/2014. Social Service Director to interview 5 residents weekly x 4 weeks beginning week of 8/1/2014 then 2 residents weekly x 2 weeks to ensure any report of abuse/neglect is investigated, reported and followed up on. Staff Development Coordinator to educate all staff that all changes to resident's plan of care will be communicated per the care directives by 8/1/14. Director of Nursing/Assistant Director of Nursing to audit 5 care directives a week for 4 weeks beginning week of 8/1/14 to ensure that all new changes to residents plans of care are communicated on care directives.		

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F 226	<p>Continued From page 3</p> <p>Interview with the MDS Coordinator, on 07/03/14 at 8:25 AM, revealed she was the Administrator on-call on 06/15/14 when Resident #1's bruises were reported. She stated she was responsible for initiating the facility investigation, which included obtaining statements from potential witnesses. She further stated it was her first time in this role, and acknowledged she should have ensured statements were obtained from the staff caring for the resident, and from the resident's daughter who first observed the bruises.</p> <p>Interview with the Social Worker (SW), on 07/03/14 at 8:50 AM, revealed her role in any facility investigation of possible abuse included working with the residents' families. She stated Resident #1's daughter visited daily, but the SW had not discussed the bruises or the outcome of the facility's investigation with the daughter. Continued interview revealed she should have followed up with the resident's daughter related to the bruises and the resultant investigation.</p> <p>2. Review of a list provided by the facility revealed there were a total of fifty (50) nursing assistants employed by the facility.</p> <p>Review of the inservice sign-in sheet titled "Support of Leg During T&amp;R (Turning and Repositioning)", dated 06/15/14, revealed twenty-five (25) of the fifty (50) SRNAs employed by the facility attended the inservice.</p> <p>Further interview with the MDS Coordinator, on 07/03/14 at 8:25 AM, revealed the in-service was directed toward specific needs of Resident #1. She stated all direct care staff should have been in-serviced related to the safe handling of Resident #1's legs during the provision of care.</p>	F 226	<p>5 random skin assessments will be completed weekly by Assistant Director of Nursing/charge nurse or skin nurse to ensure any injury of unknown origin is reported, investigated, and followed up on. This is to be completed weekly x 4 weeks beginning week of 8/1/2014. Then 5 resident's skin assessments to be completed by Assistant Director of Nursing/Charge nurse or skin nurse every other week x 2 weeks beginning week of 9/1/2014.</p> <p>#4 Quality Assurance Team consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, Activity Director, Social Service Director, Staff Development Coordinator, MDS Nurse to review all audit findings weekly x 2 beginning week of 7/31/2014 then monthly until considered resolved and make recommendations to revise plan according to audit findings.</p> <p>#5 Date of compliance: 8/2/2014</p>		

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F 226	Continued From page 4  Interview with the interim Education Nurse, on 07/03/14 at 10:35 AM, revealed it was only her second week in this role and the MDS Coordinator had conducted the in-service. She acknowledged all staff should have received the in-service.	F 226		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on record review, interview and review of the facility's policy, it was determined the facility failed to ensure the clinical medical record was maintained in accordance with accepted, professional standard of practice for four (4) of four (4) sampled residents (Residents #1, #2, #3, and #4). The facility failed to ensure all telephone or verbal orders were timed by the licensed staff when obtained.	F 514	F 514  #1 Residents #1, 2, 3, and 4 physician and medical director were notified that all telephone or verbal orders were not timed by the licensed staff when obtained on July 24th, 2014, by the DON. No new orders were noted, All residents have the potential to be affected.  #2 HIM, DON, ADON, skin nurse, and or MDS nurse to audit all records to identify that the clinical record is accurate, readily accessible and contains sufficient information to identify the resident as a record of assessment. This was completed by 7/30/2014 and any issue identified will be corrected immediately and the medical director and/or physician will be notified.  #3. RDCS to re-educate DON/SDC/ED regarding policy and procedure for maintaining an accurate clinical record and to time/date/sign all entries, completed by 7/25/2014.	

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F 514	Continued From page 5  The findings include:  Review of the facility's policy "Telephone Order Processing", with a revised date of October 2004, revealed it was the basic responsibility of the licensed nurse to obtain orders for care and treatment of the resident. Further review revealed staff was to record the date and time the order was received on the telephone order form.  1. Record review revealed Resident #1 was admitted by the facility on 03/21/08 with diagnoses which included Depression, Hypertension, Esophageal Reflux and Convulsions. Review of the telephone orders for the month of June 2014 revealed three (3) of five (5) telephone orders were dated but not timed, on 06/15/14, 06/17/14 and 06/25/14.  2. Record review revealed Resident #2 was admitted by the facility on 12/05/13 with diagnoses which included Hypertension, Parkinson's Disease, Delusions, and Psychosis. Review of the telephone orders for the month of June 2004 revealed eight (8) of nine (9) telephone orders taken on 06/13/14, 06/14/14, 06/20/14, 06/22/14 and 06/27/14 were dated but not timed.  3. Record review revealed Resident #3 was admitted by the facility on 02/15/13 with diagnoses which included Manic Depressive Disorder, Diabetes Mellitis, Psychosis, and Hypertension. Review of the telephone orders for the month of June 2014 revealed seven (7) of eight (8) total orders were dated but not timed on 06/04/14, 06/09/14, 06/10/14, 06/13/14, 06/16/14, 06/20/14 and	F 514	DON/ADON/SDC to re-educate all nursing/SW/ACT/HIM staff and consultants who make entries in the record to time/date all entries and policy related to medical record maintenance and content by 7/29/2014. Beginning the week of 8/3/2014 HIM/DON to audit 10 records weekly (including nursing notes, physician notes, phone orders) to ensure medical records are accurate and entries are dated and signed and timed.  #4 QA team consisting of ED, DON, ADON, ACT, SS, SDC, MDS to review all audit findings weekly x 2 beginning week of 7/31/2014 then monthly until considered resolved and make recommendations to revise plan according to audit findings.  #5 Date of compliance: 8/2/2014		

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06/23/14.

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4. Review of the medical record revealed Resident #4 was admitted by the facility on 06/21/13 with diagnoses which included Delirium, Chronic Obstructive Pulmonary Disease, Hypertension, Diabetes Mellitus, and Depression. Review of the telephone orders for the month of June 2014 revealed two (2) of four (4) orders were dated but not timed on 06/04/14 and 06/13/14.

Interview with Licensed Practical Nurse (LPN) #2, on 07/02/14 at 9:50 AM, revealed all telephone or verbal orders should be signed, dated and timed.

Interview with Licensed Practical Nurse (LPN) #1, on 07/02/14 at 10:00 AM, revealed telephone or verbal orders were to be dated and timed. Further interview revealed the nurses had received training on this process within the last two (2) months.

Interview with Licensed Practical Nurse (LPN) #3, on 07/03/14 at 10:30 AM, revealed she was the interim Nurse Educator. She stated all telephone or verbal orders should be signed, dated and timed. Further interview revealed the nursing staff had been trained on the proper completion of a telephone order.

Interview with the Director of Nursing (DON), on 07/02/14 at 12:55 PM, revealed it was the facility's policy and procedure that all telephone or verbal orders were to be timed and dated. She stated re-education of licensed staff was indicated and had already been initiated.