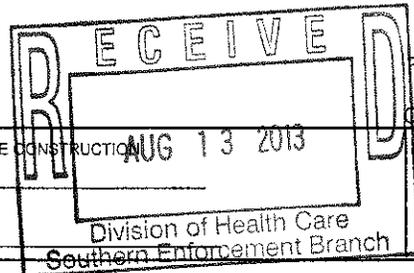


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/18/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/03/2013
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NAME OF PROVIDER OR SURPLIER PINEVILLE COMMUNITY HOSPITAL	STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977
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F 000	INITIAL COMMENTS	F 157	<p><u>Notification of Changes</u></p> <p>Resident # 6 physician was notified 7/08/13 at 8:41 am of missed dose of Insulin on 7/02/13 due to Insulin not available from Pharmacy (See attached Patient Progress Notes for 7/08/13). On 7/08/13 there were four (4) residents (Rooms 105, 107², 108², and 118²) receiving Insulin. Their medication supply was checked to ensure availability of adequate supply of medication to be administered.</p> <p>Policies and procedures for "Notification of Changes" and "Medication Error Reporting" were inserviced to Licensed Nurses on July 10-14, 2013. (See attached Inservice Attendance Record and Policies/Procedures).</p> <p>A Performance Improvement Study for Notification of Changes and Medication Errors Tracking was already in place for 2013. The Notification of Changes PI Study was revised to include notification for medication errors/incidents. Results of findings will continue to be reported monthly by the Unit Supervisor to the CNO for quarterly reporting to the Nursing Facility Committee. Medication Errors are reported quarterly also to the Pharmacy and Therapeutic Committee by the CNO as part of the facility wide Performance Improvement Program (See attached Performance Improvement Data Collection Tool, Calendar, and Plan for Notification of Changes and Medication Errors and Incidents).</p> <p>Nursing Staff were educated on the need to inventory the residents medications daily on 11-7 shift and to send a refill request form to the Pharmacy so that residents have adequate supplies of medications. (See attached Inservice Attendance Record and First South Refill Request Form and sample of completed/faxed First South Refill Request Form for 7/23/13). As of 8/12/13, there have been no issues with residents having adequate supply of medications.</p>	8/09/13
F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A standard health survey was conducted on 07/01-03/13. Deficiencies were cited with the highest scope and severity at "E" level.</p> <p>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).</p> <p>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.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Dorah James R, CNO TITLE: Chief Nursing Officer (X6) DATE: 8/13/13

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 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, interview, and facility policy review it was determined the facility failed to promptly notify the resident's physician regarding altered treatment for one of ten sampled residents (Resident #6). Resident #6 had physician's orders for a scheduled dose of Insulin three times a day; however, on 07/01/13, facility staff failed to administer the morning dose of insulin and facility staff failed to notify the physician of the medication omission.</p> <p>The findings include:</p> <p>A review of the facility policy on physician notification (revised October 2012) was conducted on 07/03/13 at 3:00 PM. The policy revealed the physician would be notified immediately of any changes to the plan of treatment that could cause adverse consequences to a resident.</p> <p>A review of resident #6's medical record conducted on 07/01/13 and 07/02/13 revealed the facility admitted the resident on 07/01/12 with a diagnosis of Diabetes Mellitus. A review of the medication administration record (MAR) and physician's orders revealed the resident was to receive 7 units of NovoLog insulin three times a day with meals, and was also on sliding scale four times a day with regular Insulin coverage for blood sugars above 350. A review of the MAR for 07/01/13 revealed Resident #6 did not receive the 8:00 AM dose of Insulin as ordered.</p>	F 157			

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F 157	Continued From page 2 An interview conducted with Licensed Practical Nurse (LPN) #1 on 07/02/13 at 4:30 PM revealed she administered medications to Resident #6 on the morning of 07/01/13. LPN #1 stated the Insulin for Resident #6 was not administered because there was no Insulin in the resident's medication drawer. LPN #1 stated she called the pharmacy to obtain the Insulin, but the Insulin had not been delivered to the Nursing Unit by the pharmacy until 11:30 AM. LPN #1 stated she did not notify Resident #6's physician of the medication omission but "should have." An interview was conducted with Registered Pharmacist (RPh) #1 on 07/03/13 at 4:10 PM. RPh #1 stated Resident #1's Insulin was filled five days prior to 07/01/13 and the resident should have had enough Insulin to last 45 days. RPh #1 stated pharmacy staff had gone to the Nursing Unit in an effort to locate the insulin but was unsuccessful. RPh #1 acknowledged the Insulin was not sent to the Nursing Unit until approximately 11:30 AM.	F 157			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the	F 282			

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F 282	<p>Continued From page 3</p> <p>facility failed to provide services in accordance with the plan of care for one of ten sampled residents (Resident #4). According to the care plan, staff was to provide Resident #4 heel protectors when the resident was in bed. However, observations revealed facility staff failed to provide/apply the heel protectors on 07/1/13 and on 07/03/13.</p> <p>The findings include:</p> <p>Review of the facility "Interdisciplinary Care Planning Committee" policy (no date) revealed the comprehensive individualized plan of care would be developed based on the comprehensive assessment completed by the Interdisciplinary Care Plan Team. The policy further revealed care plan interventions would be implemented according to the plan of care.</p> <p>Review of the medical record revealed the facility admitted Resident #4 on 08/22/12 with diagnoses including Diabetes Mellitus, Hypertension, Congestive Heart Failure, Coronary Artery Disease, and Psychosis. Review of the Significant Change comprehensive assessment dated 03/05/13 revealed the facility assessed Resident #4 to require total assistance with bed mobility, toileting, personal hygiene, and bathing. The assessment further revealed Resident #4 was assessed to be at risk for the development of pressure ulcers, and had one Stage II pressure ulcer on the buttocks area upon readmission. Review of the comprehensive care plan dated 03/05/13 revealed the facility identified and addressed a Stage II pressure ulcer on the resident's buttocks area. Interventions to promote healing and prevent further breakdown</p>	F282	<p>On 7/09/13 Resident #4's Care Plan was revised to include the use of heel protectors at night only while resident is in bed. On 7/17/13 the heel protectors were discontinued due to resident will not keep heel protectors on.</p> <p>On 7/12/13 and 7/15/13, all residents' Care Plans were reviewed and compared to documentation on the nursing daily flowcharts. Resident Care was observed by CNO to ensure that interventions were being carried out according to resident's Plan of Care. All Care Plan interventions were implemented and documented.</p> <p>On 7/15/13, a new Performance Improvement Study was developed by the CNO to assess for compliance with care planning interventions. Concurrent monitoring will be accomplished by the Unit Supervisor and reported to the CNO monthly. Results of findings will be reported quarterly to the Nursing Facility Committee by the CNO. (See attached PI Study data collection tool, calendar and performance improvement plan for Care Planning.) As of 8/12/13, the CNO conducted ten (10) resident observations and chart reviews with 100% compliance noted.</p> <p>On 7/22/13 the Nursing Facility SRNA Daily Flowchart was revised to include a location to document the use of heel protectors on residents. (See attached SRNA Flowchart). On 8/7/13, the CNO checked seven (7) residents to ensure that heel protectors were being applied according to residents' plan of care. Documentation was reviewed on SRNA flowchart and 100% compliance was noted.</p>	8/12/13	

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F 282	<p>Continued From page 4</p> <p>of the pressure ulcer included to provide air mattress, reposition the resident every two hours, provide treatments as ordered, use positional devices to prevent direct contact with bony prominences, and apply heel protectors to relieve pressure on the heels when the resident was in bed and/or chair.</p> <p>Resident #4 was observed on 07/01/13, at 3:15 PM, to be lying in bed with his/her heels elevated on a pillow. A sign was noted to be posted above the resident's bed that read, "Keep heel pads on." On 07/03/13, Resident #4 was again observed in bed at 9:05 AM with no heel protectors in place. At 11:30 AM on 07/03/13, the resident was observed to be in a reclined geri-chair in the facility hallway. Non-skid socks were observed to be in place; however, the heel protectors were not in use.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #1 on 07/03/13, at 12:50 PM, revealed she provided care to Resident #4 on 07/01/13 and on 07/03/13 and was aware the resident was supposed to have heel protectors on at all times. CNA #1 stated she had forgotten to apply the heel protectors for Resident #4 on 07/01/13 and on 07/03/13.</p> <p>Interview conducted with Registered Nurse (RN) #1 on 07/03/13, at 4:10 PM, revealed the CNAs were to follow the care plan interventions. RN #1 stated the staff nurses checked the residents whenever they were in/out of the residents' rooms to ensure care plan interventions were implemented. The RN stated she was not aware the heel pads were not in use for Resident #4.</p>	F 282			

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F 282	Continued From page 5 Interview with the Director of Nurses (DON) on 07/03/13, at 4:30 PM, revealed the staff nurses were responsible to make observations to ensure care plan interventions were implemented in accordance with each resident's plan of care. The DON stated no problems had been identified and/or reported to her.	F315	On 7/03/13 the Physician was notified of unable to locate diagnosis to support use of foley catheter for resident # 4. Diagnosis was provided by MD along with orders to try bladder training and then discontinue catheter. (See attached computerized order). On 7/05/13 resident pulled foley catheter out and bladder training was discontinued. Resident voids without difficulty and has episodes of incontinence (see attached Patient Progress Notes of Resident #4). On 7/09/13 the July PI Study for Foley Catheter Use was completed by the CNO. Nine (9) residents with foley catheters were reviewed for documentation of indication for use of catheters. (See attached July data collection form). Results were 100% compliant. On 7/09/13 resident's plan of care was updated to reflect the bladder training and the subsequent discontinuation of the bladder training when the resident pulled out catheter. Care plan was updated to reflect interventions for incontinence care. (See attached Care Plan of Resident # 4). On 7/09/13 the Physician's orders were revised to include a field to document diagnosis when a foley catheter is ordered (See attached sample of order sheet). As of 8/12/13, no newly admitted residents have had orders for foley catheters. All of the above residents were admitted prior to the change to the physician's orders. The Performance Improvement Study on Foley Catheter Care was revised on 7/15/13 to include indicators to assess for physician notification if no diagnosis is present in the resident's record and documentation of diagnosis on Physician order sheet at time catheter is ordered. Concurrent monitoring will be accomplished by the Unit Supervisor with findings quarterly to the Nursing Facility Committee. (See attached data collection tool, calendar, and performance improvement plan for Foley Catheter Care). On 8/12/13, only six (6) residents have indwelling catheters. All PI indicators were assessed by the CNO and found to be 100% compliant.	8/15/13	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure residents with an indwelling catheter had a clinical condition to support the use of an indwelling catheter for one of ten sampled residents (Resident #4). Resident #4 was readmitted to the facility with an indwelling urinary catheter in place; however, there was no evidence the facility identified a clinical condition to support the use of the indwelling catheter. The findings include: A review of the facility's policy titled "Policy for				

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F 315	<p>Continued From page 6</p> <p>Urinary Catheters," with a revision date of March 2011, revealed indwelling catheters should only be used for clinical reasons and only remain in place as long as necessary.</p> <p>Resident #4 was observed on 07/01/13, at 3:15 PM lying in bed and an indwelling catheter was in place with amber colored urine noted in the drainage bag. On 07/02/13 at 8:20 AM, 11:00 AM, and 2:30 PM, facility staff continued to utilize an indwelling catheter for Resident #4. A skin assessment conducted with facility staff on 07/03/13, at 10:15 AM, revealed Resident #4 had scar tissue on the coccyx/buttock area. No skin breakdown was observed.</p> <p>Review of the medical record revealed the facility readmitted Resident #4 on 02/20/13 with diagnoses including Diabetes Mellitus, Hypertension, Congestive Heart Failure, Coronary Artery Disease, and Pressure Ulcer. Review of the significant change comprehensive assessment (MDS) dated 03/05/13, revealed the facility assessed Resident #4 to require total assistance with toileting and required an indwelling urinary catheter.</p> <p>A review of the Care Area Assessment (CAA) dated 03/06/13 revealed the resident had an indwelling catheter and received diuretics. The CAA noted the physician would be contacted regarding the removal of the indwelling catheter. A review of the report of the recommendations revealed facility staff faxed a request to the physician on 03/06/13 to discontinue the use of Resident #4's indwelling catheter. However, there was no evidence the physician had responded to the request or any evidence facility</p>	F 315			

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F 315	Continued From page 7 staff had followed up with the physician to obtain a diagnosis or to discontinue the indwelling catheter. Interview with MDS Nurse #1 on 07/02/13, at 11:25 AM, revealed she had faxed the request to discontinue the use of Resident #4's indwelling catheter to the resident's physician on 03/06/13. The MDS Nurse stated she did not follow up with the physician to determine a diagnosis for the indwelling catheter or to discontinue the use of the catheter. MDS Nurse #1 stated the Unit Coordinator (UC) was supposed to ensure there was a diagnosis for the use of a Foley catheter; however, the UC had been on medical leave since February 2013. Interview with the Director of Nurses (DON) on 07/03/13, at 4:30 PM, revealed she had reviewed Resident #4's medical record and was aware the resident had an indwelling catheter. The DON stated she believed the resident had a diagnosis for the use of the catheter, but was unable to provide documentation of the diagnosis.	F 315			
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.	F 428			

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F 428	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure that any irregularities/recommendations for Gradual Dose Reductions (GDRs) identified by the consultant pharmacist were reported to the attending physician and the Director of Nursing (DON) for four of ten sampled residents (Residents #1, #2, #4, and #9). Residents #1, #2, and #4 were prescribed psychotropic medications on a routine basis. However, there was no evidence the pharmacist had reviewed the medication regimen for the use of the psychotropic medications or that the pharmacist had recommended a gradual dosage reduction for these medications. In addition, the pharmacist had made recommendations for Resident #9 during the months of April 2013, May 2013, and June 2013 for lab tests to be done; however, there was no evidence these recommendations had been reported to the resident's physician. The findings include: Review of the facility policy entitled "Medication Monitoring-Medication Regimen Review," (dated May 2009) revealed the consultant pharmacist was responsible to conduct a comprehensive medication regimen review monthly to ensure the resident's drug regimen would be free of any unnecessary medications and to ensure residents receiving any antipsychotic medication would have a gradual dose reduction and behavioral interventions to discontinue the antipsychotic	F428	On 7/08/13, a new procedure was developed to ensure that physicians are made aware of Pharmacist recommendations and follow-up is conducted timely. A notebook has been developed and the Pharmacists are now placing the Medication Regimen Reviews in this notebook instead of in the residents' charts. The Unit Supervisor will be responsible for checking the book for the addition of new recommendations every Friday. In the absence of the Unit Supervisor, the book will be reviewed by the MDS Coordinator or the CNO. Physician notification will be accomplished by the nurse checking the book or the Chief Pharmacist to ensure response to recommendations timely. For the month of July, all residents will be assessed for use of antipsychotics and the need for gradual dose reductions, with subsequent recommendations made to physicians of the residents. This was completed by July 31, 2013. (See attached sample of Drug Regimen Reviews with recommendations for gradual dose reductions). Eleven (11) residents were assessed for a gradual dose reduction in July. Nine (9) gradual dose reductions were attempted. The Chief Pharmacist contacted two (2) physicians on 8/12/13 due to a lack of response. On 7/02/13, the MDS Coordinator notified physician of Resident # 1 to obtain orders for a reduction in Risperdal upon resident's return to facility. Orders were obtained for the reduction and the medication was discontinued on 08/02/13. (See attached computer generated order). <i>F428 Continued on page 10</i>	8/15/13	

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F 428	<p>Continued From page 9</p> <p>medication. The policy revealed the findings and recommendations of the medication review would be reported to the Director of Nurses and to the attending physician. The policy also revealed the recommendations would be acted upon and documented by the facility staff and/or the prescriber.</p> <p>1. Review of the medical record revealed the facility admitted Resident#1 on 04/13/12 with diagnoses of Anemia, Dementia without behavior, Schizophrenia, and Diabetes Mellitus. The resident was admitted with physician's orders for Risperdal (antipsychotic medication) 1 mg to be administered on a daily basis.</p> <p>Resident #1 was observed on 07/01/13, at 3:10 PM to be lying in bed, facing the door. The resident was observed to require the use of a tracheostomy and a gastrostomy tube feeding and was nonresponsive to verbal stimuli.</p> <p>Review of the annual comprehensive assessment (MDS) dated 05/30/13 revealed Resident #1 was assessed to have no mood/behavior indicators during the assessment reference period and no symptoms of psychosis.</p> <p>Review of the Care Area Assessment (CAA) for psychotropic medications, dated 06/05/13, revealed RN #1 had completed portions of the MDS and had documented on a care plan recommendation form that there were "no behaviors documented for use or no documentation to justify the medication [Risperdal] use" for Resident #1. Continued review of documentation revealed RN #1 requested a gradual dose reduction or possible</p>	F 428	<p><i>F428 continued from page 9</i></p> <p>Resident # 2's Drug Regimen Review was completed by the Pharmacist on 7/16/13 and faxed to the physician requesting a decrease in the Klonopin and Trazodone. The physician responded to the recommendations 7/19/13 with orders to decrease the Klonopin but continue the Trazodone as prescribed (See attached Drug Regimen Review Form for Resident # 2).</p> <p>On 7/16/13, the Pharmacist conducted Resident # 4's monthly drug regimen review. Recommendations were faxed to the physician and the physician responded the same day with orders to decrease the Seroquel per Pharmacist recommendation (See attached Drug regimen Review Sheet for Resident # 4).</p> <p>On 7/22/13, Resident # 9's Drug Regimen Review was completed by the Pharmacist and faxed to the physician with recommendations to decrease Seroquel. The physician responded on 7/22/13 with orders to taper the Seroquel dosages. (See attached Drug Regimen Review and Laboratory Reports for Resident # 9).</p> <p>As of 7/31/13, 23 resident medication regimen reviews were conducted for the month of July by the two (2) Pharmacists. There were 11 residents for gradual dose reductions. Nine (9) of the eleven (11) were accepted by the physician. Two (2) physicians have been notified by the Chief Pharmacist on 8/12/13 due to lack of response.</p> <p><i>F428 Continued on page 11</i></p>		

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F 428	<p>Continued From page 10</p> <p>discontinuation of the medication (Risperdal). Documentation on the recommendation revealed the request was faxed to the resident's physician on 06/05/13. However, there was no evidence the physician had responded to the request.</p> <p>Further review of the medical record revealed the consultant pharmacist had conducted a monthly medication regimen review for Resident #1 since the resident's admission to the facility on 04/13/12. Review of the medication reviews conducted from November 2012 through June 2013 provided no evidence the pharmacist had identified the use of Risperdal for Resident #1 that had originally been ordered on 04/13/12 and no evidence the pharmacist had recommended a dosage reduction for the medication.</p> <p>Interview conducted with RN #1 on 07/02/13, at 3:35 PM, revealed she had completed the annual MDS assessment. RN #1 stated she reviewed the resident's medications when conducting the assessment and identified the use of Risperdal for Resident #1. RN #1 further stated she could not determine any indication for the use of the medication for Resident #1 because the resident no longer exhibited behaviors due a decline in physical condition and faxed the request to the resident's physician on 06/05/13. RN #1 stated the resident's physician had been out of town for approximately two weeks during that time and she "forgot" to follow up on the request.</p> <p>Interview conducted with Registered Pharmacist (RPh) #1 on 07/03/13, at 3:45 PM, revealed she and another pharmacist (RPh #2) were responsible for conducting the monthly medication reviews for residents in the facility.</p>	F 428	<p><i>F428 continued from page 10</i></p> <p>The Nursing Performance Improvement Study for Medication Use/Indication for Use was revised on 7/11/13 to include indicators to assess for compliance with gradual dose reduction of antipsychotics, evidence of Physician notification of Pharmacist recommendations and Physician response to recommendations. The Unit Supervisor will conduct concurrent monitoring and report findings to the CNO monthly. The CNO will report findings quarterly to the Nursing Facility and Pharmacy and Therapeutics Committee (See attached data collection tool, calendar, and Performance Improvement plan). Since July 11, 2013, the CNO has reviewed 21 resident's records for medication use/indications for use for evidence of physician notification of Pharmacist recommendations. As of 7/31/13, 14 of 21 responses had been received from physicians. Seven (7) residents with no response resulted in medication regimen reviews being resubmitted to the physicians by the Chief Pharmacist. As of 8/12/13, 100% of recommendations have evidence of physician response.</p> <p>The Pharmacy Performance Improvement (PI) Plan was edited to include the Goal/Indicator "Percentage of nursing home patients requiring gradual dose reduction (GDR) attempts versus number attempted". The patient data information form was edited to include the field "GDR Due". The PI data collection form was edited to include "GDR Request Date" and "GDR Completed Date". The results of this data collection will be presented by the Chief Pharmacist quarterly to the PI Committee, the Nursing Facility Committee, and Pharmacy and Therapeutics Committee. (See attached Pharmacy forms and PI plans).</p> <p><i>F428 continued on page 12</i></p>	

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F 428	<p>Continued From page 11</p> <p>RPh #1 stated the pharmacists were responsible to conduct a review of the psychotropic medications, to determine the presence of a supporting diagnosis, and to recommend a gradual dosage reduction (GDR) when indicated for these medications. According to RPh #1, RPh #2 usually conducted the drug review for Resident #1 and stated that RPh #2 was out of town and not available for interview. RPh #1 stated no other recommendations had been made regarding a GDR for Risperdal for Resident #1 except the one made by RN #1 on 06/05/13. RPh #1 stated she could not explain why there had not been any other attempts to notify the resident's physician of the recommendations.</p> <p>Interview conducted with the Director of Nurses (DON) on 07/03/13, at 4:30 PM, revealed she received a copy of the pharmacy reviews monthly. The DON stated the recommendations were to be faxed to the physician by the pharmacist and a copy of the recommendations was to be placed in the resident's medical record. The DON stated the physician should respond to the recommendation within one week, but the facility did not have a system in place to follow up on the faxed reports to ensure the physician responded to the recommendations.</p> <p>2. Review of the medical record revealed the facility admitted Resident #4 on 08/22/12 with diagnoses of Diabetes Mellitus, Hypertension, Congestive Heart Failure, Coronary Artery Disease, and Psychosis. Review of the physician's orders for July 2013 revealed the physician prescribed 25 mg of Seroquel to be administered daily at bedtime.</p>	F 428	<p><i>F428 continued from page 11</i></p> <p>Monthly Drug Regimen Review findings will be provided to the CNO at time of completion for each resident. The resident data information form that is used by the Pharmacists has been edited to include the date for which a gradual dose reduction is due. This will serve as a reminder each month of when to request the gradual dose reduction. As of 7/31/13, 23 residents' medication regimen reviews were completed by the two (2) Pharmacists, with 11 requests for gradual dose reductions. Nine (9) recommendations were acted upon. The Chief Pharmacist resubmitted gradual dose reduction recommendations to two (2) physicians on 8/12/13. The physicians responded the same day with 100% compliance noted.</p>		

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F 428	<p>Continued From page 12</p> <p>Review of the monthly medication regimen review conducted from November 2012 to June 2013 revealed the Registered Pharmacist (RPh) conducted a monthly review of Resident #4's medication. However, there was no evidence the consultant pharmacist had evaluated the use of Seroquel for Resident #4 and no recommendations for a GDR noted in the monthly reviews.</p> <p>Interview conducted with RPh #1 on 07/03/13, at 3:45 PM, revealed RPh #1 was responsible for conducting the monthly medication regimen review for Resident #4. RPh #1 stated labs and diagnoses had been the focus when the monthly reviews were conducted. The RPh stated she had not identified that the Seroquel was administered routinely to the resident and a GDR had not been recommended/attempted.</p> <p>3. Review of the medical record revealed the facility admitted Resident #9 on 07/09/08 with diagnoses of Advanced Alzheimer's Disease, History of Cerebral Vascular Accident, and Collagen Disease. Review of the July 2013 physician's orders revealed the physician prescribed 50 mg of Seroquel to be administered every morning and 100 mg of Seroquel to be administered each evening to Resident #9.</p> <p>A review of the medication regimen review dated November 2012 to June 2013 revealed the consultant pharmacist had conducted a monthly review of Resident #9's medication. A review of the medication review dated 04/23/13, revealed the RPh reviewed the resident's medications and lab test results. The RPh noted the lab results obtained on 04/09/13 were below the normal</p>	F 428			

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F 428	<p>Continued From page 13</p> <p>range and recommended a Complete Blood Count (CBC), including the White Blood Count (WBC), be monitored closely, and reported the abnormal test results could be a possible adverse drug reaction of Seroquel. However, there was no evidence the recommendation had been sent to the physician or to the Director of Nurses (DON) for further evaluation. Further record review revealed on 05/27/13, the RPh recommended a cholesterol panel be obtained; however, there was no evidence this recommendation had been sent to the physician or the DON. In addition, the medication review dated 06/24/13, revealed the RPh again identified Resident #9 was receiving Seroquel and recommended a lipid panel be obtained. There was no evidence the physician or the DON had been notified of this recommendation.</p> <p>Interview conducted with RPh #1 on 07/03/13, at 3:45 PM, revealed the recommendations are faxed to the physician by the consultant pharmacist and a copy of the recommendation is then placed in the resident's medical record. The RPh stated the DON and the UC also receive a copy of the recommendation. RPh #1 stated the UC was responsible to follow up with the physician for further orders, but the UC had been on medical leave and no one had been designated to follow up with the physician in the UC's absence.</p> <p>Interview with the DON on 07/03/13, at 4:30 PM, revealed she was unable to confirm if the physician had been informed of the recommendations for Resident #9 on 04/09/13, 05/27/13, and 06/24/13. The DON stated the physician should respond to the</p>	F 428			

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F 428	<p>Continued From page 14</p> <p>recommendations within one week. The DON stated the facility did not have a system to follow up with the recommendations after they were faxed to the physician.</p> <p>4. A review of the medical records revealed the facility admitted Resident #2 on 09/04/12 with diagnoses including Anxiety, Depression, Diabetes, Dementia, and Alzheimer's. Review of Resident #2's medical record revealed the resident was admitted with physician's orders for 0.5 mg of Klonopin (anticonvulsant) at bedtime and 100 mg of Trazodone (antidepressant) at bedtime. Further review of the physician's orders dated 05/08/13 (approximately eight months after the initial orders for the medications/dosages had been prescribed) revealed the physician continued to prescribe 0.25 mg of Klonopin two times per day (for a total of 0.5 mg per day) and 100 mg of Trazodone at bedtime for Resident #2.</p> <p>A review of the monthly Drug Regimen Reviews (November 2012 through June 2013) revealed no evidence that a GDR of the Trazodone or the Klonopin had been recommended/attempted from the time of Resident #2's admission (09/04/12) through the time of the review (06/20/13) in an attempt to decrease and/or eliminate any adverse side effects the resident could experience as a result of the medications.</p> <p>An interview conducted on 07/03/13, at 3:08 PM, with Minimum Data Set (MDS) Coordinator #1 revealed she was unaware of any attempts of GDR for Resident #2 since the resident's admission to the facility (09/04/12).</p> <p>Registered Pharmacist (RPh) #1 acknowledged</p>	F 428			

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F 428	Continued From page 15 in an interview conducted on 07/03/13 at 3:43 PM that a GDR had not been recommended to Resident #2's physician since the resident's admission to the facility on 09/04/12. RPh #1 stated although the facility had two pharmacists, she had conducted the monthly drug regimen reviews of the medications prescribed for Resident #2. The pharmacist stated recommendations for a GDR was not included in the pharmacist's audit process and she had not been doing them. The Pharmacist stated, "We are reviewing psychoactive medications that have diagnosis but may not be documenting it." She went on to say that she had not recommended any GDRs for Resident #2.	F456	On 7/08/13, a new gasket was ordered for the refrigerator door. A work order was created on 7/19/13. The gasket was replaced on 7/26/13 (See attached work order). Discussion on 7/25/13 with the Maintenance Department Secretary revealed that a semi-annual Preventative Maintenance/ Equipment Check Process is in place for equipment in the Dietary Department (See attached Sample Work Orders/ Checklist). The Maintenance Department Director will ensure that preventative maintenance checks are completed as scheduled. Results of findings will be reported bi-monthly to the Safety Committee and quarterly to the Nursing Facility Committee Meeting by the Maintenance Department Director.	8/12/13
F 456 SS=D	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure equipment was in safe operating condition. The refrigerator had a worn gasket in the door resulting in an incomplete seal in the refrigerator door. The findings include: An interview conducted with the Dietary Director 07/03/13 at 3:50 PM, revealed the facility did not have a specific policy on maintenance of the kitchen equipment. The Dietary Director also stated the facility did not have a scheduled			

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F 456	<p>Continued From page 16</p> <p>maintenance program for the kitchen equipment.</p> <p>According to the "U.S. Food and Drug Administration" manual, dated 2009, Chapter 4, "Proper maintenance of equipment to manufacturer specification helps ensure that it will continue to operate as designed. Failure to properly maintain equipment could lead to violations of the associated requirements of the Code that place the health of the consumer at risk. For example, refrigeration units in disrepair may no longer be capable of properly cooling or holding potentially hazardous (time/temperature control for safety) foods at safe temperatures."</p> <p>Observation of the reach-in refrigerator on 07/01/13 at 12:30 PM revealed a pool of water on the floor. Observation of the door gasket (seal) revealed the seal was worn and misshaped. Observation of the thermometer located inside the refrigerator revealed an internal temperature of 38 degrees Fahrenheit.</p> <p>A review of the Health Department Inspection Report revealed the worn gasket on the door of the refrigerator adjacent to the tray line had been cited during the last Health Department inspection on 06/26/12 (approximately 13 months prior to the observation of the worn gasket conducted on 07/01/13).</p> <p>An interview with the Dietary Director on 07/03/13 at 1:35 PM revealed he had been employed by the facility for approximately two months. The Dietary Director stated at the time of his employment he had been told the refrigerator had leaked for at least two months. The Dietary Director stated the facility had been "trying" to</p>	F 456			

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F 456 F 520 SS=E	Continued From page 17 correct problem areas. 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to maintain a quality assessment and assurance program to identify quality deficiencies and to develop and	F520	On 7/02/13, the MDS Coordinator notified physician of Resident # 1 to obtain orders for a reduction in Risperdal upon resident's return to facility. Orders were obtained for the reduction and the medication was discontinued on 08/02/13. (See attached computer generated order). Resident # 2's Drug Regimen Review was completed by the Pharmacist on 7/16/13 and faxed to the physician requesting a decrease in the Klonopin and Trazodone. The physician responded to the recommendations on 7/19/13 with orders to decrease the Klonopin but continue the Trazodone as prescribed (See attached Drug Regimen Review Form for Resident # 2). Resident # 4's Drug Regimen Review was completed by the Pharmacist on 7/1/13 and faxed to the physician requesting a decrease in the Ativan and Seroquel. The physician responded to the recommendations the same day. (See attached Drug Regimen Review for Resident # 2). By July 31, 2013 each resident in the facility had received a Drug Regimen Review (23 completed) by the two (2) Pharmacists. Eleven (11) residents received recommendations for gradual dose reductions. As of 7/31/13, nine (9) responses have been obtained to proceed with gradual dose reductions. Two (2) Physicians that did not respond have been contacted by the Chief Pharmacist on 8/12/13 with 100% compliance noted with physician notification of recommendations. <i>F520 Continued on page 19</i>	8/15/13

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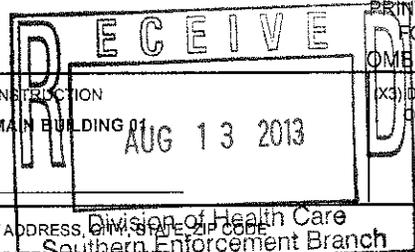
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F 520	<p>Continued From page 18</p> <p>implement appropriate plans of action to correct identified quality deficiencies. Review of the monthly medication regimen reviews conducted by the consultant pharmacists revealed the facility failed to have a system in place to ensure psychotropic medications were evaluated and a gradual dose reduction (GDR) was recommended as indicated for three of the ten sampled residents (Residents #1, #2, and #4). Refer to F428.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "2013 Performance Improvement Plan," revealed the Quality Assurance/Performance Improvement (QA/PI) committee would be responsible to plan a systematic, organization-wide approach to continuous quality improvement and to achieve an improvement in performance that would be sustained and incorporated into daily practice. The policy identified medication use would be an area to be monitored through the QA/PI program.</p> <p>Review of the monthly medication regimen reviews dated November 2012 through June 2013 conducted by the consultant Registered Pharmacists, RPh #1 and RPh #2, for Residents #1, #2, and #4 revealed there was no evidence the pharmacist had identified the routine use of psychotropic medications for these residents. In addition, there was no evidence the pharmacist had made recommendations for GDR for the use of the psychotropic medications from November 2012 through June 2013.</p> <p>Interview conducted with RPh #1 on 07/03/13, at 3:45 PM, confirmed the monthly medication</p>	F 520	<p><i>F520 continued from page 18</i></p> <p>On 7/08/13, a new procedure was developed to ensure that physicians are made aware of Pharmacist recommendations and follow-up is conducted timely. A notebook has been developed and the Pharmacists are now placing the Medication Regimen Reviews in this notebook instead of in the residents' charts. The Unit Supervisor will be responsible for checking the book for the addition of new recommendations every Friday. In the absence of the Unit Supervisor, the book will be reviewed by the MDS Coordinator or the CNO. Physician notification will be accomplished by the nurse checking the book if the physician has not already responded to the Pharmacy recommendations.</p> <p>The QA/PI indicators for Medication Regimen Reviews previously focused on completion of the Drug Regimen Review and not content or physician response to recommendations. Indicators have been added to address for recommendations for gradual dose reductions and physician notification and response to recommendations. Concurrent monitoring will be accomplished by the Unit Supervisor, CNO, or MDS Coordinator. Results of findings will be reported to the CNO monthly for quarterly reporting to the Nursing Facility Committee. (See attached Medication Use/Indications for Use Performance Improvement Study). As of 7/31/13, 23 residents have been reviewed by the CNO. As of 8/12/13, residents (100%) have evidence of physician response to recommendations, nine (9) of eleven (11) resident recommendations for gradual dose reductions have been received. Two (2) physicians were notified on 8/12/13 by the Chief Pharmacist due to no response to gradual dose reduction recommendations and responses were obtained for 100% compliance.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185182	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/03/2013
NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 520	<p>Continued From page 19</p> <p>regimen had not consisted of a review of the psychotropic medications for resident use. In addition, the RPh confirmed recommendations for a GDR of the psychotropic medications for Residents #1, #2, and #4 had not been completed from November 2012 through June 2013. The RPh stated the medication reviews had focused primarily on diagnoses and lab tests. RPh #1 stated she did attend the QA/PI committee meetings and routinely reported the monthly reviews had been conducted for each resident, but the report did not consist of a review of the psychotropic drug use.</p> <p>Interview conducted with the Director of Nurses (DON) on 07/03/13, at 4:30 PM, revealed she was the QA/PI Coordinator. The DON stated 30 medical records were reviewed each quarter to ensure the monthly medication reviews had been conducted and the pharmacy recommendations had been sent to the physician. However, the DON stated the QA/PI committee had not monitored for the use of psychotropic medications and/or recommendations for GDR. The DON confirmed the pharmacy did not routinely report to the QA/PI committee concerning psychotropic medications and GDR recommendations/attempts.</p>	F 520			

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NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS CFR: 42 CFR §483.70 (a) BUILDING: 01 PLAN APPROVAL: 1985 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One story, Type 1 (322) SMOKE COMPARTMENTS: 3 COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM FULLY SPRINKLED (WET SYSTEM) EMERGENCY POWER: Type II diesel generator A life safety code survey was initiated and concluded on 07/01/13, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition. Deficiencies were cited with the highest deficiency identified at "F" level.	K 018	On 7/19/13, a walk thru inspection of the unit was conducted by the Maintenance Department Director and CNO. Six (6) rooms were identified to have over-the-door isolation storage bins that could potentially impact compliance with LSC Standards. Three (3) rooms also had wreath holders that could potentially impact door closure/latching and compliance with LSC Standards. All storage bins and wreath hangers were repositioned to allow closure latching of the doors. The wreath holder on Room 103 had been removed. The Maintenance Department Director has purchased hangers to be bolted to the front side of each resident room door. These hangers will be used to secure wreath holders and isolation storage bins. This will allow for correct placement and compliance with LSC Standards. Walk-thru inspection will be done weekly by the Maintenance Department Director using the Environmental Rounds Checklist developed on 7/23/13. Areas to be assessed are to ensure that the hangers are being used correctly and that isolation storage bins and wreath holders are not being hung over the doors preventing the doors from closing completely. Results of inspections will be reported by the Maintenance Department Director bi-monthly to the Safety Committee and quarterly to the Nursing Facility Committee. Findings will be discussed with recommendations for corrective actions to be determined by the above committees.	8/15/13
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only			

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

Dinah James RN, CNO

TITLE

Chief Nursing Officer

(X6) DATE

8/13/13

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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NAME OF PROVIDER OR SUPPLIER PINEVILLE COMMUNITY HOSPITAL		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
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K 018	<p>Continued From page 1</p> <p>required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridor doors were maintained according to NFPA standards. This deficient practice affected one of three smoke compartments, staff, and nineteen residents. The facility has the capacity for 23 beds with a census of 19 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 07/01/13 at 12:30 PM with the secretary in the Maintenance Department, a corridor door to resident room 103 would not close and latch due to a wreath holder over the door. Corridor doors must be able to close and latch to help resist the passage of fire/smoke in a fire situation. The Director of Maintenance was away from the facility at the time of the survey. An interview with the</p>	K 018		

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K 018	Continued From page 2 secretary on 07/01/13 at 12:30 PM revealed she was not aware the door would not close and latch due to the decoration hanging on the door. In addition, during the survey the door to resident room 101 was observed not to close and latch due to a precautionary medical storage unit hanging over the doorway. The findings were revealed to the Administrator upon exit.	K 018	