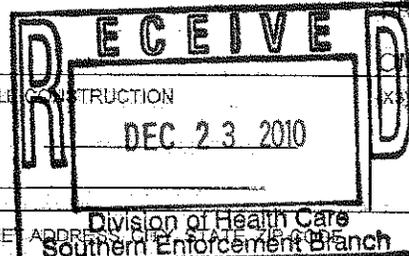


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



NOTED: 12/15/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185094	(X2) MULTIPLE INSTITUTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  12/01/2010
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS 260 SOUTH MATO TRAIL PIKEVILLE, KY 41501
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted on November 29-December 1, 2010. Deficient practice was identified at 'F' level.	F 000	Signature Health Care of Pikeville does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)  A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).  The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Edaine Jones</i>	TITLE <i>Adm. Director</i>	(X6) DATE <i>12/23/10</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to immediately notify the physician for one (1) of eighteen (18) sampled residents (resident #6). The facility failed to notify the physician for resident #6 regarding the development of skin breakdown.</p> <p>The findings include:</p> <p>Review of the facility's skin integrity policy dated November 2006 revealed it was the facility policy to identify and treat all residents with skin breakdown. The policy revealed a weekly skin assessment would be performed by licensed staff, and daily skin checks would be completed during routine care by a certified nursing aide (CNA). The policy further stated the Nursing Department would communicate with the attending physician any change necessary regarding specific skin and wound treatment.</p> <p>Record review revealed resident #6 was admitted to the facility on August 27, 2004, with diagnoses of Mental Retardation, Senile Dementia, Anxiety State, Depressive Disorder, Infantile Cerebral Palsy, and Osteoarthritis. Review of resident #6's Minimum Data Set (MDS) dated October 22, 2010, revealed the resident had behavior issues, required extensive assistance with bed mobility, bathing, and dressing. Review of the MDS also revealed resident #6 was incontinent of bowel and bladder. Review of resident #6's Resident Assessment Protocol (RAP) dated February 1, 2010, revealed resident #6 was alert and oriented only to self, pleasant, and child-like. Further review revealed resident #6's cognition was</p>	F 157	<p><b>F157 483.10 (b) (11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</b> <b>Corrective Action for Resident(s) Affected:</b> Medical record review for resident #6 revealed that a treatment order for area on buttocks was obtained on 12/3/10. Physician was notified of skin condition and non-compliance. <b>How the facility will act to protect residents in similar situations:</b> A skin audit was completed on all of the residents and no other issues were revealed on 12/12/10. <b>Measures to prevent reoccurrence:</b> All nursing staff will be in serviced by Staff Development on the skin management and prevention policy and procedure by 1/07/11.</p> <p><b>Monitoring of Corrective Action:</b> The wound care nurse will complete random skin assessments for 10% of the residents monthly for three months to ensure compliance. <b>Completion date: 1/07/11</b></p>	

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F 157	<p>Continued From page 2</p> <p>moderately impaired. Review of the RAP further revealed resident #6 was totally dependent upon staff for all activities of daily living, was nonambulatory, and incontinent of bowel and bladder.</p> <p>Observation on November 29, 2010, at 3:15 p.m., during the initial tour revealed certified nursing assistants (CNAs) #1 and #2 were conducting incontinence care for resident #6. Observation revealed resident #6's buttocks to be red, with the left gluteus maximus to have an open skin area. No bleeding or drainage was noted from the open skin.</p> <p>Interview with CNA #1 on November 29, 2010, at 3:17 p.m., revealed the CNA was not aware of the broken skin area and not aware of any treatment being applied to the area.</p> <p>Interview on December 1, 2010, at 10:35 a.m., with CNA #3 revealed any time the CNA observed skin breakdown or any new skin condition the CNA immediately informed the nurse.</p> <p>Review of resident #6's weekly skin assessment dated November 25, 2010, revealed no broken areas were noted, and the resident's coccyx was pink.</p> <p>Interview on November 30, 2010, at 12:00 p.m., with Registered Nurse (RN) #1 revealed when a CNA found skin breakdown or any new skin condition on a resident the CNA was required to notify the nurse. The nurse then assessed the skin and charted findings in the nurse's notes and on the skin assessment. The nurse was required to inform the treatment nurse so they could assess the skin breakdown, and then the</p>	F 157		

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F 157	Continued From page 3 physician would be notified for orders.  Further observation of resident #6's skin on December 1, 2010, at 9:45 a.m., revealed the left gluteus maximus remained with a broken skin area and the buttocks remained red.  Record review of resident #6's nurse's notes for November 29 and November 30, 2010, revealed no documented evidence resident #6's skin had been assessed or that the resident's physician had been notified of the resident's skin breakdown.  Interview on December 1, 2010, at 9:47 a.m., with the treatment nurse revealed the treatment nurse was unaware resident #6 had open skin.  Interview on December 1, 2010, at 10:40 a.m., with RN #1, who was assigned to provide care for resident #6, revealed the RN was unaware of skin breakdown on resident #6's buttocks area.  Interview on December 1, 2010, at 1:35 p.m., with the Assistant Director of Nursing (ADON) revealed CNAs were required to inform the nurse when new skin conditions were observed during incontinence care or bathing. In addition, the ADON stated the nursing staff performed weekly skin assessments on each resident. The interview further revealed the nurse was required to inform the treatment nurse and then call the physician to obtain orders. Interview further revealed the CNA should have informed the nurse of the broken skin area on resident #6's buttocks area on November 29, 2010.	F 157		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		

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F 312	<p>Continued From page 4</p> <p>A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to maintain good hygiene for one (1) of eighteen (18) sampled residents. Resident #4 was observed to have long untrimmed/jagged fingernails with brown substance under the nail beds.</p> <p>The findings include:</p> <p>A review of the medical record for resident #4 revealed the resident was admitted to the facility on October 9, 2008, with diagnoses that included Congestive Heart Failure, Chronic Renal Disease, Peg Tube, Urinary Retention, Sacral Wound, Obesity, Hypertension, and Osteoarthritis.</p> <p>A comprehensive Minimum Data Set (MDS) assessment completed on October 22, 2010, revealed resident #4 was dependent upon staff for personal hygiene needs.</p> <p>A review of the comprehensive plan of care for resident #4 revealed the nurse was responsible to trim resident #4's nails (plan of care did not state how often).</p> <p>Observations of resident #4 conducted on November 30, 2010, at 4:45 p.m., revealed the resident's fingernails to be long and jagged with</p>	F 312	<p><b>F312 483.25(a)(3) ADLCARE PROVIDED FOR DEPENDENT RESIDENTS</b></p> <p><b>Corrective Action for Resident(s) Affected:</b> Nail care was provided for resident #4 on 11/29/10.</p> <p><b>How the facility will act to protect residents in similar situations:</b> All residents' nails were reviewed to see if nail care was needed on 11/29/10. Nail care was provided for any resident that needed it on 11/29/10.</p> <p><b>Measures to prevent reoccurrence:</b> All licensed staff and C.N.A.'s will be in serviced by Staff Development on the nail care policy and procedure by 01/07/11.</p> <p><b>Monitoring of Corrective Action:</b> The DON or nursing administration will review 20% of residents monthly to ensure nail care is being provided. The results of the nail care audit will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated.</p> <p><b>Completion date: 1/07/11</b></p>		

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F 312	<p>Continued From page 5</p> <p>brown debris under the nail beds.</p> <p>In an interview conducted on November 30, 2010, at 4:45 p.m., with resident #4 the resident asked the surveyor if he/she would cut the resident's fingernails. The resident stated, "My fingernails would look and feel better if they were trimmed."</p> <p>An interview conducted on November 30, 2010, at 4:15 p.m., with the Registered Nurse (RN) revealed the treatment nurse was responsible for nail care for resident #4. The RN further revealed nail care was supposed to be on each resident's treatment record and initialed off by the treatment nurse after it was performed. The RN stated he/she was unsure when resident #4 received nail care because the treatment record for this resident did not contain an order for nail care.</p> <p>An interview conducted November 30, 2010, at 4:50 p.m., with the Assistant Director of Nursing (ADON) on the South Wing revealed the treatment nurse or the assigned nurse was responsible to perform nail care for resident #4. The ADON further stated he/she was responsible to review the treatment record of all residents for accuracy. The ADON was unsure why the nail care was omitted from resident #4's treatment record.</p> <p>An interview conducted on December 1, 2010, at 11:05 p.m., with the treatment nurse revealed he/she had never done nail care for resident #4. The treatment nurse stated he/she was responsible for ensuring orders were on the treatment sheet, however, resident #4's nail care was not ordered on the treatment sheet.</p> <p>An interview with the Director of Nursing (DON)</p>	F 312		

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F 312	Continued From page 6 conducted on November 30, 2010, at 12:30 p.m., revealed nurses were responsible for nail care for diabetic residents. The DON stated nail care orders for resident #4 should have been recorded on the treatment record and signed off by the nurse, however, stated resident #4's nail care orders were left off the treatment record.	F 312			
F 364 SS=D	Record review of the facility's policy on Nail Cleaning and Trimming (no date) revealed nursing staff is to provide observation and care of residents' nails daily and as necessary. 483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure each resident received food that was at the proper temperature during the evening meal on November 29, 2010.  The findings include:  Observation of tray delivery at the evening meal on November 29, 2010, revealed cart 2 was delivered to the North Hall at 5:40 p.m., and the last tray was retrieved from the cart at 6:05 p.m. An observation of a resident tray retrieved from the tray cart on the North hallway on November 29, 2010, at 6:05 p.m., revealed that milk was	F 364	<b>F364 483.35 (d) (1)-(2) NUTRITIVE VALUE/ APPEAR, PALATABLE/PREFER TEMP</b> <b>Corrective Action for Resident(s) Affected:</b> No residents were affected by this; all residents had the potential to be affected. <b>How the facility will act to protect residents in similar situations:</b> The facility ordered an ice cart for each wing of the facility. The milk will be placed in the ice cooler and will be placed on the tray before delivering the tray to the resident. All nursing staff will be in serviced on the proper way to pass milk with the trays by 01/07/11. <b>Measures to prevent reoccurrence:</b> The facility ordered an ice cart for each wing of the facility. The milk will be placed in the ice cooler and will be placed on the tray before delivering the tray to the resident. All nursing staff will be in serviced on the proper way to pass milk with the trays by 01/07/11.		

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F 364	Continued From page 7 served to residents at a temperature of 54 degrees Fahrenheit.  A review of the facility food service policy dated April 2008 revealed no evidence of required temperatures for milk. However, the policy stated that food must be palatable, attractive, and at the proper temperature.  An interview conducted with the Dietary Manager on November 30, 2010, at 2:45 p.m., revealed the facility did not have a point-of-service policy but milk was required to be served to residents at a temperature of 45 degrees Fahrenheit or below. Further interview with the Dietary Manager revealed that the plate warming pellet may have caused the milk to become warm.	F 364	<b>Monitoring of Corrective Action:</b> The Dietary Manager or dietary assistant manager will conduct milk temperatures for 10 residents monthly to milk temperature is below 45 degrees. The results will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. <b>Completion date: 1/07/11</b>
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store garbage and refuse properly to prevent the harborage of insects, rodents, roaches, and other insects. Observation of the facility dumpsters on November 29, 2010, at 2:30 p.m., revealed the inverted lid was below the surface of the closure, allowing a twelve (12) inch gap in the surface of the dumpster lid covers. The asphalt surface surrounding the metal containers was observed to have a spillage of garbage and refuse.  The findings include:	F 372	<b>F 372 483.35(i)(3) DISPOSE GARBAGE &amp; REFUSE PROPERLY</b> <b>Corrective Action for Resident(s) Affected:</b> No residents were affected by this, but all residents had the potential to be affected. <b>How the facility will act to protect residents in similar situations:</b> All staff will be in serviced by the Staff Development Coordinator on keeping the dumpster area clean by 01/07/11.

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F 372	Continued From page 8  During an initial tour of the facility on November 29, 2010, at 2:30 p.m., the dumpster area was observed to have spilled refuse on the asphalt surrounding the dumpsters. The observations revealed ten plastic gloves loose on the asphalt, a loose trash bag on the grassy area, two large mattresses behind the dumpsters, a broken wooden shelf behind the dumpster area, a soiled resident brief containing a greenish-brown substance, a discarder hose, broken brown glass, one nail, and two screws on the asphalt, and various pieces of loose trash and litter blown throughout the grassy and asphalt area.  A review of the Food Establishment Inspection Report conducted by the Pike County Health Department on August 25, 2010, revealed the facility was cited by the Pike County Health Inspector for outside garbage disposal area not insect/rodent proof and clean.  An interview was conducted with the facility Maintenance Supervisor on November 29, 2010, at 3:30 p.m. The Maintenance Supervisor stated the asphalt and dumpster was cleaned and hosed one time a month.	F 372	<b>Measures to prevent reoccurrence:</b> The maintenance supervisor contacted the city for a replacement dumpster. Earl from the City of Pikeville, Trash Division, appeared onsite at the facility on December 23, 2010 and stated he will check his inventory of new dumpsters and parts and if available, said instruments will be delivered at the earliest date possible. If said instruments are not immediately available, said instruments will be ordered by the City of Pikeville, Trash Division and delivered at the earliest date possible. The maintenance department was in serviced on conducting ground maintenance daily and ensuring that the dumpster area is clean each day on 12/17/10 by the Administrator.  <b>Monitoring of Corrective Action:</b> The Administrator or the DON will observe the dumpster area weekly to ensure that it is clean. The results of the dumpster observations will be presented to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. <b>Completion date: 1/07/11</b>	
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION  The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the large	F 456		

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F 456	Continued From page 9 Dietary Department walk-in freezer in safe operating condition. Observation of the interior portion of the freezer door frame on December 1, 2010, at 1:00 p.m., revealed a one-quarter inch layer of frost/frozen condensation around the inner door frame, as well as the overhead closure arm above the door and the exterior lower portion of the metal door at the base.  The findings include:  Observation of the walk-in freezer metal door on December 1, 2010, at 1:00 p.m., revealed the interior door frame had a one-quarter-inch layer of frozen condensation and frost around the metal door frame and the overhead closure arm. In addition, the lower exterior base of the metal door contained a layer of frost. The internal temperature of the walk-in freezer was observed to be -10 degrees Fahrenheit as required.  An interview conducted with the Food Service Supervisor (FSS) on December 1, 2010, at 1:10 p.m., revealed the facility had a refrigeration repairman replace the freezer door seal and the metal door heater, but the ice/frozen condensation continued to form around the door frame. The FSS stated the frozen condensation had been removed by a dietary employee on November 29, 2010, but had reformed since the door frame and door were cleaned two days earlier.	F 456	<b>F456 483.70 (c) (2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION</b> <b>Corrective Action for Resident(s) Affected:</b> No residents were affected by this, but all residents had the potential to be affected. <b>How the facility will act to protect residents in similar situations:</b> Hobart sales and service came and looked at the freezer on 12/9/10. They have ordered a new door, door heater, condensing unit, and evaporator for the freezer. They will put this on when the custom made door comes in. <b>Measures to prevent reoccurrence:</b> Hobart sales and service came and looked at the freezer on 12/9/10. They have ordered a new door, door heater, condensing unit, and evaporator for the freezer. They will put this on when the custom made door comes in. <b>Monitoring of Corrective Action:</b> The dietary manager or dietary assistant will observe the freezer weekly to observe for frozen condensation and frost around the metal door frame and the overhead closure arm. Results of the rounds will be presented to the quality assurance committee monthly for three months for recommendations and follow up as needed. <b>Completion date: 1/07/11</b>	
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465		

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:  <b>185094</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/01/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF PIKEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501</b>	
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F 465	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. Baseboards in resident rooms on the North Hall had an exposed sharp edge, and exposed pipes with a sharp pipe clamp were observed in an alcove in the front hallway across from the facility lobby.  The findings include:  An environmental tour conducted on December 1, 2010, at 1:20 p.m., revealed North Hall resident rooms 27-38 had baseboards that had been replaced, however, the edge of the baseboard was not complete and left a sharp edge exposed by the resident's doorway. Exposed piping, from a removed water fountain in an alcove on the front hallway across from the facility lobby, was also observed to protrude from the wall and have a sharp pipe clamp exposed.  A review of maintenance logs provided by the Maintenance Director revealed no evidence the exposed piping or the sharp baseboard edges had been identified, or were scheduled for repair.  An interview conducted with the facility Maintenance Director on December 1, 2010, at 1:20 p.m., revealed the baseboards had been replaced in all resident rooms over the past year. However, the Maintenance Director had not completed covering the edges of all the baseboards.	F 465	<b>465 483.70 (h) SAFE/FUNCTIONAL/ SANITARY/ COMFORTABLE ENVIRONMENT</b> <b>Corrective Action for Resident(s) Affected:</b> The baseboards were repaired in rooms 27-38 on 12/10/10. The exposed piping in the alcove in the front hallway was covered on 12/10/10. <b>How the facility will act to protect residents in similar situations:</b> The maintenance department did an audit of the entire building for any other baseboards that were in need of repair and also observed for any exposed pipe throughout the building. Any areas that are in need of repair will be repaired by 1/7/11. <b>Measures to prevent reoccurrence:</b> The maintenance department will conduct room rounds on a monthly basis and will observe for baseboards that are in need of repair and also observe for any exposed pipe throughout the building. <b>Monitoring of Corrective Action:</b> The administrator or DON will makes rounds on a weekly basis to look for baseboards in need of repair and exposed pipes. Results of the rounds will be presented to the quality assurance committee monthly for three months for recommendations and follow up as needed. <b>Completion date: 1/07/11</b>	
F 468	483.70(h)(3) CORRIDORS HAVE FIRMLY	F 468		

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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF PIKEVILLE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501</b>	
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F 468 SS=D	<p>Continued From page 11 <b>SECURED HANDRAILS</b></p> <p>The facility must equip corridors with firmly secured handrails on each side.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to equip corridors with firmly secured handrails. Two handrails were observed to be loose from the wall on the North Hall.</p> <p>The findings include:</p> <p>Observations conducted on the North hallway during an environmental tour conducted on December 1, 2010, at 1:20 p.m., revealed two handrails were loose from the wall.</p> <p>A review of maintenance logs at the North Hall nurses' station revealed no evidence the loose handrails had been reported to Maintenance.</p> <p>An interview on December 1, 2010, at 1:20 p.m., conducted with the facility Maintenance Director revealed the Maintenance Director had made daily rounds in the facility to identify problems requiring maintenance. Further interview revealed that Maintenance had to frequently tighten the handrails in the facility. However, there was no evidence the identified handrails had been tightened.</p>	F 468	<p><b>F468 483.70 (h) (3) COORIDORS HAVE FIRMLY SECURED HANDRAILS</b></p> <p><b>Corrective Action for Resident(s) Affected:</b> Maintenance secured the two loose handrails on North wing on 12/2/10. <b>How the facility will act to protect residents in similar situations:</b> Maintenance went throughout the building and checked all of the handrails. Any handrail that was loose was secured on 12/3/10. <b>Measures to prevent reoccurrence:</b> Maintenance will make rounds on a monthly basis and will randomly check the handrails to ensure they are secure. <b>Monitoring of Corrective Action:</b> The administrator or DON will make rounds on a monthly basis and will randomly check the handrails to ensure they are secure. Results of the rounds will be presented to the quality assurance committee monthly for three months for recommendations and follow up as needed. <b>Completion date: 1/07/11</b></p>	

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>SIGNATURE HEALTHCARE OF PIKEVILLE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501</b>
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K 000	<p>INITIAL COMMENTS</p> <p>A life safety code survey was initiated and concluded on December 1, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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.