

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

PRINTED: 03/21/2014
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 R-C 03/19/2014
--	---	--	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{F 000}	<p>INITIAL COMMENTS</p> <p>An Off-site Revisit was conducted. Based on the acceptable POC the facility was deemed to be in compliance as alleged on 03/19/14.</p>	{F 000}		
---------	--	---------	--	--

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

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

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000 INITIAL COMMENTS

A Recertification and Abbreviated Survey was conducted 02/04/14 through 02/06/14. Deficiencies were cited with the highest Scope and Severity of an "E". KY #00021280 was unsubstantiated with no deficiencies cited.

F 157 483.10(b)(11) NOTIFY OF CHANGES
SS=D (INJURY/DECLINE/ROOM, ETC)

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

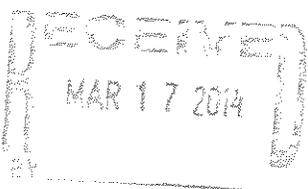
The facility must record and periodically update the address and phone number of the resident's

F 000

F 157 F 157

#1 Resident # 1 MD notification completed on February 6, 2014 by the Director of Nursing (DON).

#2 All residents have the potential to be affected by this deficient practice. The 24 hour report and change in condition log for the previous 14 days were reviewed on February 24, 2014, by the DON, for changes in condition to ensure physician notification completed as necessary. Resident record review completed by March 14, 2014 with a look back period of February 28 -- March 10, 2014 by the Director of Nursing and Regional Nurse to identify any changes in condition and ensure physician notification as necessary.



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE ED	(X6) DATE 3/14/14
---	-------------	----------------------

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.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 1
legal representative or interested family member.

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 the Physician was notified when there was a significant change in a resident's physical status and a need to alter treatment for (1) of eighteen (18) sampled residents (Resident #1).

On 01/13/14 Resident #1 was noted to have redness to the coccyx area on and according to the Progress Notes, the area opened and was noted to have yellow slough on 01/16/14; however, there was no documented evidence the Physician was notified of the deterioration of the wound in order to alter treatment.

Additionally, the Wound Nurse obtained orders for Mepilex (a protective dressing) to the coccyx for protection on 01/19/14. Interview with the Wound Nurse revealed the wound was red and slow to blanch on 01/19/14 and there was no open wound. However, skin assessments completed on 01/20/14 and 01/27/14, revealed the coccyx wound was open. There was no documented evidence the nurses who performed the skin assessments on 01/20/14 and 01/27/14 recognized the change in the Pressure Ulcer when it deteriorated from a reddened area to an open area and there was no documented evidence the Physician was notified.

The findings include:

Review of the facility's policy titled, "Changes in

F 157

#3 Licensed Nurses will be educated regarding Physician Notification of Change in Condition on March 4, 2014 by the Director of Nursing. All licensed nurses not attending on March 4, 2014, will attend education sessions prior to returning to work.

The 24 hour report and change in condition log and 5 record review will be completed daily Mon-Fri beginning March 17, 2014 by the Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), MDS nurse assistant or DON to identify changes and ensure physician notification.

#4. Results of change of condition audits with physician notification will be reviewed in Performance Improvement Committee monthly for compliance and or suggestions for 3 months.

#5 Completion Date March 19, 2014

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157	<p>Continued From page 2</p> <p>Resident's Condition or Status, undated, revealed the facility was to notify the resident and his/her attending Physician of changes in the resident's condition and/or status. Nursing services was to be responsible for notifying the resident's attending Physician when there was a significant change in the resident's physical, mental, or emotional status, and when there was a need to alter the resident's treatment or medications.</p> <p>Review of Resident #1's medical record revealed the facility admitted the resident on 07/22/13, with diagnoses which included Dementia, Aorta Femoral Bypass, and Coronary Artery Disease. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/16/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of two (2) out of fifteen (15) which indicated the resident had severe cognitive impairment. Continued review of the MDS revealed the facility assessed the resident to require extensive assist of two (2) persons for bed mobility, transfers, personal hygiene and toilet use, as frequently incontinent of bowel and bladder, and as having no Pressure Ulcers.</p> <p>Observation of Resident #1's skin, during a skin assessment performed by Licensed Practical Nurse (LPN) #10, revealed a Pressure Ulcer to the coccyx. Interview with LPN #10 during the skin assessment revealed the nurse described the Pressure Ulcer as red with a yellow center containing slough (soft moist dead tissue), which measured four (4) centimeters (cm) in width and 1.2 centimeters in length.</p> <p>Review of the Weekly Skin Integrity Data Collection (WSIDC) form completed by LPN #6,</p>	F 157		
-------	--	-------	--	--

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 3

dated 01/13/14, revealed Resident #1's skin was intact and indicated there was redness to his/her buttocks, coccyx and perineal area by circling these areas on the diagram of the body.

Review of the Physician's Orders dated 01/15/14 revealed orders for Mepilex to the coccyx area daily and as needed (prn) for redness to coccyx.

Review of a Progress Note completed by LPN #7, dated 01/16/14 at 12:49 AM, revealed new orders for Mepilex to the coccyx area due to redness and a small open area with yellow slough. Continued record review revealed no documented evidence the Physician was notified of the deterioration of the wound or of Physician's Orders received on 01/16/14.

Interview with LPN #7 on 02/06/14 at 4:45 PM, revealed she did not recall writing the Progress Note on 01/16/14 related to Resident #1's coccyx area with redness and an open area. She stated however, if the wound had changed or worsened, she should have called the Physician to obtain treatment.

Review of a verbal Physician's Order dated 01/19/14, revealed orders for Mepilex to the coccyx for protection, change every three (3) days and prn which had been obtained by the Licensed Practical Nurse (LPN) #5/Wound Nurse.

Interview with the LPN #5/Wound Nurse on 02/06/14 at 4:00 PM, revealed she had assessed Resident #1's skin on 01/19/14 and the area to the coccyx was red and slow to blanch but not open. She stated she had obtained orders for the Mepilex for protection to the area.

F 157

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 4

Continued review of the WSIDC, revealed a skin assessment completed on 01/20/14 by LPN #6, which noted Resident #1's skin was intact; however indicated there was an open area on the buttocks/coccyx by circling that area on the diagram of the body. Review revealed the area had a treatment in place. Further review of the WSIDC dated 01/20/14, revealed even though the skin assessment indicated an open area there was no documented evidence of a wound measurement, description or staging of the wound. Continued record review revealed no documented evidence of a Nurse's Note related to the wound or of the Physician having been notified of the deterioration of the wound which now contained an open area.

Interview with LPN #6 on 02/06/14 at 4:59 PM, revealed she had performed the skin assessment on 01/20/14 and noted an open area to the coccyx which looked like slough which she considered a Pressure Ulcer. She indicated she should have notified the Physician because the wound had worsened; however, she could not remember notifying the Physician of the change in the wound.

Review of the WSIDC, dated 01/27/14, completed by LPN #8, revealed the skin was intact; however, indicated there was an open area on the buttocks by circling that area of the diagram of the body.

Interview with LPN #8 on 02/06/14 at 4:15 PM, revealed he had completed the skin assessment on 01/27/14 and noted the coccyx was beefy red with a small open area, so he should not have marked the skin as intact on the WSIDC form. He stated he had notified the Wound Nurse, but

F 157

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 157 Continued From page 5
not the Physician of this information. However, record review revealed no documented evidence the Wound Nurse or Physician had been notified of the change in the wound by LPN #8.

Interview with Resident #1's Attending Physician on 02/06/14 at 4:20 PM, revealed any time a wound changed from a reddened area to an open area, or there was deterioration of a wound he should have been notified. He indicated he should have been notified on 01/16/14 when the wound was noted to be open with slough; and also on 01/20/14 and 01/27/14 when the nurses noted the wound had opened. Further interview revealed Mepilex was the treatment that had been ordered; and he may or may not have changed the treatment since Mepilex would have been appropriate for an open wound as well.

Interview with the Director of Nursing (DON) on 02/06/14 at 5:11 PM, revealed if a new area of skin breakdown was noted or a Pressure Ulcer was noted to worsen, the nurse was to notify the Physician of this information and obtain a treatment order. She indicated there was education needed for the nurses regarding when to notify the Physician related to a change in wounds.

F 157

F 241 483.15(a) DIGNITY AND RESPECT OF SS=D 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

F241

F 241

#1 A one-time observation of care on February 26, 2014 was completed by Assistant Director of Nursing for unsampled residents A & B are provided care in a manner that maintains and enhances each resident's dignity including not standing while assisting with meals.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 241 Continued From page 6
by:
Based on observation, interview and review of the facility's policy, it was determined the facility failed to provide care in a manner that maintained and enhanced each resident's dignity, in full recognition of his or her individuality for two (2) unsampled residents (Unsampled Resident A and Unsampled Resident B) as evidenced by observations of two (2) staff members standing to feed Unsampled Resident A and Unsampled Resident B.

The findings include:

Review of the facility's, "Dignity Policy", revised 06/17/08, revealed it was the policy of the facility to promote residents' independence and dignity in dining. Continued review revealed the policy did not state a specific protocol related to feeding residents.

Observation during the evening meal service, on 02/04/14 from 5:30 PM to 6:00 PM, revealed two (2) staff members were standing up while feeding Unsampled Resident A and Unsampled Resident B.

Interview with State Registered Nurse Assistant (SRNA) #3 on 02/06/14 at 5:17 PM, revealed she had been assigned to feed Unsampled Resident A for the evening meal on 02/04/14. She stated she had stood to feed the resident; however had worked at other facilities and the policy for feeding residents varied from one facility to another. Continued interview revealed she had not received training specific to whether to stand up or sit down while feeding residents. She indicated she thought she was supposed to stand up and talk to the residents to make sure they got

F 241

#2 Observation of meal services was completed on February 26, 2014, by the assistant director of nursing, to ensure each resident is provided care in a manner that maintains and enhances dignity, including not standing while assisting with meals. Any issues were immediately addressed.

#3 Nursing staff will be provided education on March 4, 2014 regarding dignity including not standing while assisting with meals. Any nursing staff not attending on March 4, 2014 will be required to attend education prior to returning to work.

#4 Observation of 5 residents care, including meal service, will be completed weekly X 4 weeks, beginning week of March 17, 2014, then monthly X 2 months by the assistant director of nursing, to ensure delivery of care in a manner that maintains and enhances resident's dignity including not standing while assisting with meals.

Results of observation of meal service and residents care observation will be reported to the Performance Improvement Committee monthly X 3 months to ensure resident's dignity is maintained.

#5 Completion Date March 19, 2014

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 241 Continued From page 7
enough to eat.

Interview with Licensed Practical Nurse (LPN) #4 on 02/06/14 at 5:23 PM, who was assigned to feed Unsamped Resident B on 02/04/14, during the evening meal revealed she normally worked at night and did not usually feed residents on her shift. She stated she had came in early on 02/04/14, and was assigned to assist with feeding residents in the dining room. She stated she had never been told she should sit down while feeding.

Interview with LPN #2 on 02/06/14 at 3:05 PM, revealed facility staff had received in-service training regarding dignity during dining. LPN #2 stated it was easier for staff to converse with residents if you were sitting down at their level.

Interview with the Staff Development Coordinator on 02/06/14 at 3:30 PM, revealed she had provided in-service training related to feeding residents. She stated staff had been instructed to sit down and converse with residents while feeding them.

Interview with the Assistant Director of Nursing on 02/06/14 at 3:42 PM, revealed she did not know what the current facility policy stated in regard to dignity during dining. She stated she knew nurses and "aides" were taught to sit down to feed residents in school. She further stated it was a dignity issue to stand up and feed residents.

Interview with the Director of Nursing (DON) on 02/06/14 at 6:30 PM, revealed it was her expectation that staff were to sit to feed residents, in order to maintain conversation. She stated it

F 241

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 241	Continued From page 8 was a matter of protecting the residents' dignity. F 253 483.15(h)(2) HOUSEKEEPING & SS=E 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, record review and review of the facility's policy, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment as evidenced by failure to ensure resident rooms were clean, in good repair and free of odors; and shower rooms were clean and free of unnecessary items stored there, such as, pillows and a mattress. In addition, the facility failed to ensure residents' bathrooms were free of had toilet bolt covers in place. Additionally, cove base and dry wall were torn or missing in resident's rooms and a bathroom floor was sticky. The findings include: Review of the facility's policy titled, "Housekeeping, Daily Room Cleaning", undated, revealed housekeeping was to provide a fresh, clean, and sanitary environment during a resident's stay in the facility; and were to reduce the potential for nosocomial infections (an infection acquired in a healthcare setting). The policy stated the housekeeping staff were to clean resident rooms by removing the trash, then	F 241 F 253	F253 #1 Room 114 was cleaned by housekeeping on February 28, 2014 to assist in the elimination of strong odors. 100 Hall Shower Room was top scrubbed and cleaned by housekeeping on February 27, 2014 to remove black substance in grout between tiles. West Wing Shower Room was top scrubbed and cleaned by housekeeping on February 27, 2014 to remove black substance in grout between tiles. Cluttered items and mattress were removed from shower room on 2/4/14 by the Director of Nursing. Room 311 toilet bolt covers were replaced by maintenance on February 27, 2014. Room 315 light cover fixture was replaced by maintenance on February 27, 2014. Room checked by Executive Director on February 27, 2014 and free of cobwebs. 200 Hall Shower Room was top scrubbed and cleaned by housekeeping on February 27, 2014 to remove black substance in grout between tiles. Room 107 toilet bolt covers were replaced by maintenance on February 27, 2014.	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 9

using a high duster, work around the room and dust every ledge, light, and vent above shoulder height. Further review revealed the housekeeping staff was the to use a damp rag with germicidal disinfectant and water, to damp dust the room starting with the overbed table, bedside table, and phone; and move to the rest of the room which included windowsills, doorframes, shelves, walls, and doors. Continued review revealed the bathrooms were to be disinfected using a germicidal disinfectant solution and clean rag; and counters, shelves, and shower were also to be wiped down with the solution. Further review revealed the Policy stated a germicidal disinfectant was to be used to clean the tile.

1. Observation during initial tour on 02/04/14 at 2:20 PM and again on 02/05/14 at 12:15 PM revealed room 114 had strong urine odors.
2. Observation of the 100 Hall shower room on 02/04/14 at 3:00 PM, revealed a black substance on the grout between the tiles on the lower half of the shower below the hand rails.
3. Observation of the West Wing shower room on 02/04/14 at 3:15 PM, revealed the tile floor in the shower and the tile walls surrounding the shower had a black substance in the grout between the tiles; and the metal baseboard around the shower walls had areas which was covered with a black substance. Continued observation revealed there was a missing tile on the shower wall, as well as, a broken tile on the shower floor; and the shower room floor grout between the tiles had areas of a brown substance. In addition, observation revealed the whirlpool tub had a bath board over it which was cluttered with four (4) pillows, and a stack of wash cloths and towels. Further

F 253

Room 306, 309, and 310 cove base and drywall repaired by maintenance on February 27, 2014. Room 307 was checked by Executive Director on February 27, 2014 with no sticky substance in floor.

#2 All resident room's were audited for strong odors by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014. Any issues found were addressed immediately.

All shower rooms addressed above.

All shower rooms checked for clutter by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014 any clutter found was removed at that time.

All toilet bolt covers were checked by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014 any missing were replaced at that time.

All light cover fixtures in the resident rooms' were checked by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014 any found were replaced.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 10
observation revealed there was a mattress on the floor in the shower room leaned up against the wall by the whirl pool tub.

Interview with the Director of Nursing (DON) on 02/05/14 at 11:30 AM, revealed the whirlpool had not been used since she had been there except for Baptisms and that was over a year ago. She stated the pillows and linens were not to be stacked up on the whirlpool tub and the mattress should have been stored elsewhere.

4. Observation, on 02/04/14 at 3:00 PM, of the West Hall bathroom in room 311 revealed toilet bolt covers were missing and there was a rusty appearance around the bolt.

5. Observation, on 02/04/14 at 3:05 PM, West Hall room 315 revealed there was no cover over the light fixture in the ceiling. Also, in room 315 there were cobwebs in the upper corner of the bathroom, over the toilet near the vent on the wall.

Interview, on 02/04/14 at 5:40 PM, with Housekeeper #1, who was working on the 300 Hall, revealed she swept and mopped the floors; cleaned the toilets; cleaned up spills of food items in the rooms from the residents' personal food items daily; and emptied trash from the residents' rooms. She further revealed if there was a maintenance issue she contacted maintenance to report it.

6. Observation of the 200 Hall shower room on 02/05/14 at 9:15 AM revealed the tile floor in the shower and the tile walls surrounding the shower had a black substance in the grout between the tiles.

F 253
All rooms were checked for loose or missing cove base and damaged walls by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014 any issues found were addressed at that time.

Resident rooms, resident bathrooms and shower rooms were checked by the Executive Director, Maintenance, and Housekeeping Supervisor on February 28, 2014 for sanitary, orderly and comfortable interior.

#3 On March 4, 2014 all staff will be educated on sanitary, orderly and comfortable interior for all residents by the Staff Development Coordinator.

On March 4, 2014 all staff will be educated on completing work orders for maintenance and notifying housekeeping of problem areas by the Staff Development Coordinator.

On March 4, 2014 housekeeping will be educated on and instructed to use "Daily Housekeeping Task Checklist" by the Housekeeping Supervisor to ensure sanitary, orderly and comfortable interior for all residents.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 253 Continued From page 11

7. Observation of the bathroom in room 107 on 02/05/14 at 11:45 AM, revealed there were no toilet bolt covers on the toilet.

8. Observation on 02/04/14 at 2:35 PM during initial tour, revealed in room 306, a piece of the cove base and drywall were missing; in room 307 the bathroom floor was sticky and had a gritty appearance; in room 309 the cove base was loose and the wall had a hole approximately the size of a quarter; in room 310 the cove base was torn and a piece of dry wall was missing.

Interview, on 02/05/14 at 9:15 AM and 02/06/14 at 7:30 PM, with the Housekeeping Supervisor (HS) revealed the general bathrooms were cleaned and mopped at least one time a day. She stated the general bathrooms had grounded-in dirt from wheelchairs; and the housekeepers used "topscrubbers" at least once a week to scrub the floors however, all the dirt did not come out of the grout. She stated the black substance on the metal baseboard in the West Wing general bathroom might have been mildew; but it did not come off with the current products they were using and it needed to be replaced. The HS stated, the housekeepers probably needed to scrub the tiles two (2) to three (3) times a week in the general bathrooms instead of once a week; however, they had been short staffed in housekeeping. Continued interview with the HS, revealed the housekeeping staff should have daily cleaned the bathroom commodes, bedside tables, window sills, head board and foot board of the beds, and swept and mopped. She stated they were to also high dust once a week which would take care of cobwebs. Further interview revealed room 112 and 114 had strong odors;

F 253

Environmental round audits including odors, dirty/sticky floors, walls and cove base in need of repair, clutter, and toilets in need of repair will be conducted by Department Managers, which include Executive Director, Director of Nursing, Assistant Director of Nursing, Staff Development, MDS Assistant, Housekeeping Supervisor, Dietary Manager, Director of Rehab, Social Services, Human Resource, Accounts Receivable, starting the week of March 10, 2014, then weekly X 4 weeks, then monthly X 3 months to ensure a sanitary, orderly and comfortable interior for all residents. Areas of concern will be addressed at time of audit by notifying housekeeping or writing work order for maintenance.

4. Results of audits will be reported to the Performance Improvement Committee monthly.

5 Completion Date March 19, 2014

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

PRINTED: 02/20/2014
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 02/06/2014
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) (X5) COMPLETION DATE
F 253	<p>Continued From page 12</p> <p>and the housekeepers cleaned the floors more than once a day and cleaned the beds at least three (3) times a week or when they caught the residents out of their beds. However, she stated the privacy curtains which could have held odors was only cleaned when soiled areas were noted.</p> <p>Interview with the Maintenance Director on 02/05/14 at 10:00 AM and 3:00 PM, revealed he had been in his position for one (1) month and he currently had a list of needed repairs. He stated he was going through residents' rooms daily and making repairs and adding to his repair list. The Maintenance Director stated he was unaware of missing toilet bolt covers. He stated the work order forms were at the nurse's station and anyone could complete them when observing the need for a repair. The Maintenance Director further stated he did not perform rounds of the environment; however, the department heads did rounds on a routine basis and gave him a list of concerns identified with the environment. He stated he had not seen missing toilet bolt covers on the list.</p> <p>Interview, on 02/06/14 at 7:50 PM, with the Administrator revealed he had been the Administrator since December 2013, and his focus was customer service. He stated he had identified issues related to housekeeping and felt this was due to the the Housekeeping Supervisor having been off work for the past ten (10) weeks. The Administrator stated "last week" he had crews which had come in to "deep" clean the west wing. Continued interview revealed the chipped tiles in the general baths had been identified and he was going to ensure the tiles were replaced immediately. He further stated the three (3) general baths were to be completely</p>	F 253	

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 253	Continued From page 13 remodeled in 2014. The Administrator stated they had recently started room rounds with the department heads assigned to specific rooms where they were to check the entire room to include the blinds, walls, and floors to identify any concerns related to housekeeping or maintenance.	F 253		
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 interview, record review and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was developed with specific interventions to meet	F 279	F 279 #1 Resident #6 comprehensive care plan was reviewed on February 7, 2014, by the DON, to ensure inclusion of specific interventions to meet the residents' medical and nursing needs. #2 Current resident's Comprehensive care plans will be audited by March 14, 2014, by the DON, ADON, MDS assistant and Regional nurse to ensure they are developed with specific interventions to meet the residents' medical and nursing needs. Any issues identified will be immediately corrected. Residents' care plans for those residents' having new physician orders for the previous 14 days were reviewed on February 27, 2014, by the Director of Nursing to ensure revision of care plan was completed.	

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 279	<p>Continued From page 14</p> <p>residents' medical and nursing needs identified for one (1) of eighteen (18) sampled residents (Resident #6).</p> <p>Review of the laboratory results revealed Resident #6's urine contained Methicillin Resistance Staphylococcus Aureus (MRSA). Review of Resident #6's Comprehensive Care Plan revealed no documented evidence a care plan had been developed which addressed the resident's MRSA (an antibiotic resistant bacteria).</p> <p>The findings include:</p> <p>Review of the facility's infection control policy titled, "Transmission-based Precautions and Isolation Procedures", revised 07/18/2011, revealed the transmission based precautions were used in addition to standard precautions for residents with suspected or confirmed infections and conditions. Residents were to be placed on appropriate transmission-based precautions until the condition had been ruled out or the criteria for removal from isolation had been met.</p> <p>Review of the Resident #6's medical record revealed the facility admitted the resident on 11/29/12, with diagnoses which included Cerebral Vascular Accident (CVA), Diabetes and Dementia. Continued review of the medical record revealed, a Physician Order dated 1/14/14 for a urinalysis culture & sensitivity to be obtained. Review of the Laboratory Report dated 01/17/14 revealed the facility had been notified that day of the results of the urine culture which revealed the organism MRSA was present in Resident #6's urine.</p> <p>Review of Resident #6's Comprehensive Care</p>	F 279	<p>#3 Licensed Nursing Staff will be provided education on March 4, 2014, regarding revision and developing of care plans, by the Director of Nursing. Licensed staff not attending on March 4, 2014, will be required to attend prior to returning to work. Interdisciplinary team members including MDS Coordinator, MDS Assistant, Social Service Director, Activities Director and Dietary Manager, will be in-serviced by the Director of Nursing regarding development of care plans on March 3, 2014. Five residents' comprehensive care plans and nursing assistant care plans will be audited, by the DON or ADON to ensure the care plans are developed with specific interventions to meet residents' medical and nursing needs, starting the week of March 17, 2014, then weekly X 4, then monthly X 2.</p> <p>#4 Results will be reviewed in the Performance Improvement Committee monthly X 3.</p> <p>#5 Completion Date: March 19, 2014</p>	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 279 Continued From page 15

Plan revealed no documented evidence a care plan had been developed to address the MRSA infection noted in the resident's urine to include interventions for infection control.

Interview, on 02/06/14 at 7:45 PM, with Certified Nursing Assistant (CNA) #7 revealed he had not been informed of Resident #6 having had MRSA in his/her urine in January and was not aware of this information at the time of the interview. CNA #7 stated during January he had only worked a day on Resident #6's unit.

Interview, on 02/06/14 at 7:50 PM, with CNA #8 revealed she had not been told Resident #6 had MRSA in his/her urine. CNA #8 stated this information was not on Resident #6's nursing assistant care plan. The CNA stated Resident #6 used a urinal which staff emptied into the bathroom commode.

Interview, on 02/6/14 at 7:30 PM, with the Infection Control (IC) Nurse revealed Resident #6's MRSA had not been care planned, because the resident had not been placed in isolation. She indicated Resident #6 had not been placed on isolation precautions because he/she was immobile, and not able to use the bathroom. The IC Nurse stated the facility only isolated residents who had MRSA in their urine if the resident was mobile.

Interview on, 02/06/14 at 8:00 PM, with the Director of Nursing (DON) revealed a care plan should have been developed in regards to Resident #6's MRSA in his/her urine. She indicated the care plan should have included interventions to address possible infection control issues related to the MRSA.

F 279

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:
Based on interview, record review, and review of facility's policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of eighteen (18) sampled residents (Resident #8).

Resident #8's Comprehensive Plan of Care was not revised when the resident was placed on Prozac (antidepressant medication).

The findings include:

Review of the facility's policy titled, "Resident

F 280

F280

#1 Resident #8 comprehensive care plan was reviewed on February 7, 2014, by the DON, to ensure inclusion of specific interventions to meet the residents' medical and nursing needs.

#2 Current resident's Comprehensive care plans will be audited by March 14, 2014, by the DON, ADON, MDS assistant and Regional nurse to ensure they are developed with specific interventions to meet the residents' medical and nursing needs. Any issues identified will be immediately corrected.

Residents' care plans for those residents' having new physician orders for the previous 14 days were reviewed on February 27, 2014, by the Director of Nursing to ensure revision of care plan was completed.

#3 Licensed Nursing Staff will be provided education on March 4, 2014, regarding revision and developing of care plans, by the Director of Nursing. Licensed staff not attending on March 4, 2014, will be required to attend prior to returning to work.

Interdisciplinary team members including MDS Coordinator, MDS Assistant, Social Service Director, Activities Director and Dietary Manager, will be in-serviced by the Director of Nursing regarding development of care plans on March 3, 2014.

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 280	<p>Continued From page 17</p> <p>Care Plan", revised December 2008, revealed review of the care plan was to be done at least quarterly and as needed to reflect the resident's current needs, problems, goals, care, treatment and services.</p> <p>Review of Resident #8's medical record revealed diagnoses which included Depression and Anxiety. Review of the Admission Minimum Data Set Assessment (MDS) dated 01/13/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15) indicating no cognitive impairment.</p> <p>Review of the Physician's Orders dated 01/24/14 revealed orders for Prozac (an antidepressant medication) ten (10) milligrams (mg) every day for one (1) week, then twenty (20) mg every day for Depression; and the resident was to be seen by psychiatric services.</p> <p>Review of Resident #8's Comprehensive Plan of Care dated 01/15/14 revealed there was a care plan problem stating the resident had trouble sleeping related to Depression; with a goal which stated the resident would have no complaints or sleeplessness. Continued review of this care plan revealed the approaches included medications were to be administered as ordered; staff were to monitor for sleeplessness and report to the Physician. Additionally, review revealed there was an approach dated 01/24/14 which stated "medication change". Further review of the Comprehensive Care Plan revealed no documented evidence of a care plan to monitor the resident's mood and behavior with interventions to assess for the risks and side effects and evaluate the effectiveness of the</p>	F 280	<p>Five residents' comprehensive care plans and nursing assistant care plans will be audited, by the DON or ADON to ensure the care plans are developed with specific interventions to meet residents' medical and nursing needs, starting the week of March 17, 2014, then weekly X 4, then monthly X 2.</p> <p>#4 Results will be reviewed in the Performance Improvement Committee monthly X 3.</p> <p>#5 Completion Date: March 19, 2014</p>	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 280	Continued From page 18 psychotropic medication, Prozac. Interview with Registered Nurse (RN) #2/MDS Coordinator, revealed the MDS nurses and also the staff nurses developed and revised care plans; however, the MDS nurses were ultimately responsible to ensure the care plans were revised as necessary. She stated an order was obtained on 01/24/14 for Resident #8's antidepressant and the care plan should have been revised related to the use of this psychotropic medication. RN #2/MDS Coordinator stated the nurse who obtained the order should have updated the care plan. She further stated she received copies of Physician's Orders in order to ensure the new orders were transcribed to the care plan and she should have "caught" it and ensured care plan revision.	F 280		
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, record review and review of facility policy, it was determined the facility failed to ensure services were provided in accordance with each resident's written Plan of Care for one (1) of eighteen (18) sampled residents (Resident #1). Resident #1's Comprehensive Care Plan, dated 11/29/14, revealed a care plan indicating the	F 282	F 282 #1 Resident # 1 care plan was reviewed to ensure intervention implementation and physician notification completed on February 6, 2014 by the Director of Nursing.	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 19

resident was at risk for impaired skin integrity, and the interventions included notifying the Physician of any change in skin integrity. Resident #1 was noted to have redness to the coccyx area on 01/13/14, and a Mepilex dressing was ordered. The Progress Notes, dated 01/16/14, revealed the area on the resident's coccyx opened and was assessed as having yellow slough; however, there was no documented evidence the Physician had been notified of the deterioration of the wound as per the care plan.

In addition, on 01/19/14, the Wound Nurse assessed the wound and obtained orders for Mepilex to the coccyx for protection. Interview with the Wound Nurse revealed the wound was red and slow to blanch on 01/19/14; and was not open. However, review of skin assessments, completed on 01/20/14 and 01/27/14, revealed the coccyx wound was open and there was no documented evidence the Physician had been notified the wound had deteriorated from a reddened area to an open area as per the care plan.

The findings include:

Review of the facility's "Resident Care Plan Policy", revised December 2008, revealed the care plan needed to reflect the resident's current needs, problems, goals, care, treatment and services. Continued review of the Policy revealed the care plan was to have identified the discipline responsible for each element of care, which would include health care, rehabilitation services, social services, activities, dietary and discharge planning.

F 282

#2 24 hour report and change in condition log for the previous 14 days were reviewed on February 24, 2014, by the DON, for changes in condition to ensure physician notification completed as necessary.

Facility rounds, using resident careguides was completed on February 28, 2014, to ensure services are provided in accordance to each residents' plan of care by Department Managers.

#3 Licensed Nurses will be educated regarding following care plans including Physician Notification of Change in Condition on March 4, 2014 by the Director of Nursing. All licensed nurses not attending on March 4, 2014, will attend education sessions prior to returning to work.

24 hour report and change in condition log will be reviewed daily Monday - Friday by the ADON, SDC, or MDS assistant to identify changes of condition and to ensure physician notification.

Facility rounds, using residents' careguides, are conducted daily Monday through Friday by department heads, including ED, DON, ADON, Activities personnel, MDS Assistant, Housekeeping Supervisor, Dietary Manager, Director of Rehab, Human Resources, Accounts Receivable, SDC to ensure residents' care plans are being followed accordingly.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 20

Review of Resident #1's medical record revealed diagnoses which included Dementia, Aorta Femoral Bypass and Coronary Artery Disease. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/16/13, revealed the facility assessed the resident to have severe cognitive impairment, and as having no Pressure Ulcers.

Review of the Comprehensive Plan of Care, dated 11/29/14, revealed the resident was at risk for impaired skin integrity, and the interventions included weekly skin assessments per nurse, and staff were to notify the Physician of any change in skin integrity. These interventions indicated the licensed nurse was the discipline responsible for ensuring these interventions were followed.

Review of the Weekly Skin Integrity Data Collection (WSIDC), dated 01/13/14, completed by Licensed Practical Nurse (LPN) #6, revealed the nurse noted the resident's skin as intact, with redness to the buttocks, coccyx and perineal area. Review of a Physician's Order dated 01/15/14 revealed the nurse had received an order for Mepilex (protective dressing) to Resident #1's coccyx area daily and as needed (prn) for the red area to the coccyx.

Review of the Progress Note dated 01/16/14 at 12:49 AM revealed it had been completed by Licensed Practical Nurse (LPN) #7, who documented redness and a small open area with yellow slough to the coccyx area. Continued review revealed Mepilex was ordered for the area. Further review revealed no documented evidence the Physician had been notified of the coccyx now having a small open area with yellow slough.

F 282

#4 Beginning the week of March 17, 2014, change in Condition Log will be audited weekly X 4, then monthly X 2 to ensure physician notification of changes in condition by the Director of Nursing. Reports of audits will be reviewed in Performance Improvement Committee monthly X 3. Results of facility rounds, including care plan implementation, will be reviewed by the Executive Director in Performance Improvement Committee monthly X 3.

#5 Completion Date March 19, 2014

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282 Continued From page 21

Interview with LPN #7 on 02/06/14 at 4:45 PM, revealed she did not recall writing the Progress Note dated 01/16/14; however, if the wound to Resident #1's coccyx had changed or worsened, she should have notified the Physician as per the care plan.

Review of the WSIDC completed by LPN #6 on 01/20/14 revealed a skin assessment had been completed which indicated Resident #1's skin was intact; however continued review revealed the resident had an open area with a treatment in place to his/her buttocks/coccyx area. Further review revealed no documented evidence the Physician had been notified of the open area noted to Resident #1's buttocks/coccyx area as per the care plan.

Interview with LPN #6 on 02/06/14 at 4:59 PM, revealed during the skin assessment on 01/20/14, she had observed an open area to Resident #1's coccyx which looked like slough. She stated she had considered the open area a Pressure Ulcer and indicated the Physician should have been notified. According to LPN #6, she could not remember notifying the Physician of the change in the wound as per the care plan.

Review of the WSIDC form dated 01/27/14, completed by LPN #8 revealed Resident #1's skin was intact; however, continued review of the form revealed open area indicated on the resident's buttocks.

Interview with LPN #8 on 02/06/14 at 4:15 PM, revealed he had completed the skin assessment on 01/27/14 and noted a small open area on the coccyx. He stated he had notified the Wound

F 282

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 282	<p>Continued From page 22</p> <p>Nurse of this information and indicated the Wound Nurse would notify the Physician. Record review revealed no documented evidence the Wound Nurse or Physician had been notified of the change in the wound to Resident #1's coccyx area as per the care plan.</p> <p>Interview with Resident #1's Attending Physician on 02/06/14 at 4:20 PM, revealed if the resident's wound changed from a reddened area to an open area, he should have been notified. He indicated he should have been notified on 01/16/14 when the wound was noted to be open with slough; and on 01/20/14 and 01/27/14 when nurses noted the wound had an open area.</p> <p>Interview with the Director of Nursing (DON) on 02/06/14 at 5:11 PM, revealed if nurses observed a new area of skin breakdown or worsening of a Pressure Ulcer they should notify the Physician as per the care plan for new treatment orders. The DON stated she was ultimately responsible for ensuring the care plans were followed.</p>	F 282		
F 314 SS=D	<p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 314	<p>F314</p> <p>#1 Resident #1 physician was updated on current condition of resident's pressure wound, after assessment, on February 6, 2014, by the DON with no change in the residents' plan of care made by the physician.</p>	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314 - Continued From page 23
by:
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a resident having Pressure Sores received necessary treatment and services to promote healing, prevent infection and prevent new sores from developing for one (1) of eighteen (18) sampled residents (Resident #1).

Resident #1 was noted to have redness to the coccyx area on 01/13/14, and a Mepilex dressing was ordered. According to the Progress Notes, the area opened and was noted to have yellow slough on 01/16/14; however, there was no documented evidence of staging and measurement of the wound and no documented evidence the Physician had been notified of the progression of the wound. On 01/19/14 the Wound Nurse assessed the wound and obtained orders for Mepilex to the coccyx for protection; however, there was no documented evidence of the Wound Nurse's skin assessment; and there was no documented evidence of measurement or staging of the wound. Interview with the Wound Nurse revealed the wound was red and slow to blanch on 01/19/14; however, was not open at that time.

Further, skin assessments, completed on 01/20/14 and 01/27/14, revealed the coccyx wound was open; however, there was no documented evidence of staging or measurement of the wound, and no documented evidence the Physician was notified the wound had progressed from a reddened area to an open area.

Resident #1 was hospitalized from 01/28/14 through 01/30/14 for an Acute Urinary Tract

F 314

#2 All residents have the potential to be affected by this deficient practice. One time audit of weekly skin assessments and skin alerts for all residents was reviewed for the previous 14 days on February 28, 2014, by the MDS Assistant to ensure proper documentation of measurements and staging, and physician notification of any changes. An audit was completed on February 28, 2014, by the Director of Nursing, to ensure completion of Braden Scale at least quarterly. Any issue identified was immediately corrected.

#3 Licensed nurses will be educated regarding staging and measuring wounds, physician notification of changes in skin condition, and completion of Braden Scales on 3/4/14 by the DON. All licensed nurses not attending on March 4, 2014 will be required to attend prior to returning to work.

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 314	Continued From page 24 Infection (UTI) and an Acute Seizure Disorder and returned to the facility on 01/30/14. On re-admission to the facility on 01/30/14, the resident was noted to have redness to the coccyx, and Mepilex was ordered. On 02/02/14, the area was noted to open and new Physician's Orders were obtained for Xeroform (a non-adhering dressing) to the open area on the coccyx, and cover with Alldress (an absorbent dressing); however, there was no documented evidence of a measurement and staging of the wound until 02/04/14. On 02/04/14, the wound was described as a Stage II Pressure Sore to the coccyx which measured five (5) centimeters in width and three and one half (3.5) centimeters in length with yellow sloughing and redness around the wound edges. The findings include: Review of the facility's, "Pressure Ulcer Care Guide, "Assessment and Monitoring of Healing", undated, revealed Pressure Ulcers were to be assessed and monitored once a week to determine if the treatment plan was working or needed to be evaluated. The Physician was to be kept informed of the progress or lack of progress toward healing. Continued review revealed the assessment included measuring the wound for surface area and depth; assessing the wound for moisture to determine if there was exudate; assessing the wound for devitalized tissue, granulation, and assessing the periwound (the tissue surrounding a wound) for color and condition. The Guide further stated the findings were to be documented including a narrative description of the wound in the medical record which was to include the location, stage, size, tissue type, wound bed, periwound condition,	F 314	Validation of weekly skin assessments completions and that skin alerts have been addressed will be conducted daily Mon-Fri beginning the week of March 10, 2014, X 4 weeks then monthly X 2 months by the MDS Assistant, to ensure proper documentation of measurements and staging and physician notification of change. Beginning the week of March 10, 2014 observation of 3 skin assessments, with random nurses and on random shifts, will be completed weekly X 4, then monthly X 2, by the MDS Assistant, to ensure competency of Licensed Nurse's to properly measure and stage open areas. Any areas of concern will be corrected immediately to ensure proper documentation of measurements and staging and notification of changes. Audits of Braden Scale completion will be completed monthly, based on MDS schedule, by the Director of Nursing. Any concerns with Braden Scale completion will be corrected immediately and re-educate nurse. #4 Results of audits will be reported to the Performance Improvement Committee monthly X3. #5 Completion Date March 19, 2014		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314 Continued From page 25
exudate, presence or absence of granulation or epithelialization, necrosis, odor, wound edges, tunneling, undermining, slough, pain, and type of wound, pressure related versus non pressure related.

Observation of Resident #1 during a skin assessment revealed a Pressure Ulcer to the coccyx which measured four (4) centimeters in width and 1.2 centimeters in length; during the skin assessment Licensed Practical Nurse (LPN) #10 described the Pressure Ulcer as red with a yellow center containing slough (soft moist dead tissue).

Review of Resident #1's medical record revealed the facility admitted the resident on 07/22/13, with diagnoses which included Dementia, Aorta Femoral Bypass, and Coronary Artery Disease. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/16/13, revealed the facility assessed Resident #1 as having a Brief Interview for Mental Status (BIMS) score of a two (2) out of fifteen (15) indicating severe cognitive impairment. Continued review revealed the facility assessed Resident #1 to be frequently incontinent of bowel and bladder; and to require assistance of two (2) staff for bed mobility, transfers, personal hygiene and toilet use. Further review revealed the facility assessed Resident #1 to have no pressure ulcers.

Review of the Braden Scale for Predicting Pressure Sore Risk form, dated 07/24/13, revealed Resident #1 was noted to have had no sensory perception impairment; his/her skin was usually dry; and he/she walked occasionally. Continued review revealed it was noted Resident #1 had probable inadequate nutrition, and had no

F 314

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 26</p> <p>apparent problem with shearing (an applied force or pressure exerted against the surface and layers of the skin as tissues slide in opposite but parallel planes). The Braden Scale Total Score Key revealed a score of less than nine (9) was very high risk and fifteen (15) to eighteen (18) was at risk. Further review of the Braden Scale for Predicting Pressure Sore Risk form revealed Resident #1's score was twenty (20) indicating low risk.</p> <p>Interview with the Director of Nursing (DON) on 02/06/14 at 5:11 PM, revealed there should have been subsequent Braden Scales performed for Resident #1 at least quarterly, however, she stated she could not find any which were completed after 07/24/13.</p> <p>Review of the Comprehensive Care Plan, dated 11/29/13, revealed Resident #1 had an at risk for impaired skin integrity care plan which interventions which included weekly skin assessments per the nurse, to notify the Physician of any change in skin integrity and treatment as ordered. Further review of the Comprehensive Care Plan revealed a care plan, dated 01/31/13, which stated Resident #1 had a Stage II pressure area to the coccyx with interventions which included providing treatment as ordered, turning and repositioning the resident, notifying the Physician if the area worsened, and monitoring for signs and symptoms of infection.</p> <p>Review of the Weekly Skin Integrity Data Collection (WSIDC) assessment form, dated 01/13/14, completed by LPN #6, revealed Resident #1's skin was noted to be intact with redness to the buttocks, coccyx, perineal area as indicated by the nurse circling these areas of the</p>	F 314			

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314 | Continued From page 27
body diagram on the form.

Review of a Physician's Order dated 01/15/14 revealed an order for Mepilex (protective dressing) to Resident #1's coccyx area daily and prn (as necessary) for redness to the coccyx.

Review of a Progress Note dated 01/16/14 at 12:49 AM, completed by LPN #7, revealed new orders for Mepilex to the coccyx area noted due to redness and a small open area with yellow slough. However, record review revealed no documented evidence the Physician had been notified of the progression of the wound as indicated by the nurse noting a small open area with yellow slough was now present. Record review revealed no documented evidence of Physician's Orders received on 01/16/14 and no documented evidence of a skin assessment recorded with measurements and description of the area.

Interview with LPN #7 on 02/06/14 at 4:45 PM, revealed she did not remember writing the Progress Note dated 01/16/14 at 12:49 AM. She stated however, if Resident #1's wound had changed or worsened, she should have notified the Wound Nurse and called the Physician. She further stated she should have measured, staged, and described the wound.

Further review of a verbal Physician's Order dated 01/19/14, revealed orders for Mepilex to the coccyx for protection, change every three (3) days and prn which was obtained by the Wound Nurse/ Licensed Practical Nurse (LPN) #5. However, record review revealed no documented evidence of a skin assessment performed by the Wound Nurse which noted measurements,

F 314

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 314	<p>Continued From page 28</p> <p>staging and description of the area on Resident #1's coccyx; and no documented evidence of a Nurse's Note written by the Wound Nurse related to the reason the order was obtained.</p> <p>Interview with the Wound Nurse on 02/06/14 at 4:00 PM, revealed she had completed a skin assessment for Resident #1 on 01/19/14, and the coccyx area was red and slow to blanch; but was not open. She stated she obtained orders for the Mepilex for protection. The Wound Nurse stated she did not know why she had not documented the skin assessment performed on 01/19/14; however, she indicated skin assessments should always be documented.</p> <p>Further review of the WSIDC, revealed a skin assessment completed on 01/20/14 by LPN #6, which stated Resident #1's skin was intact; there was an open area with a treatment in place; and the buttocks and coccyx areas were circled on the diagram of the body on the form. Record review revealed even though the skin assessment performed by LPN #6 on 01/20/14, indicated there was an open area, there was no documented evidence of wound measurements or description or staging of the wound. Additionally, record review revealed no documented evidence of a Nurse's Note recorded related to the open area; and no documented evidence the Wound Nurse or Physician had been notified of the change in the wound.</p> <p>Interview with LPN #6 on 02/06/14 at 4:59 PM, revealed when she had completed Resident #1's skin assessment on 01/20/14, she had observed an open area on the coccyx that had the appearance of slough. LPN #6 stated she had considered the area a Pressure Ulcer. She</p>	F 314		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 314 Continued From page 29

stated she should not have noted the wound as intact on the wound sheet because the area was open. According to LPN #6, she had not staged or measured the wound because she was not comfortable with staging and measuring wounds. She stated the Wound Nurse staged and measured wounds; however, was not sure she had notified the Wound Nurse when she observed the open area. Further interview revealed if a wound showed progression such as from a red area to an open area, the Physician was to be notified. LPN #6 stated she could not remember notifying the Physician of the change in the wound.

Review of the WSIDC, dated 01/27/14 completed by LPN #8, revealed the nurse had noted Resident #1's skin was intact, and there was an open area on the buttocks which she had circled on the diagram of the body on the form.

Interview with LPN #8 on 02/06/14 at 4:15 PM, revealed he had completed the skin assessment on 01/27/14. He stated he should not have noted Resident #1's skin to have been intact as there was a small open area on the coccyx. He stated the Wound Nurse was responsible for staging and measuring wounds and he had notified the Wound Nurse of his observation of the open area. However, record review revealed no documented evidence of the Wound Nurse or Physician having been notified of the open area on Resident #1's coccyx. Further record review revealed no documented evidence the area had been staged or the wound measured by LPN #8 or the Wound Nurse.

Review of a Progress Note dated 01/28/14 at 9:00 AM, revealed Resident #1 noted to have had

F 314

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 30</p> <p>rapid respirations, was not responding to staff and had facial drooping on the left side. Continued review of the Progress Note revealed the Physician was notified and orders received to send Resident #1 to the emergency room.</p> <p>Review of the Hospital Discharge Summary, dated 01/30/14, revealed Resident #1 was discharged with diagnoses which included Acute Urinary Tract Infection and Acute Seizure Disorder.</p> <p>Review of a Nurse's Note dated 01/30/14 at 8:05 PM, revealed Resident #1 had returned to the facility. Review of the Initial Data Collection Tool/ Nursing Service form, revealed Resident #1 had red skin on his/her coccyx and buttocks indicated by the nurse circling these areas on the diagram of a body on the form. Review of the Physician's Orders dated 01/30/14 for Resident #1's re-admission revealed orders for Mepilex to his/her coccyx for protection which was to be changed every three (3) days and prn.</p> <p>Review of the Progress Note dated 02/03/14 at 12:12 AM, completed by LPN #9, revealed a late entry for 02/02/14 which revealed, new treatment orders for the open area on the resident's coccyx, and "all parties" had been made aware. Further review of the Progress Note revealed no documented evidence of staging or measurement of the open area on Resident #1's coccyx.</p> <p>Review of the verbal Physician's Order obtained on 02/02/14 by LPN #9, revealed orders to discontinue the Mepilex to the coccyx, apply Xeroform (a non-adherent dressing) to the open area on the coccyx, and cover with Alldress (a self adherent absorbent dressing), change daily and prn until healed.</p>	F 314			

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 314	Continued From page 31 Interview with LPN #9 on 02/16/14 at 6:00 PM, revealed on 02/02/14, the State Registered Nursing Assistants (SRNA's) told her the Resident #1's coccyx area looked different, and when she assessed the area she observed an actual open area. She stated she had notified the Physician; however, had not measured or staged the area because she was uncomfortable with measuring and staging wounds. LPN #9 stated she was uncertain of how to measure Resident #1's wound because it was an open area in the center of a reddened area. Review of the Pressure Ulcer Status Record dated 02/04/14 completed by the Wound Nurse, revealed Resident #1 had a Stage II Pressure Sore to the coccyx which measured five (5) centimeters (cm) in width and three and one half (3.5) cm in length with yellow sloughing and redness around the wound edges. Interview, on 02/06/14 at 5:00 PM, with the Wound Nurse revealed she had not been notified to assess Resident #1's wound after the resident returned from the hospital. She stated she was not notified to assess the wound until 02/04/14, two (2) days after the wound was noted to change. The Wound Nurse stated she completed the skin assessment on 02/04/14. Interview with the Attending Physician on 02/06/14 at 4:20 PM, revealed he should be notified when wounds changed from a reddened area to an open area. He indicated he should have been notified on 01/16/14 when the wound was noted to be open with slough; and also on 01/20/14 and 01/27/14 when the nurses noted the wound had opened. The Physician stated he	F 314			

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 314	Continued From page 32 might not have changed the treatment to the coccyx area as Mepilex was already ordered and would have been an appropriate treatment for an open wound also. The Attending Physician stated his expectation was for nurses to stage and measure Pressure Ulcers. Interview with the Director of Nursing (DON) on 02/06/14 at 5:11 PM, revealed if a new area of skin breakdown was noted or a Pressure Ulcer was observed to worsen, the nurse measure and stage the wound and document his/her findings in the record. The DON stated the nurse was to notify the Physician for a treatment order. She stated the Wound Nurse was also to be notified as she performed the weekly skin assessments of residents with Pressure Ulcers; and staged and measured the Pressure Ulcers. Continued interview revealed any nurse was supposed to be able to stage and measure wounds. She indicated her nurses needed education regarding the staging and measurement of wounds, as well as, when to notify the Physician related to changes in wounds.	F 314		
F 315	483.25(d) NO CATHETER, PREVENT UTI, SS=D RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	F315 #1 Resident #1 receives perineal care, as evidenced by observation of peri-care on February 25, 2014, by the DON performed with proper infection control technique to prevent infections.	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 315	<p>Continued From page 33</p> <p>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 a resident who was incontinent of bladder received appropriate treatment and services to prevent Urinary Tract Infections (UTI's) for one (1) of eighteen (18) sampled residents (Resident #1).</p> <p>Observation revealed staff performed poor infection control technique with perineal care for Resident #1 who had a history of UTI's.</p> <p>The findings include:</p> <p>Review of the facility's, "Urinary Incontinence Policy", undated, revealed each resident who was incontinent of urine was to be identified, assessed, and provided with appropriate treatment and services to prevent UTI's.</p> <p>Review of the facility's policy titled, "Personal Hygiene for the Male Resident", undated, revealed staff were to always proceed from the least contaminated area to the most contaminated area. The policy stated for a male resident, staff were to move the washcloth in a spiral motion from the tip of the penis down it's length toward the pubic area; rinse the washed area; wash and rinse the scrotum; and dry the cleansed areas.</p> <p>Review of Resident #1's medical record revealed diagnoses which included Dementia and a History of UTI's. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/16/13, revealed the facility assessed the</p>	F 315	<p>#2 Residents dependent for peri-care were assessed for signs and symptoms of urinary tract infection on February 26, 2014, by the DON.</p> <p>#3 Licensed and Unlicensed nursing staff were provided proper perineal care training to prevent infection on March 4, 2014, by the SDC. Licensed and Unlicensed nursing staff not attending on March 4, 2014 will be required to attend prior to returning to work. Observation of perineal care for 5 residents will be performed beginning week of March 17, 2014, by the SDC, weekly X 4 weeks, then monthly X 2 months to ensure proper perineal care to prevent infection. Any concerns will be addressed immediately to prevent improper technique.</p> <p>#4 Results of audits will be reported to the Performance Improvement Committee monthly X3.</p> <p>#5 Completion Date March 19, 2014</p>	
-------	--	-------	---	--

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 315 | Continued From page 34

resident as having severe cognitive impairment. Continued review of the MDS revealed the facility assessed Resident #1 as requiring extensive assist of two (2) persons for toileting; as being frequently incontinent of bowel and bladder; and as having had a UTI in the past thirty (30) days.

Review of the Laboratory Data forms revealed a urine specimen was collected on 12/14/13 and verified on 12/16/14 to have the organism Proteus Mirabilis present in the urine. Review of the Physician's Order dated 12/16/13, revealed an order for Invanz (an antibiotic medication) one (1) gram intramuscular (IM) every day for ten (10) days.

Further review of Laboratory Data forms, revealed a urine specimen was collected on 01/09/14 and verified on 01/11/14 to have the organism Escherichia Coli present in the urine. Review of the Physician's Order dated 01/12/14, revealed an order for Ceftin (antibiotic medication) five hundred (500) milligrams twice a day for fourteen (14) days.

Review of a Hospital Discharge Summary dated 01/31/14, revealed the resident had been diagnosed with a UTI, and had been started empirically (depending upon experience or observation alone, without using scientific method or theory in medicine) on Zosyn (an antibiotic medication) intravenous (IV) which had been administered for three (3) days. Further review of the Discharge Summary revealed the urine culture revealed gram negative rods (bacteria which cause infection); and Resident #1 was discharged with orders for Bactrim DS (an antibiotic medication) two (2) tablets daily for a total of seven (7) days. Review

F 315

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 315	<p>Continued From page 35</p> <p>of the Physician's Orders dated 01/30/14, revealed an order for Bactrim DS, one (1) tablet twice a day for seven (7) days.</p> <p>Observation on 02/05/14 at 2:45 PM of perineal care for Resident #1, revealed State Registered Nursing Assistant (SRNA) #6 performed the perineal care by cleansing the resident's inner thighs and scrotum; and then cleansing the penis from base to tip.</p> <p>Interview with SRNA #6 on 02/05/14 at 2:50 PM, revealed she had received training in the past related to perineal care; however, had not received any recent inservices in regards to perineal care. She stated she had never been observed by nurses when she was completing residents' perineal care. She indicated she was aware she had washed Resident #1's scrotum prior to cleansing the penis from base to tip, and stated she knew better. She indicated she had been trying to quickly provide the perineal care as Resident #1 had behaviors at times.</p> <p>Interview with the Director of Nursing (DON) on 02/06/14 at 3:45 PM, revealed she was unsure when the last perineal care inservice had been performed. The DON stated the SRNA should have cleansed the penis from tip to base and then cleansed the resident's scrotum as per facility policy. She indicated this was important in protecting residents at risk for UTIs.</p>	F 315		
F 328 SS=E	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:</p>	F 328	F328	

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 328 | Continued From page 36

Injections;
Parenteral and enteral fluids;
Colostomy, ureterostomy, or ileostomy care;
Tracheostomy care;
Tracheal suctioning;
Respiratory care;
Foot care; and
Prostheses.

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 respiratory equipment was clean and stored appropriately in a manner to prevent the spread of infection for four (4) of eighteen (18) sampled residents (Resident #1, #3, #13 and #15), and three (3) unsampled residents (Unsampled Residents C, D, and E).

Observations revealed the oxygen tubing for Resident #3 was not labeled and dated according to facility policy, and the resident's nebulizer mask was not bagged and labeled when not in use. Observation revealed Resident #1's oxygen tubing was not bagged when not in use. In addition, oxygen concentrator filters for Resident #3, Unsampled Resident C and Unsampled Resident D were covered with a thick layer of dust. Further observation revealed Unsampled Resident C's and Unsampled Resident E's nasal cannula were lying unbagged on the floor when not in use. Additionally, Resident #13's and #15's Constant Positive Airway Pressure (CPAP) machines (a breathing assist device worn over the mouth or nose to provide nighttime relief for individuals who suffer from Sleep Apnea) were on

F 328 |

#1 Residents #1, #3, #13, and #15, unsampled residents C, D and E's respiratory equipment was assessed to ensure proper labeling, cleanliness and storage of respiratory equipment on February 7, 2014, by Central Supply.

#2 All Respiratory Equipment for residents' who require respiratory equipment was assessed to ensure proper labeling, cleanliness and storage on February 7, 2014, by Central Supply.

#3 Licensed and Unlicensed nursing staff will be educated regarding proper cleaning, labeling, and storage of respiratory equipment to prevent infection on March 4, 2014, by the Director of Nursing and Staff Development Coordinator. Licensed and Unlicensed nursing staff not attending on March 4, 2014 will be required to attend prior to returning to work.

Observation of all respiratory equipment for residents' who require respiratory equipment will be performed Mon-Fri by the Department Managers with Room Rounds beginning the week of March 17, 2014 to ensure proper cleanliness, proper labeling and storage of respiratory equipment to prevent infection. Any concerns will be corrected immediately.

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 328	Continued From page 37 the bedside tables uncovered. The findings include: Review of the facility's Respiratory Care Services Policy and Procedures, undated, revealed it was the facility's policy to replace and date the oxygen tubing, mask and nasal cannulas every seven (7) days. Continued review revealed respiratory supplies were to be stored in a bag labeled with the resident's name. 1. Observation on 02/04/14 at 2:15 PM, during the initial tour on the 100 hall, revealed in Room 100, bed 1, Resident #1's nasal cannula (the part of the tubing inserted into the resident's nostrils to deliver oxygen therapy) and oxygen tubing was unbagged, wound up and placed on top of the oxygen concentrator. 2. Observation on 02/04/14 at 3:00 PM, of Room 110, bed 1 revealed Unsampled Resident E was not present in the room; however, there was a nasal cannula and oxygen tubing lying on the floor which was connected to the oxygen concentrator by the bed. Continued observation revealed no evidence of a bag for the nasal cannula and oxygen tubing. Interview, on 02/04/14 at 3:15 PM, with Licensed Practical Nurse (LPN) #6, who was the nurse assigned to the 100 Hall, revealed residents' oxygen tubing and nasal cannulas were to be bagged; and staff were to place the new bags in residents' rooms for these items on Sundays. 3. Observation on 02/05/14 at 9:50 AM, revealed Resident #3's nebulizer mask (used to administer respiratory treatments) was lying unbagged on	F 328	Manager of Duty on Saturday and Sunday will ensure all respiratory equipment for residents' who require respiratory equipment are clean, properly labeled and stored. Any concerns will be corrected immediately. #4 Results of audits will be reported to the Performance Improvement Committee monthly X3. #5 Completion Date March 19, 2014		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 328	<p>Continued From page 38</p> <p>top of the oxygen concentrator. Continued observation revealed the oxygen concentrator filter was covered with a thick layer of dust while the equipment was in use. In addition, observation revealed Resident #3's oxygen tubing was not dated to indicate when it had been changed last.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 02/05/14 at 9:55 AM, revealed she had laid the nebulizer mask on the oxygen concentrator while she assisted Resident #3 with care. She stated the nebulizer mask should have been placed in a bag with Resident #3's name on it. LPN #1 stated she had forgotten to bag the nebulizer mask prior to leaving the room. She stated all oxygen tubing and masks were changed out every Sunday on night shift. She indicated she could not say why Resident's #3's oxygen tubing had not been dated; and stated without a dated label on the oxygen tubing it was impossible to know when the tubing had been changed last.</p> <p>4. Observation on 02/05/14 at 11:10 AM, revealed the oxygen concentrator filter for Unsampled Resident C was covered with thick dust buildup. Subsequent observation, on 02/05/14 at 3:20 PM, revealed Unsampled Resident C was not in his/her room; however, the resident's oxygen tubing and nasal cannula were unbagged and lying on the floor.</p> <p>Interview with LPN #2 on 02/06/14 at 3:25 PM, revealed Unsampled Resident C's nasal cannula would have to be changed since it had been on the floor.</p> <p>5. Observation on 02/05/14 at 11:15 AM, revealed the oxygen concentrator filter for</p>	F 328		
-------	--	-------	--	--

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE
F 328	<p>Continued From page 39</p> <p>Unsampled Resident D was coated with a heavy layer of dust.</p> <p>Interview with LPN #2 on 02/06/14 at 3:25 PM, revealed respiratory equipment, including nasal cannulas and masks for all residents were to be changed out every Sunday night and the new ones dated. She stated the respiratory equipment should have been bagged when not in use. Continued interview revealed oxygen concentrator filters were to be changed at the same time every Sunday.</p> <p>6. Observation on 02/04/14 at 2:15 PM, during the initial tour on the 100 hall, revealed Resident #15 who resided in Room 104, bed 1, and Resident #13 who resided in Room 102 bed 1, had CPAP machines lying on the bedside table uncovered.</p> <p>Interview, on 02/04/14 at 3:15 PM, with LPN #6, who was the nurse assigned to the 100 Hall, revealed she was unsure if CPAP machines were to be covered.</p> <p>Interview with the Assistant Director of Nursing on 02/06/14 at 3:42 PM, revealed all oxygen equipment and filters were to be changed out every Sunday for all residents receiving any form of respiratory therapy.</p> <p>Interview with the Director of Nursing (DON) on 02/05/14 at 11:30 AM, revealed oxygen tubing should have been in a plastic bag if not in use, and the oxygen humidifier bottle and the oxygen tubing as well as the plastic bags for the tubing was changed out on Sunday nights. She further stated the CPAP machine did not need to be covered when not in use. An additional interview</p>	F 328		

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 328	Continued From page 40 with the Director of Nursing on 02/05/14 at 6:30 PM, revealed it was her expectation oxygen equipment, including filters, masks, and nasal cannulas were to be changed weekly. She stated all respiratory equipment should have been dated when it was changed, and bagged when it was not in use.	F 328			
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions 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 store, prepare, distribute and serve food under sanitary conditions as evidenced by expired, undated and unlabeled foods in the kitchen and the unit nourishment rooms. The findings include: Review of the facility's, Food and Nutrition Services In-Service Training Manual on Food Safety, revealed if dry or frozen food were removed from a box and had no identification on the packaging, it was to be labeled with the name of the food item and that day's date. Review	F 371	F371 #1The kitchen and each nourishment refrigerators were audited for expired, undated and unlabeled foods/drinks on February 6, 2014 by the Dietary Manager. #2The kitchen and each nourishment refrigerators were audited for expired, undated and unlabeled foods/drinks on February 6, 2014 by the Dietary Manager. #3 The Dietary Manager was educated on February 27, 2014 by the Executive Director that all foods/drinks are to be labeled and dated and expired foods/drinks are to be discarded. All dietary Staff will be educated on March 4, 2014 by the Dietary Manager that all foods/drinks are to be labeled and dated and expired foods/drinks are to be discarded.		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 41</p> <p>revealed staff were to use the recorded date to ensure that leftover food was used within the appropriate amount of time. Continued review revealed all leftover food and food that had been opened, but not completely used, were to be securely covered. Review revealed when snacks were delivered, any snacks left in the nourishment refrigerator were to be brought back to the dietary department. Open or outdated snacks were to be discarded. Further review revealed food was to be securely covered, labeled to identify each item and the label was to include the date. Additionally, review revealed food items over seventy-two (72) hours old were to be discarded.</p> <p>Observation on 02/04/14 at 2:15 PM, during the initial kitchen tour revealed an open bag of marshmallows undated; a container of bread crumbs with an expiration date of 08/13/13; and a dried white powder in a white container with lid not labeled with the name of the food item. Observation of the walk-in freezer revealed five (5) frozen green leafy vegetables in clear wrap which were undated and unlabeled; one half a case of fruit buttercups which had an expiration date of 06/27/12 on the freezer shelf under the frozen green leafy vegetables. Continued observation during the initial tour revealed clear plastic containers of cereal which were undated and unlabeled and a clear container of biscuits which were undated and unlabeled on top of the milk cooler.</p> <p>Interview, on 02/04/14 at 2:30 PM, with the Dietary Manager revealed Cook #1 and himself were responsible for storage, dating, labeling and rotation of the stock. He indicated food items were to be labeled and dated and discarded if</p>	F 371	<p>Beginning February 28, 2014 audits of kitchen and nourishment refrigerators for expired, undated and unlabeled foods/drinks will be conducted by the Dietary Manager or dietary assistant daily X 4 weeks, then weekly times X 4 weeks. During the daily audits if expired, undated or unlabeled foods are found they will be discarded at that time.</p> <p>#4 Results of audits will be reported to the Performance Improvement Committee monthly X 3.</p> <p># 5 Completion Date March 19, 2014</p>	
-------	---	-------	---	--

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 371	Continued From page 42 expired. Observation on 02/04/14 at 5:30 PM, of the West Hall nourishment room revealed a brown pudding not dated and labeled; applesauce which expired 01/27/14 and 01/30/14; a prepared cake in a cake box which was undated and unlabeled; a red fruit punch in a clear plastic pitcher with lid dated 01/26/26/14 through 01/29/14; a Sysco Chocolate Shake thawed and undated; and two (2) undated containers of chocolate and vanilla ice cream. Observation on 02/04/14 at 5:45 PM, of the South Hall nourishment room revealed in the freezer a container of a white looking sauce undated and unlabeled; a frozen orange substance in a cup undated and unlabeled; two (2) chocolate and vanilla ice creams undated; two (2) popsicles which had the appearance of having melted and refrozen unlabeled and undated; and in the refrigerator a thawed Sysco Chocolate shake undated. Interview, on 02/05/14 at 9:50 AM, Dietary Manager revealed nourishments were rotated by dietary staff on a daily basis. He indicated the food items in the nourishment room refrigerators were to be labeled and dated.	F 371			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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. (a) Infection Control Program	F 441	F441 #1 Resident #1 receives perineal care as evidenced by a one-time observation of peri-care on February 25, 2014, by the DON performed with proper infection control technique to prevent infections. Resident #6 was treated for MRSA in January 2014. He is no longer showing any signs or symptoms of MRSA on February 27, 2014.		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441 Continued From page 43
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, and record review, it was determined the facility failed to 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 as evidenced by the following:

F 441
Resident # 5 receives dressing changes with proper infection control technique to prevent infections as evidenced by observation by the MDS assistant on February 27, 2014. Resident #5 wound shows no signs of infection as of February 27, 2014, assessed by MDS assistant.

Crash carts and supply rooms were audited for expired supplies on February 6, 2014, by the DON and SDC.

Room Rounds were conducted on February 10, 2014, by Department Managers and personal care items, including basins were labeled and stored properly.

#2 Residents dependent for pericare were assessed for signs and symptoms of urinary tract infection on February 26, 2014, by the DON.

Residents with infections were audited to identify diagnosis of MDRO on February 28, 2014, by the SDC to ensure staff are aware of diagnosis. There were no residents identified.

A one-time audit of residents receiving wound care were assessed, during wound care rounds and dressing observations on February 27, 2014, by the MDS assistant to ensure no signs and symptoms of wound infection.

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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

(X4) 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
--------------------	--	---------------	---	----------------------

F 441 | Continued From page 44

Observation of perineal care provided for Resident #1 revealed poor infection control technique was utilized.

Resident #6 had a diagnosis of MRSA of the urine; however, staff were unaware of the diagnosis and the resident was not placed in isolation for contact precautions per policy.

Observation of a dressing change for Resident #5 revealed poor infection control technique utilized.

Observations revealed there were expired supplies in the three (3) crash carts and a supply room.

In addition, observations on initial tour revealed wash basins which were not covered and/or labeled in resident rooms and bathrooms.

The findings include:

1. Review of the facility's policy titled, "Personal Hygiene for the Male Resident" undated, revealed when providing personal hygiene care for male residents staff were to proceed from the least contaminated area to the most contaminated area. According to the policy, staff were to move the wash the penis in a spiral motion from the tip down towards the pubic area, and rinse the washed area; then wash and rinse the resident's scrotum; and dry all the cleansed areas.

Review of Resident #1's clinical record revealed diagnoses which included Dementia and a History of UTI's. Review of the Significant Change Minimum Data Set (MDS) Assessment, dated 12/16/13, revealed facility assessed the resident

F 441 |

Crash carts and supply rooms were audited for expired supplies on February 6, 2014, by the DON and SDC.

Room Rounds were conducted on February 10, 2014, by Department Managers, including the Executive Director, DON, ADON, Activities Director, MDS Assistant, Housekeeping Supervisor, Dietary Manager, Director of Rehab, Human Resources, Accounts Receivable, and Staff Development and personal care items, including basins were labeled and stored properly.

#3 Licensed and Unlicensed nursing staff will be educated regarding infection control program measures to ensure protection of residents to prevent the spread of infection, including all MDRO's on March 4, 2014, by the Director of Nursing and Staff Development Coordinator. Licensed and unlicensed nursing staff not attending on March 4, 2014 will be required to attend prior to returning to work.

Crash cart supply list placed on crash cart by SDC on February 28, 2014, will include expiration date of supplies to ensure removal prior to expiration.

Infection Control list of communicable diagnosis will be maintained by SDC to ensure staff is aware of diagnosis as of February 27, 2014.

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 45</p> <p>as requiring extensive assistance of two (2) persons for toileting, as being frequently incontinent of bowel and bladder, and as having had a Urinary Tract Infection (UTI) in the past thirty (30) days.</p> <p>Observation on 02/05/14 at 2:45 PM, of perineal care provided for Resident #1, revealed State Registered Nursing Assistant (SRNA) #6 cleansed the resident's inner thighs and scrotal area first. Continued observation revealed SRNA #6 then cleansed the penis from base to tip.</p> <p>Interview with SRNA #6 on 02/05/14 at 2:50 PM, revealed she had received perineal care training in the past; however had not received any recent training or inservices on this. She stated she had never had nurses observe her providing perineal care for residents. SRNA #6 indicated she knew she should have washed Resident #1's penis first from tip to base, then cleansed the scrotum. She stated however, Resident #1 had behaviors at times and she had been trying to quickly provide his/her perineal care related to these behaviors.</p> <p>Interview with the Director of Nursing (DON) on 02/06/14 at 3:45 PM, revealed the SRNA should have cleansed Resident #1's penis from tip to base and then cleansed the resident's scrotum as per facility policy.</p> <p>2. Review of the facility's infection control policy titled, "Transmission-based Precautions and Isolation Procedures", revised 07/18/2011, revealed transmission based precautions were used in addition to standard precautions for residents with suspected or confirmed infections and conditions. Residents were to be placed on appropriate transmission-based precautions until</p>	F 441	<p>Observation of perineal care, for 5 residents dependent for peri-care will be performed, by the Staff Development Coordinator, beginning the week of March 10, 2014, weekly X 4 weeks, then monthly X 2 months to ensure proper perineal care to prevent infection. Any concerns identified will be corrected immediately to prevent improper technique.</p> <p>Audits of residents with diagnosis of MDRO's, ensuring staff is aware of diagnosis and precautions are in place will be performed beginning the week of March 10, 2014, weekly X 4, monthly X 2 by the Staff Development Coordinator to ensure staff is aware of diagnosis and precautions.</p> <p>Beginning week of March 17, 2014, observation of 3 wound dressing changes performed by random nurses on random shifts, will be performed weekly X4, then monthly X2, by the MDS assistant to ensure proper infection control technique. Any concerns identified will be corrected immediately to prevent improper technique. Infection control log will be audited by the Director of Nursing or Assistant Director of Nursing once a week X 4 weeks, beginning the week of March 10, 2014.</p>		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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

(X4) 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
--------------------	--	---------------	---	----------------------

F 441 Continued From page 46
the condition had been ruled out or the criteria for removal from isolation had been met.

Review of the Resident #6's medical record revealed a Physician Order dated 1/14/14 for a urinalysis with culture & sensitivity to be obtained. Record review revealed the facility received the laboratory results for the urinalysis with culture and sensitivity on 01/17/14. Review of the Laboratory Report the urine contained Methicillin Resistant Staphylococcus Aureus (MRSA), an antibiotic resistant bacteria, infection. Further review revealed no documented evidence Resident #6 was placed on precautions to prevent the spread of infection in regards to the MRSA infection in his/her urine.

Interview, on 02/06/14 at 7:50 PM, with CNA #8 revealed she had never been informed Resident #6 had MRSA in his/her urine. CNA #8 stated it was not on the nursing assistant's care plan. She stated Resident #6 had not been on any special precautions in January that she could recall. She indicated Resident #6 used a urinal and sometimes spilled urine on his/her clothing and bedding; and staff emptied the urinal in the bathroom commode.

Interview, on 02/6/14 at 7:30 PM, with the Infection Control (IC) Nurse revealed Resident #6's had not been placed in isolation because he/she was immobile and did not use the bathroom. She stated if residents were mobile and MRSA was in their urine then the facility placed them on precautions.

Interview on, 02/06/14 at 8:00 PM, with the Director of Nursing (DON) revealed Resident #6 should have been placed on precautions when

F 441

Beginning in March audits of crash cart will be conducted monthly by the Staff Development Coordinator to ensure all supplies are within expiration date.

Beginning in March an audit of supply rooms will be conducted monthly by the Central Supply Person to ensure all supplies are within the expiration date.

Beginning the week of March 17, 2014 Room Rounds will be conducted daily by Department Managers, including the Executive Director, DON, ADON, Activities Director, MDS Assistant, Housekeeping Supervisor, Dietary manager, Director of Rehab, Human Resources, Accounts Receivable, and Staff Development Director. Mon-Fri to include observation of personal care items, including basins to ensure proper labeling and storage and overall infection control procedures.

#4 Results of audits will be reported to the Performance Improvement Committee monthly X3.

#5 Completion Date March 19, 2014

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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

(X4) 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
--------------------	--	---------------	---	----------------------

F 441 Continued From page 47
diagnosed with the MRSA infection in his/her urine to address possible infection control issues related to bacteria.

3. Review of the facility's Hand Hygiene policy, revised 05/01/12, revealed the purpose was to decrease the risk of transmission of infection by utilizing appropriate hand hygiene. Continued review of the policy revealed staff were to wash or sanitize their hands after contamination.

Record review revealed the facility admitted Resident #5 on 12/19/11 with Diagnoses which included Multiple Sclerosis (MS) and Bowel Incontinence. Review of the February 2014 monthly Physician's Orders revealed an order for a daily dressing change related to the Stage II Pressure Wound on Resident #5's right buttock.

Observation on 02/05/14 at 9:38 AM, of Resident #5's dressing change on the Stage II Pressure Ulcer, performed by Registered Nurse (RN) #1 revealed the nurse placed the dressing supplies directly on the resident's bed; without providing a clean barrier between the contaminated bedding and the supplies. Continued observation revealed the nurse did not wash or sanitize her hands after she removed her soiled gloves prior to donning clean gloves.

Interview, on 02/05/14 at 10:22 AM, with RN #1 revealed she should not have placed the supplies on the resident's bed without a clean barrier. She further stated she should have washed or sanitized her hands after removal of the soiled gloves and before she donned clean gloves.

Interview, on 02/05/14 at 10:47, with the Assistant Director of Nursing (ADON) revealed RN #1

F 441

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

PRINTED: 02/20/2014
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 02/06/2014
NAME OF PROVIDER OR SUPPLIER LIFE CARE CENTER OF MOREHEAD		STREET ADDRESS, CITY, STATE, ZIP CODE 933 NORTH TOLLIVER ROAD MOREHEAD, KY 40351		
(X4) 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
F 441	<p>Continued From page 48</p> <p>should have placed a clean barrier on the resident's bed, prior to placing the supplies on the bed, to prevent contamination of the supplies. Further interview revealed the nurse should have washed or sanitized her hands after she removed the soiled gloves and prior to donning clean gloves.</p> <p>4. Interview, on 02/06/14 at 3:36 PM with the Staff Development Coordinator (SDC) revealed she was unaware of the facility having a policy regarding expired (exp) supplies. She stated expired supplies were not used.</p> <p>Observation, during inspection of three (3) facility crash (emergency) carts on 02/04/14 between 6:05 PM to 6:50 PM, revealed expired (exp) supplies were available for use on residents in the event of an emergency. Observation revealed the three (3) carts contained the following expired supplies: two (2) Bordered Gauze with exp date of September 2008; two (2) boxes of two hundred (200) Alcohol Swabs with exp date of November 2011; one (1) box of two hundred (200) Alcohol Swabs with exp date of July 2012; one (1) box of two hundred (200) Alcohol Swabs with exp date of June 2012; and six (6) Tongue Depressors with exp date of May 2013; two (2) bottles of Hand Sanitizer with exp date of February 2013; three (3) Bioclusive (thin permeable barrier) dressings with exp date of December 2010; three (3) Bioclusive dressings with exp date of September 2009; two (2) Mepore (self-adherent, absorbent, and breathable dressing with an outer film layer that protects a wound from water and contamination) dressing with exp date of January 2013; one (1) dressing change tray with exp date of October 2007; one (1) Intravenous (IV) Start Kit with exp date of</p>	F 441		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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

(X4) 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
--------------------	--	---------------	---	----------------------

F 441 Continued From page 49
January 2011; and one (1) IV Catheter with exp of March 2009.

F 441

Observation of the North Hall supply room, on 02/05/14 at 11:45 AM, revealed fourteen (14) Peripheral Transparent Dressings with exp date of November 2013, and five (5) Acticoat (antimicrobial silver dressing) dressings with exp date of November 2013.

Interview, on 02/04/14 at 6:09 PM, with the SDC revealed expired supplies were not to be in the crash carts available for resident use. She stated she was responsible for ensuring expired supplies were not in the crash carts. The SDC stated she had not been checking the crash carts however because she did not know the supplies had an expiration date. Additional interview, on 02/06/14 at 6:31 PM, with the SDC revealed she was responsible for ensuring expired supplies were not in the supply rooms. She stated expired supplies were not to be used on the residents.

5. Review of the facility's policy titled, "Bed Baths, undated, revealed the bed bath equipment was to be thoroughly cleaned and placed in an appropriate storage area after the bed bath. Continued review revealed the policy did not specify if the wash basin needed to be covered, bagged, or labeled for identification.

Observation on 02/04/14 at 2:15 PM, of the 100 Unit on initial tour revealed Room 104 bed 2 had a wash basin which was uncovered and unlabeled lying on the floor by the bed; and the bathroom in Room 111, which was shared by two (2) residents, had a wash basin lying on the floor which was uncovered and unlabeled.

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

PRINTED: 02/20/2014
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) OATE SURVEY COMPLETED 02/06/2014
--	--	--	--

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

(X4) 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
--------------------	--	---------------	---	----------------------

F 441 Continued From page 50
Interview with the Director of Nursing (DON) on 02/05/14 at 11:30 AM, revealed wash basins were to be labeled with residents' names and placed in a bag when not in use.

F 441

F 514 483.75(l)(1) RES
SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

F 514

F514

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 medical record was complete and accurate for one (1) of eighteen (18) sampled residents (Resident #3). Review of the Monthly Flow Report for January 2014 revealed no documented evidence Resident #3 had a bowel movement between 01/02/14 and 01/11/14.

The findings include:

Review of the facility's policy titled, "BM Protocol", undated, revealed staff were to document each resident's bowel movement (BM) every shift.

#1 Review of Resident #3 medical record, by the DON indicates an accurate medical record including bowel movement documentation as of February 26, 2014.

#2 All residents have the potential to be affected by this deficient practice. BM records for each resident were reviewed on February 26, 2014 by the Director of Nursing to ensure proper documentation of bowel movements.

#3 Licensed and unlicensed nursing staff will be educated on March 4, 2014, regarding accurate documentation in the medical record, including bowel movements by the Director of Nursing and Staff Development Coordinator. Licensed and Unlicensed nursing staff not attending on March 4, 2014, will be required to attend prior to returning to work.

Missing Bowel Movement reports are to be reviewed by the Director of Nursing or Assistant Director of Nursing Mon - Fri to identify any potential missing documentation beginning week of March 17, 2014.

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

PRINTED: 02/20/2014
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 02/06/2014
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)	(X5) COMPLETION DATE	
F 514	Continued From page 51 Review of the clinical record revealed Resident #3 was admitted by the facility on 01/16/12, and readmitted on 01/02/14 after a hospitalization, with diagnoses which included Constipation and Chronic Pain. Review of the current Physician's Orders and the Medication Administration Record (MAR) for January and February 2014 revealed Resident #3 was receiving the following medications to treat his/her constipation: two (2) Dulcolax suppositories daily; Dulcolax 5 milligram (mg), four (4) tablets daily; and Lizabeth, 290 micrograms daily. Review of the Comprehensive Care Plan, dated 12/10/13, revealed staff were to record all the resident's BMs in the computer system. Review of the bowel section of the computerized Monthly Flow Record for January 2014, revealed no documented evidence of Resident #3's BMs recorded from 01/02/14 to 01/11/14. Interview with the Assistant Director of Nursing (ADON) on 02/06/14 at 3:42 PM, revealed nursing staff were trained to ask the nursing assistant, resident or family member regarding residents' BMs each day. She stated she believed the nurses had asked about Resident #3's BMs, and had determined he/she was having regular BMs; however had failed to document this information. She further stated there was "no way" Resident #3 had gone nine (9) days without having a BM. Interview with the Director of Nursing (DON) on 02/06/14 at 6:30 PM, revealed nursing staff and Administration were very aware of Resident #3's BMs due to his/her history of constipation. She stated Resident #3's medications had been	F 514	Director of Nursing, Assistant Director of Nursing and/or Staff Development will randomly audit 5 resident records to ensure staff are documenting BM's. Any issue identified will be immediately resolved by reporting to physician and staff not documenting will be re-educated. Beginning the week of March 17, 2014 5 resident record reviews including, bowel movement records, will be audited by the Director of Nursing weekly X 4, then monthly X 2, to ensure proper documentation of current conditions including bowel movements. #4 Results of audits will be reported to the Performance Improvement Committee monthly X 3. # 5 Completion Date March 19, 2014		

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

PRINTED: 02/20/2014
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 02/06/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 514 Continued From page 52
adjusted by the Physician over time to ensure the resident's BM regularity. The DON stated there had been a documentation problem regarding Resident #3's BMs. She stated the facility had audited daily documentation in the past; but had stopped because staff were documenting "very well". The DON indicated after review of Resident #3's bowel record that staff had become "lax" with their documentation practices. She stated the facility would have to begin auditing resident records again to ensure documentation was performed.

F 514

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

PRINTED: 03/21/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 03/19/2014
--	---	---	---

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

{K 000}

INITIAL COMMENTS

{K 000}

An Off-site Revisit was conducted. Based on the acceptable POC the facility was deemed to be in compliance as alleged on 03/19/14.

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

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

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

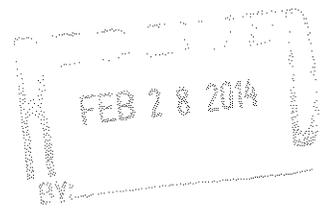
PRINTED: 02/18/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185155	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1967, 1970</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type III Protected</p> <p>Smoke Compartment: Eight (8)</p> <p>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)</p> <p>Sprinkler System: Complete sprinkler system (dry)</p> <p>Generator: Type II powered by Natural Gas with Propane backup.</p> <p>A standard Life Safety Code survey (using 2786R Short Form) was conducted on 02/05/14. Life Care Center of Morehead was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was ninety (90). The facility is licensed for ninety seven (97) beds. The highest scope and severity was at an "E" level.</p> <p>The following demonstrate non compliance:</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Means of egress are continuously maintained free</p>	K 000		
K 072 SS=E		K 072		



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Bill Evans</i>	TITLE ED	(X6) DATE 2/28/14
--	-------------	----------------------

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

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

PRINTED: 02/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 072 Continued From page 1
of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10

This STANDARD is not met as evidenced by:
Based on observation and interviews, it was determined the facility failed to ensure means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of nine (9) exits, sixty (60) residents, staff and visitors.

The findings included:

Observation on 02/05/2014 at 1:15 PM, with the Maintenance Director, revealed the outside sidewalk leading from West Wing had an accumulation of ice and snow. Ice and snow must be removed from sidewalks to ensure full and instant use during a fire or other emergency. The finding was confirmed with the Maintenance Director.

Interview on 02/05/2014 at 1:15 PM, with the Maintenance Director, revealed he had not cleared this area of ice and snow due to it not being used as a main exit.

Observation on 02/05/2014 at 01:20 PM, with the Maintenance Director, revealed the same for the two (2) exterior exit ramps leading from the South

K 072
K 072
#1 The three emergency egresses were cleared of snow and ice on February 5, 2014, by maintenance.
#2 On February 5, 2014, all exits were checked by Executive Director and Maintenance Director after cleared with no other concerns. On February 6, 2014, Executive Director and Maintenance Director checked all exits with no concerns.
#3 Maintenance Director and Maintenance Assistant were educated on February 5, 2014, by Executive Director that all exits including emergency egress need cleared of snow and ice.
#4 In the event of inclement weather the Executive Director will monitor all exits including emergency egress to ensure they are free of snow and ice.
Results of audits will be reviewed in Performance Improvement Committee monthly X 3.
#5 Completion Date March 14, 2014

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

PRINTED: 02/18/2014
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/05/2014
--	--	--	--

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)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

K 072 Continued From page 2
Side Hall. The observations were confirmed with the Maintenance Director.

Interview on 02/05/2014 at 1:20 PM, with the Maintenance Director revealed he had not cleared the outside exit ramps due to them not being used as main exits.

Interview on 02/05/2014 at 1:25 PM, with the Administrator revealed he was aware of the need to maintain the exterior exit sidewalks and ramps free and clear of snow and ice. Continued interview revealed the Administrator had been out of town for the last couple of days and this was why he had not ensured the sidewalks and ramps were free and clear of ice and/or snow. Further interview revealed the facility did not have a policy in regards to maintaining the outside exit sidewalks and ramps free and clear of ice and/or snow.

K 072