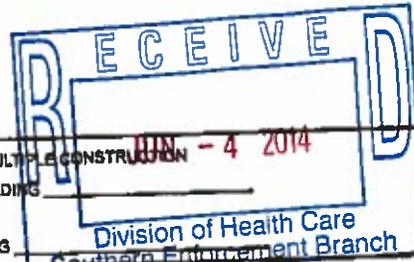


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 05/22/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING  B. WING	(X3) DATE SURVEY COMPLETED  05/08/2014
NAME OF PROVIDER OR SUPPLIER  PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(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	F 000		
F 253 SS=E	<p>A standard health survey was conducted on 05/08-08/14. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of maintenance building inspections, and a review of the facility's policy it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain an orderly and comfortable interior. During an environmental tour, observations revealed the curtain hooks were missing or unhooked from the privacy curtains in numerous resident rooms.</p> <p>The findings include: A review of the facility Housekeeping Department policy titled First South Assignment, with a review date of February 2013, revealed facility housekeepers were to monitor the privacy curtains in resident rooms to ensure they worked properly on their tracks and that every hook was connected to the corresponding hole. In addition, the policy revealed the Maintenance Director was responsible for conducting monthly inspections of the building to identify items in need of repair.</p> <p>Observations conducted during an environmental</p>	<p>F 253 On 5/7/14, the Environmental Services Director conducted a walk-thru of the Nursing Facility and completed a Maintenance Request to check all curtains for missing hooks and to obtain hooks to replace those missing and ensure curtains moving freely in tracks.</p> <p>As of 5/12/14, all hooks have been replaced to allow for full privacy of each resident in the facility. (See attached work order # 132891)</p> <p>The Housekeeping Department policy on "First South Assignment" was revised on 5/29/14 to require Housekeeping Staff to check privacy curtains daily seven days per week to ensure that missing hooks and problems with privacy curtains are addressed timely by having the Housekeeper to complete a Maintenance Request and notify Maintenance Department. All Housekeeping Staff will be educated on the policy the week of 6/2 -6/6/14.</p> <p>The Director of Housekeeping will continue to perform walk-thru inspections daily five days per week with particular attention paid to privacy curtains. Results of walk-thru inspections will be reported quarterly to the Nursing Facility Committee by the Director of Housekeeping.</p>	6/06/14	

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

*Dinah James*

TITLE

CNO

(X6) DATE

6/4/14

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  PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
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F 253	<p>Continued From page 1</p> <p>tour with the Maintenance Director on 05/07/14 at 10:00 AM, revealed 18 privacy curtains in resident rooms that failed to provide full visual privacy for the residents. The privacy curtains in resident rooms 102, 103, 104, 105, 106, 107, 113, 114, 116, 117, and 118 had hooks missing and/or the hooks were not connected to the curtain track and as a result failed to provide privacy for the residents.</p> <p>An interview with Housekeeper #1 on 05/08/14 at 9:35 AM revealed she was to check the privacy curtains on a daily basis. However, the Housekeeper stated she did not always observe each curtain and had not identified any problems related to the privacy curtains.</p> <p>An interview with the Maintenance Director on 05/07/14 at 10:15 AM, revealed he inspected the building, including resident rooms, on a monthly basis to identify items in need of repair. The Maintenance Director stated he had not observed that the privacy curtains in resident rooms were missing hooks and/or were not hooked and connected to the curtain track. In addition, the Maintenance Director stated Housekeeping staff was to report repairs that were needed to the Maintenance Department. According to the Maintenance Director, the Maintenance Department had not received any requests from the housekeepers related to the privacy curtains.</p> <p>An interview with the Director of Environmental Services on 05/08/14 at 8:57 AM revealed he supervised the housekeeping staff and stated the housekeepers should observe resident rooms, including the privacy curtains, when they conducted their daily cleaning assignments of resident rooms and should report any identified</p>	F 253			

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NAME OF PROVIDER OR SUPPLIER  PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 880 RIVERVIEW AVENUE PINEVILLE, KY 40977	
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F 253	Continued From page 2 concerns to the Director of Environmental Services. The Director of Environmental Services further stated he conducted a "walk through" of the building on at least a daily basis to observe for needed repairs and to complete a work order to request that the repairs be made. However, the Environmental Services Director stated he had failed to observe the privacy curtains that were in need of repair.	F 253		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent infections of the urinary tract for one (1) of ten (10) sampled residents (Resident #8). Facility staff failed to clean the catheter tubing away from the urethra (urinary opening to pass urine outside the body) in accordance with facility policy when they provided catheter care to Resident #8.  The findings include:	F 315	On 5/8/14 the MDS Coordinator and Unit Supervisor addressed the need to monitor the resident closely for signs/symptoms of UTI as a result of improper catheter care. This was accomplished x 1 week with no signs/symptoms of UTI reported or documented.  On 5/13-5/16/14, the Unit Supervisor observed 36 instances of catheter care for the 9 residents with catheters. Catheter care was performed correctly 100% of the time. The (NA #1) was observed to perform catheter care correctly 100% of the time (4 observations). See attached Catheter Care Compliance Checklist completed by Unit Supervisor.  A Competency Assessment Tool for Catheter Care for Licensed Nurses/Nursing Assistants was developed to be used to assess each employee's compliance with adherence to policy for catheter care. The Annual Skills Lab Proficiency Assessment was revised to include the following criteria to be assessed annually in December. Proficiency assessment will be accomplished via direct performance of skills and articulation of procedure. Criteria to be assessed include: <ul style="list-style-type: none"> <li>• Inspection of catheter tubing and drainage bag</li> <li>• Correct performance of catheter care</li> <li>• Disposal of supplies/linens</li> <li>• Documentation related to catheter care</li> </ul>	6/05/14

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F 315	<p>Continued From page 3</p> <p>Review of the policy, "Foley Catheter Care," (dated November 1987) revealed the catheter tubing should be washed from the opening of the urethra outward four inches when catheter care was provided.</p> <p>Review of the medical record revealed the facility admitted Resident #6 on 11/19/07 with diagnoses that included Dementia, Congestive Heart Failure, Diabetes Mellitus, and Terminal Care. Review of the Minimum Data Set (MDS) assessment dated 04/21/14, revealed Resident #6 required total assistance with toileting needs and required an indwelling urinary catheter for close monitoring of the resident's intake and output secondary to a diagnosis of Congestive Heart Failure.</p> <p>Observation of incontinence care was conducted on 05/07/14, at 10:35 AM, with Certified Nursing Assistants (CNAs) #1 and #2. Both CNAs were observed to wash their hands, put on gloves, and place clean towels and washcloths at the resident's bedside. However, observation revealed CNA #1 obtained a clean washcloth, wet the cloth with soap and water, and cleaned approximately four to six inches of the indwelling urinary catheter tubing toward the urethra.</p> <p>Interview conducted with CNA #1 on 05/07/14, at 2:55 PM, revealed the CNA had been trained to hold the catheter tubing when cleaning the tubing to prevent pulling and to clean the catheter tubing away from the urinary meatus. CNA #1 stated she was nervous and did not realize she had cleaned the tubing in the wrong direction.</p> <p>The Director of Nursing (DON) confirmed in an</p>	F 315	<p>(F 315 continued)</p> <p>The Foley Catheter Care Performance Improvement Study was revised to monitor and ensure catheter care is being performed per policy. This will be assessed via actual observation by the Unit Supervisor on a weekly basis. Findings will be reported to the CNO monthly and to the Nursing Facility Committee on a quarterly basis. (See attached Data Collection Tool, Reporting Calendar, and Monitoring and Evaluation Plan)</p> <p>On 5/12/14, the Infection Control Preventionist presented an In-service Education Program on Catheter Care policies/procedures.</p>		

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F 315	Continued From page 4 interview conducted on 05/08/14, at 8:00 PM, the CNA should have cleaned the catheter tubing away from the urinary meatus. The DON stated she conducted "spot" checks to observe catheter care to ensure the care was provided in a manner to prevent the development of urinary tract infection and no problems had been identified or reported.	F 315			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to	F 431	On 5/14/14, 3 (three) locking narcotic boxes were purchased to be permanently affixed to the locked medication storage cabinet in the Medication Room.  On 5/27/14, installation of the 3 (three) narcotic boxes was accomplished by Maintenance Department. (See attached completed Work Order). The Pharmacy Department Staff removed all Schedule II-V narcotics from the medication carts and stored them in the narcotic boxes in the Medication Room. Narcotic boxes are labeled as per cart (1, 2, and 3).  On 5/14/14 the Policy for Medication Carts and Controlled Substances in the Nursing Facility was revised to reflect practice and compliance with regulation. (See attached Medication policies/procedures).  On 5/31/14, a Medication Storage and Security Checklist was developed to document medication cart checks for presence of unsecured medications and schedule (II-V) narcotics on all medication carts. The following schedule for checking of carts was established: <ul style="list-style-type: none"> <li>• Every 4 hours x 7 days</li> <li>• Every shift x 1 month</li> <li>• Every day x 1 month</li> <li>• Random weekly checks</li> </ul> All checks will be accomplished by Unit/Shift Supervisors.	6/05/14	

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F 431	<p>Continued From page 5</p> <p>abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure scheduled and controlled medications were stored in a separately locked and permanently affixed compartment. The facility identified seven (7) of ten (10) sampled residents (Residents #1, #2, #4, #6, #7, #8, and #9) and six (6) unsampled residents (Residents A, B, C, D, E, and F) that received scheduled and controlled medications routinely as prescribed by the physician. Observation revealed narcotic medications were stored in the same medication drawer as the resident's routine medications. In addition, facility staff failed to ensure medications were maintained in a secure manner during the medication pass conducted on 05/07/14.</p> <p>The findings include:</p> <p>Review of the facility's "Medication Management" policy (revision date January 2013) revealed all controlled medications would be placed in "covered, limited-access bins" that required confirmation of the existing count of that bin. The policy further noted medication carts were to be kept locked at all times when a nurse was not present at the cart. In addition, the policy revealed staff should not leave medications lying on top of the medication carts.</p>	F 431	<p>(F 431 continued)</p> <p>Performance Improvement indicators were developed to monitor for compliance with medication storage and security. Results of findings will be reported quarterly to the Nursing Facility Committee by the CNO. Data Collection will be accomplished by the Unit/Shift Supervisors and CNO.</p> <p>On 5/27-6/5/14, the Unit/Shift Supervisors and CNO presented in-service education on Security and Storage of Medications for Licensed Nurses. (See attached In-service Attendance Record)</p>		

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F 431	<p>Continued From page 6</p> <p>1. The facility was observed to have three medication carts for medication use and storage. The medication carts were observed to be stored in front of the nurses' station when not being used for medication administration. Observations conducted on 05/08/14, at 7:32 PM, of the medications stored in the medication carts revealed the scheduled and controlled medications for Residents #1, #2, #4, #6, #7, #8, #9, A, B, C, D, E, and F were stored in the same compartment/drawer with the residents' other routinely prescribed medications.</p> <p>Interview with Registered Nurse (RN) #1 on 05/08/14 at 7:34 PM, revealed staff was to keep each medication cart locked. RN #1 stated nurses entered their personal data into the computer system on the medication cart and pressed the "unlock" button on the cart in order to access each compartment that contained medications. RN #1 confirmed there was not a separate locked compartment for the scheduled and controlled medications. RN #1 also stated the scheduled and controlled medications were counted at the beginning and end of each shift and staff had not identified any discrepancies in the number of medications contained in the carts.</p> <p>Interview conducted with the Director of Nurses (DON) on 05/08/14, at 8:00 PM, revealed the medication carts currently in use had been implemented sometime in August or September 2013. The DON confirmed the medication carts did not have separately locked compartments for storing the scheduled and controlled medications. The DON further stated she was not aware the scheduled and controlled medications had been stored with the residents' routinely prescribed medications.</p>	F 431			

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F 431	<p>Continued From page 7</p> <p>2. A medication observation pass conducted on 05/07/14, at 8:30 AM revealed RN #2 obtained two medications for Resident #4 from a medication cart located outside resident room 112, which was across the hall from the nurses' station. RN #2 was observed to leave the two tablets in a medicine cup, unattended, on top of the medication cart while she left the cart to obtain a container of an additional medication from the refrigerator located in the medication room behind the nurses' station. Continued observation revealed RN #2 returned to the cart with the additional medication, prepared the medication for administration, and then left the medications, unattended, on top of the medication cart while she returned the container of the additional medication to the refrigerator located in the medication room. During the course of the medication preparation for Resident #2, facility staff was observed to walk past the unsecured medications that RN #2 had left unattended on top of the medication cart.</p> <p>Further observation of the medication pass on 05/07/14, at 8:50 AM, revealed RN #2 set up one tablet in a medicine cup for Resident G and placed the medication on top of the medication cart. RN #2 was observed to leave the medication and medication cart unsecured and walk approximately 57 feet away from the cart to obtain blood pressure equipment. RN #2 returned and entered Resident G's room to obtain his/her blood pressure. RN #2 then returned the blood pressure equipment to the designated area located approximately 57 feet from the medication cart while the resident's medication remained unattended on top of the cart and the medication cart remained unsecured.</p>	F 431			

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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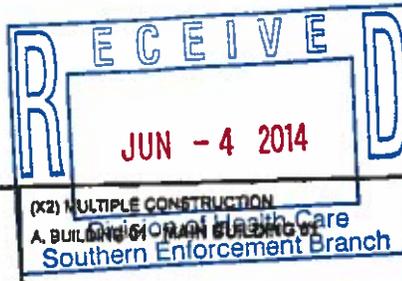
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F 431	Continued From page 8  Interview with RN #2 on 05/07/14, at 3:45 PM, revealed the facility required staff to keep medications in a locked drawer or to keep the medication with them if the medications had already been prepared. The RN stated she had been trained to always secure the medications, and acknowledged she failed to secure the medications during the medication pass. RN #1 stated she was "nervous" and failed to secure the medications.  Interview with the DON on 05/08/14, at 8:00 PM, revealed staff was not to leave medications unsupervised. The DON also stated staff should ensure the medication cart was locked at all times if they needed to leave the cart. In addition, the DON stated she monitored medication pass on a random basis to ensure staff maintained the security of the medication carts and, according to the DON, the facility had not identified any problems related to the administration of medication.	F 431			

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K 000	INITIAL COMMENTS  CFR: 42 CFR §483.70 (a)  BUILDING: 01  PLAN APPROVAL: 1985  SURVEY UNDER: 2000 Existing  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One story, Type 1 (322)  SMOKE COMPARTMENTS: 3  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM  FULLY SPRINKLERED (WET SYSTEM)  EMERGENCY POWER: Type II diesel generator  A life safety code survey was initiated and concluded on 05/06/14, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.  Deficiencies were cited with the highest deficiency identified at "E" level.	K 000		
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the	K 056	On 5/9/14 the Maintenance Department Director conducted a walk thru inspection in the Nursing Facility to ensure appropriate sprinkler heads in required areas and that no sprinkler heads were obstructed. The Maintenance Director met with the CEO to inform him of the situation with the closet and lack of sprinkler head.  On 5/28/14 the Maintenance Director requested a quote for installation of a sprinkler for the closet. The sprinkler was installed in the closet today, 6/2/14. The sprinkler system is checked on a quarterly basis by Simplex. Checking of sprinkler heads for proper working conditions, blockage, and presence of proper sprinkler equipment has been added to the monthly Preventative	6/2/14

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

TITLE

CNO

(X6) DATE

6/4/14

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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PINEVILLE COMM HOSP

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FORM APPROVED  
OMB NO. 0938-0391DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/06/2014
NAME OF PROVIDER OR SUPPLIER  PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(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 056	<p>Continued From page 1</p> <p>Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to ensure that the building sprinkler system was installed throughout the facility according to National Fire Protection Agency (NFPA) standards. This deficient practice affected one (1) of three (3) smoke compartments, staff, and eighteen (18) residents. The facility has the capacity for 30 beds with a census 23 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 05/06/14 at 12:05 PM with the Maintenance Secretary (MS), a sprinkler head was observed to be missing from a closet near the nurses' station. There must be complete coverage by the sprinkler system in all areas of the building.</p> <p>An interview with the MS on 05/06/14 at 12:05 PM revealed she and Maintenance personnel were aware the closet required sprinkler protection but she did not know what plans the facility had to remedy the situation.</p> <p>The Administrator was not available for the exit interview. The MS stated she would inform the</p>	K 056	Maintenance Checks. The first monthly check will be accomplished on 7/1/14.	

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K 056	Continued From page 2 Administrator of these findings.	K 056			