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

2nd SOD

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RECEIVED
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Division of Health Care
Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185094		C 11/19/2013

NAME OF PROVIDER OR SUPPLIER: SIGNATURE HEALTHCARE OF PIKEVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 260 SOUTH MAYO TRAIL, PIKEVILLE, KY 41501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY20989) was initiated on 11/18/13 and concluded on 11/19/13. The complaint was substantiated and deficient practice was identified at "G" level related to the staff's failure to ensure a resident who entered a facility without pressure sores did not develop pressure sores, to ensure care was provided in accordance with the resident's plan of care, and to ensure the comprehensive care plan was revised when a resident developed a pressure sore. Resident #1 was transported to the Emergency Room (ER) on 10/06/13 and diagnosed with a pathological fracture of the left femur. The physician applied a "pillow splint" to immobilize the resident's leg. On 11/13/13, Resident #1 was transported to the ER after he/she had a change in mental status. Upon admission to the ER, hospital staff removed the "pillow splint" from the resident's left leg and observed an open sore to the top of the resident's lower leg and a pressure area with black eschar to the resident's left heel. The facility had assessed Resident #1 to be at risk for impaired skin integrity prior to the diagnosis of a fracture to the left femur and developed a plan of care to address the prevention and development of pressure sores. However, the facility failed to follow the plan of care. In addition, the facility failed to revise the plan of care after the resident sustained the fracture to include when to remove the "pillow splint" to conduct an assessment of the resident's skin that was covered by the "pillow splint."	F 000	**Disclaimer:** Signature Healthcare of Pikeville does not believe and does not admit that any deficiencies existed either 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 of 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 280 SS=G	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP	F 280	**F 280 RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP** The facility will ensure the comprehensive care plan is periodically reviewed and	12/27/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Adm (X6) DATE: 12/27/13

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 280	Continued From page 1 The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure the Comprehensive Plan of Care was revised for one (1) of four (4) sampled residents (Resident #1). Resident #1 sustained a pathological fracture of the left femur on 10/06/13 and the physician requested the use of a "pillow splint" to immobilize the resident's leg. However, the facility failed to revise the Comprehensive Plan of Care after the resident sustained the fracture to include how they would ensure the resident's leg remained immobilized or how they would monitor the skin status of the resident's left leg under the "pillow splint" to ensure the resident attained or maintained his/her physical well-being.	F 280	revised as the resident's status changes. **Residents affected:** Resident #1 was out to hospital, upon return to the facility, resident #1 was immediately assessed, appropriate intervention put into place to address resident care needs and care plan/SRNA care plan updated to reflect resident on 11/26/13 by nursing staff and unit manager. 100% of residents care plans were audited and revised on 11/21/13. Skin assessments were initiated on 11/15/13 and completed on 11/18/13 for 100% of all residents to ensure no other resident(s) were affected by this deficient practice. 100% skin assessments were completed by nursing ADM on 11/20/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. **Residents potentially affected:** Residents have the potential to be affected by this deficient practice. Resident #1 was out to hospital, upon return to the facility, resident #1 was immediately assessed, appropriate intervention put into place to address resident care needs and care plan/SRNA care plan updated to reflect resident on 11/26/13. 100% of residents care plans were audited and revised on 11/21/13. 100% skin assessments were completed by	

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F 280	Continued From page 2 On 11/13/13, Resident #1 was transported to the local Emergency Room (ER) after he/she had a change in condition. Based on documentation, upon admission to the ER hospital staff removed the "pillow splint" from the resident's left leg and observed a 3.5 centimeter (cm) open pressure sore to the top of the resident's left, lower leg and black eschar (dead tissue) to the resident's left heel. The findings include: Review of the facility's policy entitled "Care Plans-Comprehensive" and dated October 2010, revealed facility staff was to revise the Comprehensive Plan of Care when a resident experienced a significant change in condition. Review of the facility's policy entitled "Splinting" and dated July 2010, revealed splints should be removed and the resident observed for areas of redness, edema, or the development of any open lesions and to report the findings to the Charge Nurse and physician. Review of the medical record for Resident #1 revealed the facility admitted the resident on 04/28/12. The resident's diagnoses included Hypertension, Cardiovascular Accident, Coronary Artery Disease, Osteoporosis, Chronic Kidney Disease, Diabetes, Severe Alzheimer's Disease, Osteoarthritis, History of Sepsis secondary to Right Lower Lobe Pneumonia, and a history of Vancomycin Resistant Enterococcus (VRE). In addition, the facility assessed the resident to be cognitively impaired. Further review of the medical record revealed Resident #1 sustained a pathological fracture of	F 280	nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/21/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. **Systemic measures:** 100% of residents care plans were audited and revised on 11/21/13. 100% skin assessments were completed by nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/21/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on	

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F 280	Continued From page 3 the femur on 10/06/13. Documentation in the progress notes by the orthopedic surgeon dated 10/07/13 revealed the resident's fracture was pathologic in nature. As a result of the fracture, the physician immobilized the resident's left femur with the use of a "pillow splint." Review of physician's orders dated 10/06/13, revealed staff was to keep the pillow splint in place to the resident's left leg and to remove the splint "as needed" to provide care. Continued review of physician's orders revealed on 10/08/13, Resident #1 was taken to the orthopedic surgeon's office and the physician ordered a "wedge cushion" to be placed to the side of the resident's left leg to aid in positioning, to continue the pillow splint to the resident's left leg at all times, and to remove only for care as necessary. Review of the comprehensive care plan for Resident #1, dated 10/02/13 and updated on 10/08/13, revealed the resident was at risk for the development of skin breakdown and needed extensive assistance with bed mobility. In addition, the goals established by staff for Resident #1 revealed the resident's skin was to remain intact and free of redness, blisters, or discoloration over bony prominences through the next review date. Interventions to achieve the established goals were based on the physician's orders and included for staff to remove the pillow splint as necessary and to use a wedge cushion to the left side of the resident's left leg to aid in positioning. However, continued review of the comprehensive care plan for Resident #1 revealed staff had not identified the conditions and/or symptoms that would require staff to remove the resident's "pillow splint" in order to assess the resident's skin status and failed to update the comprehensive care plan to reflect the	F 280	12/2/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. Effective 11/19/13 100% of all skin assessments will be completed by two licensed staff to ensure accuracy. Nursing staff will update care plans with any resident changes and/or order changes immediately. Care plans are monitored/reviewed for accuracy and if any revision/updates are needed the care plans will be updated during clinical whiteboard meeting by the MDS coordinator. The MDS coordinator will review/monitor care plans throughout the week on all residents with new orders and/or changes for compliance with needed intervention updates to accurately reflect resident care needs. The ADON/SDC will audit 10% or resident care plans weekly for accuracy and compliance for 4 weeks then as deemed necessary by the QA committee. Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6 weeks and then 8 weekly skin assessments for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks	

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F 280	Continued From page 4 requirements identified in the facility's policy entitled "Splinting." Interview with Licensed Practical Nurse (LPN) #4 on 11/19/13 at 9:35 AM, revealed she had readmitted Resident #1 to the facility after the resident returned from the ER on 10/06/13 and had added the use of the "pillow splint" to the resident's care plan. LPN #4 stated she called the orthopedic surgeon and was told to remove the splint "if necessary," that the fracture might not heal and to utilize two (2) to three (3) people to hold the resident's leg still and in position to change the "pillow splint." However, LPN #4 did not include this information on Resident #1's care plan. According to LPN #4, the nurses did not remove the pillow splint because the physician had said the resident's fracture might not heal, that he did not want the positioning of the femur to move, and did not want the pillow splint removed unless "necessary." On 11/13/13, documentation in the medical record revealed Resident #1 was transported to the ER after he/she had a change in mental status. Based on documentation in the resident's ER medical record, upon the resident's admission to the ER on 11/13/13 the ER physician and nurse removed the pillow splint from the resident's leg and discovered a 3.5 cm by 6.5 cm open pressure sore to the top of the resident's left, lower leg and black eschar to the resident's left heel. Observation of Resident #1 on 11/19/13 at 12:30 PM at the local hospital revealed the resident was not able to be interviewed as the resident was cognitively impaired. A skin observation with a nurse at the hospital revealed a gauze dressing to	F 280	to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. **Monitoring measures:** Care plans are monitored/reviewed for accuracy and if any revision/updates are needed the care plans will be updated during clinical whiteboard meeting by the MDS coordinator. The MDS coordinator will review/monitor care plans throughout the week on all residents with new orders and/or changes for compliance with needed interventions updates to accurately reflect resident care needs. The ADON/SDC will audit 10% or resident care plans weekly for accuracy and compliance for 4 weeks then as deemed necessary by the QA committee. Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6 weeks and then 8 weekly skin assessments for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks	

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F 280	Continued From page 5 the top of the resident's left leg that was removed by the hospital nurse. The nurse removed the dressing from the resident's left leg and obtained measurements of an open area on the leg. According to the nurse, the area on the resident's left leg was a Stage II pressure area that measured 3.5 cm by 6.5 cm in diameter. Upon removal of the gauze dressing from the resident's left heel by the nurse, a black area was observed on the resident's left heel. The nurse at the hospital identified the area as an unstageable pressure area that was covered with black eschar. Interview with Certified Nurse Aide (CNA) #1 on 11/18/13 at 1:55 PM, CNA #2 on 11/18/13 at 2:10 PM, CNA #3 on 11/18/13 at 2:15 PM, CNA #4 on 11/18/13 at 3:05 PM, and Certified Medication Aide (CMA) #1 on 11/18/13 at 2:22 PM revealed the aides had provided direct care to Resident #1 after his/her return from the hospital on 10/06/13 with a fractured femur. The aides stated they had not been directed to remove the resident's "pillow splint" and had left the splint intact. The aides said if the pillow splint became soiled they notified the nurse in charge. According to the aides, nurses were to remove the pillow splint and apply a clean pillowcase and/or splint as needed. The aides stated they had not observed Resident #1 to have any pressure sores, and stated if there was any change in the resident's condition they would have notified the nurses. Interview with Licensed Practical Nurse (LPN) #1 on 11/18/13 at 2:44 PM, LPN #2 on 11/18/13 at 2:55 PM, LPN #3 on 11/18/13 at 4:05 PM, Registered Nurse (RN) #1 on 11/18/13 at 5:00 PM, RN #2 on 11/19/13 at 8:55 AM, LPN #4 on 11/19/13 at 9:35 AM, LPN #5 on 11/19/13 at 3:10	F 280	and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. Findings from audits will be reviewed at the monthly QA meeting for three months to ensure compliance with state, federal and company policy, rules and regulations.	

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F 280	Continued From page 6 PM, and the South Hall Unit Manager on 11/19/13 at 3:25 PM revealed they were aware of the physician's order to remove the "pillow splint" from Resident #1's left femur on an "as needed" basis. Further interview revealed the "pillow splint" was removed when it became heavily soiled and no pressure sores had been observed. The nurses stated the CNAs had not reported any concerns, including pressure areas, related to the resident's skin condition that had not already been identified. The interviews revealed staff had provided treatment to a scabbed area on Resident #1's great toe, and applied medicated creams to the resident's buttocks after incontinence care. LPN #3 stated in interview conducted on 11/18/13 at 4:05 PM that she had performed a head to toe assessment of Resident #1 on 11/13/13 prior to the resident's transfer to the ER on that date related to a change in the resident's mental status. According to LPN #3, she had not identified pressure areas to Resident #1's lower left leg or left heel; however, LPN #3 stated she had not removed the pillow splint to examine Resident #1's skin because the physician did not want the splint removed. LPN #3 was not aware of a blackened area to Resident #1's left heel or of the open area to the resident's left lower leg. Interview with the orthopedic surgeon on 11/19/13 at 11:45 AM revealed the surgeon utilized the "pillow splint" on 10/06/13 related to Resident #1's diagnosis of Osteoporosis and the brittleness of the resident's bones. According to the physician, the pillow splint should have been removed to check for pressure and should have been changed when it became soiled.	F 280		

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F 280	Continued From page 7 The Administrator and the Nurse Consultant acknowledged in an interview conducted on 11/19/13 at 3:40 PM that the orthopedic surgeon had requested the "pillow splint" to Resident #1's left leg to only be removed, as needed, to provide care. The Nurse Consultant stated nursing staff should have contacted the resident's physician to clarify the orders related to removing the pillow splint and should have updated the care plan to reflect when and how to remove the splint to ensure Resident #1's leg remained stable and the skin integrity remained intact.	F 280		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and policy review, it was determined the facility failed to ensure care was provided in accordance with the resident's Plan of Care for one (1) of four (4) sampled residents (Resident #1). The facility assessed Resident #1 to be at risk for impaired skin integrity and developed a plan of care to address and/or implement in an effort to prevent the development of pressure areas. However, on 11/13/13, the facility transferred Resident #1 to the local Emergency Room (ER) related to a change in the resident's mental status and ER staff noted the resident had a visible area of black eschar (hardened/dead tissue) to the left heel. In addition, upon removal of a "pillow splint" that had	F 282	**F 282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** The facility will ensure the comprehensive care plan is periodically reviewed and revised by qualified persons. **Residents affected:** Resident #1 was out to hospital, upon return to the facility, resident #1 was immediately assessed, appropriate intervention put into place to address resident care needs and care plan/SRNA care plan updated to reflect resident on 11/26/13 by nursing staff and unit manager. 100% of residents care plans were audited and revised on 11/21/13. Skin assessments were initiated on 11/15/13 and completed on 11/18/13 for 100% of all residents to ensure no other resident(s) were affected by this deficient practice. 100% skin assessments were completed by nursing ADM on 11/20/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13.	12/27/13

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F 282	Continued From page 8 been utilized to support the resident's left femur due to a recent fracture, ER staff observed a 3.5 centimeter (cm) by 6.5 cm pressure sore to the top of the resident's lower leg. Continued review of the resident's medical record revealed staff failed to conduct a complete skin assessment of the resident, to include the resident's left heel and the skin underneath the "pillow splint," and failed to report the changes in the resident's skin integrity to the physician in accordance with the plan of care. The findings include: Review of the facility's policy entitled "Care Plans-Comprehensive" and dated October 2010, revealed the Comprehensive Care Plan incorporated risk factors associated with identified problems, identified interventions to aid in the prevention or reduction of declines in the resident's functional status and/or functional levels, and identified the professional services that were responsible for each element of care. Continued review of the facility's policies revealed a policy entitled "Splinting" and dated July 2010, that revealed splints should be removed and the resident observed for areas of redness, edema, or the development of any open lesions, and the findings reported to the Charge Nurse and physician. Record review revealed the facility admitted Resident #1 on 04/28/13 with diagnoses of Hypertension, Cardiovascular Accident, Coronary Artery Disease, Osteoporosis, Chronic Kidney Disease, Diabetes, Severe Alzheimer's Disease, Osteoarthritis, and History of Sepsis secondary to right Lower Lobe Pneumonia, and a history of	F 282	**Residents potentially affected:** Residents have the potential to be affected by this deficient practice. Resident #1 was out to hospital, upon return to the facility, resident #1 was immediately assessed, appropriate intervention put into place to address resident care needs and care plan/SRNA care plan updated to reflect resident on 11/26/13. 100% of residents care plans were audited and revised on 11/21/13. 100% skin assessments were completed by nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/21/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. **Systemic measures:** 100% of residents care plans were audited and revised on 11/21/13. 100% skin assessments were completed by nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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F 282	Continued From page 9 Vancomycin Resistant Enterococcus. The facility also assessed the resident to be cognitively impaired. Review of the facility's plan of care for Resident #1 dated 10/02/13 revealed due to the resident's assessed risk for skin impairment due to age and not eating/drinking well, facility staff was to immediately notify the nurse of any new areas of skin breakdown, redness, blisters, bruises, or discolorations noted during bathing and/or daily care, complete weekly skin assessments, and report changes to the physician. In addition, staff was to assist the resident, as needed, to reposition/shift his/her weight to relieve pressure to utilize "off-loading" devices (e.g., heel pads) to the resident's bilateral lower extremities to prevent pressure and to ensure prolonged skin-to-skin exposure was avoided. Documentation in the medical record revealed when staff provided morning care to Resident #1 on 10/06/13, they observed a "deformity" to the resident's left leg, and the resident was transported to the ER for evaluation. Resident #1 was assessed at the ER and diagnosed to have a fractured left femur. An orthopedic surgeon diagnosed the fracture and documented the fracture was "pathogenic in nature, related to the diagnosis of Osteoporosis and brittle bones." The physician applied a "pillow splint" to the left leg and the resident was transferred back to the facility. Continued review of the plan of care revealed facility staff revised Resident #1's plan of care on 10/08/13 after he/she had been assessed in the ER and diagnosed with a fracture of the femur to include the use of a "pillow splint." The staff identified goals related to the resident's skin	F 282	for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/21/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. Effective 11/19/13 100% of all skin assessments will be completed by two licensed staff to ensure accuracy. Nursing staff will update care plans with any resident changes and/or order changes immediately. Care plans are monitored/reviewed for accuracy and if any revision/updates are needed the care plans will be updated during clinical whiteboard meeting by the MDS coordinator. The MDS coordinator will review/monitor care plans throughout the week on all residents with new orders and/or changes for compliance with needed intervention updates to accurately reflect resident care needs. The ADON/SDC will audit 10% or resident care plans weekly for	

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F 282	Continued From page 10 status based on the physician's orders to remove the "pillow splint" only "as necessary." However, staff had not identified the conditions and/or symptoms that would require staff to remove the resident's "pillow splint" "as necessary" in order to assess the resident's skin status, and failed to update the plan of care to reflect the requirements identified in the facility's policy entitled "Splinting." Continued review of Resident #1's medical record revealed on 11/13/13, the facility transferred Resident #1 to the ER due to a change in the resident's mental status. Although the facility failed to document the time of the resident's transfer to the ER, review of the ambulance transfer form revealed Resident #1 was transported to the local Emergency Department at 12:15 PM on 11/13/13. Review of a skin assessment performed by facility staff on 11/13/13 (no time documented) prior to the resident's transfer to the ER revealed Resident #1's buttocks were pink, the left leg "pillow splint" was in use, petechia (red rash) was present to the resident's arms and legs, and the resident's skin was dry. According to the skin assessment, there was a dressing noted to the resident's left great toe and scabs were noted to the resident's left foot. However, review of documentation obtained from the ER revealed upon Resident #1's arrival to the ER on 11/13/13 at 12:36 PM, the physician removed the "pillow splint" from the resident's left leg and observed a 6.5 cm by 3.5 cm decubitus ulcer on the top of the resident's lower leg and a pressure ulcer with black eschar on the left heel. Based on review of the resident's medical record, facility staff failed to assess the discolored area to the resident's heel and the impaired skin integrity to the top of the resident's	F 282	accuracy and compliance for 4 weeks then as deemed necessary by the QA committee. Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6 weeks and then 8 weekly skin assessments for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. **Monitoring measures:** Care plans are monitored/reviewed for accuracy and if any revision/updates are needed the care plans will be updated during clinical whiteboard meeting by the MDS coordinator. The MDS coordinator will review/monitor care plan throughout the week on all residents with new orders and/or changes for compliance with needed interventions updates to accurately reflect resident care needs. The ADON/SDC will audit 10% or resident care plans weekly for accuracy and compliance for 4 weeks then as deemed necessary by the QA committee. Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6	

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NAME OF PROVIDER OR SUPPLIER: SIGNATURE HEALTHCARE OF PIKEVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE: 260 SOUTH MAYO TRAIL, PIKEVILLE, KY 41501

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F 282	Continued From page 11 left leg, and failed to report the change in the resident's condition to the physician as planned in the resident's plan of care. Interview conducted on 11/18/13 at 1:55 PM with Certified Nurse Aide (CNA) #1, 11/18/13 at 2:10 PM with CNA #2, 11/18/13 at 2:15 PM with CNA #3, 11/18/13 at 3:05 PM with CNA #4, and 11/18/13 at 2:22 PM with Certified Medication Aide (CMA) #1 revealed if the aides identified any problems related to the skin condition of any resident, or if a resident's dressing became soiled, they notified the nurse immediately. According to the aides, they were not permitted to remove the "pillow splint" from Resident #1's left leg and stated the nurses were responsible for dressing changes. The aides said after the "pillow splint" was in place for Resident #1 they had not noticed any pressure sores when they provided incontinence care or bathed the resident. The aides said when the pillow splint became heavily soiled the nurses would change the splint. The aides also stated that Resident #1 wore heel protectors to relieve pressure from the heels, and the protectors were removed to provide bathing/showers. According to the aides, they had not observed pressure sores to Resident #1's heels. Interview with Licensed Practical Nurse (LPN) #1 on 11/18/13 at 2:44 PM, LPN #2 on 11/18/13 at 2:55 PM, LPN #3 on 11/18/13 at 4:05 PM, Registered Nurse (RN) #1 on 11/18/13 at 5:00 PM, RN #2 on 11/19/13 at 8:55 AM, LPN #4 on 11/19/13 at 9:35 AM, LPN #5 on 11/19/13 at 3:10 PM, and the South Hall Unit Manager on 11/19/13 at 3:25 PM revealed if the CNAs observed any skin problems when they provided care to residents, they were to report the problems	F 282	weeks and then 8 weekly skin assessments for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. Findings from audits will be reviewed at the monthly QA meeting for three months to ensure compliance with state, federal and company policy, rules and regulations.	

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F 282	Continued From page 12 immediately to the nurse. The interviews revealed the nurse aides had not notified the nurses of any concerns related to Resident #1's skin condition. Continued interviews with the nurses revealed nursing staff was required to conduct resident skin assessments on a weekly basis and they had not observed any concerns with Resident #1's skin condition when they had assessed the resident during the weekly skin assessments. However, the nurses stated they only removed the resident's splint when it became heavily soiled because the resident's physician only wanted the "pillow splint" to be removed when necessary. LPN #3 stated she performed a "head to toe" assessment of Resident #1 on 11/13/13, prior to the resident's transfer to the ER, and observed the resident's buttock was pink, the left leg "pillow splint" was in use, petechia was present to the resident's arms and legs, and the resident's skin was dry. In addition, LPN #3 stated Resident #1 had a dressing to the left great toe and scabs were noted to the resident's left foot. However, LPN #3 stated she did not remove the pillow splint to examine Resident #1's skin prior to the resident's transfer to the ER because the physician had not wanted the splint removed. Interview with LPN #5 revealed splints and heel booties were routinely removed to perform skin assessments; however, the LPN stated the physician only wanted the splint to Resident #1's leg to be removed when necessary. Interview with the Administrator and the Nurse Consultant on 11/19/13 at 3:40 PM revealed staff was to follow each resident's plan of care when they provided care. According to interviews, staff that performed/assisted residents with the activities of daily living (bathing, incontinence care) was to assess each resident's skin	F 282		

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F 282	Continued From page 13 condition and report any abnormal findings to the nurses. The interviews also revealed as directed in the plan of care, nurses were to assess residents, document their findings, and notify the physician for orders if there were any concerns identified. The Nurse Consultant said administrative staff was to monitor CNAs and nurses to see that plans of care were followed and any problems identified were addressed immediately. The Administrator and the Nurse Consultant did not know why the black eschar observed on Resident #1's left heel and the open area on the resident's left leg were not reported by the CNAs or assessed/documented by the nurses.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy it was determined the facility failed to ensure one (1) of four (4) sampled residents (Resident #1) who entered the facility without pressure sores did not develop pressure sores. Documentation revealed Resident #1 returned from an Emergency Room visit on	F 314	**F 314 TREATMENT/SERVICES TO PREVENT/HEAL PRESSURE SORES** The facility will ensure residents who enter the facility without pressure sores does not develop pressure sores unless individuals conditions demonstrates that they were unavoidable and that a resident having pressure sores receives necessary treatment and services to promote healing and prevent new pressure sores from developing. **Residents affected:** Resident number 1 was assessed and the care plan was revised on 11/26/13 to reflect the resident's care needs. Skin assessments were initiated on 11/15/13 and completed on 11/18/13for 100% of all residents to ensure no other resident(s) were affected by this deficient practice. 100% skin assessments were completed by nursing ADM on 11/20/13. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on	12/27/13

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F 314	Continued From page 14 10/06/13 after he/she was diagnosed with a fractured left femur. At the time of Resident #1's return to the facility on 10/06/13, facility staff documented the resident's skin was intact with no open areas, and assessed the resident to have a discoloration to the left side of the left knee, reddened areas to the buttocks, and multiple red areas to the right thigh. The resident was also noted to have a "pillow splint" in place to the left leg. Review of Resident #1's medical record revealed facility staff conducted skin assessments on 10/08/13, 10/09/13, 10/10/13, 10/17/13, 10/24/13, 10/31/13, 11/05/13, 11/07/13, and 11/13/13 and noted the resident's skin was intact. On 11/13/13, the facility transferred Resident #1 to the Emergency Room (ER) due to a change in the resident's mental status. Upon Resident #1's arrival to the ER on 11/13/13, the ER physician removed the "pillow splint" from the resident's left leg and observed a 3.5 centimeter (cm) by 6.5 cm decubitus ulcer to the top of the left lower leg and purulent drainage on the "pillow splint." In addition, the ER physician documented Resident #1 had a pressure area to the left heel that had black eschar (dead tissue). The findings include: Review of the facility's policy entitled "Prevention of Pressure Ulcers" and dated October 2013, revealed staff should make every attempt to "float" heels (keep heels from direct contact with the bed) when residents were in bed to avoid pressure. According to the policy, staff was to place a pillow from the resident's knee to the ankle or to use other devices as recommended by clinical staff or the physician. Review of the facility's policy entitled "Splinting"	F 314	12/2/13. **Residents potentially affected:** Residents have the potential to be affected by this deficient practice. All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on 12/2/13. 100% skin assessments were completed by nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/22/13. **Systemic measures:** All staff was in-serviced on the facility's abuse and neglect policy and procedure by the SDC beginning 11/21/13 and completed on 12/2/13. All licensed staff was in-serviced on comprehensive care planning, revision of care planning, proper skin assessments with skills check off list and skin management and prevention of pressure sores policy and procedures by the SDC beginning 11/19/13 and completed on	

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F 314	Continued From page 15 and dated July 2010, revealed splints should be removed and the resident observed for areas of redness, edema, or the development of any open lesions and the findings reported to a Charge Nurse and physician. Based on documentation in the medical record, the facility admitted Resident #1 on 04/28/12 with diagnoses that included Hypertension, Cardiovascular Accident, Coronary Artery Disease, Osteoporosis, Chronic Kidney Disease, Diabetes, Severe Alzheimer's Disease, Osteoarthritis, History of Sepsis secondary to Right Lower Lobe Pneumonia, and a history of Vancomycin Resistant Enterococcus. According to documentation on the Minimum Data Set (MDS) assessment, Resident #1 "rarely/never understood" and as a result, a Brief Interview for Mental Status (BIMS) assessment was not conducted. However, facility staff documented on the MDS that Resident #1's cognition was "severely impaired." Continued review of Resident #1's medical record revealed on 10/06/13, facility staff transferred the resident to the ER due to a deformity of the left leg. Resident #1 was diagnosed with a "pathological" fracture of the left femur related to Osteoporosis (a disease in which bones become fragile and more likely to fracture). Documentation in the ER record revealed the ER staff applied a "pillow splint" to the resident's left femur in an effort to stabilize the resident's leg due to the fracture and transferred the resident back to the facility. Interview with the orthopedic surgeon on 11/19/13 at 11:45 AM revealed he had assessed Resident #1 when he/she had presented to the ER on 10/06/13 and determined the resident had a fractured femur. According to the orthopedic	F 314	12/2/13. 100% skin assessments were completed by nursing ADM on 11/20/13. 100% of all residents with splints were audited by nursing ADM for skin integrity on 11/19/13. 100% of all residents were visualized and audited by nursing ADM to ensure heels and lower extremities were positioned to prevent skin breakdown on 11/19/13. 100% of resident's comprehensive care plans were updated and/or revised in accordance with the skin assessment audit on 11/22/13. Effective 11/19/13 100% of all skin assessments will be completed by two licensed staff to ensure accuracy. Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6 weeks and then 8 weekly skin assessments for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. **Monitoring measures:** Effective 11/25/13 unit mangers will audit 32 weekly skin assessments weekly for 6 weeks and then 8 weekly skin assessments	

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F 314	Continued From page 16 surgeon, due to the resident's diagnosis of Osteoporosis and the "brittleness" of the resident's bones, a "pillow splint" was applied to Resident #1's left thigh for stabilization. The surgeon also stated facility staff should have removed the "pillow splint" to assess Resident #1 for pressure, and changed the splint when it became soiled. Upon Resident #1's return to the facility from the ER on 10/06/13, facility staff assessed the resident to have "discoloration" to the left side of the left knee, reddened areas to the buttocks, and multiple red areas to the right thigh. In addition, on 10/08/13, 10/09/13, 10/10/13, 10/17/13, 10/24/13, 10/31/13, 11/05/13, 11/07/13, and 11/13/13 facility staff documented that skin assessments revealed there were no open areas to Resident #1's skin. On 11/13/13 at 12:15 PM facility staff transferred Resident #1 to the ER due to a change in mental status. Documentation in Resident #1's ER record revealed the resident arrived to the ER on 11/13/13 at 12:34 PM. Based on documentation, when the ER physician removed the pillow splint from Resident #1's left leg, he observed a 3.5 cm by 6.5 cm decubitus ulcer to the resident's left lower leg and a pressure area with black eschar on the resident's left heel. Observation of Resident #1 was conducted at the hospital on 11/19/13 at 12:30 PM, and an interview was attempted; however, due to the resident's impaired cognition the interview was not successful. A skin observation of Resident #1 was conducted on 11/19/13 at 12:30 PM with a nurse at the hospital and, after the nurse removed the gauze dressing from the top of	F 314	for 12 weeks on their perspective units to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the ADON will audit 20 weekly skin assessments for 6 weeks and then 5 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. Effective 11/25/13 the DON will audit 12 weekly skin assessments weekly for 6 weeks and the 3 weekly skin assessments for 12 weeks to ensure licensed staff is accurately completing weekly skin assessments. The updating and/or revision of care planning will be completed during the morning white board meeting. Findings from audits will be reviewed at the monthly QA meeting for three months to ensure compliance with state, federal and company policy, rules and regulations.	

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SIGNATURE HEALTHCARE OF PIKEVILLE	260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501

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F 314	Continued From page 17 Resident #1's left leg, an area was observed on the resident's left lower leg that was open and had yellow drainage. According to the nurse, the area measured 3.5 cm by 6.5 cm in diameter. In addition, continued observations revealed an area on the resident's left heel that was black and unstageable. According to interviews conducted with Certified Nurse Aide (CNA) #1 on 11/18/13 at 1:55 PM, CNA #2 on 11/18/13 at 2:10 PM, CNA #3 on 11/18/13 at 2:15 PM, CNA #4 on 11/18/13 at 3:05 PM, and Certified Medication Aide (CMA) #1 on 11/18/13 at 2:22 PM, they had provided direct care to Resident #1 after his/her return from the hospital on 10/06/13. The aides stated they had not been directed to remove the resident's splint and had left the splint intact. The aides said if the splint became soiled they notified the nurse in charge, and the nurses changed the splint. According to interviews with the aides, they did not observe Resident #1 to have any pressure sores prior to the resident's transfer to the ER on 11/13/13. The aides stated if they observed a pressure area they would have reported the change in the resident's condition to the nurse. Interviews with nursing staff, Licensed Practical Nurse (LPN) #1 on 11/18/13 at 2:44 PM, LPN #2 on 11/18/13 at 2:55 PM, LPN #3 on 11/18/13 at 4:05 PM, Registered Nurse (RN) #1 on 11/18/13 at 5:00 PM, RN #2 on 11/19/13 at 8:55 AM, LPN #4 on 11/19/13 at 9:35 AM, LPN #5 on 11/19/13 at 3:10 PM, and the South Hall Unit Manager on 11/19/13 at 3:25 PM, revealed they were only to remove Resident #1's "pillow splint" as "necessary." Based on the interviews, the CNAs/CMAs were to report any concerns related to any resident to the nurses and stated they had	F 314		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185094		C 11/19/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 314	Continued From page 18 not reported any concerns related to Resident #1's condition or "pillow splint" to them. According to interview, the nurses had conducted skin assessments on a weekly basis of all residents. The interviews revealed they had not observed any concerns related to Resident #1's skin integrity; however, with the exception of LPN #5, they had not removed the splints and heel protectors to perform skin assessments. LPN #3 stated in an interview conducted on 11/18/13 at 4:05 PM that she had performed a head to toe assessment of Resident #1 prior to the resident's transfer to the ER on 11/13/13. LPN #3 stated she was not aware of a blackened area to Resident #1's left heel. In addition, the LPN stated she had not removed Resident #3's "pillow splint" because the physician did not want the splint removed. The Administrator and the Nurse Consultant stated in interview conducted on 11/19/13 at 3:40 PM that all splints, assistive devices, and pressure prevention devices should be removed prior to skin assessments unless there were physician's orders not to remove them. According to the Administrator, the physician had requested for the "pillow splint" to Resident #1's left leg to only be removed "if necessary" to provide care. The Administrator and the Nurse Consultant stated they did not know if facility staff had removed the "pillow splint" from Resident #1's left leg or why staff failed to identify the pressure areas to Resident #1's left lower leg and the left heel.	F 314		