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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185155		C 12/27/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF MOREHEAD	933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351

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F 000	INITIAL COMMENTS	F 000	The prepared plan of correction and creditable allegation of compliance does not constitute an admission or agreement to the alleged stated deficiencies by the provider or its management company. This plan of correction and creditable allegation of compliance is prepared and executed only because state and federal law require it.	
	An Abbreviated Survey investigating KY00021122 was initiated on 12/26/13 and concluded on 12/27/13. #KY00021122 was unsubstantiated; however unrelated deficiencies were identified and cited, with the highest Scope and Severity of a "D".			
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS	F 281	F 281 1.) Resident C's interim care plan was developed and documented in the medical record on December 27, 2013 by Licensed Nursing Staff. 2.) Interim Care plans for residents admitted to the facility in the previous 21 days were audited for completeness on January 6, 2014, by the Director of Nursing and the Assistant Director of Nursing.	
	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, record review and review of the facility's policy, it determined the facility failed to ensure services provided by the facility met professional standards of quality for one (1) unsampled residents, Unsampled Resident C. There was no documented evidence an interim care plan was completed upon admission.			
	The findings include:			
	Review of the facility policy titled "Resident Care Plan" revealed an interim care plan was to be completed for each resident upon admission to the facility.			
	Review of the clinical record revealed the facility admitted Unsampled Resident C on 12/19/13 with diagnoses which included Hypertension, Diabetes Mellitus, Hepatitis B, and Cirrhosis.			
	Continued review of the clinical record revealed			

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JAN 27 2014
BY:

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

Bill [illegible] Executive Director 1/22/14

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 281	Continued From page 1 the care plan was not developed until 12/26/13. Interview with the Director of Nursing (DON), on 12/27/13 at 2:05 PM, revealed each resident was to have an immediate care plan developed upon admission, according to facility policy. She acknowledged Resident C did not have a care plan developed at the time of admission and stated she did not know why it had not been done. Interview with Licensed Practical Nurse (LPN) #2, on 12/27/13 at 2:10 PM, revealed Resident C did not have a care plan developed upon admission as required. She stated the care plan should have been initiated when the resident was admitted so staff would know how to care for the resident.	F 281	3.) Licensed Nursing staff were provided education regarding the development of interim care plans for newly admitted resident upon admission, on January 7and January 22, 2014, by the Director of Nursing. Resident Medical Records for newly admitted residents will be reviewed, Monday through Friday, by the Director of Nursing, Assistant Director of Nursing, and/or Staff Development Coordinator to ensure completion of the interim care plan.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy it was determined the facility failed to ensure the environment was free of accident hazard for one (1) unsampled resident. Observation revealed a pair of scissors was left unattended on the back of Resident B's	F 323	4.) An audit of Newly admitted residents interim care plans will be completed weekly X 4 weeks, then monthly X 2 months, by the MDS Coordinator or MDS Assistant to ensure that interim care plans are developed upon admission. Results of audits of Newly admitted residents interim care plans will be reviewed in the Performance Improvement meeting monthly X 3 months. 5.) Completion Date: January 24, 2014	

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F 323	Continued From page 2 commode. The findings include: Review of the facility policy titled "Hazard Surveillance Rounds", revised 03/15/04, revealed the facility would conduct hazard surveys to identify hazards and assure corrective measures were taken to eliminate hazards identified. Observation, on 12/27/13 at 3:10 PM, revealed a pair of scissors on the back of the commode in Resident B's bathroom. Review of the clinical record revealed Resident B was admitted by the facility on 10/23/13 with diagnoses which included Vitamin Deficiency (unspecified) and Urinary Tract Infection. Continued review revealed Resident B had a colostomy in place. Review of the admission Minimum Data Set (MDS) Assessment, dated 10/30/13, revealed a Brief Interview for Mental Status Score (BIMS) of 14, which indicated Resident B was interviewable. Interview with Certified Nursing Assistant (CNA) #6, on 12/27/13 at 10:40 AM, revealed scissors should not be left unattended in a resident's room. CNA #6 stated there were residents who moved throughout the facility independently and wandered into other residents' rooms. Continued interview revealed the scissors could be dangerous to wandering residents. Interview with CNA #9, on 12/27/13 at 1:00 PM, revealed scissors should not be left unattended and accessible to residents.	F 323	F323 1.) Resident B was given a lock box and instructions to keep scissors in the lock box at all times on December 26, 2013 by Social Services Director. 2.) A safety observation round of the facility was conducted to ensure the environment was free from accident hazard, on December 26, 2013 by the Executive Director and Support Staff. 3.) Staff education was provided regarding ensuring the facility environment was free from accident hazard, on January 7 and January 22 2014, by the Staff Development Coordinator and the Director of Nursing. 4.) Hazard Surveillance Rounds will be conducted weekly X 4 weeks, then monthly X 2 months, to ensure the facility environment is free from accident hazard, by the Executive Director and/or Support Staff. Results of the Surveillance Rounds will be reported to the Performance Improvement Committee monthly X 3 to ensure the facility is free from accident hazard. 5.) Completion Date: January 24, 2014	

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F 323	Continued From page 3	F 323		
	Interview with CNA #5, on 12/27/13 at 3:15 PM, revealed Resident B was probably using the scissors to take care of his/her colostomy. CNA #5 stated the scissors should not be left out where other residents could get them and cause injury to themselves.			
	Interview with License Practical Nurse (LPN) #1, on 12/27/13 at 3:25 PM, revealed scissors left unattended and accessible to other residents was a potential hazard.			
	Interview with Registered Nurse (RN) #1, on 12/27/13 at 3:35 PM, revealed scissors should not be left in the resident's room unless they were locked up.			
	Interview with the Director of Nursing (DON), on 12/27/13 at 3:40 PM, revealed scissors left unattended was a safety hazard, and they should have been locked up.			
	Interview with the Administrator, on 11/27/13 at 3:25 PM, revealed scissors left unattended in a resident's room was a safety hazard. He stated he would talk to the Social Services Director and the DON to determine if the scissors should be locked up or kept at the nurses station.			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441	F 441	
	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.		1.) LPN # 1 was provided education and counseling regarding disposal of soiled dressing and hand washing on December 27, 2013 by the Director of Nursing.	

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F 441	Continued From page 4 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure that infection control guidelines were followed to prevent the spread of infection for one (1) of three (3) sampled residents (Resident #2).	F 441	2.) Residents were assessed for symptoms of infection on December 27, 2013, by the Director of Nursing and Assistant Director of Nursing with no symptoms identified. 3.) Nursing Staff were provided education regarding proper disposal of soiled dressings in biohazard bags and handwashing to prevent the spread of infection, on January 7, 2014 and January 24, 2014 by the Director of Nursing. Handwashing Reminder Signs were placed in each resident room on January 13, 2014, by the Staff Development Coordinator.	

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F 441	Continued From page 5 Observation of a dressing change for Resident #2 revealed the nurse completed the procedure and discarded the blood-saturated dressing in the roommate's trash can. In addition, the nurse left the room without washing her hands. The findings include: Review of the facility's policy titled "Hand Hygiene", revised 05/12, revealed its purpose was "to decrease the risk of transmission of infection by appropriate hand hygiene". Review of the "Infection Control Policy", undated, revealed written guidelines included the following: wash hands before and after all procedures, and dispose of all hazardous materials appropriately. Clinical Record review revealed Resident #2 was admitted by the facility on 08/21/13 with diagnoses which included Dementia with Behavioral Disturbance, Hypertension, and Congestive Heart Failure. Observation, on 12/27/13 at 9:05 AM, revealed Licensed Practical Nurse (LPN) #3 changed a gauze dressing on Resident #2's right arm. The dressing was saturated with a light red substance. Continued observation revealed LPN #3 discarded the saturated dressing in the trash can of Resident #2's roommate and left the room wilhout removing the trash or washing her hands. Interview with LPN #3, on 12/27/13 at 9:05 AM, revealed she knew she should not have thrown the saturated dressing into the trash can. She stated she was nervous. She further stated the dressing was considered contaminated and a potential risk as a bloodborne pathogen if not	F 441	4.) Infection control audits will be conducted by department managers through observation of staff while providing care to residents weekly times four weeks then monthly times three months to ensure compliance with the regulations. Audit of dressing changes, including disposal of dressings and handwashing, will be completed weekly X 4, then monthly X 2 to ensure infection control guidelines are followed to prevent the spread of infection, by the Staff Development Coordinator. Results of the Dressing Changes Audits and Infection Control Audits will be reported to the Performance Improvement Committee monthly X 3 to ensure infection control guidelines are followed to prevent the spread of infection. 5.) Completion Date: January 24, 2014	

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F 441	Continued From page 6	F 441		

disposed of properly. Continued interview revealed she did not wash her hands before leaving the resident's room because she usually washed her hands at the nurses station. She stated she knew she should have washed her hands before leaving the resident's room to maintain infection control.

Interview with LPN #1, on 12/27/13 at 11:03 AM, revealed handwashing should be done before and after care. She stated a saturated dressing should be placed in a biohazard bag to prevent the transmission of Infection.

Interview with the Director of Nursing (DON), on 12/27/13 at 12:05 PM, revealed if a dressing was not saturated it could be placed in a trash can if the bag was removed from the room. She stated if a dressing was saturated with blood, it should be disposed of in a biohazard bag. Continued interview revealed hands should "absolutely" be washed before leaving a resident's room after completing a dressing change.