

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

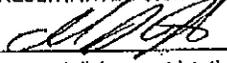
PRINTED: 06/20/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/06/2012 |
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| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1606 HILL RISE DRIVE LEXINGTON, KY 40504 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS A Recertification and Abbreviated Survey investigating KY#00018452 was conducted 06/03/12 through 06/06/12. Deficiencies were cited with the highest Scope and Severity of an "E". KY#00018452 was unsubstantiated with no deficiencies cited. | F 000 | F 157 | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (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 | F 157 | 1) Upon interviewing the two nurses who conducted the initial skin assessment, both nurses explained that resident # 5 was upset about moving into the long-term care setting and required an anti-anxiety medication to calm her down. Furthermore, both nurses also reported that resident #5 only allowed one light to be turned on in the room. The nurses reported that resident #5 rolled onto her sides during the skin assessment and while on her sides they both thought they had an excellent view of the skin as they viewed no open areas. Both nurses believe that the subcutaneous tissue from resident #5's right buttock pushed upward while resident #5 was on her right side thereby impeding the view of the implanted device located in resident #5's right lower flank region. During the skin assessment with DON and State Surveyor, the DON got the resident to agree to sit on the side of the bed and that is when the DON was able to visualize that resident #5 had an implanted device. There was no | |

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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  | TITLE Administrator | (X6) DATE 6-26-12 |
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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.

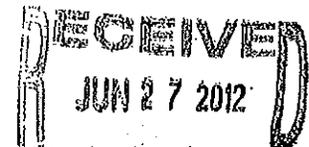
DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105215 | (X2) MULTIPLE CONSTRUCTION A. DUI/DING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/06/2012 |
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| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504 |
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| F 000 | INITIAL COMMENTS A Recertification and Abbreviated Survey Investigating KY#00018452 was conducted 06/03/12 through 06/06/12. Deficiencies were cited with the highest Scope and Severity of an "E". KY#00018462 was unsubstantiated with no deficiencies cited. | F 000 | F 157  1) Upon interviewing the two nurses who conducted the initial skin assessment, both nurses explained that resident # 5 was upset about moving into the long-term care setting and required an anti-anxiety medication to calm her down. Furthermore, both nurses also reported that resident #5 only allowed one light to be turned on in the room. The nurses reported that resident #5 rolled onto her sides during the skin assessment and while on her sides they both thought they had an excellent view of the skin as they viewed no open areas. Both nurses believe that the subcutaneous tissue from resident #5's right buttock pushed upward while resident #5 was on her right side thereby impeding the view of the implanted device located in resident #5's right lower flank region. During the skin assessment with DON and State Surveyor, the DON got the resident to agree to sit on the side of the bed and that is when the DON was able to visualize that resident #5 had an implanted device. There was no | |
| F 157 SS=D | 483.10(b)(11) NOTIFY OF CHANGES (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 | F 157 | | |

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185216 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 06/06/2012 |
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40604 | |
| (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 1</p> <p>the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the Physician was notified of a possible need to alter treatment for one (1) of twenty-one (21) sampled residents (Resident #5).</p> <p>Observation of a skin assessment on 06/04/12 revealed Resident #5, who was a new admission, had an unidentified device under the skin which protruded from his/her right lower back. The nurse recognized on 06/04/12 there was a device which had not been caught on admission during the skin assessment; however, as of 06/06/12 there was no documented evidence the Physician had been notified.</p> <p>The findings include:</p> <p>A facility policy related to Physician Notification was requested; however, not received.</p> <p>Review of Resident #5's medical record revealed he/she was admitted to the facility on 05/30/12 with diagnoses which included Renal Disorder. There was no Minimum Data Set (MDS) Assessment completed due to the recent admission.</p> <p>Observation of a skin assessment, on 06/04/12 with the Director of Nursing (DON), revealed Resident #5 had a device under the skin which was square and protruded from his/her lower</p> | F 157 | <p>mention of the implanted device in the records received from previous facility. The DON asked resident #5 what the device was and she stated, "That has been there for years, it's for my bladder." On 6/5/12, the Unit Coordinator called resident #5's husband and he informed her that his wife had the implant years ago and he didn't remember when. He could not remember where the procedure was done or any further details. On 6/5/12, the Unit Coordinator also called both sons of resident #5 and they too could not provide any information about the device. On 6/5/12, Unit Coordinator called resident #5's Urologist and the office had no knowledge of the implant. Unit Coordinator requested they fax any information that they had on resident #5. Urologist's office faxed information on resident #5 on 6/6/12 but made no mention of the implant. This document was shared with State Surveyor.</p> | |

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| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1600 HILL RISE DRIVE LEXINGTON, KY 40604 | | |
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| F 157 | <p>Continued From page 2 back. The DON stated she would check the medical record and that it was probably a bladder stimulator.</p> <p>Interview with Resident #6, at the time of the skin assessment, revealed the device was placed by Urology and he/she had a follow up appointment with Urology.</p> <p>Review of the Admission Skin Assessment, Resident Data Collection/Admission Notes, Physician's Orders and Admission Nurse's Notes, dated 05/30/12, revealed no documented evidence staff was aware of this device. Further review of the June 2012 Physician's Orders and Nurse's Notes revealed there was no documented evidence of the device.</p> <p>Interview, on 06/06/12 at 3:45 PM, with Licensed Practical Nurse (LPN) #4 revealed she had done a head to toe skin assessment on Resident #5 on 05/30/12; however, had not noted the device which protruded from the resident's back. She stated she had completed the skin assessment with a new nurse and neither of them noted the device. Continued interview revealed the head to toe skin assessment consisted of looking over the entire body; however, she did not see the device. She stated, if she had seen it, she would have documented it on the Skin Assessment.</p> <p>Interview, on 06/06/12 at 10:00 AM, with LPN #1/Unit Manager (UM) revealed she was unaware of the device until she was informed of it by the DON after the skin assessment with the State Surveyor.</p> <p>Interview, on 06/06/12 at 10:10 AM and 2:45 PM</p> | F 157 | <p>On June 25, 2012 the facility nurse supervisors conducted an audit of all residents admitted since May 1, 2012. Thirteen (13) residents were audited and either they or their responsible party were asked if they had any implanted devices such as: pain pumps, pacemakers, breast implants, shunts, bladder stimulators, hardware or other devices. If resident or responsible party were uncertain, a thorough skin assessment was completed.</p> <p>2) No other residents were affected.</p> <p>3) Upon admission the nurse will assess for implanted devices; in addition the nurse will ask the resident and/or responsible party if they have any knowledge of any implanted devices. The nurse will complete the "Admission Assessment for Implanted Devices" form.</p> | | |

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| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504 | | |
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| F 157 | Continued From page 3 with the DON revealed she had informed LPN #1/UM about the device after the skin assessment and instructed her to contact the Nephrologist and the Nurse Practitioner/ARNP. She further stated the admitting nurse should have recognized the device and followed up with documentation in the chart on the Skin Assessment, as well as followed up with reporting the device to the nursing staff and the ARNP. Interview, on 06/06/12 at 2:30 PM, with the ARNP revealed she was unaware Resident #5 had a bladder stimulator or any device in his/her back and had not been notified by the facility staff. Follow up interview, on 06/06/12 at 4:15 PM, with LPN #1/UM, revealed she had just notified the ARNP of the device, (two (2) days after it was noted in a skin assessment). | F 157 | | | |
| F 323 | 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure resident environment was as free from accident hazards | F 323 | | | |

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| F 323 | <p>Continued From page 4</p> <p>as possible. The facility failed to ensure the water temperatures were regulated to ensure water temperatures in residents' hand sinks were within acceptable temperature range of 100 degrees Fahrenheit to 110 degrees Fahrenheit. In addition the facility failed to have a system in place to ensure water temperatures in the showers were checked routinely to ensure they remained within a safe range.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Water Temperature Policy" (no date), revealed it was the policy of the facility to ensure water temperatures of resident point of service (POS) areas, fell between 100-110 degrees Fahrenheit. Further review revealed the facility was to do a weekly water temperature check of each hall and to make adjustments as needed.</p> <p>Observations of resident hand sink water temperatures on 06/05/12 and 06/06/12 revealed the following:</p> <p>Observation, on 06/05/12 from 10:30 AM to 10:45 AM, revealed the water temperature in room 101 was 118 degrees Fahrenheit; room 104 was 118 degrees Fahrenheit; room 109 was 118 degrees Fahrenheit; room 110 was 118 degrees Fahrenheit; and room 112 was 116 degrees Fahrenheit.</p> <p>Continued observation, on 06/05/12 from 10:55 AM to 11:04 AM, revealed the water temperature in the Unit I shower was 114 degrees Fahrenheit and in the Unit I hand sink was 116 degrees Fahrenheit.</p> | F 323 | <p>3) The facility will now check and log Point of Service water temperatures once-a-day, five times a week. During these checks, two rotating rooms will be checked on each of the six halls at varying times of day. Spa/shower rooms on each unit will also be checked and recorded at these times as well. If during these temperature checks a room is found to be out of compliant range the residents and SRNAs will be notified of the condition and will not use hot water in that area until adjustments are made and temperatures of 100- 110 degrees Fahrenheit are registered. Thermometers have also been placed on each unit for SRNA use if they feel that hot water may be exceeding 110 degrees Fahrenheit. If exceeding temperatures are recorded by SRNA or nurse than they will immediately notify maintenance.</p> | |

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| F 323 | <p>Continued From page 5</p> <p>Continued observation, on 06/05/12 from 11:05 AM to 11:10 AM, revealed the water temperature in room 301 was 120 degrees Farenheit and room 302 was 119 degrees Farenheit.</p> <p>Further observation, on 06/05/12 from 12:49 PM to 1:20 PM; revealed the water temperature in room 305 was 120 degrees Farenheit; room 308 was 118 degrees Farenheit; and 312 was 118 degrees Farenheit.</p> <p>Observation, on 06/06/12 from 12:30 PM to 12:45 PM, revealed the water temperature in room 506 was 112 degrees Farenheit; room 507 was 116 degrees Farenheit; and room 508 was 115 degrees Farenheit; room 202 was 111 degrees Farenheit; room 206 was 113 degrees Farenheit; room 207 was 111 degrees Farenheit; and room 208 was 112 degrees Farenheit.</p> <p>Interview with State Registered Nurse Aide (SRNA) #1, on 06/06/12 at 12:35 PM, revealed he had never had a resident tell him the water was too hot but thought the water was suppose to be below 110 degrees Farenheit.</p> <p>Interview with the Maintenance Director, on 06/06/12 at 12:50 AM in the Conference Room, revealed he had only been the Maintenance Director for two (2) weeks. Further interview revealed he was aware of the water temperature regulation for water temperatures to be in the range of 100 to 110 degrees Farenheit. He further stated they took temperatures every Monday around 7:15 AM; before showers started for the day and that rooms to have temperatures taken were picked based on availability, i.e. the resident being out of the room. Further interview</p> | F 323 | | |
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| F 323 | Continued From page 6 revealed the resident rooms were on different water heaters than the laundry/kitchen and usually the residents would tell them (Maintenance) or the care giver if the temperature was too hot or too cold. He further stated he did not notify Management if temperatures were out of range, but tried to handle it on his own. He stated he noted the temperatures were inconsistent, but he had not reported it to Quality Assurance (QA) and he did not remember the previous Maintenance Director ever mentioning taking the water temperatures to QA. Further interview revealed that inconsistent water temperatures should have been reported to the Administration or to QA. Interview with the Quality Assurance Director, on 06/06/12 at 2:25 PM in her office, revealed that to her knowledge the water temperatures had never been brought before QA but that she would expect the inconsistent water temperatures to be addressed by QA. Review of the facility's "Temperature log sheet", from 03/05/12 through 06/04/12, revealed water temperatures were taken and recorded weekly, but usually just in one (1) room on each hall (most often the same room), as well as in the Dietary and Laundry areas. There was no documented evidence, on the temperature log sheets, of water temperatures being taken in the showers or whirlpools. | F 323 | | |
| F 431 SS=D | 483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all | F 431 | <u>F 431</u> 1) On June 5, 2012 the Pharmacist Consultant conducted an audit of all medication carts, refrigerators and medication rooms and no other discontinued drugs were found. 2) No other residents were affected. On 6/25/2012 all facility nurses/KMAs were in-serviced on the removal of discontinued medications from med carts, refrigerators and medication rooms. | |

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| F 431 | <p>Continued From page 7</p> <p>controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's Disposal of Medications and Medication-Related Supplies: Discontinued Medications Policy (#IE3), it was determined the facility failed to ensure the proper</p> | F 431 | <p>3) When checking Physicians Orders daily, supervisors will have the nurses and/or KMAs recheck for discontinued medications and if any are found they will be removed from the medication cart, refrigerator or medication room.</p> <p>4) The Unit Coordinator or a designated Supervisor will conduct an audit monthly x 3 months using ten (10) MD orders per month of discontinued medications to ensure they were removed from the medication cart, refrigerator or medication room. If no deficient practice is noted this audit will be conducted every other month.</p> <p>Completion Date:</p> | 6/26/12 |

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|--|--|--|---|----------------------|---|
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1008 HILL RISE DRIVE LEXINGTON, KY 40504 | | |
| (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 431 | <p>Continued From page 8</p> <p>storage of drugs and biological. The facility failed to ensure discontinued/expired medications were removed from a medication cart and from the medication room refrigerator.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Disposal of Medications and Medication-Related Supplies: Discontinued Medications Policy", revealed when medications were discontinued by a physician or when a resident was transferred, discharged or in the event of their death, the remaining medications were to be marked as "discontinued" and destroyed. Further review of the policy revealed, upon receipt of an order to discontinue, the medications were to be removed from the medication cart immediately, to avoid inadvertent administration.</p> <p>Observation, on 06/05/12 at 9:10 AM, in the medication room refrigerator on Unit One, revealed a vial of Acetylcysteine (Mucomyst), that was marked as being opened on 05/04/12. Review of the Physicians order revealed it was ordered on 04/28/12 for 10 days. Which would constitute a discontinuation date of 05/08/12.</p> <p>Interview, on 06/06/12 at 9:10 AM, with the Assistant Director of Nursing (ADON) revealed the Mucomyst had an automatic stop date and should have been removed after the last dose on 05/06/12. Further interview revealed the nurses and the consulting pharmacy were responsible for checking the inventory and ensuring discontinued medication were removed according to the facility's policy.</p> | F 431 | | | |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____ | (X3) DATE SURVEY COMPLETED C 06/06/2012 |
|--|--|--|---|---|
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY, 40504 | |
| (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 431 | Continued From page 9 Continued observation, on 06/05/12 at 1:15 PM, of the 100 Hall medication cart, revealed nineteen (19) capsules of Spiriva, a medication which was discontinued on 05/11/12. Interview, on 06/05/12 at 1:15 PM, with Licensed Practical Nurse (LPN) #4 revealed the medication should not have been in the medication cart. Further interview revealed it was the nurses' responsibility to remove the medications from the carts and put them in the medication disposal box. Interview, on 06/06/12 at 4:32 PM, with the Director of Nursing (DON) revealed the Mucomyst and Spiriva should have been destroyed, per the facility's policy. | F 431 | | |

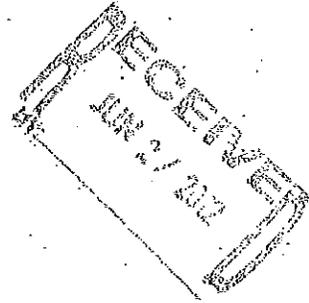
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/04/2012 |
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| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY 40504 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
|--------------------|---|---------------|---|----------------------|
| K 000 | INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 1 Survey under: NFPA 101 (2000 Edition) Plan approval: 1989, 1996 Facility type: SNF Type of structure: Type V (000) Smoke Compartments: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and basement. Single station smoke detectors in resident rooms. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by Natural Gas installed in 1989 | K 000 | | |
| K 056 SS=E | The highest scope and severity was at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard | K 056 | | |



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 her safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/04/2012 |
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY 40504 | |
| (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) | (X6) COMPLETION DATE |
| K 000 | INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 1 Survey under: NFPA 101 (2000 Edition) Plan approval: 1989, 1996 Facility type: SNF Type of structure: Type V (000) Smoke Compartments: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and basement. Single station smoke detectors in resident rooms. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by Natural Gas installed in 1989 A Standard Life Safety Code survey was conducted on 06/04/12. Pine Meadows Health Care 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 one hundred six (106). The facility is licensed for one hundred twenty (120) beds. | K 000 | | |
| K 056 SS=E | The highest scope and severity was at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard | K 056 | | |

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

TITLE

(X6) DATE

[Signature]

Administrator

6-26-12

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

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 06/04/2012 |
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | | STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504 | |
| (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 056 | Continued From page 1 for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure complete coverage of the sprinkler system was provided; furthermore, the facility failed to ensure a sprinkler wrench was provided to exchange activated sprinkler heads, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of seven (7) smoke compartments, forty (40) residents, staff and visitors. The findings include: Observation, on 06/04/12 at 1:20 PM, revealed a canopy located above the exterior exit of Nursing Station II, measured approximately twelve (12) feet by eight (8) feet and did not contain sprinkler protection. Further observation revealed the same for the 100 Hall exterior exit and the Administrative offices exterior exit. Canopies or exterior roofing measuring wider than four (4) feet must be sprinkler protected. The observation | K 056 | 1) No residents were affected by practice. 2) No residents were affected by practice. 3) Each noted area listed in the Statement of Deficiencies does have sprinklers. However, existing sprinkler heads did not extend beyond the canopy. Facility obtained quotes to have sprinkler heads that currently exist under the canopies extended to a point where they are visible and no longer covered by the canopy. The facility contracted to have the sprinklers extended into compliance. The facility also obtained the proper wrench to keep in the sprinkler head box as required. Sprinkler head extensions will be done on July 9, 2012 by contracted company. | K056 |

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186216 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 06/04/2012 |
|--|--|--|---|--|
| NAME OF PROVIDER OR SUPPLIER PINE MEADOWS HEALTH CARE | | STREET ADDRESS, CITY, STATE, ZIP CODE 1808 HILL RISE DRIVE LEXINGTON, KY 40504 | | |
| (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-056 | <p>Continued From page 2</p> <p>was confirmed with the Maintenance Director.</p> <p>Interview, on 06/04/12 at 1:20 PM, with the Maintenance Director, revealed the canopy was constructed of ordinary wooden construction.</p> <p>Observation, on 06/04/12 at 1:53 PM, revealed the wrench to change activated sprinkler heads was not in the spare sprinkler head box. A wrench must be provided to change activated sprinkler heads and limit the amount of time the sprinkler system is out of service. The observation was confirmed with the Maintenance Director.</p> <p>Interview on 06/04/12 at 1:53 PM, with the Maintenance Director, revealed he was unaware the wrench was missing from the spare sprinkler head box.</p> <p>Reference: NFPA 13 (1999 edition) 5-13.8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction. 3-2.9.2 A special sprinkler wrench shall also be provided and kept in the cabinet to be used in the removal and installation of sprinklers.</p> | K 056 | <p>4) Facility has replaced wrench and will check at time of monthly fire drill that it is located in the sprinkler head box. Extended sprinkler heads will be checked by contracted service during annual audit.</p> <p>Completion Date:</p> | 7/9/2012 |