

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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F 514	<p>Continued From page 129</p> <p>drainage, and no odor. Review of the facility's Wound Evaluation Flow Sheet dated 09/28/12, revealed the wound to Resident #1's toe measured 1.4 cm x 0.2 x 0.1 cm. However, there was no documented evidence the physician was notified of the increase in size of the wound. Review of Resident #1's Treatment Administration Record (TAR) for September and October 2012, revealed staff documented the resident's toe was cleansed with Normal Saline and treated with Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) every forty-eight hours from 09/28/12 through 10/16/12. The TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12 and on 10/14/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12, and on 10/16/12. However, review of Resident #1's medical record revealed no evidence the resident's wound to the toe was assessed at least weekly as required by the facility's policy and the according to professional standards from 09/28/12 until 10/17/12, for a nineteen day period.</p> <p>Review of Resident #1's nurse's notes dated 10/17/12, at 2:50 PM by LPN #3 revealed the area to the resident's left great toe had an odor and drainage, the physician was notified, and new orders were obtained. A nurse's note dated 10/18/12 at 10:30 AM by LPN #1 revealed Resident #1's family member insisted on observing the resident's toe. LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing to reveal the toe was red and inflamed with a necrotic area, yellow sloughing, and a foul odor. Further review revealed the</p>	F 514	<p>LPN #3 was reprimanded and placed on probation for failure to assess and document the wound of resident #1 by Mary Arms, DON on 10/20/12.</p> <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p>	

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F 514	<p>Continued From page 130 resident was transported to an acute care facility on 10/18/12 at 3:15 PM.</p> <p>Review of Resident #1's Surgical Report dated 10/20/12, revealed the resident's left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview on 10/25/12, at 1:00 PM with the Minimum Data Set (MDS) Assistant revealed on 10/15/12, she conducted a head to toe assessment on Resident #1 during the completion of the resident's Discharge MDS assessment. The interview revealed the resident's wound to the left great toe was moist, with black necrotic tissue, brown purulent drainage, a foul odor, and redness to the first joint of the toe. The MDS Assistant stated she reported the findings to LPN #1, who was responsible for the resident's care, and assumed the LPN would assess the resident's wound and call the resident's physician. However, a review of Resident #1's medical record revealed no evidence the resident's wound was assessed until 10/17/12.</p> <p>An interview on 10/24/12, at 4:30 PM with LPN #1 and on 10/24/12, at 12:50 PM with LPN #3 revealed wounds were required to be assessed during every wound care for changes and every Friday the assessment was documented on a Wound Flow Sheet. LPN #1 and #3 were not able to explain why there was no documentation that Resident #1's wound was assessed for the first two (2) weeks of October, even though they had provided the wound care to Resident #1's toe every forty-eight (48) hours, according to the TAR. LPN #1 stated that the reason nothing was</p>	F 514	<p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the form. See Attachment #13</p> <p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1)</p>		

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F 514	<p>Continued From page 131</p> <p>documented might have been that staff was too busy.</p> <p>An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician revealed the physician expected the nurses to assess the resident's wounds while performing wound care.</p> <p>Interviews on 10/23/12, at 6:15 PM with the Administrator and the Director of Nursing (DON) revealed the nurse assigned to the resident on Friday of each week was required to assess residents' wounds unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed staff was required to assess the wound, including measurements, and document the assessment on the Wound Evaluation Flow Sheet. The interview revealed they were not aware Resident #1's wound to the toe had not been assessed at least weekly until the resident's son requested to see the resident's wound and the resident was transferred to the hospital.</p> <p>Interview on 10/24/12, at 7:30 PM with Registered Nurse (RN) #2 revealed all nurses were trained upon hire to assess and document all wounds on every Friday or the closes treatment day to Friday.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 10/31/11, with diagnoses of left buttock ulcer, sacral ulcer, Anemia, Peripheral Vascular Disease and Diabetes. Resident #2's medical</p>	F 514	<p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p> <p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that</p>		

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F 514	<p>Continued From page 132</p> <p>record revealed the resident was readmitted from an acute care facility on 08/06/12 with a pressure ulcer to the left buttock and blisters to both heels. The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 and the wound to the left buttock measured 3 cm x 3.5 cm x four cm, the left heel wound measured 5 cm x 5 cm, and the right heel wound measured 5 cm x 5 cm. On 08/19/12, the left heel measured 6.1 cm x 8.6 cm x UTD, the right heel had no measurements and the left buttocks measured 3 cm x 3.4 cm x 5 cm.</p> <p>Review of the Wound Evaluation Flow Sheet revealed the next assessment was on 09/07/12 (4 weeks later) the left buttock measured 3 cm x 3 cm x UTD. There was no evidence the resident's heels were assessed.</p> <p>Further review of the Wound Evaluation Flow Sheets revealed on 09/14/12, (5 weeks later) the left heels measured 2 cm x 2 cm and the right heel measured 2.5 cm x 1 cm. Physical Therapy was providing treatment to Resident #2's buttock, which was assessed by Physical Therapy. Review of the Wound Evaluation Flow Sheet revealed the next measurement for the left heel was not until a facility wide skin sweep was conducted on 10/21/12 (four weeks later), which measured the wound to be 3 cm x 1.8 cm.</p> <p>Observation on 10/23/12, at 3:40 PM, of Resident #2's wound care with LPN #2 revealed the left heel had a dark, dry, scabbed area with redness and a small amount of swelling around the wound. The wound measured 3 cm x 1.5 cm with no drainage or odor. The observation revealed the right heel had no wound and the resident's</p>	F 514	<p>documentation is being completed as part of CQL</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk</p>		

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F 514	<p>Continued From page 133</p> <p>buttocks had a wound vacuum with an occlusive dressing.</p> <p>Interview on 10/23/12, at 7:30 PM, with Registered Nurse (RN) #2, revealed she was unsure why nurses had failed to document weekly wounds assessments for Resident #2.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12, with multiple Pressure Ulcers.</p> <p>Review of Resident #3's Wound Evaluation Flow Sheet revealed on 10/04/12, the resident had an area to a bunion on the left foot that measured 0.6 cm x 0.4 cm x unable to determine (UTD) the depth, an area to the left outer ankle with measurements of 0.4 cm x 0.4 cm x UTD, an area to the left heel that measured 1.7 cm x 2.3 cm x UTD, a Stage II to the coccyx with measurements of 3 cm x 3 cm x 0.2 cm, and an area to the right heel with no measurements.</p> <p>Further review of Resident #3's Wound Evaluation Flow Sheet revealed no other assessments of the wounds until the facility conducted a facility wide skin sweep during the weekend of 10/19-20/12. The flow sheet revealed on 10/20/12, the bunion to the resident's left foot measured slightly larger at 0.6 cm x 0.5 cm x UTD, the area to the left outer ankle measured slightly larger at 0.4 cm x 0.5 cm x UTD, the area to the left heel measured the same, the Stage II to the coccyx measured larger at 7 cm x 3.5 cm x UTD, the area to the right heel measured 3.4 cm x 4.1 cm x UTD and the area to the left third toe measuring 0.6 cm x 0.8 cm x UTD.</p>	F 514	<p>medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p>	

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F 514	Continued From page 134 Review of Resident #3's TARs for October 2012, revealed LPN #1 provided the resident's treatments on 10/04/12, 10/05/12, 10/09/12, 10/10/12, 10/14/12, 10/15/12 and on 10/18/12. The TAR further reviewed LPN #3 provided the resident's treatments on 10/06/12, 10/07/12, 10/08/12, 10/11/12, 10/12/12, 10/16/12, and on 10/17/12. According to the TAR, LPN #7 provided the resident's treatment on 10/13/12. Observation on 10/30/12, at 3:00 PM of Resident #3's wound care with LPN #3 revealed the area to the coccyx had red tissue surrounding the open wound which measured 8.3 cm x 6.2 cm, the opened wound measured 5.4 cm x 4.7 cm x 0.5 cm. The coccyx wound was pink with yellow/white sloughing noted. The right inner ankle was slightly red with no open wounds. The right heel was boggy and dark measuring 2.2 cm x 3.4 cm. The left outer ankle was yellow with a slight amount of yellow drainage noted on the old dressing and measured 1.2 cm x 1 cm x 0.1 cm. The left heel had a dark area that measured 1.5 cm x 1.2 cm. The bunion to the outer side of the left foot was dark and measured 0.4 cm x 0.4 cm and the third toe on the left foot had black edge on a dark area that measured 0.4 cm x 0.8 cm. Interviews on 10/24/12, at 12:50 PM with LPN #3, at 4:30 PM with LPN #1 and on 10/30/12, at 6:17 PM with LPN #7, revealed all wounds were to be assessed and documented once a week every Friday on the Wound Evaluation Flow Sheet. The LPNs were unable to explain why there were no weekly wound assessments of Resident #3's wounds documented once a week even though the LPNs had provided the resident's treatments.	F 514	The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12 A list of the current medications for all residents was obtained from pharmacy and compared to the electronic MAR of each resident to ensure that all medication orders were transcribed correctly. This was completed on 11/24/12 by Mary Arms, DON, Christy Moore, RN, Anna Caldwell, ADON and Chantry Purcell, LPN. 4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family. On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.	

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F 514	Continued From page 135 4. Review of the medical record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included Previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension, and Nonpsychotic Disorder. A review of Resident #14's care plan revealed facility staff revised the care plan on 05/04/12, with additional interventions to include the following: 1) for staff to cleanse area to the left lateral ankle with normal saline, apply Santyl ointment (an active enzymatic therapy that removes necrotic tissue from wounds), apply a 4 x 4 gauze and wrap with "Kling" (a roll of gauze bandage) every day, and 2) for staff to cleanse the resident's bilateral breast folds with soap and water, dry the area, and apply Nystatin powder (a prescription anti-fungal medication used to treat fungal infections) twice a day. The care plan also stated nursing would complete a skin assessment every week and report any alterations to the physician. Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #14's wound measurements on 05/18/12, as "1.5 cm x 1.5 cm x 0.0 cm," and on 06/01/12 (fourteen days after the previous assessment) as "1.0 cm x 1.2 x 0:0 cm" then weekly for the next three weeks until 06/29/12. However, there were no other measurements documented on the flow sheet from 06/29/12, until 07/27/12, (a timeframe of twenty-eight days). Review of the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a	F 514	The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4 A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries and she is an RN with 19 years experience working in Quality Assurance. The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator or the person completing the audit. See Attachment #17 A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family	

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F 514	<p>Continued From page 136</p> <p>wound and at least weekly from the date of identification. However, based on documentation, the staff failed to conduct a wound assessment for weeks of 05/21/12, 07/02/12, 07/09/12, and 07/16/12.</p> <p>5. A review of Resident #5's medical record revealed the facility admitted the resident on 01/14/12, with diagnosis of Cerebral Vascular Accident, Congestive Heart Failure, Depression, and Failure to Thrive.</p> <p>Continued review of Resident #5's medical record revealed nurse's noted dated 09/05/12 that revealed the resident's physician was notified the resident had a Stage II pressure ulcer to the coccyx. Treatment orders were obtained to cleanse the coccyx with normal saline, pat dry, apply Aquacel AG then a 4 x 4 gauze, and secure with Hypafix every seventy-two (72) hours. However, there was no documentation of the appearance or size of the pressure wound.</p> <p>Review of Resident #5's care plan revealed facility staff revised the care plan on 09/05/12, and included the additional interventions for staff to cleanse the area to the resident's coccyx with normal saline, pat dry and apply Aquacel AG, then a 4 x 4 gauze and cover with Hypafix every seventy-two (72) hours.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff failed to document the status of Resident #5's pressure ulcer until 09/14/12 (eighteen days after first identified), when the ulcer measured "1.4 cm x 1.0 cm x 0.2 cm. Review of instructions on the Wound Evaluation Flow Sheet, the sheet was to be</p>	F 514	<p>notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment #19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p>		

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F 514	<p>Continued From page 137</p> <p>completed by a nurse upon identification of a wound and at least weekly from the date of identification. Based on a review of documentation on the Wound Evaluation Flow Sheet, staff failed to conduct a wound assessment for weeks of 08/26/12 and 09/02/12.</p> <p>A review of a Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse Resident #5's coccyx pressure ulcer with normal saline, pat dry, cover with Aquacel AG and a 4 x 4 gauze, and then secure with Hypafix the treatment was to be performed every seventy-two (72) hours. The TAR revealed wound care was performed as ordered by the physician; however failed to document an assessment weekly.</p> <p>6. A review of Resident #8's medical record revealed the facility admitted the resident on 09/21/10, with diagnosis of Chronic Ischemic Heart Disease, Cerebral Vascular Accident, Kyphosis, and Anemia.</p> <p>Continued review of Resident #8's medical record revealed nurse's notes dated 08/31/12 that revealed the physician was notified the resident had a Stage II pressure ulcer to the right buttock. Treatment orders were obtained to cleanse the resident's right buttock with normal saline, pat dry then apply Bactroban ointment (an antibacterial used to treat skin infections), cover the area with a Telfa (a non-adherent absorbent cotton dressing pad), then secure with Hypafix (a self-adhesive, non-woven fabric for dressing retention) every day. However, there was no documentation of the appearance or size of the pressure wound until 09/16/12.</p>	F 514	<p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated.</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident</p>		

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F 514	<p>Continued From page 138</p> <p>Review of Resident #8's care plan revealed the care plan was revised on 09/04/12, and 09/16/12 with additional interventions for staff to cleanse area to the right buttock with normal saline, apply Bactroban ointment then cover with Telfa pad and secure with Hypafix every day. The care plan revealed nursing staff was to complete a skin assessment every week and to notify the physician of any alterations.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had failed to document the status of Resident #8's pressure ulcer from 09/16/12 until 10/06/12 (a timeframe of twenty days) and, based on documentation, the ulcer measured "0.4 cm x 0.2 cm x 0.1 cm" on both dates. However, the next measurement on 10/19/12, (thirteen days after the previous assessment), revealed the ulcer measured "4.0 cm X 0.8 cm X 0.1 cm." Review of instructions the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. However, the staff failed to conduct an assessment of the wound on a weekly basis as instructed on the Wound Evaluation Flow Sheet, and failed to assess the wound for several weeks.</p> <p>A review of Resident #8's Treatment Administration Record (TAR) for September and October 2012, revealed staff to cleanse the resident's right buttock with normal saline, pat dry then apply Bactroban ointment (an antibacterial used to treat skin infections), cover the area with a Telfa (a non-adherent absorbent cotton dressing pad), then secure with Hypafix (a self-adhesive, non-woven fabric for dressing</p>	F 514	<p>skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator, or a designee to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified</p>	

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F 514	<p>Continued From page 139 retention) every day. The TAR revealed staff performed wound care as ordered by the physician; however failed to document an assessment weekly.</p> <p>7. A review of Resident #9's medical record revealed the facility admitted the resident on 03/29/11, with diagnosis of Severe Degenerative Changes of L Spine, Weight Loss, Anemia, and Dementia.</p> <p>Review of Resident #9's care plan revealed facility staff revised the care plan on 10/04/12, to include the Stage II pressure ulcer to the right outer hip; however, no additional interventions were noted at that time. According to the care plan, nursing staff was to complete a skin assessment every week and to notify the physician of any alterations.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented on 10/06/12, that the pressure ulcer to the resident's right outer hip measured "3.2 cm X 2.0 cm X 0.1 cm." The next assessment was conducted on 10/20/12 (fourteen days later) and revealed the ulcer measured "2.5 cm X 2.5 cm X 0.1 cm."</p> <p>A review of Resident #9's Treatment Administration Record (TAR) for September and October 2012, revealed staff performed wound care as ordered by the physician; however failed to document an assessment weekly.</p> <p>8. A review of the medical record for Resident #16 revealed the facility admitted the resident on 08/09/10, with diagnoses which included Alzheimer's, Cerebral Vascular Accident,</p>	F 514	<p>will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>All orders are checked daily (7 days per week) by nursing administrative staff to ensure that orders are transcribed/entered correctly as part of CQI. The attached form is used. The results of the audits will be reported quarterly through CQI by Mary Arms, DON or a designee. This is ongoing.</p> <p>The Assistant Administrator/QA Coordinator will report all</p>	

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F 514	<p>Continued From page 140</p> <p>Hypovolemia, Chronic Obstructive Pulmonary Disease, and Arthritis. A review of physician's orders dated 06/15/10 revealed the resident had a physician's order for twenty (20) milliequivalents of Potassium Chloride to be administered to every day.</p> <p>A review of the consultant pharmacist report for Resident #16 dated 07/10/12, revealed the pharmacist documented Resident #16 had been receiving twenty (20) milliequivalents of Potassium Chloride tablets. However, the pharmacist documented Potassium Citrate had been entered into the new computer system and the medications were not interchangeable. The pharmacist asked the facility to clarify the order.</p> <p>A review of the MAR for Resident #16 revealed on 06/07/12, facility staff had entered the physician's order on the resident's MAR as twenty (20) milliequivalents of Potassium Citrate to be administered daily. A review of the MAR for Resident #16 revealed staff documented the resident had received twenty (20) milliequivalents of Potassium Citrate on 06/07/12, 06/09/12, 06/10/12, 06/11/12, 06/12/12, 06/16/12, 06/22/12, 06/23/12, 06/24/12, 06/25/12, 06/27/12, 06/28/12, 06/29/12, 06/30/12, 07/01/12, 07/03/12, 07/04/12, 07/06/12, 07/09/12, 07/12/12, and 07/13/12.</p> <p>An interview conducted with Registered Nurse (RN) #5 on 10/31/12, at 1:50 PM, revealed she had administered medications to Resident #16 on 06/12/12, 06/16/12, 06/27/12, 06/30/12, and 07/01/12. The RN stated she had administered Potassium Chloride to Resident #16 on the dates identified. The RN stated she pulled the medication from the medication drawer, saw</p>	F 514	<p>monitoring results quarterly through CQI.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 520 483.75(o)(1)QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>It is the policy of this facility to 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. This is evidenced by the following:</p> <p>1. I cannot correct this as it relates to resident #1. The resident was transferred on 10/18/12 and has not returned to this facility. This record was reviewed on 10/18/12 and 10/19/12 by Mary Arms, DON during her investigation.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of residents #2, #3, #5, #6,</p>	

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F 514	<p>Continued From page 141</p> <p>"Potassium," and had assumed it was the correct medication. The RN stated she should have checked the MAR closer and was unsure how she had missed the Potassium Citrate being on the MAR instead of the Potassium Chloride.</p> <p>An interview conducted with Licensed Practical Nurse (LPN) #4 on 10/31/12, at 2:10 PM, revealed the LPN had been responsible for administering medications to Resident #16 on 06/21/12, and 06/25/12. The LPN stated she could not recall but had probably saw the word "potassium" written on the box and administered the medication. The LPN stated she knew she was required to check the MAR with the medication and should have observed the error.</p> <p>An interview conducted with Certified Medication Aide (CMA) #1 on 10/31/12, at 2:15 PM, revealed she had administered medications to Resident #16 on 06/07/12 and 07/09/12. The CMA stated she could not recall the dates and was unsure what medication she administered to the resident. The CMA stated she was required to check the MAR with the medication to ensure the correct medication was being administered.</p> <p>LPN #5 acknowledged in interview conducted on 10/31/12, at 5:35 PM that based on documentation she had administered medication for Resident #16 on 06/22/12. The LPN stated she would have given the drug that was in the drawer and could not recall if the medication was Potassium Citrate or Potassium Chloride.</p> <p>An interview conducted with RN #2 on 11/01/12, at 9:25 AM, revealed she had administered medications for Resident #16 on 06/23/12. The</p>	F 514	<p>#7, #8, #9 and #14 to ensure that identified pressure areas were care planned.</p> <p>On 10/19/12 an individual skin assessment was completed on resident #2, #3, #5, #6, #7, #8, #9 and #14. The staff names completing the assessments are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the individual skin assessments completed on 10/19/12 for resident #2, #3, #5, #6, #7, #8, #9 and #14 was given to the MDS department for review. All residents identified on their individual skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p> <p>On 10/20/12 the individual wound monitoring records of residents #2, #3, #5, #6, #7, #8, #9 and #14 were reviewed and compared to their individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are documented on their individual</p>

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F 514	<p>Continued From page 142</p> <p>RN stated she was the Nursing Supervisor and had assisted in developing the MAR for the residents. The RN stated she had corrected the MAR after being notified of the error by the pharmacist. The RN stated Potassium was listed in several dosages and forms in the computerized system, and that when entering the physician's orders into the computerized system she thought Potassium Citrate had been keyed in by accident. The RN stated she had not caught the error during reviews of the MAR's.</p> <p>An interview conducted with RN #4 on 11/01/12, at 9:40 AM, revealed she had been administered medications to Resident #16 on 06/09/12, 06/10/12, 06/11/12, 06/24/12, 06/28/12, 06/29/12, 07/03/12, 07/04/12, 07/12/12, and 07/13/12. The RN stated she "guessed" she had just saw the word "Potassium" and had administered the medication that was in the resident's medication drawer. The RN acknowledged she should have checked the medication with the MAR to ensure the accuracy of the medication she was administered.</p> <p>An interview conducted with the Consultant Pharmacist (RPH) for the facility on 10/31/12, at 2:35 PM, revealed she had identified the transcription error on 07/10/12. The RPH stated the pharmacy had previously developed the facility's MAR's but the facility had implemented a new computer system for generating the resident MAR's. The RPH stated she had not reviewed the new MAR's until 07/10/12 and at that time the RPH printed what had previously been in the pharmacy system, compared that information with the facility's new MARs, and had identified the error. The RPH stated Potassium Citrate had</p>	F 514	<p>wound monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the individual skin assessments of residents #2, #3, #5, #6, #7, #8, #9 and #14 completed on 10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments of resident #2, #3, #5, #6, #7, #8, #9 and #14 completed on 10/19/12) were reviewed, re-measured if necessary and documented on their individual wound monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians of residents #2, #3, #5, #6, #7, #8, #9 and #14 were notified via fax on 10/22/12 of their respective residents wound, type and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of the individual wounds of resident #2, #3, #5, #6, #7, #8, #9 and #14 and the</p>	

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F 514	<p>Continued From page 143</p> <p>not been sent to the facility because it was not available for use, and that facility staff had actually administered the medication Potassium Chloride as prescribed by the physician.</p> <p>An interview conducted with the Director of Nursing (DON) on 11/01/12, at 9:45 AM, revealed the facility had begun utilizing the facility generated MAR's on 06/07/12. The DON stated RN #2 had been responsible for checking the MAR's on the second floor for accuracy prior to the facility utilizing the MAR's on 06/07/12. The DON stated when she received the RPH review of Resident #16's MAR; she immediately gave it to RN #2 to correct the error. The DON stated currently RN #2 and the Assistant Director of Nursing (ADON) were responsible for monitoring all new physician's orders every day, Monday through Friday, and the Minimum Data Set (MDS) nurses were responsible for checking all new physician orders on the weekends.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An Extended Survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>-A review of the AOC revealed the following:</p> <p>On 10/18/12, Licensed Practical Nurse (LPN) #1 was terminated by the Director of Nursing (DON) due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of the change in the resident's wound and the failure to make arrangements for the</p>	F 514	<p>current treatments for each wound of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete individual skin assessment was completed on residents #2, #3, #5, #6, #7, #8, #9 and #14 to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard, LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/16/12 the physicians were notified again of the individual resident wounds of resident #2, #3, #5, #6, #7, #8, #9 and #14 and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>2. The charts of all residents having weekly outside appointments for medical treatment outside the facility were reviewed to ensure they had not missed appointments due to</p>	

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F 514	<p>Continued From page 144</p> <p>resident's transportation to the wound clinic.</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, the Minimum Data Set (MDS) Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>On 10/19/12, Registered Nurses (RN) #4, #6 and LPNs #2, #4, and #13 conducted skin/wound assessments on all residents.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>On 10/20/12, LPN #3 was reprimanded and placed on probation by the DON due to the failure to assess/document Resident #1's wound.</p> <p>On 10/20/12, RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p>	F 514	<p>transportation not being scheduled. This was completed by Mary Arms, DON and Christy Moore, RN on 10/20/12. There were no other appointments missed for failure to make transportation arrangements.</p> <p>All current residents with randomly scheduled appointments were reviewed to ensure that transportation arrangements had been made. This was completed by Ora Little, LPN and Jessica Wireman, RN on 10/21/12.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments of all residents.</p> <p>On 10/19/12 an individual skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the individual skin assessments completed on 10/19/12 was given to the MDS department for review. The individual skin assessments of all residents were compared to the most recent individual MDS and care plan of all residents by Donna Fannin LPN and Crystal Cantrell LPN (MDS</p>		

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F 514	<p>Continued From page 145</p> <p>On 10/21/12, RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet, and TARs to ensure accuracy of the medical records. LPN #12 also compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>On 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets (utilized for in-service) were placed in the nursing policy/procedure manuals and in the wound care monitoring books kept at each nursing station for staff reference.</p> <p>On 10/21/12, the Administrator and the DON reviewed the facility's Pressure Ulcer policy and the Wound Documentation policy and no revisions required. The Medical Director was also in agreement.</p> <p>On 10/24/12, the Administrator and the DON reviewed and revised the Wound Documentation Flow Sheet which was larger, more organized, with descriptive terms used to describe wounds.</p> <p>On 10/24/12, the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The</p>	F 514	<p>Department) to ensure that all skin areas identified were coded on the MDS or if a significant change was needed and care planned appropriately. This was completed on 10/23/12.</p> <p>On 10/20/12 the individual wound monitoring records were reviewed and compared to the individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the individual skin assessments completed on 10/19/12 were compared to their individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on their individual wound monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians were notified via fax on 10/22/12 of their respective</p>	

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F 514	<p>Continued From page 146</p> <p>Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>On 10/24/12, a new Wound nurse started employment and will be assessing and providing treatments to all wounds five (5) days a week. RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The Wound Nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description, and current treatment.</p> <p>As part of the facility's CQI for monitoring skin assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will</p>	F 514	<p>residents wounds, type and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A individual skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to</p>	

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F 514	<p>Continued From page 147</p> <p>notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #1's Employee Disciplinary Report dated 10/18/12, revealed the LPN was terminated due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of Resident #1 concerning the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>Interviews on 12/12/12, at 2:15 PM with LPN #4, on 12/13/12, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6, at 1:20 PM with LPN #13, and review of notes revealed</p>	F 514	<p>ensure they were aware of the wound and the treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chanity Purcell LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>3. The facility process for making transportation arrangements for outside appointments was reviewed by Deborah Fitzpatrick, Administrator and Mary Arms, DON on 10/19/21.</p> <p>The facility transportation policy was reviewed and revised on 10/19/12 by Deborah Fitzpatrick Administrator and Mary Arms, DON on 10/19/12. The Medical Director is in agreement. See attachment #7</p> <p>A transportation log was developed to track appointment and transportation arrangements. This was completed by Deborah Fitzpatrick, Administrator, Mary Arms, DON and Christy Moore, RN on 10/20/12. See attachment #8</p> <p>An instruction sheet was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>A list of transportation services, phone numbers, required forms and</p>	

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F 514	<p>Continued From page 148</p> <p>on 10/19/12, the above licensed staff conducted skin/wound assessments on all residents.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #3's Employee Disciplinary Report dated 10/20/12, revealed LPN #3 was reprimanded and placed on probation due to the failure to assess/document Resident #1's wound.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2,</p>	F 514	<p>special requirements was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>The system used to keep the appointment information and transportation arrangements was reviewed and revised on 10/19/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. Two books had been used to make appointments. The books were combined into one book. Each nursing unit has an appointment/transportation book with the following items:</p> <ul style="list-style-type: none"> • Transportation Policy • Instructions for making appointments. • Phone numbers for the transportation services and notification requirements of each service. • Transportation Log • Appointment Calendar • Transportation Forms <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation</p>	

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F 514	<p>Continued From page 149</p> <p>and review of notes dated 10/20/12, revealed RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets where in page protectors in the front of each nursing policy/procedure manuals and in the wound care</p>	F 514	<p>policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p> <p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the form. See Attachment #13</p>	

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F 514	<p>Continued From page 150 monitoring books for staff reference.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 revealed the licensed staff were knowledgeable of the contents and use of the Wound Care book.</p> <p>Interview on 12/12/12, at 11:00 AM with RN #2 and review of the nursing policy/procedure manuals and wound care books kept at each nurses' station revealed on 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets were placed manuals and books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's policies revealed the Pressure Ulcer policy and the Wound Documentation policy were reviewed 10/21/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director was in agreement with not revising the policies.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the old and new Wound Documentation Flow Sheet revealed the sheet was larger, organized, with descriptive terms used to describe wounds.</p> <p>Interview on 12/13/12, at 3:10 PM with the Assistant Administrator and review of notes dated</p>	F 514	<p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1)</p> <p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p>	

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F 514	<p>Continued From page 151</p> <p>10/24/12, revealed the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The interview also revealed the Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed an instructional sheet to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>Interview on 12/12/12, at 2:45 PM with the newly hired wound care nurse revealed she started employment on 10/24/12, and will be assessing and providing treatments to all wounds five (5) days a week. Interview on 12/12/12, at 11:00 AM with RN #2, revealed RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The interviews revealed the wound care nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description, and current treatment. Review of the newly hired wound care nurses' employee file revealed she started employment at the facility on 10/24/12. Further review of physician notifications letters revealed faxes were being sent bi-weekly to the resident's physician notifying the physician of the resident's wound type, location, description, and current treatment.</p>	F 514	<p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI.</p> <p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-</p>	

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F 514	Continued From page 152 Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 1025/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident. Interview on 12/12/12, at 4:40 PM with the DON, at 11:00 AM with RN #2 and review of their personal hand written notes revealed the DON and RN #2 will review all weekly nurses summaries of each resident, including skin assessment and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders. Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.	F 514	Gray, Assistant Administrator and Chanity Purcell, Staff Development. See Attachment 24 Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders; transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15 Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A	
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F 520 SS=J	<p>Continued From page 153</p> <p>COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policies, it was determined the facility failed to ensure the Quality Assessment and Assurance Committee (QAAC) was effective to ensure nursing staff followed facility policies and procedures for the assessment of wounds weekly. On 09/12/12, facility staff assessed</p>	F 520	<p>form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>A CQI subcommittee was formed by the Administrator, Deborah Fitzpatrick on 10/23/12 to review and evaluate the monitoring tools recently developed to improve the facility's QA program.</p>	

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F 520	Continued From page 154 Resident #1 and documented the resident had a calloused area on the tip of the left great toe. Staff also conducted assessments of the area on 09/13/12 and 09/28/12. On 10/18/12, staff assessed Resident #1's wound to be red, inflamed, and necrotic with sloughing, and purulent drainage and an odor. Resident #1 was transported to an acute care facility on 10/18/12, and the resident's left great toe was amputated on 10/20/12. Interview with staff revealed there were nineteen residents in the facility with wounds, twelve (12) of the nineteen (19) residents were selected for record review and revealed facility staff did not consistently conduct a weekly assessment of the wound in accordance with facility policy for eight (8) resident (Residents #2, #3, #5, #6, #7, #8, #9, and #14). Interviews with the Assistant Director of Nursing (ADON) and Registered Nurse (RN) #2 revealed they had the responsibility to perform Quality Assurance (QA) activities related to resident wounds. Per interviews, they were aware nursing staff failed to consistently documented a skin assessment of wounds on a weekly basis; however, failed to ensure actions were identified as part of the QA that would be required to ensure staff assessed all wounds on a weekly basis, or as ordered, in an effort to prevent wound deterioration and promote wound healing. Further interview revealed no one was responsible for conducting QA activities related to resident wounds on the Secure Unit. (Refer to F282, F309, F314, and F514.) The failure of the facility to ensure the Quality Assessment and Assurance Committee (QAAC) was effective placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and	F 520	4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family. On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments. The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4 A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries. She is an RN with 19 years experience working in Quality Assurance. The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on	

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F 520	<p>Continued From page 155</p> <p>determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.75 Administration, with a scope and severity of "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Quality Control," (undated) revealed the facility had a quality control program that that identified specific deficiencies, measured the level of quality services by each department, and continually furnish information that would aid the facility in taking corrective action for problems that were identified. In addition, the policy revealed quality control records would be maintained and would be discussed quarterly during committee meetings. The policy also stated any items requiring corrective action would be discussed with the Administrator as they arose.</p> <p>A review of Resident #1's closed medical record revealed the facility admitted the resident on 06/26/12 for rehabilitation due to a Right below the Knee Amputation (BKA) and diagnosis of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Continued review of the medical record revealed Licensed Practical Nurse (LPN) #1 documented at 9:30 PM on 09/12/12</p>	F 520	<p>11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident.</p>	

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F 520	<p>Continued From page 156 (approximately two and one-half months after admission) that Resident #1 had a scabbed area to the left great toe that measured less than 0.1 centimeter (cm) in diameter.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #1's wound measurements on 09/13/12 as "2.2 cm x 1.8 cm x 0.1 cm," and on 09/28/12 as "1.4 cm x 0.2 x 0.1 cm"; however, staff failed to conduct and document wound assessments on a weekly basis as required by facility policy.</p> <p>Continued review of the medical record revealed at 10:30 AM on 10/18/12, (twenty (20) days after the previous assessment) Resident #1's family member insisted on observing the resident's wound. Documentation revealed LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing from the resident's left great toe and the wound was observed to be red, inflamed, with a necrotic area, yellow sloughing and an odor. Further review of the medical record revealed the resident was transported to an acute care facility on 10/18/12, at 3:15 PM for further assessment and treatment.</p> <p>A review of a Surgical Report dated 10/20/12, revealed Resident #1's the left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview on 10/23/12, at 6:15 PM the Director of Nursing (DON) revealed staff should assess, measure, and document the status of the wounds of residents at least once a week. The interview revealed the facility provided nurses in-service training twice a year related to the assessment,</p>	F 520	<p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All</p>	

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F 520	<p>Continued From page 157 measurement, and documentation of wounds.</p> <p>A review of the Wound Evaluation Flow Sheets for the eight (8) sampled residents (Residents #2, #3, #5, #6, #7, #8, #9, and #14) chosen from the nineteen (19) residents in the facility with wounds revealed the facility failed to ensure nursing staff consistently assessed/documented the status of the residents' wounds once a week in accordance with facility policy.</p> <p>An interview on 10/23/12, at 7:10 PM with the ADON revealed she gathered information on the first floor nursing unit of resident wounds for purposes of Quality Assurance (QA). The ADON stated she completed a Continuous Quality Indicator (CQI) assessment sheet once a month and had identified staff nurses failed to conduct weekly wound assessment as required. The ADON stated she had reported the problems to the former Assistant Administrator, but this problem was not discussed/addressed in the quarterly QAAC meetings.</p> <p>An interview on 10/23/12, at 7:30 PM with RN #2 revealed she gathered information on the second floor nursing unit of resident wounds for purposes of Quality Assurance (QA). RN #2 also stated she completed a CQI assessment sheet once a month and had also identified nurses had failed to conduct weekly wound assessments. The interview revealed she had not reported this problem to any Administrative staff or discussed/addressed the problem in the quarterly QAAC meetings.</p> <p>An interview on 10/25/12, at 5:10 PM with the Director of Nursing (DON) revealed the facility's</p>	F 520	<p>resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson,</p>	

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F 520	<p>Continued From page 158</p> <p>policy for wound assessments was to assess measure and document the wound assessment on the Wound Flow Sheet. According to the DON, staff was to conduct the assessments one time a week, on Fridays. The DON stated she had assisted with obtaining information for QA in September 2012, and had noticed several weekly wound assessments had not been completed. The DON stated she made a list of residents that needed a wound assessment, requested the week-end nurses obtain the assessments and had "followed up" to ensure all the assessments had been obtained. The DON stated she was unaware staff continued to fail to conduct weekly wound assessments until she started the investigation into the deterioration of Resident #1's wound on 10/18/12. According to the DON, she "knew it was missed at times but didn't realize it was such a big systems failure until the investigation was done." The interview confirmed the DON was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>An interview on 11/01/12, at 1:10 PM with the Assistant Administrator revealed she had been the Assistant Administrator for approximately one year and also functioned as the facility's QA Coordinator. The interview revealed the ADON and RN #2 had been given the responsibility to audit wound development and obtain information related to what contributed to the development of the wound. According to the Assistant Administrator, the ADON and RN #2 were also to determine the stage of wounds, ensure the wound was addressed on the resident's care plan, what the treatment was, if the treatment was effective, if there were nutritional interventions,</p>	F 520	<p>MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI</p>		

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F 520	<p>Continued From page 159</p> <p>physician/representative notification, changes in the wounds, or if there had been an increase in number of wounds. The Assistant Administrator stated she was not aware staff had not always conducted the weekly assessment of wounds in accordance to facility policy, or that staff had failed to report the information to the QAAC. The interview confirmed the Assistant Administrator was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>An interview on 10/25/12, at 5:45 PM with the Administrator revealed facility staff were to obtain information related to wounds and provide the information to the facility's Continuous Quality Improvement (CQI) program. The interview revealed nurses were to assess wounds once a week and record the assessment on the Wound Flow Sheet and the wound logbook in accordance with facility policy. According to the Administrator, she was unaware nurses had failed to conduct the weekly wound assessments until the facility initiated the investigation into the deterioration of Resident #1's wound. The Administrator acknowledged in interview conducted at 3:45 PM on 11/01/12, at 3:45 PM QA staff had not looked at the complete QA process to ensure the facility's QA program was completely effective. The interview confirmed the Administrator was unaware no one was responsible/assigned to conducted QA activities on wounds on the Secure Unit.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An</p>	F 520	<p>communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>All new orders are checked daily by nursing administrative staff to ensure that physician orders are entered correctly as part of CQI. The attached form is used. The results of the audits will be reported quarterly through CQI by Mary Arms, DON or the QA nurse. This will be ongoing.</p> <p>A CQI subcommittee was formed by the Administrator, Deborah Fitzpatrick on 10/23/12. The committee consists of the Administrator and all department managers. The Administrator will act as head of this committee and will meet weekly. The results of all audits monitored by this committee will be reported quarterly through CQI by the person completing the audit.</p> <p>The results of all audits will be reported quarterly through CQI by Emily Jones-Gray QA Coordinator or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the</p>	

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F 520	<p>Continued From page 160</p> <p>Extended Survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>--A review of the AOC revealed the following:</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>As part of the facility's CQI for monitoring skin assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>As part of the facility's CQI for monitoring the transportation arrangement, the Assistant Administrator or the Activity Director will review the transportation logs on each unit to ensure all</p>	F 520	<p>compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p>		

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F 520	<p>Continued From page 161</p> <p>transportation arrangements have been made and any problems identified will be reported to the nursing administration immediately for correction.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>The Administrator formed a QA subcommittee which consists of each department head/manager that will meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>A decision was made to hire a full time QA nurse with 19 years' experience, who will start employment on 11/19/12.</p> <p>—The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p>	F 520			

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F 520	<p>Continued From page 162</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 10/25/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the</p>	F 520		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 163</p> <p>resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>Interviews on 12/13/12, at 3:10 PM with the Assistant Administrator, on 12/12/12, at 4:25 PM and on 12/13/12, at 1:40 PM with the Activity Director and review of the Activity Director's audit book revealed as part of the facility's CQI for monitoring the transportation arrangement, the Activity Director had been reviewing the transportation logs on each unit to ensure all transportation arrangements have been made and no problems have been identified; however, if a problem is identified it will be reported to the nursing administration immediately for correction.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON, at 11:00 AM with RN #2 and review of their personal hand written notes revealed the DON and RN #2 will review all weekly nurses summaries of each resident, including skin assessment and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator, at 3:10 PM with the Assistant Administrator, at 1:40 PM with the Activity Director and review of the QA</p>	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(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 164 subcommittee meeting minutes for 10/23/12, revealed the Administrator formed a QA subcommittee which consists of each department head/manager that meet weekly to review the monitoring tools recently developed to improve the facility's QA program. Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings. Interview on 12/13/12, at 11:45 AM with the newly hired QA nurse and review of her employee file revealed she started employment on 11/19/12, and will be working full time.	F 520			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 125 EUCLID AVENUE PAINTSVILLE, KY 41240	

RECEIVED
NOV 27 2012
Division of Health Care
Southern Enforcement Branch

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1993 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 111 (211) SMOKE COMPARTMENTS: Five COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLERED, SUPERVISED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 10/31/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right 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 privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents. K038 NFPA 101 LIFE SAFETY CODE STANDARD It is the policy of this facility that exit access is arranged so that exits are readily accessible at all times. This is evidenced by the following: 1. No residents were identified as affected in building 01. 2. All residents were identified as having the potential to be affected.	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section	K 038		

LABORATORY/DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Helen F. [Signature]* TITLE: Administrator DATE: 11/27/12

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

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	<p>Continued From page 1 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were readily accessible to the public way. This deficient practice affected four of five smoke compartments, staff, and all the residents. The facility has the capacity for 112 beds with a census of 105 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 10/31/12 at 1:10 PM, with the Director of Maintenance (DOM), an exit from the first floor activities room led to an outside gate. The gate had a magnetic lock with no posted combination and an unapproved latching mechanism at the top of the gate. In an emergency situation reasonable access is required to the public way. During the survey two other gates were observed to have this same type of unapproved locking arrangement.</p> <p>An interview with the DOM on 10/31/12 at 1:10 PM, revealed the DOM was not aware the gates should be reasonably accessible to the public way.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 038	<p>3. The magnetic locks were disarmed. This was completed on 11-16-2012 by William Endicott, Maintenance.</p> <p>Employees were inserviced on 11-20-12, 11-21-12, 11-22-2012 and 11-23-12 by Maintenance staff regarding how to exit the gates. See attachment #55</p> <p>The exterior latch was removed from all the gates. This was completed on 11-16-2012 by Overhead Door. See attachment #53</p> <p>A single mechanical latch was placed inside the gates that will open when the button is pushed. This was completed on 11-16-2012 by Overhead Door. See attachment #53</p> <p>A sign is posted at each exit with instructions on how to exit the gate. This was completed on 11-20-2012 by James Endicott, Maintenance.</p> <p>4. The maintenance department will check gates weekly to ensure that the exits are operational as part of CQI. This will be ongoing. See attachment #56</p> <p>The results of the audit will be reported quarterly through CQI by the Maintenance Director.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 11-24-2012</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 038	Continued From page 2 7.2.1.5.1 Doors shall be arranged to be opened readily from the egress side whenever the building is occupied. Locks, if provided, shall not require the use of a key, a tool, or special knowledge or effort for operation from the egress side. 7.5.4.3 Each required accessible means of egress shall be continuous from each accessible occupied area to a public way or area of refuge in accordance with 7.2.12.2.2. 7.2.12.2.2 Required portions of an area of refuge shall have access to a public way, without requiring return to the building spaces through which travel to the area of refuge occurred, via an exit or an elevator.	K 038			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<div style="border: 1px solid black; padding: 5px; text-align: center;"> RECEIVED NOV 27 2012 Division of Health Care Southern Enforcement Branch </div>		(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - BUILDING 02 B. WING _____	(X3) DATE SURVEY COMPLETED 10/31/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1026 EUCLID AVENUE PAINTSVILLE, KY 41240				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
K 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 02</p> <p>PLAN APPROVAL: 2007</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (211)</p> <p>SMOKE COMPARTMENTS: One</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 10/31/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right 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 privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.</p> <p>K038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>It is the policy of this facility that exit access is arranged so that exits are readily accessible at all times. This is evidenced by the following:</p> <ol style="list-style-type: none"> 1. No residents were identified as affected in building 02. 2. All residents were identified as having the potential to be affected. 			
K 038 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1</p>	K 038				

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

TITLE

(X6) DATE

Helmah F. [Signature]

Administrator

11/27/12

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

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NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that exits were readily accessible to the public way. This deficient practice affected one (1) of one (1) smoke compartment, staff, and all the residents. The facility has the capacity for 14 beds with a census of 13 on the day of the survey. The findings include: During the Life Safety Code tour on 10/31/12 at 1:30 PM, with the Director of Maintenance (DOM), an exit from the Memory Care unit led to an outside gate. The gate had a magnetic lock with no posted combination and an unapproved latching mechanism at the top of the gate. In an emergency situation reasonable access is required to the public way. An interview with the DOM on 10/31/12 at 1:30 PM, revealed the DOM was not aware the gate should be reasonably accessible to the public way.	K 038	3. The magnetic locks were disarmed. This was completed on 11-09-2012 by William Endicott, Maintenance. Employees were inserviced on 11-20-12, 11-21-12, 11-22-2012 and 11-23-12 by Maintenance staff regarding how to exit the gates. See attachment #55 The exterior latch was removed from all the gates. This was completed on 11-09-2012 by Overhead Door. See attachment #54 A single mechanical latch was placed inside the gate that will open when the button is pushed. This was completed on 11-09-2012 by Overhead Door. See attachment #54 A sign is posted at each exit with instructions on how to exit the gate. This was completed on 11-20-2012 by James Endicott, Maintenance. 4. The maintenance department will check gates weekly to ensure that the exits are operational as part of CQI. This will be ongoing. See attachment #56 The results of the audit will be reported quarterly through CQI by the Maintenance Director. Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing. 5. Date of Completion 11-24-2012	