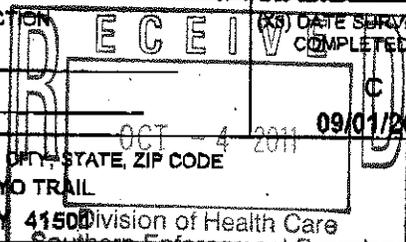


Second 50D

PRINTED: 09/29/2011
FORM APPROVED
OMB NO. 0938-0391

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

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 OCT - 4 2011 09/01/2011
--	--	--	--



NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41500
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY16587, KY16645, KY16875, KY17021) was initiated on 08/31/11 and concluded on 09/01/11. KY16587 and KY16875 were unsubstantiated with no deficiencies. KY16645 was substantiated with 'D' level deficiencies and KY17021 was substantiated with 'G' level deficiencies, with an opportunity to correct.</p> <p>F 157 SS=D 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in-room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p>	F 000	<p>Signature Health Care of Pikeville does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	
-------	--	-------	---	--

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Spencer Lee</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/3/11</i>
---	-------------------------------	-----------------------------

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

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

PRINTED: 09/29/2011
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 09/01/2011
--	---	--	---

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 157	<p>Continued From page 1</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, closed record review, and a review of facility policies, the facility failed to ensure staff notified the physician when there was a need to alter treatment due to a deterioration in condition for one of nine residents (Resident #1). Facility staff failed to notify Resident #1's physician when the resident failed to have a bowel movement for twenty- three consecutive shifts from 08/21-28/11.</p> <p>The findings include:</p> <p>A review of the facility's policy related to Bowel Care (dated 12/10) revealed the facility would monitor and track residents on a daily basis to determine the need for dietary and/or chemical intervention to treat chronic and/or acute episodes of constipation. The attending physician/designee will be notified of all residents that do not have a bowel movement within four days.</p> <p>A review of the closed medical record revealed the facility admitted Resident #1 on 03/31/10, with the following diagnoses: End Stage Renal Failure, Morbid Obesity, Diabetes, Osteoarthritis, Diabetic Neuropathy, and Anemia.</p> <p>A review of the Certified Nursing Aide Care Plan/Documentation of bowel documentation for</p>	F 157	<p>F157 483.10 (b) (11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>The facility will ensure that staff notifies physician when there is a need to alter treatment due to deterioration in condition for its residents.</p> <p>Resident(s) Affected: For resident #1, nursing staff has been inserviced on the importance of following our facility policy and procedure for notifying physicians whenever there is a change in condition. The inservice included adhering to our facility's bowel protocol. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord.</p> <p>Residents Potentially Affected: Residents of the facility who have not had a bowel movement within 4 days have the potential to be affected by the cited deficient practice. A 100% audit of bowel movements during the past 30 days was completed. Appropriate assessments were completed for any resident who had not had a bowel movement in excess of four (4) days. Physician(s) were notified and appropriate interventions were instituted.</p>	10/01/11
-------	--	-------	---	----------

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

PRINTED: 09/29/2011
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 09/01/2011
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 157	<p>Continued From page 2</p> <p>06/11 revealed Resident #1 had no bowel movement documented from 06/21-28/11.</p> <p>A review of the nurse's notes for Resident #1 dated 06/21-28/11, revealed no documentation that the bowel policy was implemented or that the resident's physician was notified that the resident had no bowel movement for 23 consecutive shifts from 06/21-28/11.</p> <p>An interview conducted with Certified Nurse Aides (CNAs) #10, #11, and #12 on 08/31/11, at 6:30 PM, 7:25 PM, and 7:40 PM, revealed resident bowel movements are documented each shift on the back of the Certified Nurse Aide Care Plan. The CNAs said Resident #1 had not had a bowel movement from 06/21-28/11. All three CNAs stated they had worked with Resident #1 during specific shifts between 06/21-28/11, and had informed the charge nurse during each shift they worked when the resident had no bowel movement.</p> <p>An interview with Registered Nurse (RN) #4 on 09/01/11, at 9:30 AM, revealed if there is no bowel movement on the activity daily living book log noted, the resident is given prune juice, and the physician is also notified if no bowel movement within four days. The RN verified there was no documentation of a bowel movement for Resident #1 from 06/21-28/11. RN #4 cared for Resident #1 on 06/24/11. RN #4 stated the facility bowel policy/protocol should have been implemented for Resident #1.</p> <p>An interview with RN #2 on 08/31/11, at 6:35 PM, revealed the CNA bowel form had no documentation that Resident #1 had a bowel</p>	F 157	<p>Systemic Measures: Nursing staff has been inserviced on the importance of following our facility policy and procedure for notifying physicians whenever there is a change in condition. The inservice included adhering to our facility's bowel protocol. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. A 100% audit of bowel movements during the past 30 days was completed. Appropriate assessments were completed for any resident who had not had a bowel movement in excess of four (4) days. Physician(s) were notified and appropriate interventions were instituted.</p> <p>Monitoring of Measures: Resident bowel movements are tracked and discussed by the IDT team during our clinical meetings Monday through Friday. Concerns specific to bowel movements are placed on the Whiteboard for immediate follow up. The results of the clinical meeting follow up will be discussed in the monthly QA meetings x 3 months.</p> <p>Completion date: Oct. 1, 2011</p> <p>10/01/11</p>

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

PRINTED: 09/29/2011
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 09/01/2011
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 157	Continued From page 3 movement from for 06/21-28/11. The RN stated the physician should have been notified prior to seven days and the requirement is for the nurse to look at the sheet daily and to check for bowel movement. This nurse verified caring for the resident (on 06/25/11 and 06/26/11) and not notifying the physician. An interview with the Assistant Director of Nursing (ADON) on the North Hall on 08/31/11, at 3:30 PM, revealed no documentation of a bowel movement or a verbal report from anyone that Resident #1 had not had a bowel movement from 06/21-28/11. The ADON further revealed the physician should have been notified that Resident #1 had not had a bowel movement in seven days. An interview with Resident #1's physician on 09/01/11, at 4:00 PM, revealed the physician was not notified of the possible need to alter treatment for Resident #1. The physician revealed he/she was not notified of resident #1 having no bowel movement from 06/21-28/11. The physician further revealed the resident was admitted to the hospital on 06/29/11, for previous diagnoses of End Stage Renal Failure and Diabetes.	F 157		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would	F 225		

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 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 225	<p>Continued From page 4</p> <p>indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and a review of policies, medical records, and the facility's investigation, it was determined the facility failed to ensure allegations of neglect were reported to the appropriate state agencies for one of nine sampled residents (Resident #9).</p> <p>The findings include:</p>	F 225	<p>F225 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility will ensure that allegations of neglect are reported to the appropriate state agencies.</p> <p>Resident(s) Affected: For resident #9, an inservice with staff was conducted on abuse, to include the appropriate timeframe for reporting any instance of alleged abuse and neglect. Additionally, an inservice was conducted with staff regarding following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord.</p> <p>Residents Potentially Affected: Residents of the facility have the potential to be affected by the cited deficient practice. An inservice with staff was conducted on abuse, to include the appropriate timeframe for reporting any instance of alleged abuse and neglect. Additionally, an inservice was conducted with staff regarding following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents/accidents were audited for the past 30 days to assure that no other residents were affected by the cited deficient practice.</p>	10/01/11
-------	---	-------	---	----------

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

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 225	<p>Continued From page 5</p> <p>A review of the facility's Abuse, Neglect, and Misappropriation policy (effective 12/10) revealed the charge nurse was to immediately notify the Administrator, the Director of Nursing (DON), and the Social Services Director when a report of alleged abuse, neglect, or misappropriation of resident property was received. The policy further revealed the Administrator/designated person was to make an immediate report to the local Department of Social Services, Office of the Inspector General, and other state designated agencies as required regarding the allegation. Continued review of the policy revealed the charge nurse would complete accident and incident reports and administrative staff would routinely monitor the reports for any indicators leading to suspected abuse, neglect, and misappropriation of property.</p> <p>A review of Resident #9's medical record revealed after an entry dated 08/30/11, at 10:30 AM, Registered Nurse (RN) #4 documented a "late" entry in the nursing notes for 08/26/11, at 6:30 PM. Based on documentation, staff called the nurse to Resident #9's room and was told when they (staff) attempted to transfer the resident they heard the resident's left arm "pop." According to the note the resident was not in any pain and was able to perform range of motion with the left arm. RN #4 noted a yellow discoloration on the inside of the resident's left upper arm. According to documentation by RN #4, the resident smiled at the nurse and was not "moaning, wincing, or crying." Documentation revealed RN #4 assessed Resident #9 and noted the resident was in bed, the head of the resident's bed was elevated, and the resident's respirations</p>	F 225	<p>Systemic Measures: An inservice with staff was conducted on abuse, to include the appropriate timeframe for reporting any instance of alleged abuse and neglect. Additionally, an inservice was conducted with staff with emphasis on following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents will be reviewed at morning meeting to help assure that incidents which are required to be reported to appropriate state agencies are reported within the required timeframe.</p> <p>Monitoring of Measures: Incidents will be tracked and trended in the monthly QA meetings x 3 months by the IDT team. This monitoring will include reportable incidents and the outcomes.</p> <p>Completion date: Oct. 1, 2011</p>	10/01/11
-------	---	-------	---	----------

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

PRINTED: 09/29/2011
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 09/01/2011
--	---	--	---

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 225	<p>Continued From page 6</p> <p>were unlabored. A review of the facility investigation, dated 08/31/11, revealed the facility did not contact any state agencies about the incident that occurred on 08/26/11, with Resident #9.</p> <p>An interview with RN #4 on 09/01/11, at 11:45 AM, confirmed CNA #3 reported that he thought Resident #9's arm was hurt. According to RN #4 the mechanical lift was at the foot of Resident #9's bed and the mechanical lift sling was under Resident #9 in the bed. According to RN #4 CNA #3 stated he heard a "pop" during the resident's transfer. RN #4 assessed Resident #9 and stated the resident did not appear to be in pain and there was no apparent injury. RN #4 stated staff continued to monitor Resident #9 throughout the rest of the shift and the resident exhibited no signs of pain or discomfort. According to RN #4, CNAs #3 and #4 did not report at that time that Resident #9 was transferred improperly. RN #4 stated, "I did not report the incident because there was no apparent injury to [Resident #9]." RN #4 stated the oncoming RN was informed of Resident #9's left arm verbally in report but RN #4 did not document any information in Resident #9's nursing notes or on the facility's 24-hour nursing report.</p> <p>An interview with CNAs #3 and #4 on 08/31/11, at 5:40 PM and 6:35 PM, revealed the CNAs transferred Resident #9 without a lift and during the transfer from the geri-chair to the bed the CNAs heard the resident's left arm "pop." CNA #3 reported the incident to RN #4 and the RN evaluated Resident #9. According to CNAs #3 and #4, Resident #9 had no injuries and did not exhibit any signs or symptoms of pain or</p>	F 225		
-------	---	-------	--	--

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/29/2011
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 09/01/2011
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 225	<p>Continued From page 7 discomfort.</p> <p>An interview with Licensed Practical Nurse (LPN) #4 on 08/31/11, at 5:00 PM, revealed she assessed Resident #9 to exhibit pain in the left arm and crying on 08/27/11, at approximately 8:50 AM. According to interview, the resident's physician was notified of the resident's condition, and Resident #9 was sent to the local Emergency Department by ambulance. LPN #4 stated the DON was notified of the resident's condition, and the CNAs that were present and worked the previous shift were asked to write statements regarding Resident #9.</p> <p>An interview with the DON on 09/01/11, at 3:00 PM, revealed the DON was called at home on 08/27/11, by LPN #4 and was notified of Resident #9's complaint of pain in the left arm and that the resident was sent to the Emergency Department. According to the DON, she was notified by LPN #4 that Resident #9 had a humeral neck fracture of the left arm. The DON requested all staff that provided care to Resident #9 to be interviewed and came to the facility to assist with the investigation. The DON confirmed that the stage agency was not notified of the resident's injury, and stated that she looked at the incident as "an accident." According to the DON, RN #4 made a late entry in the nursing notes on 08/26/11, regarding an assessment that was conducted of Resident #9 on 08/26/11, and stated an incident report was not completed.</p> <p>An interview with the Administrator on 09/01/11, at 3:30 PM, revealed the Administrator became aware of the incident with Resident #9 at 4:45 PM on 08/27/11. According to the Administrator, after</p>	F 225			

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

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 225 F 282 SS=G	<p>Continued From page 8 a discussion with the facility's home office a decision was made that the incident did not need to be reported to the appropriate state agencies.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation, it was determined the facility failed to provide services to one of nine sampled residents (Resident #9) in accordance with the resident's written plan of care. Based on the facility's assessment, Resident #9 required the assistance of two staff persons and a mechanical lift for all transfers. On 08/26/11, at 6:30 PM, two CNAs transferred Resident #9 without the use of a mechanical lift and during the process heard Resident #9's left arm "pop." Resident #9 was assessed on 08/26/11, to be pain free. However, on 08/27/11, at 8:50 AM, Resident #9 was assessed to be in pain, was sent to the local Emergency Room for evaluation, and was diagnosed with a Left Humeral Neck (upper arm/shoulder) Fracture.</p> <p>The findings include: The facility was asked to provide a care plan policy but no facility policy related to resident care plans was presented.</p>	F 225 F 282	<p>F282 483.20 (k) (3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The facility will provide services by qualified persons in accordance with each resident's care plan.</p> <p>Resident(s) Affected: For resident #9, an inservice was conducted with staff regarding following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord.</p> <p>Residents Potentially Affected: Residents of the facility have the potential to be affected by the cited deficient practice. An inservice was conducted with staff regarding the importance of following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents/accidents were audited for the past 30 days to assure that no other residents were affected by the cited deficient practice.</p> <p>Systemic Measures: An inservice was conducted with staff with emphasis on the importance of following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents will be reviewed at morning meeting to help assure that care plans have been followed in the provision of resident care.</p>	10/01/11

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

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 282	<p>Continued From page 9</p> <p>A review of the medical record for Resident #9 revealed the facility admitted the resident on 10/23/98, with diagnoses that included Mental Retardation, Cerebral Palsy, and Contracture to left elbow/wrist and both lower extremities.</p> <p>A review of the Nurse Aide Care Plan dated 07/11 revealed the facility staff had assessed Resident #9 to require the assistance of two staff persons and a mechanical lift for safe transfers.</p> <p>A review of the Annual Minimum Data Set (MDS) dated 08/04/11, revealed facility staff had assessed Resident #9 to require extensive assistance of two staff persons with the use of a mechanical lift for all transfers. Resident #9 was assessed to be cognitively impaired.</p> <p>A review of Resident #9's individual care plan dated 08/04/11, revealed facility staff assessed Resident #9 to have physical mobility impairment with transfers from a bed to a chair. A review of care plan interventions revealed staff was required to utilize a mechanical lift for transfers due to the resident's limited range of motion and cognitive deficit. The care plan also indicated staff was to provide the appropriate level of assistance to promote safety for the resident. In addition, on 08/26/11, at 6:30 PM, two CNAs transferred Resident #9 without the use of a mechanical lift and during the process heard Resident #9's left arm "pop," and although the resident was assessed to be pain free at that time the resident exhibited pain on 08/27/11, was sent to the Emergency Department, and diagnosed with a Fracture of the Left Humeral Neck. Facility staff modified the resident's care plan to reflect the resident's pain and staff obtained a</p>	F 282	<p>Monitoring of Measures:</p> <p>Incidents will be tracked and trended in the monthly QA meetings x 3 months by the IDT team. This monitoring will include adherence to care plans in the provision of resident care.</p> <p>Completion date: Oct. 1, 2011</p>	10/01/11
-------	--	-------	--	----------

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 280 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 282	<p>Continued From page 10</p> <p>physician's order for pain medication to be administered for pain as needed.</p> <p>Observation of Resident #9 on 08/31/11, at 3:45 PM and 4:30 PM, revealed the resident was in bed and the resident's left arm was observed to be in a sling. Resident #9 was smiling and did not appear to be in pain. Observation of Resident #9 on 09/01/11, at 11:00 AM, revealed the resident was sitting in a geri-chair in the dining room, smiling, and the resident's left arm was observed in a sling. No signs and symptoms of pain were observed.</p> <p>An interview with Resident #9 was not attempted due to the resident's cognitive status.</p> <p>An interview with CNA #3 on 08/31/11, at 5:40 PM, and with CNA #4 on 08/31/11, at 6:35 PM, revealed the CNAs assisted Resident #9 into bed from a geri-chair on 08/26/11. The CNAs indicated they transferred the resident without the use of a mechanical lift. CNA #3 stated during the manual lift a "popping" sound was heard from Resident #9's left arm. The CNAs stated the CNA care plan contained information related to the resident's care and they were aware two staff persons and a mechanical lift was to be used to safely transfer Resident #9 and stated they made the decision to transfer without the mechanical lift.</p> <p>A review of the facility's investigation dated 08/31/11, revealed two Certified Nursing Assistants (CNAs) transferred Resident #9 on 08/26/11, at 6:30 PM, and heard the resident's left arm "pop." The CNAs immediately reported the incident to the RN supervisor who assessed</p>	F 282		
-------	---	-------	--	--

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

PRINTED: 09/29/2011
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 09/01/2011
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 282	Continued From page 11 Resident #9. The investigation further revealed the resident did not exhibit any signs of pain or distress until 08/27/11, at 8:50 AM (approximately 14 hours after the transfer), at which time staff observed the resident cry when staff touched the resident's left arm. On 08/27/11, Resident #9 was sent to the Emergency Room for evaluation and x-ray of the left arm. Emergency Room reports revealed the resident was diagnosed with a Fracture of the Left Humeral Neck. A review of the witness statements from CNAs #3 and #4, dated 08/27/11 and 08/28/11, revealed the CNAs transferred Resident #9 without the use of a mechanical lift. An interview with the Director of Nursing (DON) on 09/01/11, at 3:00 PM, revealed the investigation into Resident #9's injury determined that CNAs #3 and #4 transferred Resident #9 improperly. Based on interview, both CNAs were terminated from the facility as a result of not following the plan of care for Resident #9.	F 282	F 309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING The facility will provide necessary care and services to attain the highest practicable physical, mental and psychosocial well-being for our residents. Resident(s) Affected: For resident #1, nursing staff has been inserviced on the importance of following our facility policy and procedure for notifying physicians whenever there is a change in condition. The inservice included adhering to our facility's bowel protocol. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Residents Potentially Affected: Residents of the facility who have not had a bowel movement within 4 days have the potential to be affected by the cited deficient practice. A 100% audit of bowel movements during the past 30 days was completed. Appropriate assessments were completed for any resident who had not had a bowel movement in excess of four (4) days. Physician(s) were notified and appropriate interventions were instituted.	10/01/11
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interviews, closed record review, and policy review, the facility failed to provide the	F 309		

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

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 309	<p>Continued From page 12</p> <p>necessary care and services to attain or maintain the highest, practicable physical, mental, and psychosocial-well being for one of nine sampled residents (Resident #1). A review of the bowel elimination record revealed a bowel movement was not recorded for Resident #1 from 6/21-28/11. However, there was no evidence the facility followed established protocols to promote regular bowel elimination for Resident #1.</p> <p>The findings include:</p> <p>A review of the facility's policy related to Bowel Care (dated 12/10) revealed the facility would monitor and track residents on a daily basis to determine the need for dietary and/or chemical intervention to treat chronic and/or acute episodes of constipation. Suggested interventions would include:</p> <p>A) If the resident had no bowel movement for three days the resident would receive additional high fiber drink and/or food supplement, such as four ounces of prune juice or comparable substitute.</p> <p>B) If the resident had no bowel movement for three days the resident would receive on the evening shift a designated laxative, and if no bowel movement by the following morning the resident would receive a suppository after breakfast; if no bowel movement by the evening of the fourth day the resident would be given a Fleets enema.</p> <p>1) The Certified Nurse's Assistant (CNA) will record all bowel movements on the CNA assignment sheet or facility specified form.</p>	F 309	<p>Systemic Measures:</p> <p>Nursing staff has been inserviced on the importance of following our facility policy and procedure for notifying physicians whenever there is a change in condition. The inservice included adhering to our facility's bowel protocol. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. A 100% audit of bowel movements during the past 30 days was completed. Appropriate assessments were completed for any resident who had not had a bowel movement in excess of four (4) days. Physician(s) were notified and appropriate interventions were instituted.</p> <p>Monitoring of Measures:</p> <p>Resident bowel movements are tracked and discussed by the IDT team during our clinical meetings Monday through Friday. Concerns specific to bowel movements are placed on the Whiteboard for immediate follow up. The results of the clinical meeting follow up will be discussed in the monthly QA meetings x 3 months.</p> <p>Completion date: Oct. 1, 2011</p>	10/01/11
-------	--	-------	--	----------

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/29/2011
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 09/01/2011
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 309	<p>Continued From page 13</p> <p>2) The assignment sheet will be turned in to the charge nurse at the end of the shift. The Charge Nurse designated staff person will then record the bowel movements on the resident bowel movement record located on the medication administration sheet.</p> <p>3) Bowel movements will be recorded with amount and consistency.</p> <p>4) Each charge nurse is responsible at the beginning of their shift to identify residents that have not had a bowel movement in more than 48 hours and implement the appropriate regimen for that resident.</p> <p>5) Medical interventions will be documented on the medication administration record.</p> <p>6) Utilize bowel record.</p> <p>7) The attending physician will be notified of all residents that do not have a bowel movement within four days.</p> <p>8) The Dietary Department will ensure that all residents are assessed for constipation and provided needed dietary interventions and hydration to prevent reoccurrence.</p> <p>9) The resident's care plan will be revised to indicate all appropriate interventions as indicated.</p> <p>A review of the closed medical record revealed Resident #1 was admitted to the facility on 03/31/10, with the following diagnoses: End Stage Renal Failure, Cerebral Vascular Accident, Morbid Obesity, Diabetes, Osteoarthritis, Diabetic Neuropathy, Restless Leg Syndrome, and Anemia.</p> <p>Review of the Certified Nursing Aide Care Plan revealed no documentation that Resident #1 had a bowel movement from 06/21-28/11.</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/29/2011
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 09/01/2011
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 309	<p>Continued From page 14</p> <p>A review of the nurse's notes for Resident #1 for 8/21-28/11, revealed no documentation/evidence facility staff had identified the lack of bowel movement for Resident #1 during this timeframe. Further review of the nurse's notes revealed no evidence facility staff had implemented the facility bowel regimen when Resident #1 had no bowel movement from 06/21-28/11 (23 consecutive shifts).</p> <p>An interview on 8/31/11, at 6:30 PM, with CNA #10 revealed bowel movements are documented on the back of the Certified Nurse Aide Care Plan during each shift. According to CNA #10, Resident #1 had not had a bowel movement from 6/21-28/11. The CNA said she had worked with Resident #1 on specific shifts between 06/21-28/11, and had reported to the nurse during each shift when Resident #1 did not have a bowel movement. CNA #10 further revealed that Resident #1's bowel movements were always recorded because the resident experienced incontinence episodes and required assistance with cleaning.</p> <p>Interviews with CNA #11 on 8/31/11, at 7:25 PM, and with CNA #12 at 7:40 PM, revealed each CNA worked with Resident #1 on specific shifts from 06/21-28/11, and reported to the charge nurse during each shift when Resident #1 did not have a bowel movement. CNA #12 stated the charge nurse is always notified if a resident does not have a bowel movement daily.</p> <p>An interview with Registered Nurse (RN) #4 on 09/01/11, at 9:30 AM, revealed Resident #1 complained of leg and back pain and a resident who received pain medication should have a care</p>	F 309			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 09/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165094	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/01/2011
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 309	<p>Continued From page 15</p> <p>plan for a bowel regimen. The RN further revealed when the physician is notified due to a resident having no bowel movement, the physician's order is sent to the nurse who completes the resident's care plans. The care plan is then updated.</p> <p>An interview with the nurse responsible for care plans on 09/01/11, at 10:30 AM, revealed the care plan is updated when an order is received from the physician and no order was received from the physician for Resident #1 between 06/21-28/11, related to the lack of bowel movements.</p> <p>An interview with Registered Nurse (RN) #2 on 8/31/11, at 6:35 PM, revealed after reviewing the CNA care plan documentation for 06/11 that Resident #1 had no bowel movement from 6/21-28/11. The RN voiced interventions should have been implemented for the resident and the physician should have been notified prior to seven days. RN #2 stated the requirement is for the nurse to review the CNA documentation daily to determine if each resident has a bowel movement.</p> <p>An interview with the Assistant Director of Nursing (ADON) on the North Hall on 8/31/11, at 3:30 PM, revealed it is the CNA's responsibility to document resident bowel movements and notify the nurse. The nurse is to notify the ADON, who takes this information to the morning meeting where a list is made related to the lack of bowel movements, and this list is given to the direct care nurse for implementation of appropriate bowel care interventions. The nurse is to notify the physician of changes and the new orders are</p>	F 309		

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

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 309	Continued From page 16 presented in the morning meetings and then passed on to the nurse who is responsible to update resident care plans. The ADON stated he/she had not received a verbal report from staff regarding Resident #1's lack of bowel movements from 6/21-28/11. In addition, the ADON stated there was no documented evidence the bowel regimen policy was implemented related to resident #1's lack of bowel movements between 06/21-28/11.	F 309	F323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility will provide the appropriate assistive devices to prevent an avoidable accident for residents. Resident(s) Affected: For resident #9, an inservice was conducted with staff regarding following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord.	10/01/11
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigation, it was determined the facility failed to provide the appropriate assistive devices to prevent an avoidable accident for one of nine sampled residents (Resident #9). Resident #9 was diagnosed with Mental Retardation, Cerebral Palsy, and Contractures of the left arm and lower extremities, and utilized a	F 323	Residents Potentially Affected: Residents of the facility have the potential to be affected by the cited deficient practice. An inservice was conducted with staff regarding the importance of following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents/accidents were audited for the past 30 days to assure that no other residents were affected by the cited deficient practice. Systemic Measures: An inservice was conducted with staff with emphasis on the importance of following the care plan for each resident related to our lift policy. Inservices began on 9/8/2011 and were completed on 9/14/2011. These were conducted by our Staff Development Coord and Regional Clinical Coord. Incidents will be reviewed at morning meeting to help assure that care plans have been followed in the provision of resident care.	

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

PRINTED: 09/29/2011
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 09/01/2011
--	---	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 280 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 323	<p>Continued From page 17</p> <p>mechanical lift with the assistance of two staff persons for safe transfers. During a transfer from Resident #9's geri-chair on 08/26/11, at 6:30 PM, staff did not utilize the mechanical lift which resulted in Resident #9's left arm "popping." Resident #9 remained pain free until 08/27/11, at 8:50 AM, when the resident was assessed to be in pain and was transported to the Emergency Room for evaluation and x-rays. Resident #9 returned to the facility on 08/27/11, with a diagnosis of a Left Humeral Neck (upper arm/shoulder) Fracture.</p> <p>The findings include:</p> <p>The Administrator was asked for a policy related to assistive devices but no policy was received.</p> <p>A review of the medical record for Resident #9 revealed the facility admitted the resident on 10/23/98, with diagnoses of Mental Retardation, Cerebral Palsy, and Contracture to left elbow/wrist and both lower extremities.</p> <p>Facility staff developed a Nurse Aide Care Plan in 07/11 and had assessed Resident #9 to require the assistance of two staff persons with use of a mechanical lift for safe transfers.</p> <p>A review of the Annual Minimum data Set (MDS) dated 08/04/11, revealed the facility staff had assessed Resident #9 to require extensive assistance of two staff persons with a mechanical lift for all transfers. Resident #9 was assessed to be cognitively impaired and therefore an interview was not conducted.</p> <p>A review of Resident #9's individual care plan</p>	F 323	<p>Monitoring of Measures:</p> <p>Incidents will be tracked and trended in the monthly QA meetings x 3 months by the IDT team. This monitoring will include adherence to care plans in the provision of resident care.</p> <p>Completion date: Oct. 1, 2011</p>	10/01/11
-------	--	-------	---	----------

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

PRINTED: 09/29/2011
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 09/01/2011
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 280 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 323	<p>Continued From page 18</p> <p>dated 08/04/11, revealed the facility staff assessed Resident #9 to have physical mobility impairment with transfers from bed to chair and required a mechanical lift related to limited range of motion and cognitive deficit. A review of the interventions revealed staff was required to utilize a mechanical lift for transfers with the assistance of two staff persons. The care plan was modified after the resident experienced a fall and sustained a Left Humeral Neck Fracture to include pain management. A review of the physician's orders dated 08/27/11, revealed Lortab 5/325 mg was prescribed every six hours for pain as needed.</p> <p>Observations were conducted of Resident #9 on 08/31/11, at 3:45 PM and 4:30 PM, and on 09/01/11, at 11:00 AM. The observations revealed the resident's left arm was in a sling and the resident did not appear to be in pain. The resident was in bed on the right side with the left arm in a sling. Resident #9 was smiling and did not exhibit signs and symptoms of pain. Observation of Resident #9 on 09/01/11, at 9:00 AM, revealed the resident was upset and trying to pinch and hit staff when staff was attempting to assist the resident to change positions. According to the staff, that was usual behavior for Resident #9, and the staff left the room so Resident #9 could calm down. Further observation of Resident #9 at 11:00 AM, revealed the resident was up in a geri-chair in the dining room with a fly swatter, watching television and smiling; the resident's left arm was in a sling. No signs and symptoms of pain were observed.</p> <p>Based on a review of the facility's investigation dated 08/31/11, on 08/26/11, Resident #9 was</p>	F 323		

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 250 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 323	<p>Continued From page 19</p> <p>transferred by two CNAs without the use of a mechanical lift, resulting in the resident's left arm "popping." On 08/27/11, Resident #9 was sent to the Emergency Room for evaluation of pain to the left arm and for x-rays. Resident #9 returned to the facility on 08/27/11, with a diagnosis of a Left Humeral Neck Fracture. A review of the witness statements from CNAs #3 and #4, dated 08/27/11 and 08/28/11, revealed the CNAs had transferred Resident #9 without the use of a mechanical lift.</p> <p>Interviews with CNA #3 on 08/31/11, at 5:40 PM, and with CNA #4 on 08/31/11, at 6:35 PM, revealed the CNAs assisted Resident #9 into bed from the gerl-chair manually, without the use of a mechanical lift. Both CNAs stated a lift was available, but the lift was on the other unit and they chose not to get the lift. CNA #3 stated during the manual lift a "popping" sound was heard from Resident #9's left arm. The CNAs immediately reported the incident to the Registered Nurse (RN) supervisor and Resident #9 was assessed. CNAs #3 and #4 stated the CNA care plan contained information regarding how to safely transfer Resident #9 and both CNAs verbalized they knew the resident required two staff persons with a mechanical lift for transfers. Interview revealed CNAs #3 and #4 made the decision to transfer Resident #9 without the mechanical lift.</p> <p>An interview with the Director of Nursing (DON) on 09/01/11, at 3:00 PM, revealed staff was instructed to utilize the CNA care plans to determine how to safely transfer residents. The DON further stated staff was to utilize any assistive device that residents were assessed to require, even if that meant staff was to go find the</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 09/29/2011
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 09/01/2011
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 280 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 323	Continued From page 20 assistive device. The DON further stated that the Assistant Director of Nurses (ADON) monitored CNAs weekly to assure equipment and assistive devices were being utilized as ordered for each resident and had not identified any problems.	F 323		
-------	---	-------	--	--