

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 333	Continued From page 81 Interview conducted with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had conducted an in-service on 03/28/14 regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had attended an in-service regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services. All audits were being reviewed by the Administrator, DON, COO, or Regional Nurse Consultant daily. Interview conducted with the Administrator on 04/03/14, at 2:55 PM, revealed he had reviewed the audits completed by the staff daily. Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits daily. Review of a QAPI meeting agenda dated 03/28/14, revealed the Medical Director was in attendance. The agenda revealed the committee addressed issues related to administering medications for which a resident had an allergy. The agenda also revealed the committee	F 333		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 333	Continued From page 82 discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned.	F 333		5/13/14	
F 371 SS=E	Interview conducted with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Medical Director on 04/02/14 at 4:30 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended a QAPI meeting on 03/28/14, and issues were addressed regarding administering a medication to a resident with an allergy to the medication. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned. 483.35(j) 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:	F 371	1. The cake, pudding, pie, cookies, corn and bread was discarded on 3/24/2014 by the Dietary Manager. Four dietary employees received one on one coaching sessions by the dietary manager on 3/27, 3/30 and 3/31 2014. 2. The Dietary Manager with staff made an inspection of the kitchen on 3/24/2014 to ensure that the kitchen had stored, prepared and served food under sanitary conditions as well as any other concerns. All refrigerators and freezers, dry stock room and kitchen area and tray delivery services were audited. No other concerns were identified. 3. The Dietary Manager received one on one education on the sanitation policy and procedure by the administrator on 3/25/2014. The Dietary Manager educated the dietary staff on proper kitchen sanitation to include proper food storage, and the sanitation policy and procedure. The dietary staff before placing items in storage will date and label all food items.		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 83</p> <p>Based on observation, interview, and review of the facility policy it was determined the facility failed to store food under sanitary conditions. During the initial kitchen tour on 03/24/14, five servings of food were observed to be stored uncovered on a tray in the walk-in refrigerator and were not labeled or dated. In addition, a bag of cookies and three bags of food items were observed in the walk-in freezer, out of the original package, and not labeled or dated.</p> <p>The findings include:</p> <p>A review of the facility food storage policy (undated) revealed staff was required to store leftover food covered or wrapped securely and each item was to be labeled and dated before being refrigerated. Further review of the policy revealed open packages of frozen food should be rewrapped to prevent spoilage and labeled and dated when stored.</p> <p>Observation of the facility walk-in refrigerator and freezer during the initial tour of the kitchen conducted on 03/24/14 at 6:38 PM, revealed two pieces of cake, two bowls of pudding, and a piece of lemon pie were on a tray in the walk-in refrigerator and were not covered, not labeled, and not dated. Further observation during the tour revealed a bag of cookies, a bag of corn, and a bag of garlic bread, out of the original package, and not labeled and dated in the walk-in freezer.</p> <p>An interview conducted with the Dietary Manager on 03/24/14 at 6:40 PM, revealed staff was to label and date leftover foods. Further interview revealed the foods in the freezer were not labeled because the staff had been putting up stock that had been received that day.</p>	F 371	<p>4. The Dietary Manager will conduct three audits weekly for four weeks beginning 4/7/2014 and then one weekly audit for four weeks to ensure sanitation conditions are met. Audits will include but not limited to proper sanitation, labeling of foods, food storage in refrigerators and freezers, food storage in dry stock room, sanitation of kitchen area and tray delivery services. Results will be brought to the monthly QA Committee for review for six months or until deficient practice is corrected.</p>	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428 SS=J	<p>483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the pharmacist reported irregularities to the attending physician and the Director of Nursing (DON) to act upon for one (1) of twenty-one (21) sampled residents (Resident #8). Review of Resident #8's medical record revealed an acute care facility had provided the facility with a copy of a History and Physical dated 08/27/13 that revealed Resident #8 was allergic to Macroclantín (antibiotic). Review of Resident #8's Medication Administration Record (MAR) revealed facility staff administered seven (7) doses of Macrobid to Resident #8 from 03/08/14 through 03/11/14. Resident #1 complained of "tightness" in his/her chest on 03/11/14 at 9:50 PM, asked what medications he/she had received, and staff informed the resident he/she had received Macroclantín. At that time, the resident informed staff he/she was allergic to the medication and the Macroclantín was discontinued. Record review and interview revealed the Consultant Pharmacist failed to</p>	F 428	<p>F 428</p> <p>1. Resident # 8 upon symptoms, the nurse notified the physician in which an order was received for intramuscular Solumedrol along with Benadryl by mouth on 3/14/2014. Treatment was effective. Resident's medical record, Medication Administration record, allergy sticker, allergy listing and care plan was updated to reflect Macordantin as a possible allergy.</p> <p>2. Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing, Assistance Director of Nursing, Staff Development Coordinator, MDS Coordinators or Regional Nurse Consultant on 3/27/14 for all residents to ensure allergies are appropriately identified. Interviews were completed on 3/27/2014 by the Social Service Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or MDS coordinators for residents with BIMS score above 8 regarding their knowledge of allergies. This was compared to what is listed in the medical record and allergies were updated with assessment and/or</p>	5/13/14	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 85</p> <p>identify Resident #8 had an allergy to Macroclantin and, as a result, failed to inform the resident's attending physician and the Director of Nursing (DON) of the resident's allergy.</p> <p>The facility's failure to ensure the pharmacist reported any irregularities to the attending physician and the DON caused or was likely to cause serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 03/08/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.25 Quality of Care (F333). The facility was notified of the Immediate Jeopardy on 03/28/14.</p> <p>An acceptable Allegation of Compliance was received on 04/01/14, and alleged removal of the Immediate Jeopardy on 03/31/14. The State Survey Agency determined the Immediate Jeopardy was removed on 03/31/14, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Summary</p>	F 428	<p>physician order as needed. Residents with BIMS less than 8, responsible party interview were completed on 3/27/14 by the Social Services Director, Director of Nursing, MDS Coordinators, Assistant Directors of Nursing, Administrator or Regional Nurse Consultant to identify and allergies or concerns with medication and allergies. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed.</p> <p>During the above audits a medication allergy sheet was completed for each resident on 3/14/14 by the Director of Nursing, Assistant Director of Nursing, Staff Development coordinators, MDS Coordinator and Regional Nurse Consultant and placed in front of each resident's Medication Administration Record along with an allergy sticker on the outside of the resident's charts were reviewed to ensure accuracy. All allergies were clarified with the physician.</p> <p>The pharmacy consultants were on site on 3/29/2014 and reviewed all resident records to ensure allergies have been appropriately identified along with any other medication concerns.</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 86</p> <p>Pharmerica Consulting Standards and Expectations," undated, revealed the policy stated the pharmacist was responsible to complete a medication regimen review on all residents. The policy stated the pharmacist would visit and exit with the Administrator and the DON.</p> <p>Review of Resident #8's medical record revealed the facility admitted the resident on 09/09/13 with diagnoses that included Chronic Ischemic Heart Disease, Atrial Fibrillation, and Coronary Artery Disease. Although documentation in the Record of Admission dated 09/09/13 failed to indicate Resident #8 had any allergies, review of a History and Physical report dated 08/27/13 from an acute care facility, which was included in the resident's medical record, revealed the resident had allergies to Darvocet, Elavil, Flu Vaccine, Penicillin, Macroductin, Ultram, and Codeine. In addition, the Nursing Admission Information dated 09/09/13, revealed the resident had allergies to Codeine, Influenza, Elavil, Darvocet, and Tussionex. Resident #8's attending physician acknowledged the History and Physical by documentation of the date and his initials on the History and Physical on 09/12/13.</p> <p>Review of Resident #8's Medication Administration Record (MAR) revealed the resident received seven doses of Macrobid from 03/08/14 through 03/11/14. Further record review revealed the resident received one dose of Macrobid on 03/08/14, two doses on 03/09/14, two doses on 03/10/14, and two doses on 03/11/14. Continued review revealed on 03/11/14 at 9:50 PM, Resident #1 complained of "tightness" in his/her chest and asked what medications he/she had received. The resident was informed he/she had received Macroductin,</p>	F 428	<p>3. The Pharmacy consultant received education on 3/28/14 from the Administrator, Director of Nursing or the Regional Nurse Consultant regarding reviewing of hospital discharge records for all residents to ensure allergies are appropriately identified along with any other medication concerns.</p> <p>Education for licensed staff/Kentucky medication aid was completed by the Regional Nurse Consultant, Director of Nursing, MDS Coordinator, Facility Formulary nurse or the Staff Development Coordinator regarding reviewing hospital documentation upon admission or readmission to ensure allergies are appropriately identified. A posttest was completed in which a 100% was obtained as a passing score.</p> <p>Allergies will be identified on day of admission and/or re-admission by the admitting nurse on the nursing admission information document. The admitting nurse will document allergies on the resident's medication allergy record that will be placed in the front of the Medication Administrations Record for that resident. The admitting nurse will review the residents allergies with the resident and/or POA for confirmation.</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 87</p> <p>and the resident informed staff he/she was allergic to the medication. Based on documentation, facility staff informed the resident's physician of the resident's complaint and the Macrochantin was discontinued.</p> <p>Review of the Pharmacy Drug Regimen Review dated 09/16/13, for Resident #8 revealed the pharmacist failed to document the resident had an allergy to Macrochantin on the review.</p> <p>An interview with the facility's Consultant Pharmacist on 03/27/14 at 4:40 PM revealed that he was not aware Resident #8 was allergic to Macrochantin. The Consultant Pharmacist stated when the facility admitted a resident, the pharmacist reviewed the medical record and discharge information located in the hospital's paperwork to determine if the resident had any drug allergies. The Consultant Pharmacist stated he had reviewed Resident #8's medical record and the information from the acute care facility's discharge information and had identified Resident #8 had allergies to Antibiotics, Penicillin, Opioids, and Darvocet. However, the Pharmacist stated he failed to identify Resident #8's allergy to Macrochantin and, as a result, had not informed the resident's physician or the DON of the resident's allergy.</p> <p>Resident #8's attending physician stated in interview conducted on 03/27/14, at 3:37 PM, the resident "could have been harmed" from the administration of the Macrochantin since the resident had experienced a "similar allergic reaction with tightness in the chest" after the resident had received Macrochantin during a previous hospitalization. The physician stated the facility's Consultant Pharmacist had not informed</p>	F 428	<p>The procedure which includes identification of allergies on day of admission/re-admission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment and physician orders and reviewing of discharge summaries along with review of all hospital paper work, and interview with resident/POA will be included in orientation for new staff.</p> <p>Physician will be notified of any allergies by the charge nurse following review of all documents sent by hospital, resident or POA.</p> <p>Charts for newly admitted residents and re-admitted residents will be reviewed and discussed in the daily clinical meeting weekdays which is attended by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Social Service Director, Medical Records, Chaplain, Facility Formulary Nurse with a comparison review completed at that time against all documents to ensure allergies are appropriately identified. On weekends, this review will be completed by two charge nurses.</p>		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	Continued From page 88 him of Resident #8's allergy to Macroductin. An interview with the Administrator and the DON on 03/28/14 at 8:45 AM revealed the pharmacist was required to conduct a monthly medication regimen review and that the pharmacist always met with both him and the DON prior to leaving the facility. The Administrator stated the pharmacist was required to review all acute care paperwork sent to the facility. **The facility provided an acceptable Allegation of Compliance (AOC) on 04/01/14. The facility implemented the following actions to remove the Immediate Jeopardy: The physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to the administration of Macroductin. Physician's orders were obtained immediately and intramuscular Solu-Medrol along with Benadryl by mouth was administered by the staff nurse on 03/11/14 to treat the resident's symptoms. The treatment was effective as evidenced by every shift assessment along with supporting documentation. The resident was monitored by staff nurses to ensure continued effectiveness. The physician was notified by the Assistant Director of Nursing (ADON) for Resident #6 on 03/28/14 to clarify the resident's allergy to Morphine. A sheet was added in front of the resident's medication administration record (MAR) to identify the resident's allergy to Morphine. A care plan was initiated with interventions to decrease the risk of an allergic reaction.	F 428	Pharmacy consultant upon visit to facility will exit with the Director of Nursing and/or Administrator to include the consultant report and findings of chart review to include allergies as well as other medication concerns. 4. A follow up questionnaire which includes questions concerning allergies will be completed by the Administrator, Director of Nursing, Assistant Director of Nursing, MDS coordinators, Social Service Director, Chaplin, Medical Records, Human Resource Director, Staff Development Director, Business Office Manager, Facility Formulary Nurse, Plant Operations, or Environmental Services Manager for 10 staff members weekly for 4 weeks, then monthly to ensure continued understanding of allergies, medication errors, QA, care plans for allergies, and neglect. The Director of Nursing, Assistant Directors of Nursing, Staff Development coordinators, MDS Coordinators or Facility Formulary Nurse will audit 20% of medical Records monthly regarding not only review of allergies but also review of the pharmacy consultant documentation for accuracy and	

pertinent information regarding

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 89</p> <p>Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), MDS Coordinators, and Regional Nurse Consultant on 03/27/14 for all residents to ensure allergies were appropriately identified. During the audit, allergy stickers on the outside of residents' charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 03/27/14 by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician.</p> <p>The Regional Nurse Consultant, DON, and SDC initiated education for licensed staff and Kentucky Medication Aides (KMAs) on 03/27/14 and advised staff to review hospital documentation upon each resident admission or readmission to ensure allergies were appropriately identified. Licensed nursing staff/KMAs were not allowed to work prior to receiving the above stated education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of 100 percent would be educated on the spot and retested.</p> <p>Resident #8's attending physician, who is also the facility's Medical Director, received education from the Administrator, SDC, and the Regional Nurse Consultant on 03/28/14 regarding appropriately identifying resident allergies.</p> <p>The Administrator, DON, and Regional Nurse</p>	F 428	<p>resident's medication. Concerns identified will be reported to the Administrator and to pharmacy in order for a correction and plan of action.</p> <p>Results of these audits will be reported to the QA committee monthly to evaluate responses in order to determine further need of education or revision of plan. At that time based upon evaluation the QA Committed will determine at what frequency the audits will need to continue.</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 90</p> <p>Consultant provided education to the Pharmacy Consultant on 03/28/14 regarding reviewing hospital discharge records for all residents to ensure allergies were appropriately identified.</p> <p>The Pharmacy Consultants were on-site on 03/29/14 and reviewed all resident records to ensure allergies were appropriately identified.</p> <p>The Regional Nurse Consultant provided education to the Administrator, DON, SDC, and ADONs on 03/28/14 regarding reporting of neglect for any significant medication error.</p> <p>The SDC, DON, ADONs, and the Regional Nurse Consultant initiated staff education on 03/28/14 regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement (QAPI) process to include reporting of concerns to the Administrator, and front line staff participation in development of QAPI plans. Staff was not permitted to work prior to receiving the education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of 100 percent would be educated on the spot and retested.</p> <p>Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from the discharge summary, resident history or POA history, verification of allergy orders from the physician, as well as places on the MAR or medical record for placement of allergies will be included in the orientation for licensed nurses and KMAs.</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	Continued From page 91 A follow-up questionnaire would be completed by the Administrator, DON, ADONs, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplain, Medical Records, Human Resources Director, SDC, Business Office Manager, Facility Formulary Nurse, or the Environmental Services Manager for ten staff members daily to include all shifts and different staff members until removal of immediacy, then weekly for four weeks, to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process to include reporting concerns to the Administrator, and front line staff participation in the development of QAPI plans. The Social Services Director, DON, ADONs, SDC, and MDS Coordinator conducted interviews on 03/27/14 with residents who had a BIMS score above 8 regarding their knowledge of allergies. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed. The Social Services Director, DON, ADONs, MDS Coordinator, Administrator, or Regional Nurse Consultant conducted interview with the responsible party for residents with a BIMS score of less than 8 by 03/27/14 to identify any allergies or concerns with medications. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed. Allergies will be identified on the day of admission	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	Continued From page 92 and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse will document allergies on the resident's medication allergy record that will be placed in the front of the MAR for that resident. The admitting nurse will review the resident's allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on the day of admission/readmission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders; and review of discharge summaries and all paperwork sent by the hospital along with the interview of the resident/POA will also be included in orientation for all new staff. The physician will be notified of any allergies by the charge nurse following review of all documents sent by the hospital, resident, and POA interview. Charts for newly admitted residents and readmitted residents will be reviewed and discussed in the Daily Clinical meeting on weekdays by the DON, MDS Coordinator, Social Services Director, Medical Records, SDC, ADONs, Activities Director, Dietary Manager, and Chaplain with a comparison review completed at that time of the resident's admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, this review will be completed by the DON, ADONs, SDC, or MDS Coordinator until removal of immediacy. Following removal of immediacy, on weekends, two charge nurses will	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 93</p> <p>review the discharge documentation and history and physical for newly admitted or readmitted residents to ensure allergies are appropriately identified as well as all paperwork complete and accurate, care plan updated, physician notification complete, and all allergy lists updated or initialed.</p> <p>Allergy stickers and allergy lists were updated for all residents to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, and Regional Nurse Consultant on 03/28/14.</p> <p>Education was provided for licensed nursing staff/Kentucky Medication Aides by the Director of Nursing, Assistant Director of Nursing, the Staff Development Coordinator, and the Regional Nurse Consultant regarding all paperwork forwarded from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listings, physician orders, and MARs. Licensed nursing staff will not be allowed to work prior to receiving the above stated education.</p> <p>Nursing Administration to include the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators, Facility Formulary Nurse, or Regional Nurse Consultant are reviewing every physician's order daily to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. This will continue daily until immediacy lifted. Once immediacy is lifted a daily review will continue (Monday-Friday) by the above team.</p>	F 428			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 94</p> <p>During care plan conference for each elder the allergy list will also be reviewed for any updates.</p> <p>Medication pass audits were completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 03/28/14 to ensure that allergies are appropriately identified and medications are administered without significant medication error. Medication pass audits will be completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 03/28/14 until all nurses and certified medication technicians have had a medication pass audit completed. During the medication pass audit, a questionnaire will be completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication.</p> <p>The Assistant Director of Nursing, MDS Coordinator, or the Staff Development Coordinator will audit the Medication Administration Record daily for newly admitted and readmitted residents to ensure allergies are identified on the resident's medication allergy record and allergy sticker on the outside of the chart.</p> <p>All allergy clarifications for all residents have been sent to Pharmacy as of 03/29/14 in which Pharmacy has updated their listing in their computer system. Pharmacy will review all new orders and compare to any allergies listed and</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 95</p> <p>notify facility if an allergy exists regarding the new medication at which time the nurse will notify the physician for any new orders.</p> <p>All incident reports were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any further significant medication errors by 03/29/14. None was identified.</p> <p>All incidents or concerns are reviewed daily during the daily standup meeting to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manger, Chaplain, MDS Coordinators, Plant Operations Director, Medical Records, Admissions Director, Housekeeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager, or Regional Staff to identify any allegation of abuse or neglect. The Administrator has been on-site daily to review all concerns or incidents to ensure abuse or neglect has been appropriately identified and reported.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer daily until removal of immediacy, then weekly for four weeks after removal of immediacy, and then monthly.</p> <p>Education was provided by the Regional Nurse Consultant on 03/28/14 for the Administrator, the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manger, and Admission</p>	F 428			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	<p>Continued From page 96</p> <p>Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant medication errors, failure to report neglect, and auditing pharmacy services.</p> <p>The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits daily until removal of immediacy, and then twice weekly for four weeks and report findings during weekly QA for four weeks, for recommendations and further follow-up as indicated.</p> <p>A Quality Assurance meeting was held on 03/28/14 with the Medical Director for further recommendations regarding the plan for removal of jeopardy. A Quality Assurance meeting will be held weekly for four weeks, and then monthly for recommendations and further follow-up regarding the above stated plan.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of a physician's order for Resident #8 dated 03/11/14, at 9:50 PM, revealed the nurse was to administer 120 milligrams (mg) of Solu-Medrol intramuscularly "now," and Benadryl 50 mg orally "now."</p> <p>Review of the MAR for Resident #8 revealed staff administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally on 03/11/14.</p> <p>Interview conducted with RN #2 on 03/27/14, at 4:55 PM, revealed she administered 120</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 97</p> <p>milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally to Resident #8 after Resident #8 complained of "tightness" of the chest, after learning the resident had an allergy to Macrodantin (antibiotic), and obtained a physician's order. The RN stated the treatment was effective and she continued to monitor the resident throughout the night.</p> <p>Interview conducted with Resident #6's physician on 04/02/14, at 4:30 PM, revealed he had been contacted by ADON #2 regarding the resident's allergy to Morphine.</p> <p>Review of an allergy sheet for Resident #6 on 04/02/14, at 5:00 PM, revealed Morphine was listed on the allergy sheet which was located in the front of the resident's MAR.</p> <p>Review of a care plan dated 03/30/14, revealed interventions to address Resident #6's allergy to Morphine.</p> <p>Review of a chart audit sheet the facility used to audit all residents' medical records for hospital discharge summaries and discharge documentation was reviewed to ensure allergies were identified. The audits were signed by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant as being completed on 03/27/14.</p> <p>The reviews of the medication allergy sheets for all residents were dated 03/27/14.</p> <p>Reviewed physician telephone orders to verify facility staff had contacted physicians to clarify the resident's drug allergies.</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 98</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had assisted with the chart audits on 03/27/14 to identify medication allergies by reviewing hospital discharge summaries, outside consultation notes, and discharge documentation. The interviews revealed allergy stickers were reviewed for accuracy, and medication allergy sheets were completed for all residents and placed in the front of each resident's MAR. The interview revealed all allergies were then clarified with the resident's physician. The interview also revealed the DON had assisted with the audits; however, she was no longer employed by the facility.</p> <p>Review of an in-service roster dated 03/27/14, revealed nurses and KMAs were in-serviced by the Regional Nurse Consultant, DON, and SDC regarding reviewing all hospital documentation upon admission or readmission to the facility to ensure allergies were appropriately identified.</p> <p>Posttests taken by licensed nurses and KMAs regarding in-service roster dated 03/27/14 were reviewed.</p> <p>Interview with the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to the licensed nurses and KMAs regarding reviewing all hospital documentation upon each resident admission or readmission to the facility to ensure allergies were appropriately identified.</p> <p>Interviews conducted with RN #6 on 04/03/14 at</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 99</p> <p>9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM all revealed they had attended an in-service regarding reviewing all hospital documentation to ensure allergies were appropriately identified with every admission or readmission.</p> <p>Review of an in-service roster dated 03/28/14 revealed the Medical Director attended an in-service provided by the Regional Nurse Consultant, SDC, and the Administrator regarding appropriately identifying allergies for residents.</p> <p>Interview conducted with the Medical Director on 04/02/14, at 4:30 PM, revealed he had attended an in-service provided by the facility on 03/28/14, regarding identifying allergies for the residents.</p> <p>Interview with the SDC on 04/03/14 at 2:40 PM, Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had provided an in-service to the Medical Director on 03/28/14 regarding ensuring resident allergies were appropriately identified.</p> <p>Review of an in-service syllabus and an email confirmation revealed the Consultant Pharmacist had been in-serviced by the Administrator, DON, and Regional Nurse Consultant on 03/28/14, regarding reviewing of all hospital discharge records for residents to ensure allergies were appropriately identified.</p> <p>Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed he had attended an in-service by phone on 03/28/14 provided by the facility regarding reviewing all</p>	F 428			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	Continued From page 100 hospital discharge documentation to ensure residents' allergies were appropriately identified. Interview with the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they, along with the former DON, had provided an in-service to the Consultant Pharmacist on 03/28/14 regarding reviewing all hospital discharge documentation to ensure resident allergies were appropriately identified. Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified. Review of an in-service roster dated 03/28/14, revealed the Administrator, DON, SDC, and ADONs attended an in-service provided by the Regional Nurse Consultant regarding the reporting of significant medication errors as neglect. Interview with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had provided an in-service to the Administrator, DON, ADONs, and SDC on 03/28/14 regarding reporting of significant medication errors as neglect to the appropriate state agencies and investigating them as an allegation of neglect.	F 428		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	<p>Continued From page 101</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had attended an in-service provided by the Regional Nurse Consultant regarding reporting of significant medication errors to the state agencies and they were to investigate them as an allegation of neglect.</p> <p>Review of an in-service roster dated 03/28/14, revealed the SDC, DON, ADONs, and the Regional Nurse Consultant provided an in-service for all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of posttests regarding the in-service had been completed by staff.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator.</p> <p>Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had attended an</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 102</p> <p>in-service regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. The staff also revealed they had been required to take a posttest on the in-service prior to working.</p> <p>Review of a syllabus for all new licensed nurses and KMAs revealed staff would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders.</p> <p>Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.</p> <p>Review of the follow-up questionnaire revealed the facility had completed ten questionnaires daily from all shifts and different staff regarding understanding of the Abuse/Neglect policy, appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process, and their participation in the QAPI process, and reporting to the Administrator.</p> <p>Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 103</p> <p>on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had randomly completed a follow-up questionnaire regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator.</p> <p>Review of an interview sheet revealed on 03/27/14, all residents with a BIMS score of greater than 8 had been interviewed by the Social Services Director, DON, ADONs, SDC, and the MDS Coordinator. Review of physician's orders where new allergies were identified was confirmed with the physician.</p> <p>Interviews conducted on 04/02/14, at 4:40 PM with Resident #6, at 4:50 PM with Resident #9, and at 4:55 PM with Resident #8 revealed they had been interviewed by the facility staff and had been asked about their allergies.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had interviewed all residents who had a BIMS score above 8 regarding their knowledge of their medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy.</p> <p>Record review revealed on 03/27/14, responsible parties of residents with a BIMS score of less</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 104</p> <p>than 8 were interviewed about the residents' allergies. The interviews were conducted by the Social Services Director, DON, ADONs, SDC, Administrator, MDS Coordinator, or the Regional Nurse Consultant. Any new allergies that were identified as a result of the interviews were confirmed with the resident's physician.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had interviewed all responsible parties of residents who had a BIMS score of less than 8 regarding their knowledge of the resident's medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy.</p> <p>Interviews conducted with Resident #7's responsible party on 04/02/14, at 5:45 PM, and Resident #14's responsible party on 04/02/14, at 6:00 PM, revealed the facility had contacted them regarding the resident's allergies.</p> <p>Review of Resident B's medical record revealed the resident was readmitted to the facility on 03/28/14, the resident did not have any known allergies, and the information was documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and was verified with the resident/responsible party.</p> <p>Review of Resident C's medical record revealed</p>	F 428			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	<p>Continued From page 105</p> <p>the resident was readmitted to the facility on 03/29/14, and the resident was allergic to Aspirin (analgesic) and Tubersol (medication to test for Tuberculosis) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party.</p> <p>Review of Resident A's medical record revealed the resident was readmitted to the facility on 04/01/14, and the resident was allergic to Morphine (pain medication) and Levaquin (antibiotic) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party.</p> <p>Review of a syllabus for all new staff revealed staff would be provided education regarding allergies and that they would be identified on the day of the resident's admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse would document allergies on the resident's medication allergy record that would be placed in the front of the MAR for that resident. The admitting nurse would review the resident's allergies with the resident and/or the responsible party for confirmation. A care plan would be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The admitting nurse would review any discharge summaries and all paperwork sent by the hospital, along with the interview of the resident/responsible party, and notify the</p>	F 428		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 428	<p>Continued From page 106</p> <p>physician of any allergies. The admitting nurse would then document the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders.</p> <p>Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.</p> <p>Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who were readmitted to the facility and all three residents' records had been reviewed for allergies being identified, action taken, allergies listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, Nursing Admission Assessment Form, care plan for allergies initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited for allergies being identified, any action taken to correct, allergies being listed on the</p>	F 428		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 107</p> <p>MAR, Medication Allergy Sheet, Physician's Order Sheet, and Nursing Admission Assessment Form, a care plan for allergies being initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.</p> <p>Review of the allergy stickers on the front of residents' medical records and review of medication allergy lists revealed they had been updated on 03/28/14.</p> <p>Review of an audit dated 03/28/14, conducted by the DON, ADONs, MDS Coordinator, Staff Development Coordinator, and Regional Nurse Consultant revealed medication allergies for all residents had been updated in the residents' chart. The audit was reviewed and no concerns were identified.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of residents' allergy stickers and Medication Allergy Sheets for all residents had been updated.</p> <p>Review of an in-service roster and syllabus dated 03/28/14 provided by the DON, ADONs, SDC, and Regional Nurse Consultant for licensed nursing staff/KMAs regarding Abuse, Neglect, and Misappropriation of funds, Medication Administration-Medication Discrepancies, Care Plans, Admission Process, Clinical Meeting, and QAPI revealed the Admission Process included reviewing/referencing hospital discharge paperwork, specifically noting allergies and</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 108</p> <p>interviewing residents/family to ensure appropriate information was received. It was also noted that if any discrepancies were found the nurse must get clarification from the physician. Also noted under the Admission Process was the Medication Allergy Sheet that was required to be completed upon admission and compared against hospital discharge documentation to check for allergies.</p> <p>Interview with RN #7 on 04/03/14 at 2:33 PM revealed he reviewed resident allergies on discharge information from the hospital. If the resident was admitted from home, he would contact the resident's physician and family to verify drug allergies. He also indicated that he had been provided with an in-service by the facility on drug allergies last week to include making sure that the resident's drug allergies were listed on the allergy sticker on the front of the chart, on the face sheet, on the MARs, and MD orders. RN #7 also stated that he had taken a posttest after being educated and had to pass it before he was allowed to be on the floor working. A copy of the notice informing the licensed nursing staff that they must be educated and pass the posttest before they would be allowed to work was provided.</p> <p>Review of audits conducted by the DON, ADONs, MDS Coordinator, SDC, or Regional Nurse Consultant, and which were reviewed daily by the Administrator, regarding checking all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list revealed this was being reviewed daily.</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 109</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list. The staff stated this was being done daily and was reviewed daily by the Administrator.</p> <p>Review of a document titled "2013 Updated Care Conference Agenda" updated on 03/29/14 revealed that allergies would be reviewed during care plan conference.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed allergies would be discussed as part of the Care Conference Agenda and no Care Conference had been done yet.</p> <p>Review of a medication pass audit completed by the DON, ADONs, SDC, and Regional Nurse Consultant for all nurses and KMAs working on 03/28/14 and the questionnaire to ensure nursing staff had knowledge regarding location of a resident's allergies prior to administering medication and without a significant medication error revealed all licensed nurses and KMAs been observed during medication administration</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 110 and had a completed questionnaire.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted medication audits for all nurses and KMAs working on 03/28/14, and had the employees complete a questionnaire regarding allergies and where to locate allergies prior to administering medications. The staff stated all nurses and KMAs had been observed during medication administration and had completed a questionnaire regarding allergies.</p> <p>Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM, revealed they had all been observed during medication administration and had completed a questionnaire regarding allergies.</p> <p>Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who had been readmitted to the facility and all three residents' records had been reviewed for Medication Allergy Record and an allergy sticker being on the chart.</p> <p>Review of all resident medical records on 04/03/14, revealed all residents had an allergy sticker on the front of the resident's medical record.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse</p>	F 428		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 111</p> <p>Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited the Medication Allergy Sheet and the allergy sticker being on the resident's chart.</p> <p>Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified and a copy sent to the pharmacy.</p> <p>Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified.</p> <p>Review of an audit of incident reports conducted on 03/29/14, by the DON, ADONs, SDC, or Regional Nurse Consultant to verify that no further significant medication errors had occurred revealed none had been identified by the facility.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted the audits on 03/29/14 of incident reports to verify that no further significant medication errors had occurred and none was identified.</p> <p>Review of documentation of incidents reviewed in the Daily Clinical Meeting to identify any allegations of abuse or neglect revealed the</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 112</p> <p>Administrator had documented he had reviewed them daily.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meeting and had reviewed all incidents or concerns to identify any allegations of abuse or neglect and there were none. The Administrator revealed he had reviewed the incidents daily.</p> <p>Review of a sign-in sheet verified that the Chief Operating Officer (COO) was present at the facility on 03/29/14, 03/30/14, 03/31/14, 04/01/14, and 04/02/14.</p> <p>Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits and been present for facility meetings.</p> <p>Review of an in-service roster dated 03/28/14 revealed the Administrator, DON, ADONs, SDC, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager, and Admissions Director attended an in-service regarding the QAPI process; appropriate methods to identify significant medication errors; failure to report neglect; and auditing of pharmacy services. The in-service was provided by the Regional Nurse Consultant.</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	<p>Continued From page 113</p> <p>Interview conducted with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had conducted an in-service on 03/28/14 regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had attended an in-service regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services.</p> <p>All audits were being reviewed by the Administrator, DON, COO, or Regional Nurse Consultant daily.</p> <p>Interview conducted with the Administrator on 04/03/14, at 2:55 PM, revealed he had reviewed the audits completed by the staff daily.</p> <p>Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits daily.</p> <p>Review of a QAPI meeting agenda dated 03/28/14, revealed the Medical Director was in attendance. The agenda revealed the committee addressed issues related to administering medications for which a resident had an allergy. The agenda also revealed the committee discussed ways to analyze and identify</p>	F 428			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 428	Continued From page 114 opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned. Interview conducted with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Medical Director on 04/02/14 at 4:30 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended a QAPI meeting on 03/28/14, and issues were addressed regarding administering a medication to a resident with an allergy to the medication. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned.	F 428			
F 441 SS=D	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 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	F 441	F 441 1. Resident # 1's medical was reviewed by Assistant Director of Nursing for any signs of documentation of concerns regarding infections upon notification. The ADON reassessed the resident on 4/24/2014 for any further signs of infection that could be related to the deficient practice. None was indicated. 2. A review of infection control reports for the last three months was conducted by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators', Facility Formulary Nurse/Infection Control nurse to identify any trending and concerns with infections regarding infection control techniques by May 13, 2014. Current residents' records and orders were reviewed regarding infections by the above team to identify any trending and concerns related to infection control procedures and techniques. 3. Education was provided by the staff development coordinator related to	5/13/14	

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 115 actions related to infections.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure a safe, sanitary environment was maintained. Staff failed to follow appropriate handwashing procedures to prevent the development and transmission of disease and infection when they provided incontinence care for one (1) of twenty-one (21) sampled residents (Resident #6).</p> <p>The findings include: Review of the Handwashing policy, dated December 2010, revealed staff and residents</p>	F 441	<p>the provisions of F tag 441, infection control policy and procedures to include hand washing and perennial care to licensed staff and State Registered Nursing Assisfants and was completed by May 13, 2014. A posttest was provided to each staff member attending the education in which a 100% score must be obtained. A competency was performed for all SRNAs, on pericare by the Director of Nursing, Assistant Directors of Nursing, Staff Development coordinators, MDS Coordinators', or Facility Formulary/Infection Control Nurse and completed by May 13, 2014. Staff not passing competency was re-educated and re-tested until competency achieved.</p> <p>Any change of condition and physiican orders to include new antibiotics will be reviewed by the clinical team during the daily clinical meeting which is attend by the Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Medical Records, Quality of life, Dietary Director and Staff Development Coordinator (Monday – Friday) to discuss root</p>	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 116</p> <p>were to wash their hands as necessary to prevent the spread of infections or germs. The policy revealed staff was to wash their hands before and after caring for each resident and/or their units. The policy did not include specific guidelines to be followed when incontinence care was provided.</p> <p>Review of the medical record revealed the facility admitted Resident #6 on 11/08/13 with diagnoses of Bronchitis, Chronic Obstructive Pulmonary Disease, Chronic pain, and multiple Sacral Decubitus Ulcers.</p> <p>Review of the Minimum Data Set (MDS) dated 02/08/14 revealed the facility assessed Resident #6 to require extensive assistance with the activities of daily living (ADLs). The assessment also revealed Resident #6 was frequently incontinent.</p> <p>Observation of incontinence care for Resident #6 was conducted on 03/27/14 at 10:50 AM, with State Registered Nurse Aide (SRNA) #6. The SRNA was observed to enter the room and stated she had just left the room of another resident. SRNA #6 proceeded to put on clean gloves without performing hand hygiene. SRNA #6 was observed to wipe the resident's perineal area from front to back and used a new wipe each time. Resident #6 was observed to roll to his/her right side and SRNA #6 was observed to wipe stool from the resident's buttocks. Resident #6's brief held copious amounts of stool that was on his/her upper thighs and that had also come into contact with the resident's bed sheet. After the SRNA had cleansed the resident's perineal/buttock area, the SRNA applied a barrier cream to the resident's perineal area without</p>	F 441	<p>cause and trends with identification of any educational needs.</p> <p>4. Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinators, MDS Coordinators', or Facility Formulary/Infection Control Nurse will audit 10% of nursing staff weekly for 4 weeks regarding infection control techniques to include hand washing and perennal care.</p> <p>Results of the above audit will be reported to the QA Committee monthly to include the analysis, interventions, and need for further education or revision of plans.</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 117</p> <p>changing gloves or washing her hands. In addition, the SRNA changed the resident's bed linens without changing her gloves.</p> <p>SRNA #6 was unavailable for interview after incontinence care due to a family emergency and was unable to be reached by phone. Review of the facility's in-service record for SRNA #6 revealed he/she attended an infection control and handwashing in-service on 01/24/14.</p> <p>Interview on 03/27/14 at 3:00 PM with SRNA #3 revealed that the facility provided staff training every year on infection control. SRNA #3 stated staff was to wash hands and put on new gloves prior to incontinence care and during incontinence care when gloves became soiled. SRNA #3 stated she had been trained to wash hands and put on new gloves prior to applying barrier cream to the perineal area after incontinence care was provided.</p> <p>Interview on 03/27/14 at 3:30 PM with Assistant Director of Nursing (ADON) #2 revealed staff was inserviced "at least" four times a year regarding washing of hands and infection control. ADON #2 stated staff was frequently reminded to wash their hands. ADON #2 stated administrative staff observed direct care staff, on a random basis, for infection control techniques, including proper handwashing, and had not identified problems.</p> <p>Interview conducted with the Director of Nursing (DON) on 03/28/14, at 8:45 AM, revealed staff was required to change their gloves and to wash/sanitize their hands whenever their gloves become soiled during incontinence care. The DON stated the facility had not identified any concerns with staff not washing/sanitizing their</p>	F 441			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 118 hands and changing gloves during incontinence care.	F 441	F 520	5/13/14
F 520 SS=J	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, the facility's investigation, and review of the facility's policies entitled "Abuse, Neglect, and Misappropriation" and "Performance Improvement Plan," it was	F 520	1. Resident # 8 was administered Solumedrol IM and PO Bendaryl related to the chest tightness after physician notification. Resident's medical record, allergy list, allergy sticker on the outside of the medical record, care plan and MARs were updated to reflect all allergies. 2. Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, MDS Coordinators, and Regional Nurse Consultant on 3/27/14 for all residents to ensure allergies are appropriately identified. During the audit, allergy stickers on the outside of resident's charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 3/27/14 by the Director of	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 119</p> <p>determined the facility failed to maintain a Quality Assessment and Assurance Committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies for one (1) of twenty-one (21) sampled residents (Resident #8). Review of the medical record revealed the facility admitted Resident #8 on 09/09/13 and received a History and Physical report from an acute care facility, dated 08/27/13, that indicated Resident #8 was allergic to Macroclantim (antibiotic), but staff failed to document the resident's allergy to Macroclantim on documents in the resident's medical record and on the Medication Administration Record (MAR). From 03/08/14 to 03/11/14, staff administered Macroclantim to Resident #8 for treatment of a Urinary Tract Infection (UTI) for a total of seven (7) doses, and on 03/11/14, Resident #8 experienced "tightness" in the chest, asked facility staff what medications he/she had received, and was informed he/she had received Macroclantim. At that time, the resident informed staff he/she had an allergy to Macroclantim and facility staff contacted the resident's physician and the Macroclantim was discontinued.</p> <p>Further review of the Incident/Occurrence Investigation revealed the facility determined Registered Nurse (RN) #1 had reviewed all of Resident #8's medications with the resident at the time of admission and not been made aware the resident had an allergy to Macroclantim.</p> <p>Interview and review of the facility's investigation revealed the facility failed to identify the resident's allergy to Macroclantim and, as a result, failed to develop and implement appropriate plans of action through a Quality Assurance Program to</p>	F 520	<p>Nursing, Assistant director of Nursing, Staff development coordinator, MDS coordinator and Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician.</p> <p>The Pharmacy Consultants were on site on 3/29/14 and reviewed all resident records on 3/29/14 to ensure allergies have been appropriately identified.</p> <p>Interviews were completed on 3/27/14 by the Social Services Director, Director of Nursing, Assistant Director of Nursing, Staff Development Coordinator, or MDS Coordinators for residents with a BIMS score above 8 regarding their knowledge of allergies. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed.</p> <p>Residents with a BIM score less than 8, responsible party</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 120</p> <p>correct the identified deficiency to prevent significant medication errors, the pharmacist's failure to identify and report drug irregularities to the physician, and the facility's failure to report/investigate allegations of neglect. (Refer to F225, F333, and F428.)</p> <p>The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding reporting/investigating all allegations of neglect, preventing significant medication errors, and pharmacist reporting irregularities to the physician, caused or was likely to cause serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 03/08/14 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) at a scope and severity of "J." Substandard Quality of Care was identified at 42 CFR 483.13 Resident Behavior and Facility Practices (F225) and 42 CFR 483.25 Quality of Care (F333). The facility was notified of the Immediate Jeopardy on 03/28/14.</p> <p>An acceptable Allegation of Compliance was received on 04/01/14, and alleged removal of the Immediate Jeopardy on 03/31/14. The State Survey Agency determined the Immediate Jeopardy was removed on 03/31/14, prior to exit, which lowered the scope and severity to "D" at 42 CFR 483.13 Resident Behavior and Facility Practices (F225), 42 CFR 483.25 Quality of Care (F333), 42 CFR 483.60 Pharmacy Services (F428), and 42 CFR 483.75 Administration (F520) while the facility monitors the effectiveness of</p>	F 520	<p>interviews were completed on 3/27/14 by Social Services Director, Director of Nursing, MDS Coordinators, Assistant Directors of Nursing, Administrator, or Regional Nurse Consultant to identify any allergies or concerns with medications. This was compared to what is listed in the medical record and allergies were updated with assessment and/or physician order as needed.</p> <p>All incident reports from January 2014 to March 29, 2014 have been reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator or Regional nurse consultant to identify any further significant medication error by 3/29/14. None were identified.</p> <p>3. Education was initiated for licensed staff/Kentucky Medication aid on 3/27/14 by the Regional Nurse Consultant, Director of Nursing, and the</p>		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 121</p> <p>systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's "Abuse, Neglect, and Misappropriation" policy with an effective date of April 2013, revealed the Quality Assurance/ Performance Improvement (QAPI) Committee would review allegations of abuse/neglect for resolution related to educational opportunities.</p> <p>Review of the facility's "Performance Improvement Plan" policy, undated, revealed the facility would conduct an ongoing performance improvement program designed to systematically monitor, evaluate, and improve the quality and appropriateness of resident care. The policy also revealed the Performance Committee would examine both outcomes and processes in an effort to improve the organization's overall performance. In addition, the policy revealed the performance improvement committee would include the Administrator, Director of Nursing, Medical Director, Nurse Practitioner, Consulting Pharmacist, Registered Dietitian, Medical Records, and any other staff deemed necessary.</p> <p>Review of the medical record revealed the facility admitted Resident #8 on 09/09/13 and received a copy of a History and Physical report from an acute care facility (dated 08/27/13) that revealed Resident #8 was allergic to Macroclantfin (antibiotic). Review of the Admission Assessment dated 09/09/13 revealed Registered Nurse (RN) #1 assessed Resident #8 but failed to identify or document that the resident had an allergy to Macroclantfin (antibiotic). In addition, interview with Resident #8 on 03/26/14, at 2:25 PM</p>	F 520	<p>Staff Development Coordinator regarding reviewing the hospital documentation upon admission or re-admission to ensure that allergies are appropriately identified. Post test was given upon completed of education. A score of 100% was obtained by each staff or re-education and re-test was completed.</p> <p>The Medical Director received education from the Administrator, the Staff Development Coordinator, and the Regional Nurse Consultant on 3/28/14 regarding appropriately identifying allergies for residents.</p> <p>The Pharmacy Consultant received education on 3/28/14 from the Administrator, Director of Nursing, and Regional Nurse Consultant regarding reviewing of hospital discharge records for all residents to ensure that allergies are appropriately identified.</p>	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 122</p> <p>revealed he/she had informed RN #1 on 09/09/13 that he/she was allergic to Macrochantin. Review of the Medication Administration Record (MAR) for Resident #8 revealed the facility administered Macrobid to the resident from 03/08/14 to 03/11/14, for a total of seven doses. Interview and review of the Incident/Occurrence Investigation completed by the facility on 03/11/14, revealed on 03/11/14 at 9:50 PM, Resident #8 informed RN #2 that she had "tightness" in the chest, asked the nurse what medications he/she had received, and was informed he/she had received Macrochantin. At that time, the resident informed the nurse he/she was allergic to Macrochantin, the nurse contacted the resident's physician, and the physician discontinued the Macrochantin.</p> <p>Interview with the facility's Consultant Pharmacist on 03/27/14 at 4:40 PM revealed he/she had reviewed Resident #8's medical record, including the History and Physical report dated 08/27/13, and had failed to identify Resident #8 had an allergy to Macrochantin.</p> <p>Review of the facility's investigation revealed the ADON interviewed RN #1, and noted the nurse had reviewed all medications with Resident #8 at the time of admission. However, the facility's investigation failed to reveal the information related to the resident's allergy to Macrochantin was documented in the History and Physical report in the medical record and that staff had failed to identify the resident's allergy to the medication when the resident was admitted.</p> <p>Interview conducted with the Administrator on 03/28/14, at 9:00 AM, revealed he was responsible for coordinating the Performance</p>	F 520	<p>Education was completed for the Administrator, Director of Nursing, Staff Development Coordinator and Assistant Director of Nurses were educated by the Regional Nurse Consultant on 3/28/14 regarding reporting of neglect for any significant medication error.</p> <p>Education for all staff was initiated on 3/28/14 by the Staff Development Coordinator, Director of Nursing, Assistant Directors of Nursing and the Regional Nurse Consultant regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plans. A post test was given at completed of education in which staff had to make 100%. If passing score not made the</p>		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 123</p> <p>Improvement program for the facility. The Administrator stated the facility was unaware the documentation of the resident's allergy to Macroclantin was listed on the History and Physical in the resident's medical record until the day of the interview on 03/28/14. The Administrator stated because staff and the facility's investigation failed to identify the resident's allergy documented on the History and Physical in the medical record, the Performance Improvement Committee had not identified or developed quality assurance interventions, actions, or plans of correction necessary to address and correct the identified deficiency. The Administrator also stated the facility's investigation and the Performance Improvement Committee had not identified the incident related to the administration of Macroclantin to Resident #8 as neglect and, as a result, did not report the incident to the state agencies as a suspected incident of neglect.</p> <p>**The facility provided an acceptable Allegation of Compliance (AOC) on 04/01/14. The facility implemented the following actions to remove the Immediate Jeopardy:</p> <p>The physician for Resident #8 was notified by the staff nurse immediately upon identification of symptoms that may have been related to the administration of Macroclantin. Physician's orders were obtained immediately and intramuscular Solu-Medrol along with Benadryl by mouth was administered by the staff nurse on 03/11/14 to treat the resident's symptoms. The treatment was effective as evidenced by every shift assessment along with supporting documentation. The resident was monitored by staff nurses to ensure continued effectiveness.</p>	F 520	<p>staff will be re-educated on the spot and tested again.</p> <p>Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from discharge summary, resident history or POA history, verification of allergy orders from physician as well as places on Medication Administration Record or medical record for placement of allergies will be included in orientation for licensed nursing and Kentucky Medication Aides.</p> <p>Allergies will be identified on day of admission and/or re-admission by the admitting nurse on the nursing admission information document. The admitting nurse will document allergies on the resident's medication allergy record that will be placed in the front of the Medication Administration Record for that resident. The admitting nurse will review the residents allergies with the resident and/or POA for</p>	

confirmation. A care plan will
If continuation sheet Page 124 of 150

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	Continued From page 124 The physician was notified by the Assistant Director of Nursing (ADON) for Resident #6 on 03/28/14 to clarify the resident's allergy to Morphine. A sheet was added in front of the resident's medication administration record (MAR) to identify the resident's allergy to Morphine. A care plan was initiated with interventions to decrease the risk of an allergic reaction. Chart audits to include review of hospital discharge summaries and/or discharge documentation and outside consultation visits were completed by the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Coordinator (SDC), MDS Coordinators, and Regional Nurse Consultant on 03/27/14 for all residents to ensure allergies were appropriately identified. During the audit, allergy stickers on the outside of residents' charts were reviewed to ensure accuracy. A medication allergy sheet was completed for each resident on 03/27/14 by the DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant and placed in front of each resident's MARs. All allergies were clarified with the physician. The Regional Nurse Consultant, DON, and SDC initiated education for licensed staff and Kentucky Medication Aides (KMAs) on 03/27/14 and advised staff to review hospital documentation upon each resident admission or readmission to ensure allergies were appropriately identified. Licensed nursing staff/KMAs were not allowed to work prior to receiving the above stated education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those	F 520	be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on day of admission/re-admission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment and physician orders and look at discharge summaries and all paperwork sent by the hospital, along with interview of resident/POA will also be included in orientation for new staff. Physician will be notified of any allergies by the charge nurse following review of all documents sent by hospital, resident and/or POA interview. Charts for newly admitted residents and re-admitted residents will be reviewed and discussed in the Daily Clinical Meeting on weekdays attended by the Director of Nursing, MDS Coordinators, Social Service Director, Medical Records, Staff		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 125</p> <p>staff members not obtaining a passing score of 100 percent would be educated on the spot and retested.</p> <p>Resident #8's attending physician, who is also the facility's Medical Director, received education from the Administrator, SDC, and the Regional Nurse Consultant on 03/28/14 regarding appropriately identifying resident allergies.</p> <p>The Administrator, DON, and Regional Nurse Consultant provided education to the Pharmacy Consultant on 03/28/14 regarding reviewing hospital discharge records for all residents to ensure allergies were appropriately identified.</p> <p>The Pharmacy Consultants were on-site on 03/29/14 and reviewed all resident records to ensure allergies were appropriately identified.</p> <p>The Regional Nurse Consultant provided education to the Administrator, DON, SDC, and ADONs on 03/28/14 regarding reporting of neglect for any significant medication error.</p> <p>The SDC, DON, ADONs, and the Regional Nurse Consultant initiated staff education on 03/28/14 regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, the Quality Assurance Performance Improvement (QAPI) process to include reporting of concerns to the Administrator, and front line staff participation in development of QAPI plans. Staff was not permitted to work prior to receiving the education. A posttest was given upon completion of education. A score of 100 percent must be obtained before being allowed to work. Those staff members not obtaining a passing score of</p>	F 520	<p>Development Coordinator, Assistant Directors of Nursing, Activities Director, Dietary Manager and Chaplain, with a comparison review completed at that time of the resident's nursing admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or re-admitted residents to ensure allergies are appropriately identified as well as all paperwork is complete accurate, care plan updated, physician notification complete and all allergy lists updated or initiated.</p> <p>During care plan conference for each resident the allergy list will also be reviewed for any updates.</p> <p>All incidents or concerns are</p>		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 126</p> <p>100 percent would be educated on the spot and retested.</p> <p>Education regarding reporting abuse, reporting of significant medication errors, obtaining allergies from the discharge summary, resident history or POA history, verification of allergy orders from the physician, as well as places on the MAR or medical record for placement of allergies will be included in the orientation for licensed nurses and KMAs.</p> <p>A follow-up questionnaire would be completed by the Administrator, DON, ADONs, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplain, Medical Records, Human Resources Director, SDC, Business Office Manager, Facility Formulary Nurse, or the Environmental Services Manager for ten staff members daily to include all shifts and different staff members until removal of immediacy, then weekly for four weeks, to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process to include reporting concerns to the Administrator, and front line staff participation in the development of QAPI plans.</p> <p>The Social Services Director, DON, ADONs, SDC, and MDS Coordinator conducted interviews on 03/27/14 with residents who had a BIMS score above 8 regarding their knowledge of allergies. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed.</p>	F 520	<p>stand up meeting (Monday – Friday) to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manager, Chaplain, MDS coordinators, Plant Operations Director, Medical Records, Admission Director, House Keeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager or Regional staff to identify any allegation of abuse or neglect.</p> <p>Education was provided by the Regional Nurse Consultant on 3/28/14 for the Administrator, Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager and Admissions Director regarding the Quality Assurance Process and appropriate methods of identification of concerns</p>

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 127</p> <p>The Social Services Director, DON, ADONs, MDS Coordinator, Administrator, or Regional Nurse Consultant conducted interview with the responsible party for residents with a BIMS score of less than 8 by 03/27/14 to identify any allergies or concerns with medications. This was compared to what was listed in the medical record and allergies were updated with assessment and/or physician's order as needed.</p> <p>Allergies will be identified on the day of admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse will document allergies on the resident's medication allergy record that will be placed in the front of the MAR for that resident. The admitting nurse will review the resident's allergies with the resident and/or POA for confirmation. A care plan will be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The procedure which includes identification of allergies on the day of admission/readmission by the admitting nurse along with documenting the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders; and review of discharge summaries and all paperwork sent by the hospital along with the interview of the resident/POA will also be included in orientation for all new staff. The physician will be notified of any allergies by the charge nurse following review of all documents sent by the hospital, resident, and POA interview.</p> <p>Charts for newly admitted residents and readmitted residents will be reviewed and discussed in the Daily Clinical meeting on weekdays by the DON, MDS Coordinator, Social Services Director, Medical Records, SDC,</p>	F 520	<p>including significant medication errors, failure to report neglect, auditing pharmacy services.</p> <p>Pharmacy consultant will exit with the Administrator and/or Director of Nursing to review the findings of the consultant's medication review not only to include allergies but any other concerns regarding medications reconciliation or interaction or reductions.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or the Chief Operating Officer weekly for 4 weeks beginning 3/30/14 then monthly.</p> <p>The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above twice weekly for 4 weeks starting 3/30/14 and report findings during weekly QA for 4 weeks beginning 3/30/14, for</p>		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 128</p> <p>ADONs, Activities Director, Dietary Manager, and Chaplain with a comparison review completed at that time of the resident's admission packet and their medication allergy form, against the hospital discharge summary and/or discharge documentation of resident allergies, to ensure that allergies are appropriately identified. On weekends, this review will be completed by the DON, ADONs, SDC, or MDS Coordinator until removal of immediacy. Following removal of immediacy, on weekends, two charge nurses will review the discharge documentation and history and physical for newly admitted or readmitted residents to ensure allergies are appropriately identified as well as all paperwork complete and accurate, care plan updated, physician notification complete, and all allergy lists updated or initialed.</p> <p>Allergy stickers and allergy lists were updated for all residents to include all medication allergies identified. This was completed by the Director of Nursing, Assistant Director of Nursing, MDS Coordinators, Staff Development Coordinator, and Regional Nurse Consultant on 03/28/14.</p> <p>Education was provided for licensed nursing staff/Kentucky Medication Aides by the Director of Nursing, Assistant Director of Nursing, the Staff Development Coordinator, and the Regional Nurse Consultant regarding all paperwork forwarded from the hospital, interview with resident/POA, verifying allergies with physician, noting allergies on the allergy sticker, allergy listings, physician orders, and MARs. Licensed nursing staff will not be allowed to work prior to receiving the above stated education.</p> <p>Nursing Administration to include the Director of</p>	F 520	<p>recommendations and further follow-up as indicated.</p> <p>The Administrator will review any concerns related to all aspects of resident care to ensure resources are utilized effectively in order to maintain the highest practicable physical, mental and psychosocial well-being of each resident by reviewing incidents, grievances, nursing reports, and concerns voiced by the Department managers during the daily stand up meetings conducted Monday through Friday.</p> <p>4. A follow-up questionnaire will be completed by the Administrator, Director of Nursing, Assistant Directors of Nursing, MDS Coordinator, Social Services Director, Quality of Life Director, Dietary Manager, Plant Operations Director, Chaplin, Medical Records, Human Resource Director, Staff Development Coordinator, Business Office Manager, Facility Formulary Nurse or the Environmental</p>		

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 129</p> <p>Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators, Facility Formulary Nurse, or Regional Nurse Consultant are reviewing every physician's order daily to audit for medication or any other orders for appropriateness, any new allergy orders, if new medications are listed and compared to allergy list. This will continue daily until immediacy lifted. Once immediacy is lifted a daily review will continue (Monday-Friday) by the above team.</p> <p>During care plan conference for each elder the allergy list will also be reviewed for any updates.</p> <p>Medication pass audits were completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant for all nurses and Certified Medication Technicians working on 03/28/14 to ensure that allergies are appropriately identified and medications are administered without significant medication error. Medication pass audits will be completed for all nurses and certified medication technicians during their initial medication pass for shifts scheduled after 03/28/14 until all nurses and certified medication technicians have had a medication pass audit completed. During the medication pass audit, a questionnaire will be completed by the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, and Regional Nurse Consultant to ensure their knowledge of where to review for allergies prior to the administration of medication.</p> <p>The Assistant Director of Nursing, MDS Coordinator, or the Staff Development Coordinator will audit the Medication</p>	F 520	<p>Services Manager for 10 staff members to include all shifts and different staff weekly for 4 weeks beginning 3/30/14, then monthly to ensure continued understanding of regarding the abuse/neglect policy and appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the Quality Assurance Performance Improvement process to include reporting of concerns to the Administrator and line staff participation in development of QAPI plan.</p> <p>Nursing Administration to include the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, MDS Coordinators, Facility Formulary Nurse or Regional Nurse Consultant are reviewing every physician order daily, Monday through Friday, to audit for medication or any other orders for appropriateness, any new allergy orders, if new</p>	

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 130</p> <p>Administration Record daily for newly admitted and readmitted residents to ensure allergies are identified on the resident's medication allergy record and allergy sticker on the outside of the chart.</p> <p>All allergy clarifications for all residents have been sent to Pharmacy as of 03/29/14 in which Pharmacy has updated their listing in their computer system. Pharmacy will review all new orders and compare to any allergies listed and notify facility if an allergy exists regarding the new medication at which time the nurse will notify the physician for any new orders.</p> <p>All incident reports were reviewed by the Director of Nursing, the Assistant Director of Nursing, Staff Development Coordinator, or Regional Nurse Consultant to identify any further significant medication errors by 03/29/14. None was identified.</p> <p>All incidents or concerns are reviewed daily during the daily standup meeting to include Administrator, Director of Nursing, Assistant Director of Nursing, Dietary Manger, Chaplain, MDS Coordinators, Plant Operations Director, Medical Records, Admissions Director, Housekeeping/Central Supply Director, Quality of Life Director, Business Office Manager, Rehabilitation Manager, or Regional Staff to identify any allegation of abuse or neglect. The Administrator has been on-site daily to review all concerns or incidents to ensure abuse or neglect has been appropriately identified and reported.</p> <p>Administrative oversight of the facility will be completed by the Special Projects Administrator, the Regional Vice President of Operations, or the</p>	F 520	<p>medications are listed and compared to allergy list.</p> <p>Medication pass audits will be conducted by the Director of Nursing, Assistant Directors of Nursing, MDS Coordinators, Staff Development Coordinator, Facility Formulary Nurse/ Infection or Regional Nurse consultant for 10% of the staff monthly beginning 3/30/14.</p> <p>The Director of Nursing, Assistant Directors of Nursing, Staff Development coordinators, MDS Coordinators or Facility Formulary Nurse will audit 20% of medical Records monthly regarding not only review of allergies but also review of the pharmacy consultant documentation for accuracy and pertinent information regarding resident's medication. Concerns identified will be reported to the Administrator and to pharmacy in order for a correction and plan of action.</p>	

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	<p>Continued From page 131</p> <p>Chief Operating Officer daily until removal of immediacy, then weekly for four weeks after removal of immediacy, and then monthly.</p> <p>Education was provided by the Regional Nurse Consultant on 03/28/14 for the Administrator, the Director of Nursing, Assistant Directors of Nursing, Staff Development Coordinator, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manger, and Admission Director regarding the Quality Assurance Process and appropriate methods of identification of concerns including significant mediation errors, failure to report neglect, and auditing pharmacy services.</p> <p>The Administrator, Director of Nursing, Chief Operating Officer, Chief Nurse Executive, or Regional Nurse Consultant will audit compliance of the above stated audits daily until removal of immediacy, and then twice weekly for four weeks and report findings during weekly QA for four weeks, for recommendations and further follow-up as indicated.</p> <p>A Quality Assurance meeting was held on 03/28/14 with the Medical Director for further recommendations regarding the plan for removal of jeopardy. A Quality Assurance meeting will be held weekly for four weeks, and then monthly for recommendations and further follow-up regarding the above stated plan.</p> <p>**The surveyors validated the Immediate Jeopardy was removed as follows:</p> <p>Review of a physician's order for Resident #8 dated 03/11/14, at 9:50 PM, revealed the nurse</p>	F 520	<p>A Quality Assurance meeting will be held weekly for 4 weeks beginning 3/30/14, then monthly in which analysis of these audits as well as other information to include safety, environmental concerns, infection control, occurrences, staff turnover, and other plans /audits that are being performed by members of any sub-committees will be reported to the QA committee to evaluate the plan, intervention, in order to determine further need of education or revision of plan. At that time based upon evaluation the QA Committee will determine at what frequency the audits will need to continue. The Administrator has the oversight to ensure an effective plan is in place to meet resident wellbeing as well as an effective plan to identify facility concerns and implement a plan of correction to involve all staff of the facility.</p>	

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 132</p> <p>was to administer 120 milligrams (mg) of Solu-Medrol intramuscularly "now," and Benadryl 50 mg orally "now."</p> <p>Review of the MAR for Resident #8 revealed staff administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally on 03/11/14.</p> <p>Interview conducted with RN #2 on 03/27/14, at 4:55 PM, revealed she administered 120 milligrams of Solu-Medrol intramuscularly and 50 milligrams of Benadryl orally to Resident #8 after Resident #8 complained of "tightness" of the chest, after learning the resident had an allergy to Macroclantin (antibiotic), and obtained a physician's order. The RN stated the treatment was effective and she continued to monitor the resident throughout the night.</p> <p>Interview conducted with Resident #6's physician on 04/02/14, at 4:30 PM, revealed he had been contacted by ADON #2 regarding the resident's allergy to Morphine.</p> <p>Review of an allergy sheet for Resident #6 on 04/02/14, at 5:00 PM, revealed Morphine was listed on the allergy sheet which was located in the front of the resident's MAR.</p> <p>Review of a care plan dated 03/30/14, revealed interventions to address Resident #6's allergy to Morphine.</p> <p>Review of a chart audit sheet the facility used to audit all residents' medical records for hospital discharge summaries and discharge documentation was reviewed to ensure allergies were identified. The audits were signed by the</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 133</p> <p>DON, ADON, SDC, MDS Coordinator, and the Regional Nurse Consultant as being completed on 03/27/14.</p> <p>The reviews of the medication allergy sheets for all residents were dated 03/27/14.</p> <p>Reviewed physician telephone orders to verify facility staff had contacted physicians to clarify the resident's drug allergies.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had assisted with the chart audits on 03/27/14 to identify medication allergies by reviewing hospital discharge summaries, outside consultation notes, and discharge documentation. The interviews revealed allergy stickers were reviewed for accuracy, and medication allergy sheets were completed for all residents and placed in the front of each resident's MAR. The interview revealed all allergies were then clarified with the resident's physician. The interview also revealed the DON had assisted with the audits; however, she was no longer employed by the facility.</p> <p>Review of an in-service roster dated 03/27/14, revealed nurses and KMAs were in-serviced by the Regional Nurse Consultant, DON, and SDC regarding reviewing all hospital documentation upon admission or readmission to the facility to ensure allergies were appropriately identified.</p> <p>Posttests taken by licensed nurses and KMAs regarding in-service roster dated 03/27/14 were reviewed.</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	Continued From page 134 Interview with the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to the licensed nurses and KMAs regarding reviewing all hospital documentation upon each resident admission or readmission to the facility to ensure allergies were appropriately identified. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM all revealed they had attended an in-service regarding reviewing all hospital documentation to ensure allergies were appropriately identified with every admission or readmission. Review of an in-service roster dated 03/28/14 revealed the Medical Director attended an in-service provided by the Regional Nurse Consultant, SDC, and the Administrator regarding appropriately identifying allergies for residents. Interview conducted with the Medical Director on 04/02/14, at 4:30 PM, revealed he had attended an in-service provided by the facility on 03/28/14, regarding identifying allergies for the residents. Interview with the SDC on 04/03/14 at 2:40 PM, Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had provided an in-service to the Medical Director on 03/28/14 regarding ensuring resident allergies were appropriately identified. Review of an in-service syllabus and an email	F 520			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	Continued From page 135 confirmation revealed the Consultant Pharmacist had been in-serviced by the Administrator, DON, and Regional Nurse Consultant on 03/28/14, regarding reviewing of all hospital discharge records for residents to ensure allergies were appropriately identified. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed he had attended an in-service by phone on 03/28/14 provided by the facility regarding reviewing all hospital discharge documentation to ensure residents' allergies were appropriately identified. Interview with the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they, along with the former DON, had provided an in-service to the Consultant Pharmacist on 03/28/14 regarding reviewing all hospital discharge documentation to ensure resident allergies were appropriately identified. Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified. Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified. Review of an in-service roster dated 03/28/14, revealed the Administrator, DON, SDC, and ADONs attended an in-service provided by the Regional Nurse Consultant regarding the	F 520		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 136 reporting of significant medication errors as neglect.</p> <p>Interview with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had provided an in-service to the Administrator, DON, ADONs, and SDC on 03/28/14 regarding reporting of significant medication errors as neglect to the appropriate state agencies and investigating them as an allegation of neglect.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Administrator on 04/03/14 at 2:55 PM revealed they had attended an in-service provided by the Regional Nurse Consultant regarding reporting of significant medication errors to the state agencies and they were to investigate them as an allegation of neglect.</p> <p>Review of an in-service roster dated 03/28/14, revealed the SDC, DON, ADONs, and the Regional Nurse Consultant provided an in-service for all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. Review of posttests regarding the in-service had been completed by staff.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM revealed they had provided an in-service to all staff regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 137</p> <p>significant medication errors, the QAPI process which included reporting of any concerns to the Administrator.</p> <p>Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had attended an in-service regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator. The staff also revealed they had been required to take a posttest on the in-service prior to working.</p> <p>Review of a syllabus for all new licensed nurses and KMAs revealed staff would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders.</p> <p>Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.</p> <p>Review of the follow-up questionnaire revealed</p>	F 520		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 138</p> <p>the facility had completed ten questionnaires daily from all shifts and different staff regarding understanding of the Abuse/Neglect policy, appropriate reporting of neglect to include significant medication errors, implementing care plans for allergies, the QAPI process, and their participation in the QAPI process, and reporting to the Administrator.</p> <p>Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, LPN #1 on 04/03/14 at 10:05 AM, SRNA #1 on 04/03/14 at 1:55 PM, SRNA #2 on 04/03/14 at 2:00 PM, SRNA #3 on 04/03/14 at 2:05 PM, and SRNA #4 on 04/03/14 at 2:10 PM, all revealed they had randomly completed a follow-up questionnaire regarding the facility's Abuse/Neglect policy and the appropriate reporting of neglect to include significant medication errors, the QAPI process which included reporting of any concerns to the Administrator.</p> <p>Review of an interview sheet revealed on 03/27/14, all residents with a BIMS score of greater than 8 had been interviewed by the Social Services Director, DON, ADONs, SDC, and the MDS Coordinator. Review of physician's orders where new allergies were identified was confirmed with the physician.</p> <p>Interviews conducted on 04/02/14, at 4:40 PM with Resident #6, at 4:50 PM with Resident #9, and at 4:55 PM with Resident #8 revealed they had been interviewed by the facility staff and had been asked about their allergies.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, SDC on</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 139</p> <p>04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had interviewed all residents who had a BIMS score above 8 regarding their knowledge of their medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy.</p> <p>Record review revealed on 03/27/14, responsible parties of residents with a BIMS score of less than 8 were interviewed about the residents' allergies. The interviews were conducted by the Social Services Director, DON, ADONs, SDC, Administrator, MDS Coordinator, or the Regional Nurse Consultant. Any new allergies that were identified as a result of the interviews were confirmed with the resident's physician.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had interviewed all responsible parties of residents who had a BIMS score of less than 8 regarding their knowledge of the resident's medication allergies. The allergies were then compared to what had been listed and the physician was notified for orders with any new allergy.</p> <p>Interviews conducted with Resident #7's responsible party on 04/02/14, at 5:45 PM, and Resident #14's responsible party on 04/02/14, at 6:00 PM, revealed the facility had contacted them regarding the resident's allergies.</p>	F 520			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
(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 520	Continued From page 140 Review of Resident B's medical record revealed the resident was readmitted to the facility on 03/28/14, the resident did not have any known allergies, and the information was documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and was verified with the resident/responsible party. Review of Resident C's medical record revealed the resident was readmitted to the facility on 03/29/14, and the resident was allergic to Aspirin (analgesic) and Tubersol (medication to test for Tuberculosis) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of Resident A's medical record revealed the resident was readmitted to the facility on 04/01/14, and the resident was allergic to Morphine (pain medication) and Levaquin (antibiotic) and the allergies were documented on the resident's medication allergy record, on the allergy sticker on the front of the resident's medical record, on the nursing admission assessment, physician's orders, and were verified with the resident/responsible party. Review of a syllabus for all new staff revealed staff would be provided education regarding allergies and that they would be identified on the day of the resident's admission and/or readmission by the admitting nurse on the nursing admission information document. The admission nurse would document allergies on the	F 520		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 141</p> <p>resident's medication allergy record that would be placed in the front of the MAR for that resident. The admitting nurse would review the resident's allergies with the resident and/or the responsible party for confirmation. A care plan would be initiated that identifies allergies and interventions to decrease the risk of allergic reactions. The admitting nurse would review any discharge summaries and all paperwork sent by the hospital, along with the interview of the resident/responsible party, and notify the physician of any allergies. The admitting nurse would then document the allergies on the medication allergy record, the nursing admission assessment, and the physician's orders.</p> <p>Interview with the SDC on 04/03/14, at 2:40 PM, revealed she was responsible for providing all new employee orientation. The SDC stated all new licensed nurses and KMAs would be provided education regarding reporting of abuse, reporting of significant medication errors, where to review and document allergies, and verification of allergy orders. The SDC stated no new licensed nurses or KMAs had been hired since the facility had added the new education to the syllabus.</p> <p>Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who were readmitted to the facility and all three residents' records had been reviewed for allergies being identified, action taken, allergies listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, Nursing Admission Assessment Form, care plan for allergies initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 142</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited for allergies being identified, any action taken to correct, allergies being listed on the MAR, Medication Allergy Sheet, Physician's Order Sheet, and Nursing Admission Assessment Form, a care plan for allergies being initiated, allergy sticker on chart, and allergies listed on the resident's face sheet.</p> <p>Review of the allergy stickers on the front of residents' medical records and review of medication allergy lists revealed they had been updated on 03/28/14.</p> <p>Review of an audit dated 03/28/14, conducted by the DON, ADONs, MDS Coordinator, Staff Development Coordinator, and Regional Nurse Consultant revealed medication allergies for all residents had been updated in the residents' chart. The audit was reviewed and no concerns were identified.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of residents' allergy stickers and Medication Allergy Sheets for all residents had been updated.</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	Continued From page 143 Review of an in-service roster and syllabus dated 03/28/14 provided by the DON, ADONs, SDC, and Regional Nurse Consultant for licensed nursing staff/KMAs regarding Abuse, Neglect, and Misappropriation of funds, Medication Administration-Medication Discrepancies, Care Plans, Admission Process, Clinical Meeting, and QAPI revealed the Admission Process included reviewing/referencing hospital discharge paperwork, specifically noting allergies and interviewing residents/family to ensure appropriate information was received. It was also noted that if any discrepancies were found the nurse must get clarification from the physician. Also noted under the Admission Process was the Medication Allergy Sheet that was required to be completed upon admission and compared against hospital discharge documentation to check for allergies. Interview with RN #7 on 04/03/14 at 2:33 PM revealed he reviewed resident allergies on discharge information from the hospital. If the resident was admitted from home, he would contact the resident's physician and family to verify drug allergies. He also indicated that he had been provided with an in-service by the facility on drug allergies last week to include making sure that the resident's drug allergies were listed on the allergy sticker on the front of the chart, on the face sheet, on the MARs, and MD orders. RN #7 also stated that he had taken a posttest after being educated and had to pass it before he was allowed to be on the floor working. A copy of the notice informing the licensed nursing staff that they must be educated and pass the posttest before they would be allowed to work was provided.	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	Continued From page 144 Review of audits conducted by the DON, ADONs, MDS Coordinator, SDC, or Regional Nurse Consultant, and which were reviewed daily by the Administrator, regarding checking all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list revealed this was being reviewed daily. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had assisted in the audit completed on 03/28/14 regarding review of all new physician's orders to ensure any new allergies were identified, to check for medication appropriateness, and comparison of new medications to the resident's allergy list. The staff stated this was being done daily and was reviewed daily by the Administrator. Review of a document titled "2013 Updated Care Conference Agenda" updated on 03/29/14 revealed that allergies would be reviewed during care plan conference. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed allergies would be discussed as part of the Care Conference Agenda and no Care Conference had	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	Continued From page 145 been done yet. Review of a medication pass audit completed by the DON, ADONs, SDC, and Regional Nurse Consultant for all nurses and KMAs working on 03/28/14 and the questionnaire to ensure nursing staff had knowledge regarding location of a resident's allergies prior to administering medication and without a significant medication error revealed all licensed nurses and KMAs been observed during medication administration and had a completed questionnaire. Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted medication audits for all nurses and KMAs working on 03/28/14, and had the employees complete a questionnaire regarding allergies and where to locate allergies prior to administering medications. The staff stated all nurses and KMAs had been observed during medication administration and had completed a questionnaire regarding allergies. Interviews conducted with RN #6 on 04/03/14 at 9:40 AM, RN #5 on 04/03/14 at 9:50 AM, LPN #4 on 04/03/14 at 10:00 AM, and LPN #1 on 04/03/14 at 10:05 AM, revealed they had all been observed during medication administration and had completed a questionnaire regarding allergies. Review of the audit sheets completed during the Daily Clinical Meeting revealed the facility had three residents who had been readmitted to the facility and all three residents' records had been reviewed for Medication Allergy Record and an	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 146 allergy sticker being on the chart.</p> <p>Review of all resident medical records on 04/03/14, revealed all residents had an allergy sticker on the front of the resident's medical record.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meetings and had assisted in the audits of residents who had been readmitted. The staff revealed they had audited the Medication Allergy Sheet and the allergy sticker being on the resident's chart.</p> <p>Review of documentation from the facility's pharmacy revealed the Pharmacy Consultants had completed a review of all residents' medical records to ensure all allergies had been identified and a copy sent to the pharmacy.</p> <p>Interview conducted with the Consultant Pharmacist on 04/02/14, at 4:35 PM, revealed the consulting pharmacy had completed an audit on all resident medical records in the facility on 03/29/14, to ensure residents' allergies were appropriately identified.</p> <p>Review of an audit of incident reports conducted on 03/29/14, by the DON, ADONs, SDC, or Regional Nurse Consultant to verify that no further significant medication errors had occurred revealed none had been identified by the facility.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM,</p>	F 520			

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 147</p> <p>ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the Regional Nurse Consultant on 04/03/14 at 2:45 PM, revealed they had conducted the audits on 03/29/14 of incident reports to verify that no further significant medication errors had occurred and none was identified.</p> <p>Review of documentation of incidents reviewed in the Daily Clinical Meeting to identify any allegations of abuse or neglect revealed the Administrator had documented he had reviewed them daily.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended the Daily Clinical Meeting and had reviewed all incidents or concerns to identify any allegations of abuse or neglect and there were none. The Administrator revealed he had reviewed the incidents daily.</p> <p>Review of a sign-in sheet verified that the Chief Operating Officer (COO) was present at the facility on 03/29/14, 03/30/14, 03/31/14, 04/01/14, and 04/02/14.</p> <p>Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was identified. The COO stated he was providing oversight to the facility and had reviewed audits and been present for facility meetings.</p> <p>Review of an in-service roster dated 03/28/14</p>	F 520			

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

PRINTED: 05/07/2014
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 _____	(X3) DATE SURVEY COMPLETED C 04/03/2014	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 148</p> <p>revealed the Administrator, DON, ADONS, SDC, Quality of Life Director, Social Services Director, Plant Operations Director, Chaplain, Medical Records Coordinator, Dietary Manager, and Admissions Director attended an in-service regarding the QAPI process; appropriate methods to identify significant medication errors; failure to report neglect; and auditing of pharmacy services. The in-service was provided by the Regional Nurse Consultant.</p> <p>Interview conducted with the Regional Nurse Consultant on 04/03/14, at 2:45 PM, revealed he had conducted an in-service on 03/28/14 regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services.</p> <p>Interview with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, and the MDS Coordinator on 04/03/14 at 2:35 PM, revealed they had attended an in-service regarding the QAPI process and appropriate methods of identification of significant medication errors, failure to report neglect, and auditing of pharmacy services.</p> <p>All audits were being reviewed by the Administrator, DON, COO, or Regional Nurse Consultant daily.</p> <p>Interview conducted with the Administrator on 04/03/14, at 2:55 PM, revealed he had reviewed the audits completed by the staff daily.</p> <p>Interview conducted with the COO on 04/03/14, at 3:00 PM, revealed he had been present at the facility daily since the Immediate Jeopardy was</p>	F 520		

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

PRINTED: 05/07/2014
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 _____		(X3) DATE SURVEY COMPLETED C 04/03/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501		
(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 520	<p>Continued From page 149</p> <p>identified. The COO stated he was providing oversight to the facility and had reviewed audits daily.</p> <p>Review of a QAPI meeting agenda dated 03/28/14, revealed the Medical Director was in attendance. The agenda revealed the committee addressed issues related to administering medications for which a resident had an allergy. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned.</p> <p>Interview conducted with ADON #1 on 04/03/14 at 1:40 PM, ADON #2 on 04/03/14 at 2:30 PM, the SDC on 04/03/14 at 2:40 PM, the MDS Coordinator on 04/03/14 at 2:35 PM, the Medical Director on 04/02/14 at 4:30 PM, the Regional Nurse Consultant on 04/03/14 at 2:45 PM, and the Administrator on 04/03/14 at 2:55 PM, revealed they had attended a QAPI meeting on 03/28/14, and issues were addressed regarding administering a medication to a resident with an allergy to the medication. The agenda also revealed the committee discussed ways to analyze and identify opportunities for quality improvement, provide oversight of quality, and compliance performance, and to identify and communicate best practices and lessons learned.</p>	F 520			