

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

Amended

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCALID AVENUE PAINTSVILLE, KY 41240		
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY19246) was initiated on 10/23/12, and a standard health survey was conducted on 10/29/12-11/01/12. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "G" level, with no opportunity to correct.</p> <p>AMENDED--</p> <p>After review by The Centers for Medicare and Medicaid Services (CMS), Immediate Jeopardy was determined to exist and an extended survey was conducted on 12/11-13/12.</p> <p>Immediate Jeopardy was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified on 12/11/12. Observation, interview, and record review revealed the facility failed to have an effective system in place to ensure staff: 1) notified the resident's physician of a change in the resident's condition, 2) assessed the resident's wound weekly per facility policy, 3) arranged transportation to medical appointments, and 4) documented the resident's wound assessments weekly per facility policy. On 09/12/12, facility staff noted Resident #1 had a scabbed wound to the left great toe. Facility staff notified the resident's physician of the wound and new orders were obtained that included referring the resident to a Wound Care Clinic (WCC). Resident #1 was seen at the WCC on 09/13/12 and 09/20/12, and staff was to schedule a follow-up appointment for Resident #1 to be seen at the WCC on 09/27/12; however, there was no documented evidence Licensed Practical Nurse (LPN) #1 arranged transportation for the</p>		<p>Mountain Manor of Paintsville does not believe and does not admit that any deficiencies existed, either, before, during or after the survey. Mountain Manor of Paintsville reserves all rights to contest the survey findings through informal dispute resolution, formal legal appeal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds, nor is it meant to establish any standard of care, contract obligation or position, and Mountain Manor reserves the right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance, or self-critical examination privileges which Mountain Manor of Paintsville does not waive, and reserves the right to assert in any administrative, civil, criminal claim, action or proceeding. Mountain Manor of Paintsville offers its responses, credible allegation of compliance, and plan of correction as part of its ongoing effort to provide quality care to its residents.</p> <p>F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>It is the policy of this facility to immediately inform the resident; consult with the resident's physician; and if known, notify the residents legal representative or an interested family member when there is 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.</p>	

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JAN - 7 2013
Division of Health Care
Southern Enforcement Branch

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

TITLE

(X6) DATE

Debrah F. [Signature] Administrator 1-7-13

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 000	<p>Continued From page 1</p> <p>resident's follow-up appointment for the 09/27/12 appointment and therefore the resident was not assessed/treated at the WCC.</p> <p>Facility staff documented an assessment of the wound on Resident #1's left great toe on 09/28/12 (15 days after the previous documented assessment of the wound on 09/13/12), and noted the wound was red with pink surrounding tissue measuring 1.4 centimeters (cm) x 0.2 cm x 0.1 cm.</p> <p>The Minimum Data Set (MDS) Assistant revealed in an interview that she conducted an assessment of Resident #1 on 10/15/12, and the resident's toe was moist with black necrotic tissue, brown purulent drainage, a foul odor, and redness to the first joint of the toe. According to the MDS Assistant, she did not document the assessment but reported her concerns related to the resident's wound to LPN #1 to notify the physician. However, a review of documentation revealed LPN #1 failed to notify the physician of the change in Resident #1's wound on 10/15/12.</p> <p>Although facility staff documented treatments were administered to the wound on Resident #1's left foot from 09/28/12 to 10/16/12, facility staff failed to document an assessment of the wound until 10/17/12, 19 days after the previous assessment of the wound on 09/28/12. A review of the nurse's notes dated 10/17/12, revealed the wound to the resident's left toe had an odor, was draining, and facility staff notified the resident's physician and orders were received to culture the wound and refer the resident to the WCC. Facility staff also notified Resident #1's family member of the changes and new orders.</p>	F 000	<p>1. The attending physician and the family of resident #1 was notified on 10/17/12 by Mona Jacobs, LPN of the change in condition related to the wound on the left great toe. See attachment #1</p> <p>The attending physician of resident #1 was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being transferred to KDMC to the physician that had previously performed surgery on her prior to her admission to this facility. See Attachment #2</p> <p>Mary Arms, DON began reviewing the record of Resident #1 on 10/18/12 and continued to review and investigate on 10/19/12.</p> <p>The attending physician of resident #1 was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3</p> <p>The MDS and care plan of resident #1 was reviewed on 10/19/12 by Roberta Thompson, RN MDS Coordinator.</p> <p>On 10/20/12 the son of Resident #1 came to the facility. At this time Mary Arms DON spoke with the son and notified him that his mother,</p>	

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F 000	<p>Continued From page 2</p> <p>On 10/18/12, Resident #1's family member insisted on observing the wound on the resident's left great toe. Documentation revealed the wound was assessed and LPN #1 documented the wound was red and inflamed, had a yellow sloughing and an odor, and was necrotic. Resident #1 was transported to an acute care facility on 10/18/12. Resident #1's toe was amputated on 10/20/12, due to a diagnosis of wet gangrene.</p> <p>Deficiencies were cited at 42 CFR 483.10 Resident Rights (F157), 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.25 Quality of Care (F309), 42 CFR 483.75 Administration (F490), Maintain Clinical Records (F514), and Quality Assurance (F520) at a scope and severity of "J". In addition, deficient practice was identified at 42 CFR 483.25 Quality of Care (F314) at a scope and severity of "H". Substandard Quality of Care (SQC) was identified at 42 CFR 483.25 Quality of Care (F309 and F314).</p> <p>An acceptable Allegation of Compliance (AOC) was received on 12/13/12, which alleged removal of Immediate Jeopardy on 10/25/12. The State Agency determined the Immediate Jeopardy was removed on 10/25/12, prior to exit, which lowered the scope and severity to "D" level at 42 CFR 483.10 Resident Rights (F157); 42 CFR 483.25 Quality of Care (F309); 42 CFR 483.75 Administration (F490), Maintain Clinical Records (F514), and Quality Assurance (F520) while the facility monitors the effectiveness of systemic changes and quality assurance activities. The scope and severity for the deficiency cited at 42</p>	F 000	<p>resident #1 had missed the appointment to wound care clinic and that the facility had notified APS and the OIG.</p> <p>Resident #1 has not returned to this facility.</p> <p>On 10/19/12 a full skin assessment was completed on Resident #2 by Jessica Arnett, RN and Heather Mowery, LPN.</p> <p>All wounds identified on the 10/19/12 individual skin assessment for resident #2 was compared to the treatment MAR to ensure that each identified wound had a treatment ordered. This was completed by Christy Moore, RN on 10/20/12.</p> <p>The individual wound documentation flow sheet for resident #2 was reviewed and compared to the individual skin assessment performed on 10/19/12 to ensure that all identified wounds had been measured and are on the resident's individual wound documentation flow sheet. This was completed on 10/20/12 by Christy Moore, RN.</p> <p>The skin assessment for resident #2 was compared to the most recent MDS to ensure that all wounds were identified and care planned. This was</p>		

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F 000	Continued From page 3 CFR 483.20 Resident Assessment (F282) was lowered to "G" level due to other examples of actual harm.	F 000	completed on 10/21/12 by Donna Fannin; LPN MDS staff.	
F 157 SS=J	Additional deficiencies were cited as a result of the standard health survey. 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	F 157	On 10/22/12 the attending physicians of Resident #2 was notified by fax of the resident wounds, the type and location. This was completed by Christy Moore, RN. See Attachment #4 On 11/20/12 the family of Resident #2 was contacted by Brenda Humphries, RN regarding the resident wounds to ensure that the family was aware of the resident wounds and treatments ordered. On 10/19/12 an individual skin assessment was completed on Resident #3 by Jeri Frazier, LPN. All wounds identified on the 10/19/12 individual skin assessment for resident #3 was compared to the treatment MAR to ensure that each identified wound had a treatment ordered. This was completed by Christy Moore, RN on 10/20/12. The individual wound documentation flow sheet for resident #3 was reviewed and compared to the individual skin assessment performed on 10/19/12 to ensure that all identified wounds had been measured and are on the resident's individual wound documentation flow sheet.	

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F 157	<p>Continued From page 4 legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure the resident's physician and legal representative were notified of a significant change in condition and the need to alter treatment for one (1) of twenty-four (24) sampled residents (Resident #1). On 09/12/12, documentation in the nurse's notes revealed Resident #1 had a scabbed area less than 0.1 centimeter (cm) in diameter with redness noted around a scabbed area to the left great toe. Interview with the Minimum Data Set (MDS) Assistant revealed on 10/15/12 she assessed a wound to Resident #1's left great toe and noted the wound was moist with necrotic (dead tissue) black tissue, brown purulent drainage, and a foul odor. The MDS Assistant stated she immediately informed Licensed Practical Nurse (LPN) #1 of the assessment of Resident #1's wound on 10/15/12. However, there was no documented evidence the physician and legal representative were notified on 10/15/12, concerning the change in condition to Resident #1's left great toe. On 10/17/12 (2 days after the MDS Assistant's assessment on 10/15/12) LPN #3 notified Resident #1's physician of drainage and odor to the resident's left great toe wound and obtained new orders. On 10/18/12, at 10:30 AM a nurse's note revealed Resident #1's legal representative insisted on observing the wound to Resident #1's left great toe after the legal representative was informed that new orders had been received on 10/17/12, related to the resident's wound. LPN</p>	F 157	<p>This was completed on 10/20/12 by Christy Moore, RN:</p> <p>The individual skin assessment completed on 10/19/12 for resident #3 was compared to the most recent MDS to ensure that all wounds were identified and care planned. This was completed on 10/21/12 by Donna Fannin, LPN MDS staff.</p> <p>On 10/22/12 the attending physicians of Resident #3 was notified by fax of the resident wounds, the type and location. This was completed by Christy Moore, RN. See Attachment #4</p> <p>On 11/20/12 the family of Resident #3 was contacted by Chanity Purcell, LPN regarding the resident wounds to ensure that the family was aware of the resident wounds and treatments ordered.</p> <p>2. On 10/19/12 a skin assessment was completed on all residents by licensed staff to ensure that all alterations in skin integrity had been identified. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p>	
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F 157	<p>Continued From page 5</p> <p>#1 and the Assistant Director of Nursing (ADON) were present during the observation of the wound on 10/18/12, at 10:30 AM and LPN #1 documented the toe was "red/inflamed" with a "necrotic area," "yellow sloughing" (a mass or layer of dead tissue separated from the surrounding or underlying tissue), and had an odor. Resident #1 was transported to an acute care facility on 10/18/12, and the resident's left great toe was amputated on 10/20/12, due to "wet gangrene" (death of tissue due to a loss of blood supply with a bacterial infection), and the resident remains at the acute care facility. (Refer to F309.)</p> <p>The failure of the facility to ensure staff immediately notified the resident's physician and responsible party when residents experienced a change of condition placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.10 Resident Rights, at a scope and severity of "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance process.</p> <p>The findings include:</p>	F 157	<p>All attending physicians were notified via fax on 10/22/12 of their respective resident's wounds, the type of wound and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>The Medical Director, Dr. Charles Hardin reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. He signed each sheet. See attachment #4</p> <p>On 10/28/12, 10/29/12 and 10/30/12 each attending physicians was notified of all wounds of their respective residents and the current treatment orders for those wounds. The physicians were notified via fax using the WOUND NOTIFICATION FORM. The physicians were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chanity Purcell LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the</p>	

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F 157	Continued From page 6 Review of the facility policy entitled "Change in a Resident's Condition or Status" (undated) revealed the facility was to notify the resident's attending physician and representative of changes in the resident's condition/status. The policy revealed Nursing Services would be responsible for notifying the resident's attending physician and representative when there had been a significant change in the resident's physical status, when there had been a need to alter the resident's treatment significantly or when deemed appropriate in the best interests of the resident. The review further revealed all notifications should be made as soon as practical, "but in no case shall such notification exceed twenty-four (24) hours." The policy also revealed, "All changes in the resident's medical condition must be properly recorded in the resident's medical record in accordance with our charting and documentation policies and procedures." 1. An interview on 10/25/12, at 1:00 PM with the MDS Assistant revealed Resident #1 was initially admitted to the facility on 06/26/12, for rehabilitation following a Right BKA to learn how to ambulate with prosthesis prior to the resident's discharge home. The MDS Assistant stated she conducted a head to toe assessment of Resident #1 on 10/15/12, during the completion of an MDS assessment. The interview revealed at the time the assessment was conducted, the MDS Assistant was very concerned about the resident's wound to the left great toe; however did not document the status of the wound. According to the MDS Assistant, at the time of her assessment, Resident #1's wound was moist,	F 157	current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6 The nurse's notes for all residents were reviewed for the months of October, November and through December 15, 2012 for documented changes in resident condition and physician and family notification. This was completed by Mary Arms DON, Anna Caldwell ADON, Emily Jones-Gray Assistant Administrator, Brenda Humphries Quality Assurance, Kathy Meadows Social Services, Misty Pennington Social Services and Marie Pennington Activities Director. If it could not be determined by reviewing the nurse's notes that the family and MD were notified of changes in resident condition then the MD and family were contacted regarding the change. The respective physicians were faxed by Mary Arms, DON on December 18 - 19, 2012 to ensure that they were aware. None of the physicians responded back to the facility indicating that they were unaware of any of the documented changes in the resident condition. Families were contacted on December 14 - 16, 2012 by Anna Caldwell, ADON, Chanity		

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F 157	<p>Continued From page 7</p> <p>had a foul odor, brown purulent drainage, black necrotic tissue, and was red from the wound on the tip of the toe to the first joint of the left great toe. The MDS Assistant revealed she reported her concerns about Resident #1's wound to LPN #1. The interview revealed the MDS Assistant thought LPN #1 would notify Resident #1's physician of the wound condition.</p> <p>An interview on 10/24/12, at 4:30 PM with LPN #1 revealed Resident #1's left great toe had a "small black spot" when she last assessed the wound but could not recall the date. However, according to the LPN, on 10/18/12, Resident #1's family member insisted on observing the wound and, at that time, the resident's entire toe was red with black necrotic tissue, sloughing to the side. LPN #1 stated staff was to assess a resident wound with each treatment and the physician was to be notified of any changes in the wound. LPN #1 stated she did not recall being informed that the wound on Resident #1's great toe had changed or had an odor.</p> <p>An interview on 10/24/12, at 12:50 PM with LPN #3 revealed when she performed wound care to the wound on Resident #1's left great toe on 10/12/12, the wound had not changed and appeared to be a dry callus. However, according to LPN #3 when she assessed the wound on 10/17/12, the wound had an odor and drainage, and the LPN notified the physician and received new orders. LPN #3 could not explain why she notified the physician on 10/17/12, when she signed the wound care as being completed on 10/16/12, according to the Treatment Administration Record (TAR).</p>	F 157	<p>Purcell, LPN, Emily Gray, Assistant Administrator, Kathy Meadows, Social Services, and Misty Pennington, Social Services to ensure that families were aware of documented changes in resident condition. There was one documented change in one resident that the family was unaware of.</p> <p>All accident/ incident reports for September, October and through November 23, 2012 were reviewed and compared to the resident record to ensure that the MD and family had been notified. This was completed by November 23, 2012 by Mary Arms, DON.</p> <p>3. LPN #1, Rose Ratliff was terminated on 10/18/12 by Mary Arms, DON for failure to assess and document the resident wounds, failure to notify the MD and family of a change in condition and failure to make the transportation arrangements to the wound care clinic.</p> <p>LPN #3, Mona Jacobs was given a disciplinary warning and placed on probation On 10/20/12 by Mary Arms, DON for failure to assess and document the resident wound.</p> <p>Licensed staff was in-serviced on resident assessment, measuring</p>	

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F 157	<p>Continued From page 8</p> <p>Review of Resident #1's closed record revealed the facility admitted the resident on 06/28/12, with diagnoses of Right below the Knee Amputation (BKA), Hypertension, Diabetes Insipidus, and Mild Malnutrition. On 09/12/12, approximately two and one half months after admission, documentation in the nurse's notes at 9:30 AM by LPN #1 revealed the resident had a scabbed area less than 0.1 centimeter (cm) in diameter with redness noted around a scabbed area to the left great toe. The note revealed Resident #1's physician and representative were notified at that time and new orders were received for treatment to the area on the left great toe and for a referral to the Wound Care Clinic (WCC).</p> <p>Review of Resident #1's WCC notes dated 09/13/12, revealed the wound to the resident's left great toe was assessed to be a Diabetic Ulcer that measured 2.2 cm x 1.8 cm x 0.1 cm. Continued review of the WCC notes revealed Resident #1 received treatment on 09/20/12 and at that time the resident's wound measured 0.7 cm x 0.6 cm x 0.1 cm and the base of the wound was pale pink, with scabbed epithelium partial coverage to the wound. The note revealed there was no eschar, no yellow sloughing, and no drainage or on odor noted. The resident was not seen again at the WCC due to the facility's failure to arrange transportation for the 09/27/12, follow up appointment. (Refer to F309.) There was no further documentation from the WCC addressing the status of Resident #1's wound.</p> <p>Continued review of Resident #1's medical record revealed a Treatment Administration Record (TAR) for September and October 2012, which revealed staff was to cleanse the wound on the</p>	F 157	<p>wounds, treatments and documentation; maintaining accurate medical records, physician and family notification, policies and staff responsibility, making appointments, scheduling transportation to appointments, making transportation arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was started on 11/08/12 and completed on 11/23/12</p>	

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
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F 157	<p>Continued From page 9</p> <p>resident's left great toe with normal saline, cover the wound with Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) and a "4 x 4" gauze, then wrap the wound with a "Kling" dressing every forty-eight (48) hours. A review of the TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12, 10/14/12 and on 10/18/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12, and on 10/16/12.</p> <p>Although staff documented the wound care every forty-eight (48) hours on the TAR from 10/02/12, through 10/16/12, there was no documentation from 09/28/12 through 10/16/12 that described the status of Resident #1's wound on the left great toe until 10/17/12. On 10/17/12, at 2:50 PM, LPN #3 documented the wound to the resident's left great toe had an odor and drainage; notified the resident's physician of the assessment made on 10/17/12; and received new orders for a culture of the wound and another referral to the WCC.</p> <p>Continued review of the nurse's note revealed on 10/18/12, at 10:30 AM Resident #1's family member insisted on observing the wound, and LPN #1 and the ADON removed the dressing covering the resident's wound. Documentation revealed the resident's toe was red and inflamed, had a necrotic area, yellow sloughing, and had an odor. According to documentation by LPN #1, Resident #1's family member insisted the resident be transported to an acute care facility for evaluation and treatment.</p>	F 157	<p>by Mary Arms, DON. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>All nursing staff on medical leave at the time of in-servicing will be in-serviced prior to their return to work by Mary Arms, DON.</p> <p>The Pressure Policy was reviewed by Mary Arms, DON and Deborah Fitzpatrick, Administrator on 10/21/12 with no changes needed. The Medical Director, Dr. Charles Hardin is in agreement. See Attachment #11</p> <p>The Wound Documentation policy was revised on 10/21/12 by Mary</p>	

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

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F 157	<p>Continued From page 10</p> <p>A review of the Surgical Report dated 10/20/12, revealed Resident #1's left great toe was amputated due to ulceration with wet gangrene.</p> <p>An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician confirmed she had not been informed of the decline in the status of Resident #1's wound until 10/17/12. According to the Physician, she expected the nurses to assess the resident's wounds while performing wound care and to be notified of any changes in the wound. The interview revealed the Physician was unaware Resident #1 had not kept the follow up appointment at the WCC as ordered by the WCC until after the resident was sent to the hospital on 10/18/12.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on 10/31/11, with diagnoses of left buttock ulcer, sacral ulcer, Anemia, Peripheral Vascular Disease and Diabetes. Resident #2's medical record revealed the resident was readmitted from an acute care facility on 08/06/12, with a pressure ulcer to the left buttock and blisters to both heels.</p> <p>The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 and the wound to the left buttock measured 3 cm x 3.5 cm x 4 cm, the left heel wound measured 5 cm x 5 cm, and the right heel wound measured 5 cm x 5 cm. On 08/19/12, the left heel measured 6.1 cm x 8.6 cm x unable to determine (UTD), the right heel had no measurements and the area on the left buttock measured 3 cm x 3.4 cm x 5 cm. There was no documentation that the resident's physician was notified of the increase in size of the resident's wounds.</p>	F 157	<p>Arms, DON and Deborah Fitzpatrick, Administrator with. The Medical Director, Dr. Charles Hardin is in agreement. See Attachment 12</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1)</p> <p>The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)</p> <p>The treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse 5 days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will</p>	

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

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F 157	<p>Continued From page 11</p> <p>Interview conducted on 12/13/12, at 1:30 PM, with Resident #2's physician revealed he could not recall being made aware of an increase in the size of Resident #2's wounds in August 2012.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12, with multiple Pressure Ulcers.</p> <p>Review of Resident #3's Wound Evaluation Flow Sheet revealed on 10/04/12, the resident had an area to a bunion on the left foot that measured 0.6 cm x 0.4 cm x unable to determine (UTD) the depth, an area to the left outer ankle with measurements of 0.4 cm x 0.4 cm x UTD, an area to the left heel that measured 1.7 cm x 2.3 cm x UTD, a Stage II to the coccyx with measurements of 3 cm x 3 cm x 0.2 cm, and an area to the right heel with no measurements.</p> <p>Further review of Resident #3's Wound Evaluation Flow Sheet revealed no other assessments of the wounds until the facility conducted a facility wide "skin sweep" (is when the facility conducts skin assessments on all residents to ensure accurate assessments) during the weekend of 10/19-20/12. The flow sheet revealed on 10/20/12, the bunion to the resident's left foot measured slightly larger at 0.6 cm x 0.5 cm x UTD, the area to the left outer ankle measured slightly larger at 0.4 cm x 0.5 cm x UTD, the area to the left heel measured the same, the Stage II to the coccyx measured larger at 7 cm x 3.5 cm x UTD, the area to the right heel measured 3.4 cm x 4.1 cm x UTD and the area to the left third toe measuring 0.6 cm x 0.8 cm x UTD. There was no documentation the resident's</p>	F 157	<p>be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI.</p> <p>All stage I wounds have also been placed on the wound monitoring sheet. The staff nurse assigned the responsibility of providing care for the resident will administer treatments to Stage I or other wounds (such as surgical wounds) and for documenting the condition of the wound daily. The staff nurse should also notify the MD and family if there are any changes to the wound.</p> <p>An instruction sheet for treatment nurses was developed on 12/15/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator and placed in the treatment books. See Attachment #57</p>		

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

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F 157	<p>Continued From page 12</p> <p>physician was notified of the increase in size of the resident's wounds.</p> <p>An interview with the DON on 11/01/12, at 2:35 PM revealed licensed nurses were to notify a resident's physician of any changes in the resident's condition. The interview revealed the facility did not conduct audits to ensure physicians were notified of a resident's change in condition.</p> <p>An interview on 11/01/12, at 3:45 PM with the Administrator revealed all nurses were responsible to notify a residents' physician of any change in a resident's condition as soon as the nurse becomes aware of the change. The interview revealed the facility monitored a sample of charts monthly to ensure notification was conducted for all change of condition; however, the monitoring had been discontinued.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An extended survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>--A review of the AOC revealed the following:</p> <p>On 10/18/12, Licensed Practical Nurse (LPN) #1 was terminated by the Director of Nursing (DON) due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p>	F 157	<p>Both treatment nurses (Tracy Thompson, LPN on 12/16/12 and Christy Moore, RN on 12/17/12) have been in-serviced on the instruction sheet and have initialed. See Attachment #57</p> <p>A new 24 hour shift report was created on 10/24/12 by Mary Arms, DON and includes physician and family notification See Attachment #58</p> <p>The new shift report created on 10/24/12 was revised again on 12/14/12 by Mary Arms, DON to include the signatures of the shift nurses completing the reports and signature of the administrative nursing staff reviewing the report. See Attachment # 58</p> <p>A full time Quality Assurance nurse was hired on 11/19/12. Her name is Brenda Humphries. She is an RN who has 19 years experience as a quality assurance nurse for home health and also has experience as a nursing instructor</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family and</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 157	<p>Continued From page 13</p> <p>On 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported back to the acute care facility the resident had previously been treated, prior to admission to this facility.</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, Registered Nurses (RN) #4, #6 and LPNs #2, #4, and #13 conducted skin/wound assessments on all residents.</p> <p>Initiated on 10/19/12, and completed on 10/21/12, the DON in-serviced all licensed staff regarding physician and responsible party notification of change in condition.</p> <p>On 10/21/12, the DON notified Resident #1's physician by fax regarding the missed appointment to the wound care clinic.</p> <p>On 10/22/12, RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p> <p>On 10/24/12, a new Wound nurse started employment and will be assessing and providing treatments to all wounds five (5) days a week. RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The Wound Nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description, and current treatment.</p>	F 157	<p>failure to make transportation arrangements.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>On 11/27/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the plan of correction related to the abbreviated and standard surveys beginning on 10/23/12 and ending on 11/01/12.</p> <p>On 12/28/12 Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator met to discuss the extended survey completed on 12/13/12 and corrective actions.</p> <p>A full time Quality Assurance nurse was hired on 11/19/12. Her name is Brenda Humphries. She is an RN who has 19 years experience as a quality assurance nurse for home health and also has experience as a nursing instructor</p>		

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F 157	<p>Continued From page 14</p> <p>As part of the facility's CQI for monitoring skin assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #1's Employee Disciplinary Report dated 10/18/12, revealed the LPN was terminated due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of Resident #1 concerning the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p>	F 157	<p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or the ADON Anna Caldwell or Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray Assistant Administrator or the person completing the monitoring. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be updated weekly by Emily Gray, Assistant Administrator. This may be assigned to other staff in the future. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator or the person completing the monitoring. 10/26/12 See Attachment #18</p> <p>Mary Arms, DON or the QA Nurse will review the skin assessments on new admissions and readmissions.</p>	

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F 157	Continued From page 15 Interview on 12/12/12, at 4:40 PM with the DON and review of a faxed letter revealed on 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported back to the acute care facility the resident had previously been treated, prior to admission to this facility. Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues. Interviews on 12/12/12, at 2:15 PM with LPN #4, on 12/13/12, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6, at 1:20 PM with LPN #13, and review of notes revealed on 10/19/12, the above licensed staff conducted skin/wound assessments on all residents. Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding physician and responsible party notification of change in condition. Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on physician and responsible party notification of change in condition.	F 157	They will then assess the resident skin and compare it with the skin assessment completed by the staff nurse to ensure that all areas have been identified properly and that the staging and measurements are accurate, if the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. 10/25/12 See attachment #20 A shift report review will be completed at least 3 times weekly and compared with the resident nurses' notes to ensure that the MD and family have been notified of changes in resident condition. This will be ongoing and will be completed by Mary Arms DON, Anna Caldwell, ADON or the QA nurse. The results of this audit will be reported quarterly through CQI by the person completing the audit. 12/14/12 A chart audit will be completed on 4 charts per unit per week (48 charts per month) to ensure that MD and families are notified of changes in resident condition and that it is documented. This will be completed		

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F 157	<p>Continued From page 16</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON and review of a letter with a faxed confirmation dated 10/21/12, revealed the DON notified Resident #1's physician regarding the missed appointment to the wound care clinic.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, on 12/13/12, at 1:30 PM with the Medical Director and review notification letters dated 10/22/12, revealed RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p> <p>Interview on 12/12/12, at 2:45 PM with the newly hired wound care nurse revealed she started employment on 10/24/12, and will be assessing and providing treatments to all wounds five (5) days a week. Interview on 12/12/12, at 11:00 AM with RN #2, revealed RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The interviews revealed the wound care nurse or RN #2 will fax each resident's physician a bi-weekly notification of the resident's wound type, location, description, and current treatment. Review of the newly hired wound care nurses' employee file revealed she started employment at the facility on 10/24/12. Further review of physician notification letters revealed faxes were being sent bi weekly to the resident's physician notifying the physician of the resident's wound type, location, description, and current treatment.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 10/25/12, revealed</p>	F 157	<p>for 6 months and then re-evaluated. This will be completed by the QA nurse or Mary Arms, DON using the Call Log Audit Form. This started on 12/1/12. See Attachment #59</p> <p>The results of all audits will be reported quarterly through CQI by Emily Jones QA Coordinator or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 01/08/13</p> <p>F 241 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>It is the policy of this facility to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This is evidenced by the following:</p> <ol style="list-style-type: none"> All nursing staff were in-serviced on Dignity, specifically knocking on doors before entering the resident room and requesting permission to enter and standing while feeding as it relates to the residents identified during the survey as being affected with the exception of Resident I who was discharged to home on 11/4/12. This in-service was started on 11/8/2012 and was completed by 	

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

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FORM APPROVED
OMB NO. 0938-0391

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F 157	Continued From page 17 as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident. Interview on 12/12/12, at 4:40 PM with the DON, at 11:00 AM with RN #2 and review their personal hand written notes revealed the DON and RN #2 will review all weekly nurses summary of each resident, including skin assessment and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders, and update the resident's plan of care with the new orders.	F 157	11/23/2012. Emily Jones-Gray, Assistant Administrator, Mary Arms, DON and Chanity Purcell, Staff Development completed the in-services. See attachment #24 2. Kitty Harmon, Housekeeping Supervisor conducted an audit related to knocking on doors and requesting permission to enter before entry, sitting on bed while feeding, and standing while feeding on 11/19/12. Amanda Sparks, Kitchen manager conducted an audit on dignity during meal times, standing while feeding, sitting on bed while feeding and knocking on doors and requesting permission to enter before entering the room on 11/16/12. Deborah Fitzpatrick, Administrator performed an audit/via camera system on 11/5/12 related to knocking on doors prior to entering resident rooms.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the	F 241	3. All nursing staff was in-serviced on Dignity, specifically knocking on doors of all residents before entering the room and requesting permission to enter and standing while feeding as it relates to all residents requiring this service. This in-service was started on 11/8/2012 and was completed by 11/23/2012. Emily Jones-Gray, Assistant Administrator, Mary Arms,	

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

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OMB NO. 0938-0391

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F 241	<p>Continued From page 18</p> <p>facility policy and Mosby Nurse Aide Training textbook, it was determined the facility failed to provide care for each resident that promoted the resident's dignity and respect. Observation of the evening meal service on 10/29/12 and the noon meal on 10/30/12, revealed staff stood the residents bedside when they fed residents, and failed to sit face to face with the residents in an effort to promote the resident's dignity for two of twenty-four sampled residents (Residents #8 and #14) and two unsampled residents (Residents I and J) that were fed by facility staff. Additionally, observation during medication pass on 10/29/12 and a wound care treatment on 10/29/12 revealed staff failed to obtain permission prior to entering the room of two sampled residents (Residents #7 and #21) and one unsampled resident (Resident B).</p> <p>The findings include:</p> <p>Review of the facility policy titled Assistance with Meals (revised 10/20/08), revealed residents who could not feed themselves would be fed with attention to safety, comfort and dignity. The policy directed staff that dignity should be maintain by not standing over residents while assisting the resident with meals.</p> <p>Review of the facility's Quality of Life-Dignity policy (revised 12/20/08), revealed residents' private space and property would be respected at all times. The policy directed staff to knock on the resident's door and request permission before entering the resident's room.</p> <p>According to the 6th Edition (2011) Mosby textbook for Long Term Care Nurse Aide Training,</p>	F 241	<p>DON and Chanity Purcell, Staff Development completed the in-services. See Attachment #24</p> <p>All nursing staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #24 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. This in-service was started on and was completed on 12/17/12 and will be completed on 1/7/13 by Deborah Fitzpatrick, Administrator, Emily Jones Gray, Assistant Administrator and Mary Arms, DON.</p> <p>All nursing staff on medical leave at the time of in-servicing will be in-serviced prior to their return to work by Mary Arms, DON.</p> <p>All Ancillary staff was in-serviced on resident Dignity in general using the interpretive guidelines. This in-service was started on 11/8/2012 and was completed by 11/23/2012.</p>		

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

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F 241	<p>Continued From page 19</p> <p>revealed Certified Nursing Assistants (CNAs) were to sit facing the residents during feeding and the textbook explained the sitting position was more relaxing and demonstrated staff had time for the resident. The textbook also revealed by facing the resident, staff could observe if the resident experiences any swallowing problems and could see how well the resident was eating.</p> <p>1. Observation of the evening meal on 10/29/12, revealed staff delivered meal trays to residents that remained in their rooms for the evening meal. Observation revealed CNA #4 stood over Resident J during part of the meal, as she fed the resident and was not face to face with the resident.</p> <p>Interview on 10/30/12, at 3:10 PM, with CNA #4 revealed staff could sit or stand to feed resident the meals. CNA #4 stated she was not aware staff should not stand beside the residents when assisting the residents with their meals.</p> <p>Continued observation of the evening meal service, revealed CNA #6 assisted Resident #14 with the evening meal and stood at the resident's bedside. CNA #6 failed to sit face to face with the resident during the meal.</p> <p>Interview on 10/30/12, at 3:30 PM with CNA #6 revealed staff could sit or stand while feeding residents. CNA #6 stated she was short in height and thought the resident could not see her unless she stood at the resident's bedside.</p> <p>Further observation revealed CNA #5 stood during the meal as she fed Resident I. CNA #5 failed to sit face to face with the resident during</p>	F 241	<p>was completed by 11/23/2012. Emily Jones-Gray, Assistant Administrator, Mary Arms, DON and Chanity Purcell, Staff Development are responsible for completing the in-services. See Attachment #24</p> <p>All ancillary staff was in-serviced a second time on the same information contained in the in-service completed on 11/23/12 (Attachment 24). The department managers were in-serviced by Emily Gray, Assistant Administrator and the department managers then in-serviced their employees. This was completed by 1/7/13.</p> <p>The Quality of Life – Dignity policy was reviewed on 11/15/12 by Deborah Fitzpatrick Administrator with minor changes. Dr. Hardin, Medical Director is in agreement with the changes. See Attachment #25</p> <p>4. A CQI monitoring tool was developed on 11/16/12 by Kathy Meadows, Social Services to monitor dignity during meal times, standing over residents while feeding, infection control during meal times and knocking on doors and requesting permission to enter prior to entering the room. See Attachment #26</p> <p>Kitty Harmon, Housekeeping Supervisor, Brandy Cooper, Dietary Manager, and Amanda Sparks,</p>	

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

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F 241	<p>Continued From page 20</p> <p>the meal. In addition, observation of the noon meal on 10/30/12, at 12:50 PM revealed CNA #5 stood at the bedside of Resident I as she fed the resident the meal, and failed to sit face to face with the resident.</p> <p>Interview on 10/30/12 at 12:50 PM, with CNA #5 revealed she had been trained to be at eye level of the resident when assisting the resident with meals. CNA #5 stated she should have seated herself on a chair beside the resident during the meal to better assist the resident with the meal.</p> <p>Observation of the noon meal on 10/30/12, at 12:45 PM, revealed Resident #8 was seated in a wheelchair and CNA #14 stood while she assisted the resident with the meal. CNA #14 failed to sit face to face with the resident during the meal.</p> <p>An interview conducted with CNA #14 on 10/30/12, at 1:00 PM revealed she thought she could sit or stand when feeding a resident. CNA #14 stated she had never been informed it was unacceptable to stand when feeding a resident.</p> <p>Interview on 10/30/12 at 5:55 PM with the Director of Nursing (DON) revealed staff was required to be seated at eye level with the resident when assisting residents with meals.</p> <p>2. Observation during the medication pass on 10/29/12, at 5:35 PM, revealed Licensed Practical Nurse (LPN #2) entered Resident B's room but failed to obtain the resident's consent prior to entering the room. LPN #2 exited Resident B's room and returned to the medication cart positioned in the hallway. LPN #2 was observed to reenter Resident B's room to evaluate the</p>	F 241	<p>Kitchen manager are monitoring dignity during meal times, infection control during meal times/sitting on the bed while feeding and knocking on doors prior to entering the room at a minimum of 3 times a week at different intervals using the monitoring tool. If staff is observed during the audit to violate any of the above they are corrected by the person auditing immediately. The violation and the person committing the violation are reported to Mary Arms, DON for further corrective action if necessary. This was started on 11/16/12 and will continue for 6 months and then be re-evaluated.</p> <p>Audit results are reported weekly in the QA subcommittee meeting by the person completing the audit. All results will be reported quarterly through CQI by Emily Gray Assistant Administrator or the person completing the audits.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of completion 01/08/13</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 241	<p>Continued From page 21 resident's pain; however, LPN #2 failed to obtain consent prior to reentering the room.</p> <p>Continued observation of the medication pass on 10/29/12, at 5:45 PM revealed LPN #2 prepared two oral medications and one inhaler for Resident #21. LPN #2 entered Resident #21's room but failed to knock to obtain consent prior to entering the resident's room.</p> <p>Continued observation of the medication pass revealed LPN #2 entered Resident #7's room to obtain the resident's oxygen saturation and heart rate prior to medication administration. LPN #2 failed to knock to obtain consent prior to entering Resident #7's room.</p> <p>3. Observation on 10/29/12, at 7:35 PM revealed LPN #2 prepared supplies to provide a dressing change for Resident #14. LPN #2 entered Resident #14's room; however, LPN #2 failed to knock on the resident's door prior to entering the resident's room to obtain consent to enter. LPN #2 exited the resident's room to obtain additional supplies from the treatment cart, positioned in the hallway near the resident's door, and reentered Resident #14's room without obtaining consent to reenter the room. After the completion of the wound treatment LPN #2 left Resident #14's room to discard the soiled dressing in a waste receptacle on the wound treatment cart, and entered Resident #14's room again without knocking on the resident's door.</p> <p>Interview on 10/29/12, at 7:45 PM, with LPN #2 revealed staff should knock on the resident's door and introduce themselves prior to entering the room. LPN #2 stated she always knocked on</p>	F 241	<p>F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>It is the policy of this facility to utilize the results of the assessment to develop, review and revise the resident's comprehensive care plan for each resident which includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. This is evidenced by the following:</p> <ol style="list-style-type: none"> The behavioral care plan for resident #6 was completed and placed on the chart on 11/1/12 by Misty Pennington, Social Services. <p>Kathy Meadows, Social Services and Misty Pennington, Social Services reviewed resident #6's entire care plan on 11-15-2012.</p> <p>Crystal Cantrell, Assistant MDS Coordinator reviewed resident #6's MDS and care plan again on 11-23-2012 to ensure that resident needs and behaviors are identified and care planned.</p> <ol style="list-style-type: none"> Kathy Meadows, Social Services generated a list of all residents from the MDS/Care Plan computer program for the past year (November 		

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

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F 241	Continued From page 22 resident's door at the beginning of the shift and introduced herself to residents but did not knock on the resident's door prior to entering the room during the remainder of the shift.	F 241	2011 -- November 2012) who were identified on the MDS as having behaviors. Kathy and Misty Pennington, Social Services then took all residents who had identified behaviors on the MDS and compared it with the care plan for each resident to ensure all identified behaviors were addressed on the care plan. This was started on 11-15-2012 and was completed on 11-19-2012.		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy it was determined the facility failed	F 279	All resident care plans were reviewed by the MDS Department and compared with the Care Area Assessment Summary Sheet to ensure that all identified problems had been care planned. No other residents were identified as being affected. 11/23/12 3. The Comprehensive Care Plan Policy was reviewed on 11-16-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Roberta Thompson, MDS Coordinator with no changes made. The Medical Director is in agreement. See attachment #28 The Preliminary (Initial) Care Plan Policy was reviewed on 11-16-2012 by Deborah Fitzpatrick, Administrator, Mary Arms, Director of Nursing and Roberta Thompson, MDS Coordinator with no changes		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 279	<p>Continued From page 23</p> <p>to use the results of the resident assessment to develop a comprehensive plan of care for one (1) of twenty-four (24) sampled residents (Resident #6). A review of a Minimum Data Set (MDS) Assessment and interview with staff revealed Resident #6 often rejected care provided by facility staff. However, a review of the comprehensive plan of care developed by facility staff for Resident #6 revealed the facility failed to ensure staff addressed Resident #6's behavior of rejecting care, with goals and approaches identified, in the resident's plan of care.</p> <p>The findings include:</p> <p>A review of the facility policy titled Care Plans-Comprehensive (revised 10/20/08), revealed it was the policy of the facility to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs. Further review of the policy revealed the comprehensive care plan had been designed to incorporate identified problem areas, and to prevent declines in the resident's functional status and/or functional level. The policy revealed the Certified Nursing Assistant (CNA) care plans were developed from the comprehensive care plan and identified specific care area needs and approaches necessary for the CNA to provide daily care to individual residents.</p> <p>A review of Resident #6's medical record revealed the facility admitted the resident on 08/17/12, with diagnoses to include Fracture of the Tibia, Ulna, and Dorsal Vertebrae, Alzheimer's, and Senile Depression.</p>	F 279	<p>made. The Medical Director is in agreement. See attachment #29</p> <p>All nursing staff was in-serviced on turning and repositioning of residents and following the CNA Care Plan. This in-service was started on 11/8/2012 and was completed on 11/23/2012. Emily Jones-Gray, Assistant Administrator, Mary Arms, DON and Chanity Purcell, Staff Development are responsible for completing the in-services. See Attachment #24</p> <p>Nursing staff were in-serviced on documenting refusal of care beginning on 12/17/12 and completed on 1/7/13 by Mary Arms, DON, Emily Jones-Gray Assistant Administrator and Deborah Fitzpatrick, Administrator.</p> <p>Kathy Meadows, Social Services and Misty Pennington, Social Services were in-serviced on 11-21-2012 by Deborah Fitzpatrick, Administrator regarding care planning rejection of care and completing documentation by placing the completed care plan on the chart. See attachment #30</p> <p>4. Social Services staff will interview staff caring for residents during their respective assessment period to identify any undocumented behaviors. This will be ongoing.</p>	

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

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F 279	<p>Continued From page 24</p> <p>A review of Resident #6's admission MDS assessment dated 08/24/12, revealed the facility assessed Resident #6 to be cognitively intact. Further review revealed, based on the facility's assessment, Resident #6 rejected care one (1) to three (3) days out of the seven (7) day assessment period. The assessment further revealed Resident #6 was dependent on staff for bed mobility.</p> <p>A review of the comprehensive plan of care and the nurse aide care plan for Resident #6, dated October 2012, revealed facility staff was required to turn and reposition the resident every two (2) hours. However, observation on 10/25/12, at 12:00 PM, 2:00 PM, and 4:00 PM revealed Resident #6 was lying on his/her backside. Continued observations conducted on 10/29/12 at 6:14 PM, 6:45 PM and on 10/30/12, at 8:55 AM, 9:35 AM, 10:25 AM, 11:15 AM, 3:15 PM revealed Resident #6 positioned on his/her backside.</p> <p>Interview with Certified Nursing Assistant (CNA) #13 on 10/30/12, at 12:00 PM and CNA #16 at 7:30 PM revealed they were aware they were required to turn and reposition Resident #6 every two hours. However, both CNA #13 and #16 stated the resident refused to be turned and repositioned and stated when a resident refused care, they were to chart the resident's refusal in the nurse aide care plan book. A review of documentation of the nurse aide care plan book revealed no documentation of Resident #6 refusal of care. The CNA's further stated by the end of their shift they did not have time to chart if a resident refused care or would forget to chart it for each resident.</p>	F 279	<p>Kathy Meadows, Social Services developed a Care Plan/QA check sheet on 11-16-2012. This will be used with each resident's care plan to ensure all problems or potential problems have been identified, a care plan is in place and is on the chart for that problem or potential problem. This will be completed by the Care Plan Team during the care plan meeting and will be kept in the monitoring book in the Social Service office.</p> <p>This will be completed for 6 months and then re-evaluated.</p> <p>The results of this audit will be reported quarterly through CQI by Social Services. See attachment #31</p> <p>Emily Jones-Gray QA Coordinator will ensure that all audit results are reported quarterly through CQI. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p>	5 Date of Completion 01/08/13	

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

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F 279	Continued From page 25	F 279		
F 282 SS=J	<p>Interview with the Social Worker on 11/01/12, at 10:55 AM revealed it was her responsibility to develop a plan of care when a resident was assessed by the facility to refuse care. The social worker stated Resident #6 should have had a plan of care developed for rejection of care based on the MDS assessment.</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, record review, and a review of the facility's policy, the facility failed to ensure services provided by the facility were provided in accordance with each resident's written plan of care for five (5) of twenty-four (24) sampled residents (Residents #1, #2, #3, #7 and #14). Facility staff assessed Resident #14 to require the assistance of a minimum of two staff persons for transfers. On 04/09/11, one staff person transferred Resident #14 from the bed to a wheelchair and the resident sustained soft tissue injury to the left ankle. (Refer to F323.) Facility staff addressed in a care plan for Resident #1 that staff would observe the resident's wound to the left great toe for signs/symptoms of infection such as an increase in drainage and to notify the physician of any of the signs. However, on</p>	<p>F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>It is the policy of this facility that services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This is evidenced by the following:</p> <ol style="list-style-type: none"> The care plan for resident #14 was reviewed on 11/23/12 by Crystal Cantrell, LPN MDS staff to ensure that the resident needs were care planned. <p>On 12/29/12 the CNA care plan and the CNA assignment sheet for resident #14 was reviewed and updated to ensure that identified resident care needs were care planned and that both the care plan and assignment sheets identify how care is to be provided to resident #14. This was completed by Crystal Cantrell, LPN MDS Staff.</p> <p>A medication/treatment report was filled out by Mary Arms, DON on 11/2/12 regarding treatment not being completed as ordered. See Attachment #32</p> <p>The MD was notified on 11/2/12 by Mary Arms, DON.</p> <p>The MDS and care plan for resident #1 was reviewed on 10/19/12 by</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 26</p> <p>10/15/12, Resident #1 was assessed to have foul purulent drainage and staff failed to notify the resident's physician. Resident #1 was transported to an acute care facility on 10/18/12, upon the insistence of the resident's family member and the resident's left great toe was amputated on 10/20/12. (Refer to F309, F514). The facility also failed to notify the physician of alteration in wound size for two (2) residents (Resident #2 and #3) and failed to provide wound treatments as ordered by the physician for Resident #3. In addition, Resident #7 was assessed to require turning and repositioning every two hours while in bed; however, observation on 10/29/12, and 10/30/12, revealed staff failed to provide turning and repositioning as directed on the plan of care.</p> <p>The failure of the facility to ensure services provided were in accordance with each residents' written plan of care placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the immediate Jeopardy on 12/11/12.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, and alleged removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.20 Resident Assessment, at a scope and severity of "G" while the facility develops and implements a plan of correction and the facility's Quality Assurance.</p>	F 282	<p>Roberta Thompson, RN MDS Coordinator to ensure that resident care needs were identified.</p> <p>The attending physician and the family of resident #1 was notified on 10/17/12 by LPN #3 of the change in condition related to the wound on the left great toe. See attachment #1</p> <p>The attending physician of resident #1 was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being transferred to KDMC to the physician that had previously performed surgery on her prior to her admission to this facility. See Attachment #2</p> <p>On 10/18/12 Mary Arms, DON began an investigation by reviewing the medical record of resident #1 and continued the review and investigation on 10/19/12.</p> <p>The attending physician of resident #1 was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3</p> <p>The medical record of resident #1 was reviewed on 10/20/12 by Mary Arms, DON to ensure that other appointments had not been missed.</p>	

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

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F 282	<p>Continued From page 27</p> <p>The findings include:</p> <p>A review of the facility's policy titled, Care Plans-Comprehensive (revised 10/20/08) revealed it was the policy of the facility to develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet the resident's medical, nursing, and psychosocial needs. Further review of the policy revealed the comprehensive care plan had been designed to incorporate identified problem areas, and to prevent declines in the resident's functional status and/or functional level. The policy revealed the Certified Nursing Assistant (CNA) care plans were developed from the comprehensive care plan and would identify specific care area needs and approaches necessary for the CNA to provide daily care to individual residents.</p> <p>1. Review of the record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included a previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension, and Nonpsychotic Disorder.</p> <p>A review of a Quarterly Minimum Data Set (MDS) Assessment dated 10/09/12, and the last Comprehensive Annual Assessment dated 01/10/12, revealed the facility assessed Resident #14 to be at risk for falls related to impaired balance and coordination during transitions. The assessments revealed Resident #14 had an unsteady gait, a decreased awareness for safety, cognitive impairment, hearing problems, limited</p>	F 282	<p>The son of Resident #1 was notified on 10/20/12 by Mary Arms, DON of the missed appointment and that we had reported this to OIG and APS.</p> <p>Resident #1 has not returned to this facility.</p> <p>On 11/24/12 Mary Arms, DON attempted to interview resident #7 but was unable to due to resident confusion. Mary interviewed staff providing care to Resident #7 on the evening shift. Staff interviews by the DON revealed that resident #7 is unable to lie on left side due to complaints of smothering and when she is positioned to her right side she rolls herself back on to her back. The comprehensive care plan, the CNA care plan and assignment sheet for resident #7 was reviewed on 11/24/12 by Mary Arms, DON and updated to reflect this.</p> <p>Resident #7 expired on 12/3/12.</p> <p>On 10/19/12 a full skin assessment was completed on Resident #2 by Jessica Arnett, RN and Heather Mowery, LPN.</p> <p>All wounds identified on the 10/19/12 individual skin assessment for resident #2 was compared to the treatment MAR to ensure that each identified wound had a treatment</p>	

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F 282	<p>Continued From page 28</p> <p>range of motion to the left upper extremity secondary to a previous CVA, incontinence, generalized weakness and required the use of a wheelchair for mobility. The MDS Assessment revealed the facility had assessed the resident to require extensive physical assistance of, at a minimum, two (2) staff persons with transfers. Continued review of the (MDS) Assessment revealed CNAs were to assist the resident with all transfers and were to apply non-skid footwear to the resident's feet for safety.</p> <p>The review of the MDS Assessment contained a document entitled Care Area Assessment (CAAs), dated 01/13/11, revealed nursing staff developed a Care Area Trigger (CAT) Worksheet that identified Resident #14 to have a "Problem for Falls", and addressed care plan considerations for staff to assist the resident with mobility and two (2) staff to be utilized to transfer the resident.</p> <p>A review of the Comprehensive Care Plan developed on 01/27/2011, reviewed with the quarterly assessment on 04/14/12, and the most recent review dated 10/09/12, also revealed Resident #14 was at risk for falls with injury, had impaired mobility, generalized weakness, and required assistance with transfers. Furthermore, a review of the CNA Care Record dated April 2012, and the most recent CNA Care Record dated October 2011, revealed Resident #14 had been assessed to be at risk for falls, had weakness of the left hand and arm, and required the use of a gait belt and the assistance of two for transfers. The CNA Care Record also revealed staff members were to report any sign of injury to the nurse.</p>	F 282	<p>ordered. This was completed by Christy Moore, RN on 10/20/12.</p> <p>The individual wound documentation flow sheet for resident #2 was reviewed and compared to the skin assessment performed on 10/19/12 to ensure that all identified wounds had been measured and are on the resident's individual wound documentation flow sheet. This was completed on 10/20/12 by Christy Moore, RN.</p> <p>The individual skin assessment for resident #2 was compared to the most recent MDS to ensure that all wounds were identified and care planned. This was completed on 10/21/12 by Donna Fannin, LPN MDS staff.</p> <p>On 10/22/12 the attending physician of Resident #2 was notified by fax of the resident wounds, the type and location. This was completed by Christy Moore, RN. See Attachment #4</p> <p>On 11/20/12 the family of Resident #2 was contacted by Brenda Humphries, RN regarding the resident wounds to ensure that the family was aware of the resident wounds and treatments ordered.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 29</p> <p>Review of the nurse's notes, the Incident Report Tracking log, and Patient Transfer Sheet, revealed on 04/09/12, at approximately 9:30 AM, CNA #15 transferred Resident #14 from the bed to a wheelchair without assistance and, as a result, Resident #14 sustained injury to the left ankle and was transported to an Emergency Department for evaluation.</p> <p>An interview conducted on 10/31/12, at 2:15 PM, with CNA #15 revealed she had been trained to review CNA Care Records to determine resident needs prior to providing assistance with care. CNA #15 stated she was aware that Resident #14 required the assistance of two staff members for transfers, and confirmed she failed to follow the plan of care and did not obtain assistance with transferring Resident #14 from the bed to a wheelchair on 04/09/12. CNA #15 stated staff members were busy assisting other residents on 04/09/12, and she had transferred Resident #14 to a wheelchair, without problems, in order to take the resident to the shower room for a shower. CNA #15 stated she was not aware Resident #14 had an injury until the afternoon of 04/09/12, at which time the nurse questioned the CNAs that were on duty on 04/09/12, about Resident #14's swollen ankle. CNA #15 also stated after she had taken Resident #14 to the shower room approximately 9:30 AM, CNA #13 assisted her with Resident #14's shower and they had not observed any abnormal areas to the resident's skin at that time.</p> <p>Interview on 10/31/12, at 2:45 PM with CNA #13 confirmed staff was required to provide resident care as outlined on the CNA Care Records. The</p>	F 282	<p>On 10/19/12 a full skin assessment was completed on Resident #3 by Jeri Frazier, LPN.</p> <p>All wounds identified on the 10/19/12 individual skin assessment for resident #3 was compared to the treatment MAR to ensure that each identified wound had a treatment ordered. This was completed by Christy Moore, RN on 10/20/12.</p> <p>The individual wound documentation flow sheet for resident #3 was reviewed and compared to the individual skin assessment performed on 10/19/12 to ensure that all identified wounds had been measured and are on the resident's individual wound documentation flow sheet. This was completed on 10/20/12 by Christy Moore, RN.</p> <p>The individual skin assessment for resident #3 was compared to the most recent MDS to ensure that all wounds were identified and care planned. This was completed on 10/21/12 by Donna Fannin, LPN MDS staff.</p> <p>On 10/22/12 the attending physician of Resident #3 was notified by fax of the resident wounds, the type and location. This was completed by Christy Moore, RN. See Attachment #4</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 30</p> <p>interview revealed the CNA was aware Resident #14 was care planned to require two (2) staff for transfers. CNA #13 stated Resident #14 had already been transported to the shower room on 04/09/12, by CNA #15.</p> <p>Interview on 11/01/12, at 4:00 PM, with Licensed Practical Nurse (LPN) #4 revealed she had been responsible to provide and direct care for Resident #14 on 04/09/12. LPN #4 stated, at the start of the shift, CNAs were provided a copy of each resident's planned care needs and were expected to follow the plan of care. LPN #4 stated she was not aware CNA #15 had failed to follow the plan of care for Resident #14 and had transferred the resident without assistance until the details of the incident was discussed with the surveyor. LPN #4 stated the incident report was forwarded to the Director of Nursing.</p> <p>Interview with the Director of Nursing (DON) on 11/01/12, at 2:30 PM, revealed staff was expected to follow each resident's plan of care. The DON confirmed CNA #15 failed to follow the plan of care and transferred Resident #14 from the bed to a wheelchair without assistance. According to the DON, it was discovered during the facility's investigation that Resident #14 sustained an injury to the left ankle as the result of hitting the left ankle against the wheelchair foot pedal during the improper transfer.</p> <p>2. A review of Resident #1's closed medical record revealed the resident was admitted on 05/26/12, for rehabilitation due to a Right Below the Knee Amputation (BKA) with diagnoses of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Review of Resident #1's</p>	F 282	<p>On 11/20/12 the family of Resident #3 was contacted by Chantry Purcell, LPN regarding the resident wounds to ensure that the family was aware of the resident wounds and treatments ordered.</p> <p>The wound care for resident #3 was completed on 10/30/12 by Mona Jacobs, LPN.</p> <p>Medication/Treatment error report was filled out for 10/27/12, 10/28/12 and 10/29/12 for omitted treatments on resident #3 for 3 days. This was completed on 11/23/12 by Mary Arms, DON.</p> <p>The MD was notified of the error on 11/23/12 by Mary Arms, DON.</p> <p>In-services for nurse aides (Attachment 24) and licensed staff (Attachment 15) were held starting on 11/8/12 and completed on 11/23/12. The in-services included assessment and documentation of wounds, physician and family notification, following the plan of care for individual residents, transferring residents and turning and repositioning of residents. In-services were completed by Emily Jones-Gray, Assistant Administrator and Chantry Purcell, Staff Development, and Mary Arms, DON.</p>		

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F 282	<p>Continued From page 31</p> <p>Significant Change MDS Comprehensive Assessment dated 09/07/12, revealed the resident was assessed to be at risk for development of pressure ulcers. Review of Resident #1's Comprehensive Care Plan dated 07/16/12, revealed the facility had addressed the resident's risk of alteration in skin integrity secondary to history of skin tears, assistance required for bed mobility, general weakness, right BKA, peripheral vascular disease, history of malnutrition diabetes, and VRE carrier. Some interventions on the care plan were for staff to check the resident's skin condition daily during care and report any changes to the nurse, and for staff to provided skin care as ordered by the physician.</p> <p>Review of Resident #1's nurse's noted dated 09/12/12, at 9:30 AM, Licensed Practice Nurse (LPN) #1 documented Resident #1 had a new scabbed area to the left great toe measuring less than 0.1-centimeter (cm) in diameter. LPN #1 notified the physician and obtained orders for treatment to the wound and a referral to the WCC.</p> <p>Continued review of Resident #1's care plan revealed the care plan was revised on 09/20/12, with additional interventions to include the following: 1) for staff to cleanse area to the left great toe with normal saline, dry and apply Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound), then a 4 X 4 gauze and wrap with "Kling" (a roll of gauze bandage) every forty-eight (48) hours, and 2) for staff to observe for signs and symptoms of infection such as an increase in drainage, an elevated temperature, an rapid</p>	F 282	<p>2. All CNA resident care plans and assignment sheets were reviewed to ensure that resident care needs were identified and that assignment sheets reflect how care is to be provided to each resident. This was completed by Roberta Thompson, MDS Coordinator and Crystal Cantrell, LPN MDS Staff on 12/29/12.</p> <p>On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified as being affected.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of all residents identified as having a pressure area for to ensure that all areas had been identified.</p> <p>On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the skin assessments completed on 10/19/12 was given to</p>		

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F 282	Continued From page 32 pulse, or a decreased blood pressure and to notify the physician of any of the signs. Review of Resident #1's facility Wound Evaluation Flow Sheet and a Wound Care Clinic note (note documented by staff at a Wound Care Clinic outside the facility) dated 09/13/12, revealed the wound to Resident #1's toe measured 2.2 cm X 1.8 cm X 0.1 cm. According to the Wound Care Clinic note, the wound was a diabetic ulcer. Further review of the Wound Care Clinic notes dated 09/20/12, revealed the wound to the resident's toe was a scabbed area with a pale, pink base, measuring 0.7 cm X 0.6 cm X 0.1 cm with no eschar, no yellow sloughing, no drainage, and no odor. Review of the facility's Wound Evaluation Flow Sheet dated 09/28/12, revealed the wound to Resident #1's toe measured 1.4 cm X 0.2 X 0.1 cm. However, there was no documented evidence the physician was notified of the increase in size of the wound. Review of Resident #1's Treatment Administration Record (TAR) for September and October 2012, revealed staff documented the resident's toe was cleansed with Normal Saline and treated with Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) every forty-eight hours from 09/28/12 through 10/16/12. The TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12 and on 10/14/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12, and on 10/16/12. However, review of Resident #1's medical record revealed no evidence the resident's wound to the toe was assessed at least weekly as required by the facility's policy and the according to	F 282	the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their most recent MDS and Care Plan reviewed and revised if needed by Donna Fannin, LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12. On 10/23/12 the MDS staff reviewed all weekly nurse summaries which include a skin assessment to ensure that resident care plans are up to date. The MDS staff reviews all physician orders and updates each resident's care plan daily. On 10/20/12 the individual wound monitoring records were reviewed and compared to the individual skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet and that there is documentation of the wound. This was completed by Christy Moore, RN. All areas identified on the individual skin assessments completed on 10/19/12 were compared to the individual treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This		

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

PRINTED: 12/28/2012
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OMB NO. 0938-0391

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F 282	<p>Continued From page 33</p> <p>professional standards from 09/28/12 until 10/17/12, for a nineteen day period.</p> <p>Review of Resident #1's nurse's notes dated 10/17/12, at 2:50 PM by LPN #3 revealed the area to the resident's left great toe had an odor and drainage, the physician was notified, and new orders were obtained. A nurse's note dated 10/18/12 at 10:30 AM by LPN #1 revealed Resident #1's family member insisted on observing the resident's toe. LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing to reveal the toe was red and inflamed with a necrotic area, yellow sloughing, and a foul odor. Further review revealed the resident was transported to an acute care facility on 10/18/12 at 3:15 PM.</p> <p>Review of Resident #1's History and Physical dated 10/18/12, from the acute care facility revealed the resident had Cellulitis of the toe associated with a Diabetic Ulcer that appeared to have central gangrene. A Vascular Surgical Consultation, was ordered.</p> <p>Review of Resident #1's Vascular Surgical Consultation Report dated 10/19/12 revealed the resident had a quarter sized ulceration to the left great toe, with purulent drainage, and a foul odor when the dressing was removed. The entire great toe was erythematous (red) up to the base of the foot. The surgeon's recommendation was for amputation of Resident #1's toe.</p> <p>Review of Resident #1's Surgical Report dated 10/20/12, revealed the resident's left great toe was amputated secondary to ulceration with wet gangrene.</p>	F 282	<p>was completed by Christy Moore RN on 10/20/12.</p> <p>Any new areas or areas in question (identified on the individual skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12.</p> <p>All physicians were notified via fax on 10/22/12 of their respective residents' wounds, type and location. This was completed by Christy Moore, RN. See attachment #4</p> <p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12,</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 34 An interview on 10/25/12, at 1:00 PM with the Minimum Data Set (MDS) Assistant revealed on 10/15/12, she conducted a head to toe assessment on Resident #1 during the completion of the resident's Discharge MDS assessment. The interview revealed the resident's wound to the left great toe was moist, with black necrotic tissue, brown purulent drainage, a foul odor, and redness to the first joint of the toe. The MDS Assistant stated she reported the findings to LPN #1, who was responsible for the resident's care, and assumed the LPN, would assess the resident's wound and call the resident's physician. However, a review of Resident #1's medical record revealed no evidence the resident's wound was assessed until 10/17/12. An interview on 10/24/12, at 4:30 PM with LPN #1 and on 10/24/12, at 12:50 PM with LPN #3 revealed wounds were required to be assessed during every wound care for changes and every Friday the assessment was documented on a Wound Flow Sheet. LPN #1 and #3 were not able to explain why there was no documentation that Resident #1's wound was assessed for the first two (2) weeks of October, even though they had provided the wound care to Resident #1's toe every forty-eight (48) hours, according to the TAR. LPN #1 stated that the reason nothing was documented might have been that staff was too busy. An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician revealed the physician expected the nurses to assess the resident's wounds while performing wound care.	F 282	11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard, LPN, Teresa Kidd RN, Jessica Arnett, RN, Yvette Short RN, and Bonnie Prater, LPN. On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6 The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell ADON, Chanity Purcell LPN, Christy Moore RN and Brenda Humphries RN. 3. LPN #1 was terminated on 10/18/12 by Mary Arms, DON for failure to follow facility policy regarding notification of change, assessment, documentation and monitoring of wounds and failure to follow physician orders in send resident for return visit to the WCC. LPN #3 was given a disciplinary warning and placed on probation on 10/20/12 by Mary Arms, DON.	

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

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F 282	Continued From page 35 Interviews on 10/23/12, at 6:15 PM with the Administrator and the Director of Nursing (DON) revealed the nurse assigned to the resident on Friday of each week was required to assess residents' wounds unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed staff was required to assess the wound, including measurements, and document the assessment on the Wound Evaluation Flow Sheet. The interview revealed they were not aware Resident #1's wound to the toe had not been assessed at least weekly until the resident's son requested to see the resident's wound and the resident was transferred to the hospital. Interview on 10/24/12, at 7:30 PM with Registered Nurse (RN) #2 revealed all nurses were trained upon hire to assess and document all wounds on every Friday or the closes treatment day to Friday. 3. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12 with multiple Pressure Ulcers and diagnoses of Contractures of Tendons in Lower Extremities, Dementia and Anorexia. Review of Resident #3's admission Minimum Data Set (MDS) Assessment dated 10/10/12 revealed the resident was at risk for pressure ulcers and was admitted with several pressure ulcers at various stages.	F 282	LPN #7 was terminated on 11/17/12 by Mary Arms, DON for failure to follow MD orders and for falsification of records. LPN #6 was terminated on 11/17/12 by Mary Arms, DON for failure to follow MD orders and falsification of records. The nurse aide was counseled on following the plan of care for Resident #14 and given a disciplinary a-warning on 4/20/12 as a result of the facility investigation. This was completed by Mary Arms, DON. The nurse aides last day of employment with facility was 4/21/12. Licensed staff was in-serviced on resident assessment, measuring wounds, treatments and documentation, maintaining accurate medical records, physician and family notification, policies and staff responsibility, making appointments, scheduling transportation to appointments, making transportation arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10		

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

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F 282	<p>Continued From page 36</p> <p>Review of Resident #3's plan of care dated 10/24/12, revealed the facility addressed the resident's risk for impaired skin integrity related to stage II pressure ulcer to the coccyx, unstageable ulcers to bilateral heels, stage II to left ankle and identified interventions for nursing 1) to complete a skin assessment every week and report any alterations to the physician and 2) to provide treatments as ordered by the physician.</p> <p>Review of Resident #3's Treatment Administration Record (TAR) for October 2012, revealed Licensed Practical Nurse (LPN) #7 documented the treatment had been provided to the resident's feet on 10/27/12 and 10/28/12. In addition, documentation revealed LPN #6 provided the treatment on 10/29/12.</p> <p>Observation on 10/30/12, at 3:00 PM of Resident #3's wound care performed by LPN #3 revealed the area to the resident's coccyx had red tissue surrounding the open wound which, based on measurements obtained by the LPN, measured 8.3 cm x 6.2 cm, and the open wound measured 5.4 cm x 4.7 cm x 0.5 cm. The coccyx wound was pink with yellow/white sloughing noted. The observation revealed the "Kling" dressings to both heels had a date of 10/26/12, written in black marker on both dressings. LPN #3 acknowledged the initials on the dressings were hers and stated although she had not worked for the last three (3) days, the wound care to the resident's feet was ordered to be completed every day. The resident's right inner ankle was slightly red with no open wounds, the right heel was boggy and dark measuring 2.2 cm x 3.4 cm, and the left outer ankle was yellow, with a slight amount of yellow drainage noted on the old</p>	F 282	<p>In-services for nurse aides and licensed staff were held starting on 11/8/12 and completed on 11/23/12. The in-services included following the plan of care for individual residents, transferring residents and turning and repositioning of residents.</p> <p>Restorative nursing care related to turning and repositioning. These in-services were given by Emily Jones-Gray, Assistant Administrator and Charity Purcell, Staff Development. See Attachment 24</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, turn and reposition of residents, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, catering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 37</p> <p>dressing, and measured 1.2 cm x 1 cm x 0.1 cm. The left heel had a dark area that measured 1.5 cm x 1.2 cm. The bunion to the outer side of the resident's left foot was dark and measured 0.4 cm x 0.4 cm and the third toe on the left foot had black edge on a dark area that measured 0.4 cm x 0.8 cm.</p> <p>Interview on 10/30/12, at 6:17 PM with LPN #7 revealed she had signed that the treatments to Resident #3's heels on 10/27/12 and 10/28/12 had been provided; however, the LPN acknowledged she had not completed the treatments. LPN #7 stated she ran out of time, but had reported the treatments had not been provided to the night nurse (LPN #8) who was supposed to provide the treatments.</p> <p>During an interview on 10/30/12, at 6:40 PM with LPN #8, the LPN stated she had not provided treatments to Resident #3's heels on 10/27/12 and 10/28/12. LPN #8 also stated she had not been notified that Resident #3's treatments needed to be provided.</p> <p>Interview on 10/30/12, at 5:20 PM with LPN #6 confirmed the LPN signed off the treatment to Resident #3's heels on 10/29/12, but did not complete the treatment. LPN #6 stated she provided wound care to the resident's coccyx, but was called out of the room before providing wound care to the resident's heels. The interview revealed the LPN "forgot" to go back and provide the wound care to the resident's heels.</p> <p>4. Review of Resident #2's medical record revealed the facility admitted the resident on 10/31/11, with diagnoses of left buttock ulcer,</p>	F 282	<p>Mary Arms, DON on 11-08-2012 and completed on 11-23-12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>All nursing staff on medical leave at the time of in-servicing will be in-serviced prior to their return to work by Mary Arms, DON.</p> <p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will</p>	

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

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F 282	<p>Continued From page 38</p> <p>sacral ulcer, Anemia, Peripheral Vascular Disease, and Diabetes. Resident #2's medical record revealed the resident was readmitted from an acute care facility on 08/06/12 with a pressure ulcer to the left buttock and blisters to both heels. The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 (one day after re-admission) and the wound to the left buttock measured 3 cm x 3.5 cm x 4 cm; the left heel wound measured 5 cm x 5 cm; and the right heel wound measured 5 cm x 5 cm.</p> <p>Review of Resident #2's Significant Change MDS Assessment dated 08/10/12, revealed a decline in the resident's cognition, Activities of Daily Living (ADL) status, continence, and new development of pressure ulcers following a hospitalization.</p> <p>Review of Resident #2's plan of care dated 11/20/11; revealed the facility addressed the resident's risk for alteration in skin integrity and identified the resident to be at risk for the development of pressure ulcers. Continued review of the plan of care revealed facility staff identified interventions for nursing to complete skin assessment every week and notify the physician of any alterations in the resident's skin integrity.</p> <p>Continued review of Resident #2's Wound Evaluation Flow Sheet dated 08/19/12, revealed documentation that the resident's left heel wound measured 6.1 cm x 8.8 cm x UTD, and the wound on the resident's left buttocks measured 3 cm x 3.4 cm x 5 cm. There were no documented measurements of the wound to the resident's right heel.</p>	F 282	<p>be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI.</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries and she is an RN. She has 19 years experience in Quality Assurance.</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical</p>		

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

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F 282	<p>Continued From page 39</p> <p>The Wound Evaluation Flow Sheet revealed the next documented assessment of Resident #2's wound to the left buttock was on 09/07/12, (nineteen days after the previous assessment on 08/07/12, and the wound measured 3 cm x 3 cm x UTD. However, there was no documentation of an assessment and/or measurement of the wounds on Resident #2's heels.</p> <p>Further review of the Wound Evaluation Flow Sheets revealed on 09/14/12 (approximately five weeks after the previous assessment on 08/19/12) the wound to the resident's left heel measured 2 cm x 2 cm and the right heel wound measured 2.5 cm x 1 cm. Review of the Wound Evaluation Flow Sheet revealed the next measurement of the resident's left heel was on 10/21/12 (four weeks after the previous assessment on 09/14/12) and revealed the wound measured 3 cm x 1.8 cm.</p> <p>Interview on 10/23/12, at 7:30 PM, with Registered Nurse (RN) #2, revealed she was unsure why nursing staff had failed to document weekly wounds assessments for Resident #2.</p> <p>5. Review of Resident #7's medical record revealed the facility admitted the resident on 08/23/12, with diagnoses to include Syncope, Lung Cancer, Frontal Lobe Mass, and Chronic Obstructive Pulmonary Disease.</p> <p>A review of Resident #7's admission Minimum Data Set (MDS) Assessment dated 08/30/12, revealed the facility assessed the resident to be cognitively intact. Further review revealed the facility assessed Resident #7 to require extensive</p>	F 282	<p>Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. Her name is Brenda Humphries and she is an RN. She has 19 years experience working in Quality Assurance. She will work full time.</p> <p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse, ADON or Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 40 assistance with bed mobility.</p> <p>A review of Resident #7's comprehensive plan of care dated 09/12/12 revealed the resident was at risk for alteration in skin integrity because the resident required assistance with position changes and bed mobility. The facility approach was to provide weight-bearing assistance to change the resident's position every two (2) hours and as needed.</p> <p>A review of the October Certified Nursing Assistant (CNA) care plan revealed staff was required to reposition Resident #7 every two (2) hours.</p> <p>Observation of Resident #7 on 10/30/12, at 8:57 AM, 9:38 AM, 11:18 AM, 12:27 PM, 3:20 PM, 4:50 PM and 6:30 PM revealed the resident was lying in bed on his/her right side.</p> <p>Interview with Resident #7 on 10/25/12, at 11:55 AM revealed staff did not assist the resident with turning and repositioning every two (2) hours. Resident #7 stated, "they [staff] don't offer" to turn and reposition the resident. Resident #7 further stated staff encouraged the resident to stay off his/her right side, but stated, "Sometimes I forget". A second interview with Resident #7 on 10/30/12, at 7:50 PM revealed, it "would be nice if staff helped [her/him] turn".</p> <p>Interview with CNA #5 on 10/30/12, at 12:42 PM, and CNA #13 at 12:00 PM revealed they were not aware Resident #7 required assistance with turning and repositioning every two (2) hours. Both CNA #5 and CNA #13 stated Resident #7 turned her/himself in bed and were not aware</p>	F 282	<p>Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI. This will be ongoing.</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p>	

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

PRINTED: 12/28/2012
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F 282	<p>Continued From page 41</p> <p>Resident #7's care plan stated the resident required assistance with turning and repositioning every two (2) hours.</p> <p>Interview with Registered Nurse (RN) #2 on 10/30/12, at 3:15 PM revealed CNAs were required to review care plans daily for each resident and provide the care that the care plan required.</p> <p>Review of an in-service conducted 01/31/12; revealed CNAs were instructed to review the CNA care plan/assignment sheet and carry it at all times. The in-service informed staff the care plan listed all the care needs of residents. The in-service stressed failure to follow the CNA assignment sheet could result in resident and employee injury and staff would be subject to written warnings or termination for not following the care plan/assignment sheet. Further review revealed resident safety was a priority and every effort should be made to avoid resident/staff injury during transfers.</p> <p>**An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An extended survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged.</p> <p>—A review of the AOC revealed the following:</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, the Minimum Data Set (MDS)</p>	F 282	<p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident.</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%.</p> <p>All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 42</p> <p>Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>On 10/21/12, RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. LPN #12 also compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>On 10/23/12, the MDS staff (MDS Coordinator, MDS Assistant and LPN #12) reviewed all weekly nurses' summary including skin assessments to ensure the resident's plan of care were up to date. The staff also reviews all residents' new orders daily (seven (7) days a week) and updates</p>	F 282	<p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p>	

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

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F 282	<p>Continued From page 43 each resident's plan of care.</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review in-service records dated 10/19/12, through 10/21/12, revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at</p>	F 282	<p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	<p>Continued From page 44</p> <p>11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Interviews on 12/12/12, at 3:15 PM with the MDS Coordinator, at 10:55 AM with the MDS Assistant On 10/23/12, the MDS staff (MDS Coordinator, MDS Assistant and LPN #12) reviewed all weekly nurses' summary including skin assessments to ensure the resident's plan of care were up to</p>	F 282	<p>Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>A form was created to use in monitoring of turning and repositioning of residents. This was developed by Mary Arms, DON on 12/7/12. See Attachment #36</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week to observe turning and repositioning to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/26/12. The results of the audits will be reported weekly in the QA meeting and quarterly through CQI by Emily Jones- Gray Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The facility will continue to use the original form that was used prior to</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 282	Continued From page 45 date. The staff also reviews all residents' new orders daily (seven (7) days a week) and updates each resident's plan of care.	F 282	the survey to monitor safe transfer of residents. See Attachment #37.	
F 309 SS=J	Interviews on 12/13/12, at 2:55 PM with the Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review and facility policy review, it was determined the facility failed to ensure residents received and facility staff provided the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care for two (2) of twenty-four (24) sampled residents (Residents #1 and #14). On 09/12/12, facility staff assessed Resident #1 and noted the resident had a scabbed wound to the left great toe. Facility staff notified the resident's physician of the wound and new orders were obtained that included to refer the resident to a Wound Care Clinic (WCC).	F 309	The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week for appropriate transfer. This will be completed for 6 months and then re-evaluated. This started on 11/28/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future. A form was created on 11/23/12 to use in evaluation of treatment procedures performed by licensed staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #33 Four (4) treatments per week will be observed by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA	

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

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F 309	<p>Continued From page 46</p> <p>Resident #1 was seen at the WCC on 09/13/12, 09/20/12, and staff was to schedule a follow-up appointment for Resident #1 to be seen in the WCC on 09/27/12; however, there was no documented evidence Licensed Practical Nurse (LPN) #1 arranged transportation for the resident's follow up appointment for the 09/27/12, appointment, and the resident was not assessed/treated at the WCC.</p> <p>Facility staff documented an assessment of the wound on Resident #1's left great toe on 09/28/12, (fifteen days after the last documented assessment of the wound on 09/13/12) and noted the wound was red with pink surrounding tissue measuring 1.4 centimeters (cm) x 0.2 cm x 0.1 cm.</p> <p>The Minimum Data Set (MDS) Assistant revealed in an interview that she had conducted an assessment of Resident #1 on 10/15/12, and the resident's toe was moist with black necrotic tissue, brown purulent drainage, a foul odor and redness to the first joint of the toe. According to the MDS assistant, she did not document the assessment but reported her concerns related to the resident's wound to LPN #1 to notify the physician. However, a review of documentation revealed LPN #1 failed to notify the physician of the change in Resident #1's wound on 10/15/12.</p> <p>Although facility staff documented treatments were administered to the wound on Resident #1's left foot from 09/28/12, to 10/16/12, facility staff failed to document an assessment of the wound until 10/17/12, nineteen (19) days after the previous assessment of the wound on 09/28/12. A review of the nurses notes dated 10/17/12,</p>	F 309	<p>Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of medication administration by licensed staff regarding following physician orders. This was developed by Mary Arms DON and Deborah Fitzpatrick Administrator. See Attachment #34</p> <p>Four (4) med pass observations will be completed weekly by the QA nurse to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/27/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>The results of all audits will be reported quarterly through CQ by Emily Jones-Gray Assistant Administrator or the person completing the audits. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of</p>		

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F 309	<p>Continued From page 47</p> <p>revealed the wound to the resident's left toe had an odor, was draining, and that facility staff notified the resident's physician and orders were received to culture the wound and refer the resident to the WCC. Facility staff also notified Resident #1's family member of the changes and new orders.</p> <p>On 10/18/12, Resident #1's family member insisted on observing the wound on the resident's left great toe. Documentation revealed the wound was assessed and LPN #1 documented the wound was red and inflamed, had a yellow sloughing and an odor, and was necrotic. Resident #1 was transported to an acute care facility on 10/18/12. Resident #1's toe was amputated on 10/20/12, due to a diagnosis of wet gangrene. (Refer to F157, F282 and F514.)</p> <p>In addition, facility staff failed to ensure physician's orders for wound treatments were followed for Resident #14, and failed to document an assessment of Resident #14's wound from 06/29/12 until 07/27/12 (a timeframe of twenty-eight days).</p> <p>The failure of the facility to ensure residents received and facility staff provided the necessary care and services to attain or maintain the highest practicable physical well-being, in accordance with the comprehensive assessment and plan of care placed residents at risk for serious injury, harm, impairment, or death. Immediate Jeopardy and Substandard Quality of Care was identified on 12/11/12, and determined to exist on 10/15/12. The facility was notified of the Immediate Jeopardy on 12/11/12.</p>	F 309	<p>all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of completion 1/8/13</p> <p>F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>It is the policy of this facility that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>1. The attending physician and the family of resident #1 was notified on 10/17/12 by LPN #3 of the change in condition related to the wound on the left great toe. See attachment #1</p> <p>The attending physician was notified on 10/18/12 via fax by Mary Arms, DON that resident #1 was being sent transferred to KDMC to the physician that had previously performed surgery on resident #1 prior to her admission to this facility. See Attachment #2 Mary Arms, DON began reviewing the medical record of resident #1 on 10/18/12 and investigating the</p>		

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F 309	<p>Continued From page 48</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 12/13/12, with the facility alleging removal of the Immediate Jeopardy on 10/25/12. Immediate Jeopardy was verified to be removed on 10/25/12, as alleged prior to exiting with the facility on 12/13/12, with remaining noncompliance at 42 CFR 483.25 Quality of Care, with a scope and severity of "D", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Skin Care" revised September 2001, revealed all wounds were to measured and recorded weekly.</p> <p>Review of the facility policy entitled "Wound Documentation" (undated) revealed pressure ulcers, diabetic ulcers and other wounds deemed necessary to measure should be measured weekly by licensed staff. The policy revealed documentation should include wound location, stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, and granulation, description of surrounding tissue, pain and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified.</p> <p>Review of the facility policy entitled "Transportation Policy" dated May 2008, revealed the facility would assist resident by making transportation arrangements for resident's scheduled appointments. The review revealed nursing staff was responsible to make</p>	F 309	<p>incident. She completed the review on 10/19/12 and continued to investigate.</p> <p>The attending physician of resident #1 was notified on 10/21/12 via fax that the resident had missed the appointment to the wound care clinic by Mary Arms DON. See Attachment #3</p> <p>The medical record of resident #1 was reviewed on 10/20/12 by Mary Arms, DON to ensure that other appointments had not been missed.</p> <p>The MDS and care plan of resident #1 was reviewed on 10/19/12 by Roberta Thompson, RN MDS Coordinator.</p> <p>The son of resident #1 was notified on 10/20/12 by Mary Arms, DON of the missed appointment to the wound care clinic and that we had reported this to APS and OIG.</p> <p>Resident #1 has not returned to this facility.</p> <p>A medication error form was completed on 11/2/12 by Mary Arms, DON regarding failure to follow the physician order for resident #14. See Attachment #32</p>	

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

PRINTED: 12/28/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
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F 309	<p>Continued From page 49</p> <p>transportation arrangements as soon as aware of the resident's appointment. The policy further stated staff would maintain a record of appointments, would obtain confirmation of transportation arrangements, and would check the appointment book daily to ensure appointments were kept.</p> <p>Interview on 11/01/12, at 3:45 PM with the Administrator revealed the facility did not have a policy related to facility staff following physician's orders. However, according to the Administrator, following physician orders was a "standard of practice" and nursing staff were to follow physician's orders in the provision of resident care.</p> <p>1. A review of Resident #1's closed medical record revealed the resident was admitted on 06/26/12, for rehabilitation due to a Right Below the Knee Amputation (BKA) with diagnoses of Diabetes Insipidus, Mild Malnutrition, and Hypertension. Review of Resident #1's Significant Change MDS Comprehensive Assessment dated 09/07/12, revealed the resident was assessed to be at risk for development of pressure ulcers. Review of Resident #1's Comprehensive Care Plan dated 07/16/12, revealed the facility had addressed the resident's risk of alteration in skin integrity secondary to history of skin tears, assistance required for bed mobility, general weakness, right BKA, peripheral vascular disease, history of malnutrition diabetes, and VRE carrier. Some interventions on the care plan were for staff to check the resident's skin condition daily during care and report any changes to the nurse, and for staff to provided skin care as ordered by the</p>	F 309	<p>The MD was notified on 11/2/12 of the error by Mary Arms, DON.</p> <p>LPN #2 was in-serviced and verbally counseled on 11/2/12 by Mary Arms, DON at the time she signed the Medication/Treatment error.</p> <p>Licensed staff was in-serviced on reading the entire physician order prior to beginning treatment and on following the physician orders for resident #14 and all other residents receiving treatments by Mary Arms, DON. In-services started on 11/8/12 and were completed on 11/23/12.</p> <p>On 10/19/12 a full skin assessment was completed on Resident #14 by Jessica Arnett, RN and Heather Mowery, LPN to ensure that all wounds were identified and assessed.</p> <p>A copy of the skin assessment for resident #14 completed on 10/19/12 was given to the MDS department for review. The skin assessment was compared with the most recent MDS and care plan of resident #14. The MDS and care plan was revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 50 physician.</p> <p>Continued review of Resident #1's medical record revealed nurse's noted dated 09/12/12, at 9:30 AM, by Licensed Practice Nurse (LPN) #1 that noted Resident #1 had a new scabbed area to the left great toe that measured less than 0.1 centimeter (cm) in diameter. LPN #1 notified the physician and obtained orders for treatment to the wound and a referral to the WCC.</p> <p>Review of Resident #1's Wound Care Clinic's (WCC) note dated 09/13/12, revealed the wound was assessed and determined to be a Diabetic Ulcer measuring 2.2 cm x 1.8 cm x 0.1 cm. The WCC sent orders back to the facility on 09/13/12, for multiple tests, antibiotics, treatment of Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound), 4 x 4 gauze and wrap with "Kling" (a roll of gauze bandage) every forty-eight (48) hours, and a follow up appointment for 09/20/12. On 09/20/12, documentation by the WCC revealed the wound was a scabbed wound with a pale pink base, measuring 0.7 cm x 0.6 cm x 0.1 cm with no eschar, no yellow sloughing, no drainage and no odor. The WCC sent orders back to the facility on 09/20/12, for oral antibiotic and for a follow up appointment in one (1) week, on 09/27/12. However, there was no documented evidence LPN #1 made transportation arrangements for the resident's follow up appointment on 09/27/12, and the resident was not seen again at the WCC.</p> <p>Continued review of Resident #1's care plan revealed the care plan was revised on 09/20/12, with additional interventions to include the</p>	F 309	<p>On 10/20/12 the wound monitoring record for resident #14 was reviewed and compared to the skin assessment completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the skin assessment of resident #14 completed on 10/19/12 were compared to the treatment MAR to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12.</p> <p>The physician of resident #14 was notified via fax of the wound, type and location by Christy Moore, RN on 10/22/12.</p> <p>The care plan and MDS of resident #14 was reviewed for accuracy by Crystal Cantrell, LPN MDS Staff. 11/23/12</p> <p>2. The charts of all residents having weekly outside appointments for medical treatment outside the facility were reviewed to ensure they had not missed appointments due to transportation not being scheduled. This was completed by Mary Arms, DON and Christy Moore, RN on</p>		

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

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F 309	<p>Continued From page 51</p> <p>following: 1) for staff to cleanse area to the left great toe with normal saline, dry and apply Aquacel AG then a 4 x 4 gauze and wrap with "Kling" every forty-eight (48) hours, and 2) for staff to observe for signs and symptoms of infection such as an increase in drainage, an elevated temperature, an rapid pulse, or a decreased blood pressure and to notify the physician of any of the signs.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #1's wound measurements on 09/13/12, as "2.2 cm x 1.8 cm x 0.1 cm," and on 09/28/12, as "1.4 cm x 0.2 x 0.1 cm"; however, there were no other measurements documented on the flow sheet. Review of the Wound Evaluation Flow Sheet revealed the sheet contained instructions on the top of the sheet stating the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. According to the instructions, the staff failed to conduct a wound assessment for weeks of 09/21/12, 10/05/12 and 10/12/12.</p> <p>A review of a Treatment Administration Record (TAR) for September and October 2012, revealed every forty-eight hours, staff was to cleanse Resident #1's left great toe wound with normal saline, cover with Aquacel AG and a 4 x 4 gauze, and then wrapped with Kling, the treatment was to be performed every forty-eight (48) hours. The TAR revealed LPN #1 performed wound care to Resident #1's left great toe on 10/04/12, 10/10/12, 10/14/12 and on 10/18/12. The TAR further revealed LPN #3 performed wound care to Resident #1's left great toe on 10/02/12, 10/06/12, 10/08/12, 10/12/12 and on 10/16/12.</p>	F 309	<p>10/20/12. There were no other appointments missed for failure to make transportation arrangements.</p> <p>All current residents with scheduled appointments were reviewed to ensure that transportation arrangements had been made. This was completed by Ora Little, LPN and Jessica Wireman, RN on 10/21/12.</p> <p>On 10/19/12 Roberta Thompson, MDS Coordinator reviewed the two most recent MDS assessments and Care Plan of all residents identified as having a pressure area for accuracy.</p> <p>On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified</p>	

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

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F 309	Continued From page 52 Further review of nurse's notes revealed on 10/17/12, at 2:50 PM LPN #3 documented the wound to Resident #1's left great toe had an odor and drainage. Documentation revealed Resident #1's physician was notified of the assessment and the physician requested facility staff to obtain a culture of the wound and to refer the resident to the WCC. The documentation further revealed the resident's family member was also notified of the change and the new orders. Review of Resident #1's nurse's notes dated 10/18/12, at 10:30 AM, Resident #1's family member insisted on observing the resident's wound. Documentation revealed LPN #1 and the Assistant Director of Nursing (ADON) removed the dressing for the resident's left great toe and the wound was observed to be red and inflamed with a necrotic, yellow sloughing and an odor. Further review revealed the resident was transported to an acute care facility on 10/18/12, at 3:15 PM for further assessment and treatment. A review of a "History and Physical" report dated 10/18/12 revealed a physician at the acute care facility noted Resident #1 had Cellulitis of the toe associated with a Diabetic Ulcer that appeared to have central gangrene, and the physician recommended a consultation with a Vascular Surgical. Review of a Vascular Surgical Consultation Report dated 10/19/12, revealed Resident #1 had a quarter sized ulceration to the left great toe with purulent drainage. The report revealed a foul odor was noted when the dressing was removed and the entire great toe up to the base of the foot	F 309	were care planned appropriately. This was completed on 10/24/12. On 10/20/12 the wound monitoring records for each individual resident were reviewed and compared to the individual resident skin assessments completed on 10/19/12 to ensure that all wounds(both pressure and non-pressure) have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN. All areas identified on the individual resident skin assessments completed on 10/19/12 were compared to the individual resident treatment MARs to ensure that treatments were ordered if necessary to all identified areas. This was completed by Christy Moore RN on 10/20/12. Any new areas or areas in question (both pressure and non-pressure areas identified on the skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12. All physicians were notified via fax on 10/22/12 of their respective residents with the type of wound. This was completed by Christy Moore, RN. See attachment #4	

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

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F 309	<p>Continued From page 53</p> <p>was erythematous. Based on documentation in the report, the Vascular Surgeon recommended amputation of Resident #1's great toe.</p> <p>A review of a Surgical Report dated 10/20/12, revealed Resident #1's the left great toe was amputated secondary to ulceration with wet gangrene.</p> <p>An interview with the Minimum Data Set (MDS) Assistant on 10/25/12, at 1:00 PM revealed she had conducted a Discharge Assessment of Resident #1 on 10/15/12. According to the MDS Assistant, at that time, Resident #1's toe was assessed to be moist, with black necrotic tissue, brown purulent drainage, a foul odor and up to the first joint of the toe was red. According to the MDS assistant, the Discharge Assessment only addressed pressure ulcer and because the</p>	F 309	<p>On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on both pressure and non-pressure wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley Maggard LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell, ADON, Charity Purcell</p>	
	<p>resident's wound was not a pressure ulcer, she did not document the assessment; however, the MDS assistant stated she reported her concerns to LPN #1 and thought LPN #1 would notify Resident #1's physician of the assessment. However, a review of documentation revealed Resident #1's physician was not notified of the resident's wound on 10/15/12, and the care plan was not revised to reflect the change in the resident's wound.</p> <p>An interview on 10/24/12, at 4:30 PM with LPN #1 revealed wounds were assessed/measured every Friday and documented on the wound flow sheet. LPN #1 revealed Resident #1's left great toe had "a small black spot" when she last assessed the wound but could not remember the date. The LPN stated she did not know why there was no documentation of an assessment of the wound</p>			

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

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F 309	<p>Continued From page 54</p> <p>during the first two (2) weeks of October 2012. LPN #1 acknowledged on 10/18/12, Resident #1's family member insisted on observing the resident's wound and, at that time, the resident's entire toe was red with black necrotic tissue, with sloughing to the side. LPN #1 stated staff was to assess a resident's wound with each treatment and the physician was to be notified of any changes in the wound; (however, there was no documented evidence from 09/12/12 until 10/18/12). LPN #1 stated she did not recall being informed that the wound on the Resident #1's great toe had changed or had an odor. The LPN also could not recall why she did not make transportation arrangements for the follow up appointment to the WCC for 09/27/12.</p> <p>An interview on 10/24/12, at 12:50 PM with LPN #3 revealed wounds were to be assessed/measured every Friday during wound care and documented on the wound flow sheet. LPN #3 revealed the wound on Resident #1's great toe appeared as a dry callused wound when she performed wound care to the wound on 10/12/12. However, according to LPN #3 when she assessed the wound on 10/17/12, the wound had an odor and drainage, so the LPN notified the physician and orders were obtained. LPN #3 did not know why there were no wound assessments/measurements on the wound flow sheet for Resident #1 during first two (2) weeks in October 2012.</p> <p>An interview on 10/25/12, at 11:30 AM with Resident #1's Primary Physician confirmed she had not been informed of the decline in the status of Resident #1's wound until 10/17/12. According to the physician, she expected the nurses to</p>	F 309	<p>LPN, Christy Moore RN and Brenda Humphries RN.</p> <p>On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified.</p> <p>3. LPN #1 was terminated on 10/18/12 by Mary Arms, DON.</p> <p>LPN #3 was given a disciplinary warning and placed on probation on 10/20/12 by Mary Arms, DON.</p> <p>LPN #2 was in-serviced and verbally counseled on 11/2/12 by Mary Arms, DON at the time she signed the Medication/Treatment error.</p> <p>The facility process for making transportation arrangements for outside appointments was reviewed by Deborah Fitzpatrick, Administrator and Mary Arms, DON on 10/19/12.</p> <p>The facility transportation policy was reviewed and revised on 10/19/12 by Deborah Fitzpatrick Administrator and Mary Arms, DON on 10/19/12. The Medical Director is in agreement with the revision. See attachment #7</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 55</p> <p>follow physician's orders, to assess the resident's wounds while performing wound care, and to be notified of any changes in the wound. The interview revealed the physician was unaware Resident #1 missed the follow up appointment at the WCC until after the resident was transported to the hospital on 10/18/12.</p> <p>Interviews on 10/23/12, at 6:15 PM and on 11/01/12, at 2:35 PM with the Director of Nursing (DON) revealed when a wound was identified on a resident the nurse was required to notify the resident's physician, obtain orders for treatment, assess the wound to include measurements and document the assessment on the Wound Evaluation Flow Sheet. The DON stated all wound should be assessed/measured and documented at least once a week, by the nurse assigned to the resident while providing wound care every Friday unless the resident's dressing was not scheduled to be changed on Friday. In that case, the resident's wound was required to be assessed on the day the dressing was changed, either Wednesday or Thursday. The interview revealed nurses received in-service training twice a year on assessments, measurements and documentation of wounds. The interview revealed the facility did not conduct any audits to ensure physicians were notified of a resident's change in condition; however, licensed nurses were to notify a resident's physician of any changes in the resident's condition. The DON stated she was unaware Resident #1 had missed the follow up appointment at the WCC, until investigating the resident's wound deterioration. According to the DON, staff was responsible to provide care in accordance with each resident's plan of care. The interview revealed the Quality</p>	F 309	<p>A transportation log was developed to track appointment and transportation arrangements. This was completed by Deborah Fitzpatrick, Administrator, Mary Arms, DON and Christy Moore, RN on 10/20/12. See attachment #8</p> <p>An instruction sheet was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>A list of transportation services, phone numbers, required forms and special requirements was developed as a guide for staff in making appointments. This was completed by Mary Arms, DON on 10/20/12. See attachment #9</p> <p>The system used to keep the appointment information and transportation arrangements was reviewed and revised on 10/19/12 by Deborah Fitzpatrick, Administrator and Mary Arms, DON. Two books had been used to make appointments. The books were combined into one book. Each nursing unit has an appointment/transportation book with the following items:</p> <ul style="list-style-type: none"> • Transportation Policy • Instructions for making appointments. 	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 309	<p>Continued From page 56</p> <p>Assurance (QA) nurses (the Assistant Director of Nursing (ADON) and RN #2) were responsible for conducting the QA of wounds on first and second floor. (Refer to F520.)</p> <p>Interviews on 10/23/12, at 6:15 PM and on 11/01/12, at 3:45 PM with the Administrator revealed when a wound was identified on a resident the nurse was required to notify the resident's physician, obtain orders for treatment, assess the wound to include measurements and document the assessment on the Wound Evaluation Flow Sheet. The Administrator revealed the facility monitored a sample of charts monthly to ensure notification was conducted for all change of condition; however, the monitoring had been discontinued due to meeting the goal. According to the Administrator, staff was responsible to provide care in accordance to the president's plan of care.</p> <p>2. Review of the medical record revealed the facility admitted Resident #14 on 01/07/11, with diagnoses that included Previous Cerebrovascular Accident (CVA) with Hemiparesis, Atrial Fibrillation requiring Anticoagulation, Atherosclerotic Cerebrovascular Disease, Hypertension and Nonpsychotic Disorder.</p> <p>A review of Resident #14's care plan revealed facility staff revised the care plan on 05/04/12, with additional interventions to include the following: 1) to cleanse the area to the resident's left lateral ankle with normal saline, apply Santyl ointment (an active enzymatic therapy that removes necrotic tissue from wounds), a 4 x 4 gauze and wrap the wound with "Kling" (a roll of</p>	F 309	<ul style="list-style-type: none"> • Phone numbers for the transportation services and notification requirements of each service. • Transportation Log • Appointment Calendar • Transportation Forms <p>Licensed staff was in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10</p> <p>Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service.</p> <p>The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10</p> <p>The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED G 12/13/2012
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F 309	<p>Continued From page 57</p> <p>gauze bandage) every day; and 2) for staff to cleanse the resident's bilateral breast folds with soap and water, dry, and apply Nystatin (a prescription anti-fungal medication used to treat fungal infections) powder twice a day. The care plan also revealed nursing staff were to complete a skin assessment every week and report any alterations to the physician.</p> <p>A review of the monthly Physicians orders for October 2012, revealed staff were to cleanse the folds underneath Resident #14's breast with soap and water, pat dry, and apply Nystatin powder (an antifungal agent) to the breast folds every shift.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff had documented Resident #14's wound measurements of the resident's left, lateral ankle on 05/18/12, as "1.5 cm x 1.5 cm x 0.0 cm," and on 06/01/12 (fourteen days after the last assessment) as "1.0 cm x 1.2 x 0.0 cm", then weekly for the next three weeks until 06/29/12. However, there were no other measurements documented on the flow sheet until 07/27/12 (twenty-eight days later). Review of the Wound Evaluation Flow Sheet revealed the sheet was to be completed by a nurse upon identification of a wound and at least weekly from the date of identification. However, a review of the sheet revealed staff failed to conduct a wound assessment for weeks of 05/21/12, 07/02/12, 07/09/12 and 07/16/12.</p> <p>Observation on 10/29/12, at 7:35 PM revealed Licensed Practical Nurse (LPN) #2 applied Nystatin powder to Resident #14's breast folds; however, LPN #2 failed to cleanse the breast folds with soap and water and dry the area prior to applying the Nystatin powder.</p>	F 309	<p>Administrator with no changes. The Medical Director is in agreement. See Attachment #11</p> <p>The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12</p> <p>The current wound documentation flow sheet was reviewed on 10/24/12 and revised so that the areas for documentation are larger, more organized with descriptive terms used to describe wounds. This was completed by Mary Arms, DON and Deborah Fitzpatrick, Administrator. See Attachment #13</p> <p>On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12.</p> <p>A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah</p>	

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

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OMB NO. 0938-0391

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F 309	Continued From page 58 Interview on 10/29/12, at 7:45 PM with LPN #2 revealed she failed to read the entire physician's order prior to the treatment for Resident #14. LPN #2 stated she was "nervous" during the observation, had rushed to complete the treatment, and failed to ensure the treatment was performed in accordance with the physician's orders. Interview on 11/01/12, at 2:30 PM with the Director of Nursing (DON) revealed staff should review physician's orders prior to treatments to ensure treatments were performed in accordance with physician's orders. The DON stated the facility did not monitor to ensure physician's orders were followed. Interview on 11/01/12, at 3:45 PM with the	F 309	Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. See Attachment #14 (1) The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2) All documentation guidelines, policies related to wound prevention, assessment and identification, MD and family notification and treatment procedure and wound monitoring should be used for both pressure and non-pressure wounds.	
	Administrator revealed nurses were to follow physician's orders and this was a nursing "standard of practice." The Administrator stated the facility monitored to ensure physician's orders were entered into the computer system correctly; however, there was no monitoring conducted to ensure physician's orders were followed. **An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy (IJ) was submitted by the facility on 12/13/12, which alleged removal of IJ effective 10/25/12. An extended survey was conducted on 12/11-13/12, which determined the IJ was removed on 10/25/12 as alleged. --A review of the AOC revealed the following: On 10/18/12, Licensed Practical Nurse (LPN) #1		Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk	

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

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F 309	<p>Continued From page 59</p> <p>was terminated by the Director of Nursing (DON) due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>On 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported to the acute care facility the resident had previously been treated prior to admission to this facility.</p> <p>On 10/19/12, the DON reviewed Resident #1's medical record and continued to investigate.</p> <p>On 10/19/12, the Minimum Data Set (MDS) Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all residents for accuracy.</p> <p>On 10/19/12, Registered Nurses (RN) #4, #6 and LPNs #2, #4, and #13 conducted skin/wound assessments on all residents.</p> <p>Initiated on 10/19/12 and completed on 10/21/12, the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, 7) the revisions to the transportation policy/procedures.</p> <p>On 10/19/12, the Administrator and the DON</p>	F 309	<p>medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/23/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 60</p> <p>reviewed and revised the facility's transportation policy and procedure. The Medical Director was in agreement with the revision of the policy. The revisions included combining the appointment book and transportation book into one (1) book. The book is kept at each nurses' station and contains the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, and 6) Transportation Forms.</p> <p>On 10/20/12, the Administrator, the DON and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff reference.</p> <p>On 10/20/12, the DON reviewed Resident #1's chart to identify if any other appointments had been missed. The DON and RN #2 reviewed all residents' charts with weekly outside medical appointments to ensure arrangements had been made for transportation to each appointment with no problems identified.</p> <p>On 10/20/12, LPN #3 was reprimanded and placed on probation by the DON due to the failure to assess/document Resident #1's wound.</p> <p>On 10/20/12, RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment</p>	F 309	<p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQI.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment</p>		

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

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F 309	<p>Continued From page 61</p> <p>Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>On 10/21/12, the DON notified Resident #1's physician by fax regarding the missed appointment to the wound care clinic.</p> <p>On 10/21/12, RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. LPN #12 also compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>On 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets (utilized for in-service) were placed in the nursing policy/procedure manuals and in the wound care monitoring books kept at each nursing station for staff reference.</p> <p>On 10/21/12, the Administrator and the DON reviewed the facility's Pressure Ulcer policy and the Wound Documentation policy and no revisions required. The Medical Director was also in agreement.</p>	F 309	<p>of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>The Medical Director reviewed all the initial physician notification regarding wounds that was sent on 10/22/12. See attachment #4</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department. She will work full time.</p> <p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or</p>	

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

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F 309	<p>Continued From page 62</p> <p>On 10/21/12, LPNs #10 and #14, reviewed all residents' charts with outside medical appointments to ensure transportation arrangements had been made.</p> <p>On 10/22/12, RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification.</p> <p>On 10/24/12, the Administrator and the DON reviewed and revised the Wound Documentation Flow Sheet which was larger, more organized, with descriptive terms used to describe wounds.</p> <p>On 10/24/12, the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.</p> <p>On 10/24/12, a new wound care nurse started employment and will be assessing and providing treatments to all wounds five (5) days a week. RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The wound care nurse or RN #2 will fax each resident's physician a bi weekly notification of the resident's wound type, location, description and current treatment.</p> <p>As part of the facility's CQI for monitoring skin</p>	F 309	<p>other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator or a designee. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment #19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then</p>		

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

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F 309	<p>Continued From page 63</p> <p>assessments upon admission, the DON has 1) Reviewed all skin assessments on new admissions and readmissions and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. 2) Reviewed the new admissions and readmissions chart to ensure the physician and family were notified of any skin areas, that appropriate treatment is being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>As part of the facility's CQI for monitoring the transportation arrangement, the Assistant Administrator or the Activity Director will review the transportation logs on each unit to ensure all transportation arrangements have been made and any problems identified will be reported to the nursing administration immediately for correction.</p> <p>The DON and RN #2 will review all residents' weekly nurses summary (which include a skin assessment) and assess each resident to ensure the skin assessment matches and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>The Administrator formed a QA subcommittee which consists of each department head/manager that will meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p>	F 309	<p>perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%.</p> <p>All weekly summaries will continue to be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per</p>		

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

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F 309	<p>Continued From page 64</p> <p>The Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.</p> <p>--The surveyors validated the corrective actions taken by the facility as follows:</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #1's Employee Disciplinary Report dated 10/18/12, revealed the LPN was terminated due to the failure to assess/document Resident #1's wound, notify the physician and responsible party of Resident #1 concerning the change in the resident's wound and the failure to make arrangements for the resident's transportation to the wound clinic.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of a faxed letter revealed on 10/18/12, the DON notified Resident #1's physician the family requested the resident be transported back to the acute care facility the resident had previously been treated, prior to admission to this facility.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review notes dated 10/19/12, revealed the DON reviewed Resident #1's medical record investigating the resident's wound and appointment issues.</p> <p>Interview on 12/12/12, at 3:15 PM with the MDS Coordinator and review of notes dated 10/19/12, revealed the MDS Coordinator reviewed Resident #1's MDS assessment and care plan for accuracy and also reviewed the two (2) most recent MDS assessments of all resident for accuracy.</p>	F 309	<p>week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective</p>	

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240		
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F 309	<p>Continued From page 65</p> <p>Interviews on 12/12/12 at 2:15 PM with LPN #4; on 12/13/12 at 11:00 AM with RN #4; at 11:10 AM with LPN #2; at 1:15 PM with RN #6; at 1:20 PM with LPN #13; and review of notes revealed on 10/19/12, the above licensed staff conducted skin/wound assessments on all residents.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of in-service records dated 10/19/12 through 10/21/12 revealed the DON in-serviced all licensed staff regarding the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12 at 11:00 AM with RN #2; at 2:15 PM with LPN #4; at 5:00 PM with LPN #12; on 12/13/12 at 2:00 PM with LPN #9; at 11:00 AM with RN #4; at 11:10 AM with LPN #2; at 1:15 PM with RN #6; and at 1:20 PM with LPN #13 confirmed the licensed staff were in-serviced on the following: 1) assessment, measuring, treatments and documentation of wounds, 2) maintaining accurate medical records, 3) physician and responsible party notification of change in condition, 4) scheduling appointments, 5) making transportation arrangements, 6) utilizing the transportation log, and 7) the revisions to the transportation policy/procedures.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's transportation</p>	F 309	<p>action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported quarterly through CQI by Emily Gray Assistant Administrator. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS</p>		

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

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F 309	<p>Continued From page 66</p> <p>policy/procedure revealed the policy was revised on 10/19/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director and review of the facility's transportation policy/procedure revealed the Medical Director was in agreement with the revision of the policy.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed an Appointment/Transportation book kept at each nursing station. The book contained the following: 1) Transportation Policy, 2) Instructions for making appointments, 3) Phone numbers of each transportation service and notification requirements for each service, 4) Transportation Log, 5) Appointment Calendar, 6) Transportation Forms and 7) Instructional sheet.</p> <p>Interviews on 12/12/12 at 11:00 AM with RN #2; at 2:15 PM with LPN #4; at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2; at 1:15 PM with RN #6 and at 1:20 PM with LPN #13 revealed the licensed staff were knowledgeable of the contents and use of the Appointment/Transportation book.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/12/12, at 11:00 AM with RN #2, on 12/13/12, at 2:55 PM with the Administrator, and review of the facility's transportation policy/procedure revealed on 10/20/12, the Administrator, the DON and RN #2 developed a Transportation Log to track appointments/transportation arrangements and an instructional sheet as a guide for staff for</p>	F 309	<p>Coordinator. This will be ongoing. See attachment #23</p> <p>All results will be reported quarterly through CQI by the QA Coordinator, Emily Jones-Gray or the person completing the audit. This will be ongoing.</p> <p>Dr. Charles Hardin, Medical Director will provide oversight during the compliance process. The results of all audits will be reported to the Medical Director quarterly through CQI by Emily Jones-Gray, Assistant Administrator. This will be ongoing.</p> <p>5. Date of Completion 1/8/13</p> <p>F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>It is the policy of this facility 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 is evidenced by the following:</p> <ol style="list-style-type: none"> 1. The MDS and care plan of residents #2, #3, #5, #6, #7, #8 and #9 was reviewed for accuracy by Roberta 		

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

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F 309	<p>Continued From page 67</p> <p>making appointments, where forms are located, different transportation services and contact information which will be kept in the front of the Appointment/Transportation books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/12/12, at 11:00 AM with RN #2, and review of notes dated 10/20/12, revealed the DON reviewed Resident #1's chart to identify if any other appointments had been missed. The interviews and record review further revealed the DON and RN #2 reviewed all residents' charts with weekly outside medical appointments to ensure arrangements had been made for transportation to each appointment with no problems identified.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of LPN #3's Employee Disciplinary Report dated 10/20/12, revealed LPN #3 was reprimanded and placed on probation due to the failure to assess/document Resident #1's wound.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, and review of notes dated 10/20/12, revealed RN #2 compared the skin/wound assessments completed on 10/19/12, for all residents to each resident's Treatment Administration Records (TARs) and each resident's individual wound documentation flow sheets to ensure all alteration in the residents' skin integrity had been accurately documented.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON and review of a letter with a faxed confirmation dated 10/21/12, revealed the DON notified Resident #1's physician regarding the missed</p>	F 309	<p>Thompson, MDS Coordinator on 10/19/12.</p> <p>On 10/19/12 residents #2, #3, #5, #6, #7, #8 and #9 had skin assessments completed by staff nurses working on 10/19/12. Their names are Jeri Frazier, LPN, Jessica Arnett, RN, Heather Mowery, LPN, Donna McDowell, LPN, Yvette Short, RN and Christy Allen, LPN.</p> <p>On 10/20/12 the individual resident wound monitoring flow sheets for residents, #2, #3, #5, #6, #7, #8 and #9 were reviewed and compared to their respective skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>The physicians for resident #2, #3, #5, #6, #7, #8 and #9 were notified on 10/22/12 (via fax) of their respective resident's wounds. This was completed by Christy Moore, RN. See attachment #4</p> <p>Medication error sheet was completed on 10/25/12 for resident #6 regarding treatment not being completed per physician order by Christy Moore, RN.</p>		

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

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F 309	<p>Continued From page 68 appointment to the wound care clinic.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 5:00 PM with LPN #12 and review of notes dated 10/21/12, revealed RN #2 and LPN #12 compared the skin/wound assessments completed on 10/19/12, for all residents with the documentation in each resident's plan of care, wound documentation flow sheet and TARs to ensure accuracy of the medical records. The interview and record review also revealed LPN #12 compared the skin/wound assessments with the most recent MDS assessment to ensure all alteration in the residents' skin integrity had been accurately care planned. The interview and record review further revealed RN #2 re-assessed/re-measured all new alteration in the residents' skin integrity that had been identified on the skin/wound assessments to ensure the areas were documented accurately on each resident's wound documentation flow sheet.</p> <p>Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets where in page protectors in the front of each nursing policy/procedure manuals and in the wound care monitoring books for staff reference.</p> <p>Interviews on 12/12/12, at 11:00 AM with RN #2, at 2:15 PM with LPN #4, at 5:00 PM with LPN #12, on 12/13/12, at 2:00 PM with LPN #9, at 11:00 AM with RN #4, at 11:10 AM with LPN #2, at 1:15 PM with RN #6 and at 1:20 PM with LPN</p>	F 309	<p>The MD of resident #6 was notified of the omitted treatment on 10/25/12 by Christy Moore, RN.</p> <p>Medication/Treatment error sheets for residents #3 and #7 were completed due to omitted treatments. This was completed on 11/23/12 by Mary Arms, DON.</p> <p>The MD was notified of the omitted treatments for their respective residents on 11/23/12 by Mary Arms, DON.</p> <p>On 10/28/12 and 10/29/12 the physicians for residents #2, #3, #5, #6, #7, #8 and #9 were notified of their respective residents wounds and the current treatments for the wounds using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5</p> <p>The DON attempted to interview resident #7 on 11/24/12 but was unable to due to resident confusion. Interviews with staff by the DON revealed that resident is unable to lie on left side due to complaints of smothering. The comprehensive care plan and the CNA care plan and assignment sheet for resident #7 was reviewed on 11/24/12 by Mary Arms, DON and updated to reflect this.</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 309	<p>Continued From page 69</p> <p>#13 revealed the licensed staff were knowledgeable of the contents and use of the Wound Care book.</p> <p>Interview on 12/12/12, at 11:00 AM with RN #2 and review of the nursing policy/procedure manuals and wound care books kept at each nurses' station revealed on 10/21/12, RN #2 placed the "Pressure Ulcer documentation guideline" and "How to Identify and Stage Pressure Ulcers" sheets were placed manuals and books for staff reference.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the facility's policies revealed the Pressure Ulcer policy and the Wound Documentation policy were reviewed 10/21/12, by the DON and Administrator. Interview on 12/13/12, at 1:30 PM with the Medical Director was in agreement with not revising the policies.</p> <p>Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 1:30 PM with the Medical Director and review of an e-mail revealed on 10/21/12, the DON notified the Medical Director of the issues identified related to the investigation of Resident #1's wound and missed appointment with the WCC. The Medical Director was also notified and in agreement with the facility's corrective measures taken.</p> <p>Interviews on 12/12/12, at 6:00 PM with LPN #10, LPN#14, and review of the LPNs notes dated 10/21/12, revealed the LPNs reviewed all residents' charts with outside medical appointments to ensure transportation arrangements had been made.</p>	F 309	<p>Resident #7 expired on 12/3/12.</p> <p>2. On 10/19/12 a skin assessment was completed on all residents by licensed staff. The staff names are Jeri Frazier LPN, Jessica Arnett RN, Heather Mowery LPN, Yvette Short RN, Donna McDowell, LPN and Christy Allen LPN.</p> <p>A copy of the skin assessments completed on 10/19/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned appropriately. This was completed on 10/24/12.</p> <p>On 10/20/12 the wound monitoring records were reviewed and compared to the skin assessments completed on 10/19/12 to ensure that all wounds have been measured and are on a monitoring sheet. This was completed by Christy Moore, RN.</p> <p>All areas identified on the skin assessments completed on 10/19/12 were compared to the treatment MARs to ensure that treatments were ordered if necessary to all identified</p>	

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

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F 309	Continued From page 70 Interviews on 12/12/12 at 11:00 AM with RN #2, on 12/13/12 at 1:30 PM with the Medical Director and review notification letters dated 10/22/12, revealed RN #2 notified each physician of their respective resident's wounds addressing the stage and location of each wound after the facility's Medical Director had reviewed/signed each physician's notification. Interviews on 12/12/12, at 4:40 PM with the DON, on 12/13/12, at 2:55 PM with the Administrator and review of the old and new Wound Documentation Flow Sheet revealed the sheet was larger, organized, with descriptive terms used to describe wounds. Interview on 12/13/12, at 3:10 PM with the Assistant Administrator and review of notes dated 10/24/12, revealed the Assistant Administrator started in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The interview also revealed the Assistant Administrator also placed an instructional sheet in the Wound Care books at each nursing station to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. Observations conducted on 12/12/12, at 3:00 PM on the Secure Unit, at 3:10 PM on the 2nd floor and at 3:20 PM on the 1st floor revealed a Wound Care Book kept at each nurses' station. The observation revealed an instructional sheet to inform staff of how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly.	F 309	areas. This was completed by Christy Moore RN on 10/20/12. Any new areas or areas in question (identified on the skin assessments completed on 10/19/12) were reviewed, re-measured if necessary and placed on a monitoring sheet. New orders were obtained for newly identified areas. This was completed by Christy Moore RN on 10/21/12. All physicians were notified via fax on 10/22/12 of their respective residents with the type of wound. This was completed by Christy Moore, RN. See attachment #4. On 10/28/12 and 10/29/12 all physicians were notified of all wounds and the current treatments for the wounds of their respective residents using the WOUND NOTIFICATION FORM. They were asked to sign and return. This was completed by Christy Moore, RN. See attachment #5 A complete skin assessment was completed on all residents to ensure that all skin issues (with special focus on wounds) have been identified and documented. These assessments were completed over a four (4) day period on 11/13/12, 11/14/12, 11/15/12 and 11/16/12 by Mary Arms DON, Christy Moore RN, Ashley	

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

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F 309	<p>Continued From page 71</p> <p>Interview on 12/12/12, at 2:45 PM with the newly hired wound care nurse revealed she started employment on 10/24/12, and will be assessing and providing treatments to all wounds five (5) days a week. Interview on 12/12/12 at 11:00 AM with RN #2 revealed RN #2 will be assessing and providing treatments to all wounds the other two (2) days a week. The interviews revealed the wound care nurse or RN #2 will fax each resident's physician a bi-weekly notification of the resident's wound type, location, description and current treatment. Review of the newly hired wound care nurses' employee file revealed she started employment at the facility on 10/24/12. Further review of physician notifications letters revealed faxes were being sent bi-weekly to the residents' physician notifying the physicians of the residents' wound type, location, description and current treatment.</p> <p>Interview on 12/12/12, at 4:40 PM with the DON and review of documentation of the only resident that had been admitted since 10/25/12, revealed as part of the facility's CQI for monitoring skin assessments upon admission, the DON reviewed the resident's skin assessments and compared the skin assessment with her own skin assessment of the resident to ensure all areas have been identified, staged and measured accurately. The DON further reviewed the resident's chart to ensure the physician and family were notified of any skin areas, that appropriate treatment was being utilized to all skin areas and all skin areas were appropriately documented on the wound monitoring flow sheet for the resident.</p> <p>Interviews on 12/13/12, at 3:10 PM with the</p>	F 309	<p>Maggard, LPN, Teresa Kidd RN, Jessica Arnett RN, Yvette Short RN, and Bonnie Prater, LPN.</p> <p>A copy of the skin assessments completed on 11/16/12 was given to the MDS department for review. All residents identified during the skin assessments as having a wound of any kind had their individual MDS and Care Plan reviewed and revised if needed by Donna Fannin LPN and Crystal Cantrell LPN (MDS Department) to ensure that all skin areas identified were care planned. This was completed on 11/24/12.</p> <p>On 11/15/12 the physicians were notified again of all wounds and the current treatments for their respective residents using the WOUND NOTIFICATION FORM. This was completed by Christy Moore, RN. See attachment #6</p> <p>The families of all residents with any type of wound were contacted to ensure they were aware of the wound and treatments ordered. This was completed on 11/20/12 by Anna Caldwell, ADON, Chanity Purcell, LPN, Christy Moore RN and Brenda Humphries, RN.</p> <p>On 11/5/12, 11/6/12, 11/8/12, 11/9/12, 11/10/12 and 11/16/12 Mary Arms, DON observed treatments</p>	

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F 309	<p>Continued From page 72</p> <p>Assistant Administrator, on 12/12/12, at 4:25 PM and on 12/13/12, at 1:40 PM with the Activity Director and review of audit book kept by the Activity Director notes revealed as part of the facility's CQI for monitoring the transportation arrangement, the Activity Director had been reviewing the transportation logs on each unit to ensure all transportation arrangements have been made and no problems have been identified; however, if a problem is identified, it will be reported to the nursing administration immediately for correction.</p> <p>Interview on 12/12/12 at 4:40 PM with the DON, at 11:00 AM with RN #2, and a review of personal hand written notes revealed the DON and RN #2 will review all weekly nurse summaries of each resident, including skin assessments, and assess each resident to ensure the skin assessments match and ensure the physician was notified of any new alterations in skin integrity or changes in condition. The nurse completing the weekly skin assessments will notify the physician of any changes, obtain new orders and update the resident's plan of care with the new orders.</p> <p>Interviews on 12/12/12 at 4:40 PM with the DON; on 12/13/12 at 2:55 PM with the Administrator; at 3:10 PM with the Assistant Administrator; at 1:40 PM with the Activity Director, and review of the QA subcommittee meeting minutes for the 10/23/12, meeting revealed the Administrator formed a QA subcommittee which consists of each department head/manager that meet weekly to review the monitoring tools recently developed to improve the facility's QA program.</p> <p>Interviews on 12/13/12 at 2:55 PM with the</p>	F 309	<p>provided to 8 residents. Staff followed MD orders during the treatments. No other residents were identified.</p> <p>On 12/7/12 an audit was completed facility wide to observe turning and repositioning of residents using the facility turn and reposition schedule. If residents were observed not to be in the scheduled position staff was questioned as to the reason why. This was completed by Kathy Meadows and Misty Pennington, Social Services, Marie Pennington, Activity Director, Brenda Humphries RN, QA nurse, Kitty Harmon, Housekeeping Supervisor, Crystal Cantrell LPN, MDS staff.</p> <p>3. Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p> <p>LPN #6 and LPN#7 were terminated on 11/7/12 for failure to follow MD orders and falsification of records by Mary Arms, DON.</p> <p>Licensed staff were in-serviced on resident assessment, measuring wounds, treatments and documentation, physician and family notification, policies and staff responsibility in scheduling transportation to appointments, making arrangements, the</p>	

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F 309	Continued From page 73 Administrator, and at 3:10 PM with the Assistant Administrator revealed the Assistant Administrator/QA Coordinator will report all monitoring results in the quarterly CQI meetings.	F 309	transportation log, transportation policy and the new transportation books for easier use. These were completed on 10/19/12 thru 10/21/12 by Mary Arms DON. See attachment #10		
F 314 SS=H	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 a review of facility policies/procedures, it was determined there were fifteen (15) residents in the facility with pressure sores and nine (9) of the fifteen residents were selected for review. A review of the nine (9) residents with pressure sores revealed the facility failed to ensure necessary treatment/services to promote healing or prevent the development of new pressure sores was provided for seven (7) of the residents (Resident #2, #3, #5, #6, #7, #8 and #9). The facility failed to perform weekly wound assessments as per facility policy for Residents #2, #3, #5, #8 and #9. In addition, the facility failed to follow physician orders related to wound care for Resident #3, #6 and #7 and also failed to turn/reposition Resident #7 in accordance with the resident's care plan. (Refer to F282 and	F 314	Pressure Ulcer Documentation Guidelines were given to staff as handouts during the in-service. The Pressure Ulcer Documentation Guidelines were placed in the wound care monitoring book for reference. This was completed by Mary Arms, DON and Christy Moore on 10/19/12 thru 10/21/12. See attachment #10 The Pressure Ulcer Policy was reviewed on 10/21/12 by Mary Arms DON and Deborah Fitzpatrick Administrator with no changes. The Medical Director is in agreement. See Attachment #11 The Wound Documentation Policy was reviewed and revised. The Medical Director is in agreement. See attachment #12 A new wound monitoring sheet was created by Deborah Fitzpatrick Administrator on 10/24/12. This will be used for all wound documentation. The Medical Director approved the new wound monitoring form. See Attachment #13		

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

PRINTED: 12/28/2012
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OMB NO. 0938-0391

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F 314	Continued From page 74 F514.) The findings include: Review of the facility policy entitled "Skin Care" revised September 2001, revealed wounds were required to be measured and recorded weekly. Review of the facility policy entitled "Wound Documentation" (undated) revealed pressure ulcers, diabetic ulcers and other wounds deemed necessary to measure should be measured weekly by licensed staff. The policy revealed documentation should include wound location, stage, size, tunneling, undermining, necrotic tissue, sloughing tissue, eschar, drainage, granulation, description of surrounding tissue, pain, and support surface. Review further revealed if the wound did not show improvement or there were changes (such as warmth, redness of surrounding tissue, necrotic tissue or odor) the physician should be notified. 1. Review of Resident #3's medical record revealed the facility admitted the resident on 10/04/12 with multiple Pressure Ulcers and diagnoses of Contractures of Tendons in Lower Extremities, Dementia, and Anorexia. Review of Resident #3's Wound Evaluation Flow Sheet revealed on 10/04/12, the resident had an area to a bunion on the left foot that measured 0.6 centimeters (cm) x 0.4 cm x unable to determine (UTD); an area to the left outer ankle with measurements of 0.4 cm x 0.4 cm x UTD; an area to the left heel that measured 1.7 cm x 2.3 cm x UTD; a Stage II to the coccyx with measurements of 3 cm x 3 cm x 0.2 cm; and an	F 314	On 10/24/12 the Assistant Administrator, Emily Jones-Gray began in-servicing all licensed staff on how to utilize the revised Wound Documentation Flow Sheet. The Assistant Administrator also placed an instruction sheet in the Wound Care books at each nursing station to inform staff on how to utilize the revised Wound Documentation Flow Sheet and that all wounds should be measured and documented weekly. This was completed on 10/24/12. A Wound Notification Form was developed on 10/28/12 by Dr. Charles Hardin Medical Director, Mary Arms DON and Deborah Fitzpatrick Administrator. This form will be used to notify the attending physicians' bi-weekly of their respective resident wounds, condition of the wounds and current treatments. (See Attachment #14 (1)) The Wound Notification Form was revised on 12/14/12 by Mary Arms, DON and Deborah Fitzpatrick, Administrator to include a space for measurements, instructions to notify family of any changes and a place to document family member notified. The Medical Director is in agreement with the revision. See Attachment #14 (2)	

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

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F 314	<p>Continued From page 75 area to the right heel with no measurements.</p> <p>A review of the monthly Physician's orders for October 2012, revealed an order for staff to treat Resident #3's right heel, left heel, bunion to the left foot, and the left outer ankle with Granuflex Spray, apply 4 x 4 gauze, then wrap with "Kling" (gauze bandage) every day. The orders revealed staff was to cleanse the coccyx with normal saline, apply Aquacel AG Extra Hydrofiber dressing cover with Transparent dressing every three (3) days.</p> <p>Review of Resident #3's admission Minimum Data Set (MDS) Assessment dated 10/10/12 revealed the resident was at risk for pressure ulcers and was admitted with several pressure ulcers at various stages.</p> <p>Review of Resident #3's plan of care dated 10/24/12, revealed the facility addressed the resident's risk for impaired skin integrity related to stage II pressure ulcer to the coccyx, unstageable ulcers to bilateral heels, and stage II pressure areas to the resident's lower ankle. A review of interventions revealed nursing staff was 1) to complete a skin assessment every week and report any alterations to the physician and 2) to provide treatments as ordered by the physician.</p> <p>Further review of Resident #3's Wound Evaluation Flow Sheet revealed no other assessments of the wounds had been conducted until 10/20/12 (a timeframe of sixteen days after the last assessment). The flow sheet revealed on 10/20/12, the bunion to the resident's left foot measured slightly larger at 0.6 cm x 0.5 cm x UTD; the area to the left outer ankle measured</p>	F 314	<p>A treatment nurse was hired on 10/24/12. Her name is Tracy Thompson and she is an LPN. She will work full time as a treatment nurse five days per week.</p> <p>Christy Moore, RN a current employee will also work 2 days a week as a treatment nurse. There will be a designated treatment nurse 7 days a week.</p> <p>The treatment nurse will administer treatments on all wounds Stage II or greater (includes diabetic or stasis ulcers), monitor wounds daily for changes, measure wounds weekly, document daily on wounds or surrounding skin (of those wound with treatments order other than daily), notify physicians bi-weekly of all resident wounds and condition of each wound, monitor daily to see that documentation is being completed as part of CQL.</p> <p>Licensed staff were in-serviced regarding notification of change, causes of skin breakdown, Braden scale, nutrition in skin breakdown, risk factors for skin breakdown, how to write a complete treatment order, assessing, staging and measuring wounds, weekly summaries and skin assessments, the new wound monitoring sheet, proper disposal of soiled dressings, proper procedure</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 76</p> <p>slightly larger at 0.4 cm x 0.5 cm x UTD; the area to the left heel measured the same; the Stage II to the coccyx measured larger at 7 cm x 3.5 cm x UTD; and the area to the right heel measured 3.4 cm x 4.1 cm x UTD and the area to the resident's left third toe measuring 0.6 cm x 0.8 cm x UTD. There was no documented evidence the resident's physician was notified for the increase in size of the resident's wounds to the left foot, left outer ankle, and coccyx.</p> <p>Review of Resident #3's Treatment Administration Record (TAR) for October 2012, revealed Licensed Practical Nurse (LPN) #7 documented the treatment had been provided to the resident's feet on 10/27/12 and 10/28/12. In addition, documentation revealed LPN #6 provided the treatment on 10/29/12.</p> <p>Observation on 10/30/12, at 3:00 PM of Resident #3's wound care performed by LPN #3 revealed the area to the resident's coccyx had red tissue surrounding the open wound which, based on measurements obtained by the LPN, measured 8.3 cm x 6.2 cm, and the open wound measured 5.4 cm x 4.7 cm x 0.5 cm. The coccyx wound was pink with yellow/white sloughing noted. The observation revealed the "Kling" dressings to both heels had a date of 10/26/12, written in black marker on both dressings. LPN #3 acknowledged the initials on the dressings were hers and stated although she had not worked for the last three (3) days, the wound care to the resident's feet was ordered to be completed every day. The resident's right inner ankle was slightly red with no open wounds, the right heel was boggy and dark measuring 2.2 cm x 3.4 cm, and the left outer ankle was yellow, with a slight</p>	F 314	<p>required in completing a treatment/dressing change, storage of medication with focus on Mycalcin spray, procedure for returning home meds to family, entering medication orders/following physician orders, transcription of high risk medications, a second nurse should review all new and readmission orders. This in-service was given by Mary Arms, DON on 11-08-2012 and was completed on 11/24/12. See attachment #15</p> <p>Licensed staff were in-serviced a second time on the same information contained in the in-service completed on 11-23-12. Attachment #15 This in-service was conducted on an individual basis for some staff and/or very small groups for others with more staff interaction encouraged. A form was developed so that each staff attending the in-service initialed each item (as it was discussed/explained) an item was discussed indicating that they understood. Staff were asked if they had questions and if so all items in question were discussed prior to their initialing. In-servicing started on 12/18/12 and will be completed on 1/7/13 by Mary Arms, DON.</p> <p>Certified Medication Aides will no longer be allowed to do treatments to skin effective 10/25/12.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 77</p> <p>amount of yellow drainage noted on the old dressing, and measured 1.2 cm x 1 cm x 0.1 cm. The left heel had a dark area that measured 1.5 cm x 1.2 cm. The bunion to the outer side of the resident's left foot was dark and measured 0.4 cm x 0.4 cm and the third toe on the left foot had black edge on a dark area that measured 0.4 cm x 0.8 cm.</p> <p>Interview on 10/30/12, at 6:17 PM with LPN #7 revealed she had signed that the treatments to Resident #3's heels on 10/27/12 and 10/28/12 had been provided; however, the LPN acknowledged she had not completed the treatments. LPN #7 stated she ran out of time, but had reported the treatments had not been provided to the night nurse (LPN #8) who was supposed to provide the treatments.</p> <p>During an interview on 10/30/12, at 6:40 PM with LPN #8, the LPN stated she had not provided treatments to Resident #3's heels on 10/27/12 and 10/28/12. LPN #8 also stated she had not been notified that Resident #3's treatments needed to be provided.</p> <p>Interview on 10/30/12, at 5:20 PM with LPN #8 confirmed the LPN signed off the treatment to Resident #3's heels on 10/29/12, but did not complete the treatment. LPN #8 stated she provided wound care to the resident's coccyx, but was called out of the room before providing wound care to the resident's heels. The interview revealed the LPN "forgot" to go back and provide the wound care to the resident's heels.</p> <p>2. Review of Resident #2's medical record revealed the facility admitted the resident on</p>	F 314	<p>A wound care reference guide has been placed on each treatment cart as a reference for appropriate treatment/products for specific wound types. This was completed on 11/5/12 by Mary Arms, DON. See attachment #16</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. Roberta Thompson, MDS Coordinator will be responsible to ensure this is completed. 11/24/12</p> <p>4. On 10/21/12 Mary Arms DON notified Dr. Charles Hardin Medical Director of the missed appointment of resident #1, the change in condition related to the wound and failure of LPN #1 to notify the attending physician and family.</p> <p>On 10/28/12 a meeting was held with Dr. Charles Hardin, Medical Director, Mary Arms, DON and Deborah Fitzpatrick, Administrator to discuss the issues identified in the current survey and Quality Improvement related to assessment, wound care, documentation, physician and family notification and transportation to appointments.</p> <p>The Medical Director reviewed all the initial physician notification</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 78</p> <p>10/31/11, with diagnoses of left buttock ulcer, sacral ulcer, Anemia, Peripheral Vascular Disease and Diabetes. Resident #2's medical record revealed the resident was readmitted from an acute care facility on 08/06/12 with a pressure ulcer to the left buttock and blisters to both heels. The Wound Evaluation Flow Sheet revealed the wounds were assessed on 08/07/12 (one day after re-admission) and the wound to the left buttock measured 3 cm x 3.5 cm x 4 cm; the left heel wound measured 5 cm x 5 cm; and the right heel wound measured 5 cm x 5 cm.</p> <p>Review of Resident #2's Significant Change MDS Assessment dated 08/10/12, revealed a decline in the resident's cognition, Activities of Daily Living (ADL) status, continence, and new development of pressure ulcers following a hospitalization.</p> <p>Review of Resident #2's plan of care dated 11/20/11, revealed the facility addressed the resident's risk for alteration in skin integrity and at risk for development of pressure ulcers was revised on 08/06/12, when the resident was readmitted with unstageable pressure ulcers to both heels and a Stage IV to the left buttocks, with interventions to provide treatments as ordered by the physician.</p> <p>Continuous review of Resident #2's Wound Evaluation Flow Sheet dated 08/19/12, revealed documentation that the left heel wound measured 6.1 cm x 8.6 cm x UTD; there were no documented measurements of the wound to the resident's right heel and the wound on the resident's left buttocks measured 3 cm x 3.4 cm x 5 cm. There was no documented evidence the</p>	F 314	<p>regarding wounds that was sent on 10/22/12. See attachment #4</p> <p>A Quality Assurance nurse was hired on 11/19/12 and will work under the supervision of the Director of Nursing to provide quality assurance monitoring specifically for the nursing department.</p> <p>The CQI skin monitoring sheet for pressure ulcers was revised by Emily Gray Assistant Administrator on 11/20/12. Twelve (12) charts will be reviewed monthly. This also includes notification of physician and family. This will be completed by the Quality assurance nurse or other nursing staff assigned by Mary Arms, DON. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray, Assistant Administrator. See Attachment #17</p> <p>A SKIN/WOUND QI LOG was ordered and will be used to track wounds (facility acquired or admitted with), type of wound, interventions and physician and family notification. This will be completed weekly by Emily Gray, Assistant Administrator. This will be ongoing. All results will be reported quarterly through CQI by Emily Jones-Gray,</p>	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

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F 314	<p>Continued From page 79</p> <p>physician was notified of the increase in size of the left heel wound.</p> <p>The Wound Evaluation Flow Sheet revealed the next documented assessment of the Resident #2's wound to the left buttock was on 09/07/12 (4 weeks after the previous assessment on 08/07/12) and the wound measured 3 cm x 3 cm x UTD. There was no documentation of an assessment and/or measurement of the wounds on Resident #2's heels.</p> <p>Further review of the Wound Evaluation Flow Sheets revealed on 09/14/12 (5 weeks after the previous assessment on 08/19/12) the wound to the resident's left heel measured 2 cm x 2 cm and the right heel wound measured 2.5 cm x 1 cm. Review of the Wound Evaluation Flow Sheet revealed the next measurement of the resident's left heel was on 10/21/12 (four weeks after the previous assessment) and revealed the wound measured 3 cm x 1.8 cm.</p> <p>Observation on 10/23/12, at 3:40 PM, of Resident #2's wound care with LPN #2 revealed a dark, dry, scabbed area with redness of the wound on the left heel and a small amount of swelling around the wound. The wound measured 3 cm x 1.5 cm with no drainage or odor. The observation revealed the right heel had no wound and the resident's buttocks had a wound vacuum with an occlusive dressing.</p> <p>Interview on 10/23/12, at 7:30 PM, with Registered Nurse (RN) #2, revealed she was unsure why nurses had failed to document weekly wounds assessments for Resident #2.</p>	F 314	<p>Assistant Administrator. See Attachment #18</p> <p>All weekly nursing summaries will be turned in to Mary Arms, DON. Mary will monitor for completeness. The weekly summary includes a skin assessment. This started on 10/22/12 and will be ongoing.</p> <p>A tracking form was developed on 10/25/12 by Mary Arms, DON to use in monitoring when weekly summaries are due for each resident. See Attachment 19</p> <p>Mary Arms, DON will review all weekly nursing summaries for completeness. She will review the skin assessment. She will then perform a skin assessment on the resident and compare this to the one completed on the weekly summary to ensure that the resident skin is assessed correctly. This will be completed for 4 weeks at 100% until 11/25/12 and then re-evaluated. The QA nurse will assist Mary Arms, DON in the review of the weekly summaries and the weekly skin assessments after 11/19/12.</p> <p>If there are no problems identified then the percentage of review will decrease to 50%. All weekly summaries will continue to be reviewed at 100% for</p>	
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F 314	<p>Continued From page 80</p> <p>3. A review of Resident #5's medical record revealed the facility admitted the resident on 01/14/12, with diagnosis of Cerebral Vascular Accident, Congestive Heart Failure, Depression, and Failure to Thrive.</p> <p>Continued review of Resident #5's medical record revealed nurse's notes dated 08/27/12, that the resident's physician was notified the resident had a Stage II pressure ulcer to the coccyx. Treatment orders were obtained to cleanse the resident's coccyx area with normal saline, pat the area dry, apply Bactroban ointment (an antibacterial used to treat skin infections), and to cover the area with a "Telfa" pad (non-adherent absorbent cotton dressing) and Hypafix (self-adhesive, non-woven fabric for dressing retention) every day. However, there was no documentation of the appearance or size of the pressure wound.</p> <p>Review of Resident #5's plan of care revealed a revision date of 09/05/12, with additional interventions for staff to cleanse area to the coccyx with normal saline, pat dry and apply Aquacel AG (a silver impregnated antimicrobial dressing which reduces the number of bacteria in the wound) and a 4 x 4 gauze and cover with Hypafix every seventy-two (72) hours.</p> <p>Review of a Wound Evaluation Flow Sheet revealed facility staff failed to document the status of Resident #5's pressure ulcer until 09/14/12, (eighteen days after first identified), and at that time, the ulcer measured 1.4 cm x 1.0 cm x 0.2 cm. Review of the Wound Evaluation Flow Sheet revealed the form was to be completed by a nurse upon identification of a wound and at</p>	F 314	<p>completeness and that a weekly skin assessment was completed on all residents. Fifty percent (50%) of all residents will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 weeks or until 12/25/12 and then be re-evaluated.</p> <p>If there are no problems identified then the percentage of review will decrease to 8 residents per week. All resident weekly nursing summaries will be reviewed at 100% for completeness and that a weekly skin assessment was completed on all residents. Eight (8) residents per week will have their skin reassessed by Mary Arms, DON or the QA nurse and compared with the one on the weekly nursing summary to ensure that the skin is assessed correctly. This will continue for 4 months and then be re-evaluated. See Attachment 19</p> <p>Mary Arms, DON or the QA nurse will review the skin assessments on new admissions and readmissions. They will then assess the resident skin and compare with the skin assessment to ensure that all areas have been identified properly and that the staging and measurements are</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 314	<p>Continued From page 81</p> <p>least weekly from the date of identification. However, a review of the Wound Evaluation Flow Sheet revealed staff failed to conduct an assessment of Resident #5's wound during the weeks of 08/26/12, and 09/02/12.</p> <p>A review of instructions on a Treatment Administration Record (TAR) for September and October 2012, revealed staff was to cleanse Resident #5's coccyx pressure ulcer with normal saline, pat dry, cover with Aquacel AG and a 4 x 4 gauze, and then secure with Hypafix Kling. The treatment was to be performed every seventy-two (72) hours. The TAR revealed wound care was performed as ordered by the physician.</p> <p>4. A review of Resident #6's medical record revealed the facility admitted the resident on 08/17/12. A review of Resident #6's Wound Evaluation Flow Sheet revealed on 10/21/12, the facility identified a new Stage II pressure sore to the right buttock area on Resident #6. The facility assessed the wound to measure 1.0 cm x 1.5 cm x 0.1 cm. The facility further assessed the wound to be red with no drainage and a small amount of brown crust.</p> <p>A review of physician's orders dated 10/21/12, revealed an order to clean the Stage II on Resident #6's right buttock with normal saline, pat the area dry, apply "Bactroban" (a topical treatment for bacterial skin infections) and "Telfa" (a cotton, non-adherent dressing), and secure with "Hypafix" (a self-adhesive non-woven fabric for dressing retention) daily for fourteen (14) days.</p> <p>Observation of a skin assessment of Resident #6</p>	F 314	<p>accurate, the family and MD were notified, the appropriate treatment is in place and that all areas have been placed on the wound monitoring flow sheet and monthly log. This will continue for 6 months and then will be re-evaluated. The findings will be reported quarterly through CQI by Mary Arms, Don. See attachment #20</p> <p>The Braden scale is completed on Admission, Re-admission and change in condition by the licensed nurses for 4 weeks. Roberta Thompson, MDS Coordinator will monitor as part of CQI the completion of the Braden Scale by Licensed staff. Any failure to complete the form will be reported to the DON for corrective action. The results of the audit will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See Attachment #21</p> <p>As part of CQI the transportation logs will be reviewed weekly by Emily Gray Assistant Administrator or Marie Pennington, Activity Director to ensure that transportation arrangements are being made. This began on 10/26/12 and will be continuous. Any issues identified will be reported immediately to nursing administration for correction. All findings will be reported</p>	

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185414	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/13/2012
NAME OF PROVIDER OR SUPPLIER MOUNTAIN MANOR OF PAINTSVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 EUCLID AVENUE PAINTSVILLE, KY 41240	
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F 314	<p>Continued From page 82</p> <p>on 10/25/12, at 4:08 PM revealed a dressing in place on the right buttock. Observation revealed a Stage II wound was approximately three (3) inches from the dressing. Interview with LPN #5 during the skin assessment at 4:08 PM on 10/25/12, revealed Resident #6 had previously received wound care on 10/25/12, by Certified Medication Aide (CMA) #1, so the dressing was not removed for this observation. LPN #5 stated she was not aware Resident #6 had developed a second Stage II wound and stated the wound did not "look new."</p> <p>Interview on 10/25/12, at 4:40 PM with Certified Medication Assistant (CMA) #1 revealed the CMA had performed wound care on Resident #6 at approximately 10:00 AM on the morning of 10/25/12. The CMA stated during wound care to Resident #6 the resident only had one wound on the right buttock and that wound was treated as per physician order. The CMA further stated she had not identified another wound on Resident #6's buttocks during wound care.</p> <p>Review of facility's "Job Description" for "Certified Medication Technician" undated revealed CMTs can observe, monitor, and report symptoms of potential skin breakdown and/or decubitus ulcers to the Charge Nurse and provide treatment as directed.</p> <p>A review of a physician note dated 10/26/12, revealed Resident #6 had a Stage II pressure sore to the right buttock and a tape abrasion to the right buttock in the same vicinity. The note further revealed a nursing aide had inadequately covered the abrasion with the treatment that was ordered for the Stage II pressure sore, and as a</p>	F 314	<p>quarterly through CQI by Emily Gray Assistant Administrator or Marie Pennington, Activity Director. See attachment #22</p> <p>The MDS Nurses will document the results of their skin assessments in the resident's medical records. The MDS Nurse will complete a CQI Skin Communication Sheet with the results of their skin assessment as well. A copy of the Communication Sheet will be given to the Staff Nurse for the resident and a copy of the sheet will be given to the Director of Nursing. This is a CQI communication tool. This began on 11-23-2012. All findings will be reported quarterly through CQI by Roberta Thompson, MDS Coordinator. This will be ongoing. See attachment #23</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week to observe turning and repositioning to ensure that the individual resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/26/12. The results of the audits will be reported weekly in the QA meeting and quarterly through CQI by Emily Jones- Gray Assistant Administrator, QA Coordinator or the QA nurse.</p>	

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F 314	<p>Continued From page 83</p> <p>result, facility staff failed to provide the treatment as ordered by the physician to the Stage II pressure sore on the resident's right buttock.</p> <p>5. Review of Resident #7's medical record revealed the facility admitted the resident on 08/23/12. A review of Resident #7's Minimum Data Set (MDS) Assessment completed after admission, dated 08/30/12, revealed the facility assessed Resident #7 to be cognitively intact. Further review revealed the facility assessed Resident #7 to require extensive assistance from two (2) staff with bed mobility.</p> <p>A review of Resident #7's comprehensive plan of care dated 09/12/12 revealed the resident was at risk for alteration in skin integrity due to the resident's dependency on two (2) staff to provide the resident "weight-bearing" assistance, position changes, and bed mobility every two (2) hours and as needed.</p> <p>A review of the October 2012, Certified Nursing Assistant (CNA) care plan revealed staff was required to reposition Resident #7 every two (2) hours.</p> <p>Observations were conducted of Resident #7 on 10/30/12, at 8:57 AM, 9:38 AM, 11:18 AM, 12:27 PM, 3:20 PM, 4:50 PM and 6:30 PM. During each observation Resident #7 was positioned in bed on his/her right side.</p> <p>Interview with Resident #7 on 10/25/12, at 11:55 AM revealed staff did not assist the resident with turning and repositioning every two (2) hours. Resident #7 stated, "They [staff] don't offer" to assist the resident with turns and reposition.</p>	F 314	<p>This audit may be delegated to other staff in the future.</p> <p>Room checks are completed 3 times a week by Kathy Meadows and Misty Pennington, Social Services, Marie Pennington, Activity Director, Brenda Humphries RN, QA nurse, Kitty Harmon, Housekeeping Supervisor, MDS staff and Chanity Purcell, Staff Development. As of 12/7/12 turning and repositioning is being audited as room checks are completed. This will be ongoing. The results will be reported quarterly through CQI by Kathy Meadows, Social Services or Emily Jones-Gray, QA Coordinator.</p> <p>The QA nurse will monitor 4 residents per unit 3 times weekly for a total of 12 residents per week for appropriate transfer to ensure that the resident care plan and physician orders are being followed. This will be completed for 6 months and then re-evaluated. This started on 11/28/12. The results of the audits will be reported weekly in the QA meeting and Quarterly through CQI by Emily Jones-Gray, Assistant Administrator, QA Coordinator or the QA nurse. This audit may be delegated to other staff in the future.</p> <p>A form was created on 11/23/12 to use in evaluation of treatment procedures performed by licensed</p>	