

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

PRINTED: 08/22/2012
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 08/08/2012
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY18872) was conducted on 08/07-08/12. The complaint was substantiated with deficient practice identified at 'D' level.	F 000		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility's investigation, and review of the facility's policy and employee written statements, it was determined the facility failed to ensure physical restraints were used to treat a medical symptom and not imposed for staff convenience for one of three sampled residents (Resident #1). On 07/29/12, Licensed Practical Nurse (LPN) #1 instructed State Registered Nursing Assistants (SRNAs) #4 and #5 to apply a gait belt to physically restrain Resident #1 to the wheelchair. On 07/31/12, SRNA #5 again applied a gait belt to physically restrain Resident #1 to the wheelchair. A review of documentation in the medical record of Resident #1 revealed there was not a documented medical reason for the use of the restraint. The findings include: A review of the facility's Gait Belt policy (revised March 2011) revealed each employee who	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>provided direct patient care should apply a gait belt snugly to the resident's waist when they assisted the resident with ambulation, transfer, or movement of residents. In addition, the policy revealed staff was to sign an agreement regarding the protocol for use of the gait belt. The policy stated employees would be oriented upon hire regarding the use of the gait belt and failure to comply with the facility policy would result in disciplinary action that could include termination.</p> <p>A review of the medical record for Resident #1 and a review of the facility's investigation initiated on 08/01/12, revealed on 07/29/12, Licensed Practical Nurse (LPN) #1 instructed State Registered Nursing Assistants (SRNAs) #4 and #5 to apply a gait belt to physically restrain Resident #1 to the wheelchair. On 07/31/12, SRNA #5 again applied a gait belt to physically restrain Resident #1 to the wheelchair. A review of documentation in the medical record of Resident #1 revealed there was not a documented medical reason for the use of the restraint and there was no assessment/physician's order for a seat belt restraint to be utilized.</p> <p>An interview conducted on 08/08/12, at 12:00 PM, with LPN #1 revealed Resident #1 became agitated and anxious on 07/29/12, at approximately 10:00 PM, and the resident was transferred from the bed to the wheelchair and brought to the nurses' station. LPN #1 stated while in the wheelchair at the nurses' station the resident continued to lean forward to pick imaginary items off the floor. The interview revealed the LPN was concerned Resident #1</p>	F 221		
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F 221	<p>Continued From page 2</p> <p>would fall out of the wheelchair due to the leaning behavior, and the LPN instructed the SRNAs to apply a gait belt around Resident #1's waist and the back of the wheelchair and to place the buckle at the back of the wheelchair. LPN #1 confirmed Resident #1 was not assessed for the use of a restraint, nor was a physician's order obtained for the use of a restraint. The LPN stated she did not consider utilizing a gait belt around a wheelchair back to be a restraint because the resident continued to be able to lean forward to pick imaginary items off the floor without falling.</p> <p>A review of LPN #1's employee file revealed the LPN had successfully completed a skills competency exam dated 06/02/12, related to the use of restraints. The competency exam revealed an interdisciplinary team should assess each restrained resident for the least restrictive restraint possible. In addition, the review of the competency exam revealed restraints were to be applied only upon proper physician's order that stated the type of restraint, the time the restraint was to be applied, the reason for the restraint, and release of restraint.</p> <p>An interview conducted on 08/08/12, at 1:00 PM, with SRNA #4 and a written statement obtained by the facility on 08/01/12, from SRNA #5 confirmed LPN #1 had requested them to apply a gait belt around Resident #1's waist and the back of the wheelchair and to place the buckle at the back of the wheelchair. SRNA #4 revealed Resident #1 had attempted to ambulate and LPN #1 said she did not want to fill out an incident report or have any more falls so the LPN instructed the SRNAs to apply the gait belt to</p>	F 221			

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F 221	<p>Continued From page 3</p> <p>prevent the resident from being able to get out of the wheelchair. SRNA #5's statement revealed on 07/31/12, at approximately 8:30 PM, Resident #1 was again constantly getting up out of the wheelchair, so she and SRNA #6 applied the gait belt around Resident #1's waist and the back of the wheelchair to prevent the resident from being able to get out of the wheelchair.</p> <p>Interviews conducted on 08/08/12, at 12:35 PM, with Occupational Therapy Assistant #1 and at 4:50 PM, with Physical Therapy Assistant (PTA) #1 revealed on 07/31/12, at approximately 8:35 PM, the therapist witnessed Resident #1 at the nurses' station in a wheelchair with a gait belt around the resident's waist and the back of the wheelchair, preventing the resident from being able to get out of the wheelchair. The therapist informed RN #1, who was unaware of Resident #1 being restrained, and immediately removed the gait belt and instructed the SRNAs that it was an improper use of a gait belt. The PTA notified the Therapy Supervisor immediately after the incident.</p> <p>An interview conducted on 08/08/12, at 1:45 PM, with the Director of Nursing (DON) revealed all nursing staff received training on the proper use of a gait belt and dealing with residents with behaviors and/or dementia at the time of employment and prior to their assignment to provide direct resident care.</p> <p>An interview conducted on 08/08/12, at 2:40 PM, with the Administrator revealed on 08/01/12, at approximately 8:45 AM, the Therapy Supervisor and the Nurse Manager notified him of the incident that occurred on 07/31/12, involving</p>	F 221		

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F 221	Continued From page 4 Resident #1. The interview revealed an investigation was immediately initiated, the appropriate state agencies and local police were notified of the allegation, and all staff involved was suspended pending the results of the investigation. The Administrator revealed while interviewing the staff involved he was informed of the incident on 07/29/12, and stated LPN #1 and SRNAs #5 and #6 were terminated from employment on 08/03/12. The interview revealed written statements were obtained from all other staff to ensure no other incidents of improper utilization of gait belts had occurred. In addition, the Administrator stated all staff received mandatory in-service education on proper gait belt use, restraints, resident rights, and the abuse policy. The Administrator revealed after he became aware of the incidents all residents were assessed for an increase or change in behaviors. According to the Administrator, all residents were also assessed for restraint use to ensure the appropriate restraint was utilized, that there was a current physician's order for the use of any restraints identified, that a signed consent for the use of the restraint had been obtained, and that staff had assessed the residents appropriately/accurately and had developed a care plan to address the use of the restraint.	F 221			