

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

PRINTED: 04/24/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING RECEIVED MAY 23 2013	(X3) DATE SURVEY COMPLETED 04/11/2013
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS CITY STATE ZIP CODE 26000 W. 5th Health Care Southern Enforcement Branch PIKEVILLE, KY 41501
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F 000 F 514 SS=E	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 04/09-11/13. Deficient practice was identified at "E" level.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>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.</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, medical record review, and review of the facility's policy, it was determined the facility failed to maintain accurate clinical records for two residents (Residents #13 and D).</p> <p>The findings include: Review of the facility's policy entitled "Medication Administration-Physician's Telephone Orders," dated December 2010, revealed telephone orders will be taken by the nurse and are to be recorded on a telephone order form which will include the date, medication, strength, method of</p>	F 000 F 514	<p>Disclaimer:</p> <p>Signature Healthcare of Pikeville does not believe and does not admit that any deficiencies existed either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Adm	(X6) DATE 5/7/13
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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.

Received Time May. 23. 2013 11:59AM No. 7347

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
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F 514	Continued From page 1 administration, frequency of administration, the physician's name, and the nurse's name and title. The policy revealed the physician's orders would be recorded on the medication administration record (MAR) or the treatment administration record (TAR). Interview on 04/11/13, at 3:25 PM with the Director of Nursing (DON) revealed the nurses that receive a telephone order from the physician were responsible to write the order on a Physician's Telephone Order sheet and then "flag" the order and inform the charge nurse a new order had been obtained for that particular resident. The DON stated the charge nurse was then responsible to record the new order on that particular resident's MARs or TARs. The DON reported the Physician's Telephone Order sheets are in triplicate; one copy stays on the resident's chart; one copy is sent to Medical Records to be entered into the resident's electronic chart (IHN) system; and one copy is attached to the 24-hour report. The interview revealed that every morning in the morning meeting the 24-hour reports for both units were brought to the meeting, and all new orders were reviewed and discussed. According to the DON, the Assistant Director of Nursing (ADON) then takes the 24-hour reports along with all new orders and reviews each resident's chart with new orders or changes to ensure all orders or changes have been appropriately documented on the resident's medical record, MARs, and/or TARs. 1. Observation on 04/10/13 at 8:50 AM revealed Registered Nurse (RN) #1 administered medications to Resident D. The RN was observed to administer 120 cubic centimeters	F 514	F 514 Resident Records – Complete/Accurate/Accessible The facility will maintain accurate clinical records for its residents. Residents affected: For resident "D", the MAR was corrected on 4/11/13 to reflect the order change and the physician was notified of the delay in order transcription. For resident #13, a clarification order was obtained from the physician and notification was sent to Medical Records for entry into the monthly Physician Order Sheet. Licensed staff will be inserviced by the SDC on 5/10/13 on the importance of assuring accuracy of the clinical records, including the Physician Order Sheets, Telephone Orders MARs and TARs. Medical Records will be inserviced by the SDC on 5/10/13 on the importance of assuring the completeness and accuracy of POS entry. Residents potentially affected: Residents of the facility have the potential to be affected by this cited practice. A 100% audit of the MARs, TARs and Physician Orders was completed by May 1, 2013 by Nursing Administration staff to ensure the current accuracy of records. Licensed staff will be inserviced by the SDC on 5/10/13 on the importance of assuring continued accuracy of the clinical records, including the Physician Order Sheets, Telephone Orders MARs and TARs. Medical Records will be inserviced by the SDC on 5/10/13 on the importance of assuring the completeness and accuracy of POS entry. Systemic measures: A 100% audit of the MARs, TARs and Physician Orders was completed by May 1, 2013 by Nursing Administration staff to ensure the current accuracy of records.	5/20/13	

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F 514	<p>Continued From page 2</p> <p>(cc) of a nutritional supplement to Resident D during the medication pass.</p> <p>Review of Resident D's physician's orders revealed a Physician's Telephone Order sheet dated 04/08/13, documented by the ADON for staff to discontinue the resident's supplement during the medication pass.</p> <p>Review of Resident D's MAR revealed the resident had received 120 cc of supplement four times a day from 04/01-10/13 during the medication pass (two days past the physician's order to discontinue the supplement with the medication pass).</p> <p>Interview on 04/11/13 at 4:20 PM with the ADON confirmed she was responsible to review all new physician's orders to ensure the orders had been documented appropriately on the resident's MARs or TARs. The ADON stated, "I review the physician's orders most of the time, unless I have an appointment." When questioned about Resident D's physician's order (dated 04/08/13) to discontinue the resident's supplement during the medication pass, the ADON revealed she had taken the telephone order, had documented the new order on a Physician's Telephone Order sheet, and had signed the order off as being transcribed to the MARs/TARs. However, the ADON revealed she failed to flag the order for the charge nurse and, as a result, the charge nurse had not transcribed the new order onto the resident's MAR. According to the ADON, she was unable to explain why she had not identified the failure following the morning meeting when she conducted a review of the physician's orders.</p>	F 514	<p>Licensed staff will be inserviced by the SDC on 5/10/13 on the importance of assuring accuracy of the clinical records, including the Physician Order Sheets, Telephone Orders MARs and TARs.</p> <p>Medical Records will be inserviced on 5/10/13 on the importance of assuring the completeness and accuracy of POS entry.</p> <p>On May 14-15, 2013, Pharmerica will conduct a white paper audit to ensure the accuracy of the MARs, TARs and Physician orders.</p> <p>Monitoring measures: On May 14-15, 2013, Pharmerica will conduct a white paper audit to ensure the accuracy of the MARs, TARs and Physician orders. Daily during Whiteboard meeting, Clinical staff will review telephone and physician orders. ADONs will follow-up to ensure that these orders were accurately transcribed to the MARs and TARs and report compliance or any non-compliance at daily Stand Down meetings. Any non-compliance will be corrected by the ADONs. Results of these reviews will be discussed in monthly QA.</p>		

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F 514	<p>Continued From page 3</p> <p>2. Observation of the medication administration for Resident #13 on 04/09/13 at 5:00 PM revealed a Fioricet (non-narcotic pain reliever) tablet was administered to the resident for complaint of a headache.</p> <p>Review of Resident #13's medical record revealed there was a phone order written on 12/31/12 for Fioricet, one tablet by mouth, to be administered to the resident three times a day on an "as needed" basis for complaints of headaches. However, a review of the monthly physician's order sheets that are printed and provided to the facility by the pharmacy, revealed the physician's phone order for the Fioricet that had been prescribed on 12/31/12 was not listed on the order sheets. However, a review of Resident #13's monthly MARs revealed Fioricet tablets were on the MAR and the resident had been receiving the medication.</p> <p>An interview with Resident #13 on 04/11/13 at 3:00 PM revealed the resident needed the medication for frequent headaches and had been receiving the medications from the nurses when needed.</p> <p>An interview with the South Side ADON on 04/11/13 revealed the nurses receive phone orders and transcribe the orders to the MAR. The nurse then faxes the order to the pharmacy and gives a copy to the Medical Records Department. The Medical Records Department enters the order into the computer to generate a monthly medication sheet. The ADON stated the charge nurses and designees were to compare the monthly orders to the physician phone orders to ensure accuracy.</p>	F 514			

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F 514	Continued From page 4 An interview with the Medical Records Clerk on 04/11/13 at 3:35 PM revealed the clerk had been assigned in January 2013 to enter the physician phone orders into the computer. According to the clerk, if the phone orders are not written on the typed computer copies of the orders, the order does not get typed into the computer for the next month; the clerk stated the Fioricet order for Resident #13 must have been overlooked. An interview with the Director of Nursing (DON) on 04/11/13 at 3:45 PM revealed the phone orders were to be checked with the typed orders at the end of the month by the ADONs, DON, Staff Development Coordinators, and designated floor nurses for accuracy. The DON stated the Fioricet for Resident #13 had been overlooked.	F 514			