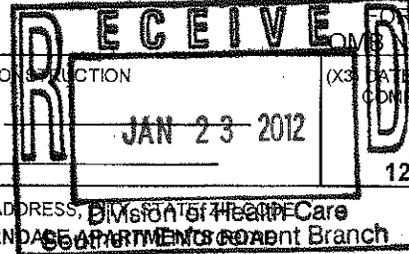


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/11/2012
FORM APPROVED
D. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185243	(X2) MULTIPLE COMPLETION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 12/22/2011
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NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE AND ZIP CODE 39 FERNDALE APARTMENTS PINEVILLE, KY 40977
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Mountain View Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this plan of correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provision of quality of care of the residents. The plan of correction is submitted as a written allegation of compliance.	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law, or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property, and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance	F 225	Mountain View Nursing and Rehabilitation Center's response to the Statement of Deficiencies and Plan of Correction does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Mountain View reserves the right to submit documentation to refute any of the stated deficiencies on this Statement of Deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kelley M. Gardner* TITLE: Administrator (X6) DATE: 1-19-2012

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 225	<p>Continued From page 1</p> <p>with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of facility policies, the facility failed to ensure all allegations related to abuse and injuries of unknown origin were thoroughly investigated and immediately reported to the appropriate state officials for one of three sampled residents (Resident #1). On 11/24/11, at 4:43 AM, Resident #1 was observed to have a bruise on the left hand and initially reported a nurse had caused the injury. However, the facility failed to thoroughly investigate the injury and failed to immediately report an allegation of abuse to state agencies as required.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Abuse, Neglect, or Misappropriation of Resident Property Policy" (dated 02/09) revealed any witnessed or suspicion of abuse, neglect, or misappropriation of property was to be promptly reported to the Administrator. The policy further stated when an allegation of abuse and/or neglect occurred the Administrator would investigate the allegation. According to the policy, the Administrator was responsible to direct the investigation process and to ensure that appropriate agencies were notified.</p>	F 225	<p><u>ID Prefix Tag F225</u></p> <p>The investigation into resident #1's bruise was reopened on December 22, 2011 by the Administrator. Resident #1 was reassessed by the licensed nurse on 12/22. No new skin areas were noted.</p> <p>An audit of investigations completed within the last 60 days was completed by the Administrator DON, QIN, and Facility Nurse Consultant on 12/22/2011 to identify that each event had been investigated thoroughly & reported to the appropriate state agencies as required. No other allegations of abuse, neglect or misappropriation of resident property or injuries of unknown origin were identified. The facility will continue to conduct a thorough investigation of any allegations of abuse, neglect, misappropriation or injuries of unknown injury & report any allegations of abuse, neglect,</p>	

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F 225	<p>Continued From page 2</p> <p>Review of Resident #1's medical record revealed the resident's diagnoses included a History of Stroke with Dementia, Low Back Pain, Mental Retardation, Parkinson's Disease, and Paralysis Agitans. Review of the Annual Minimum Data Set (MDS) Assessment dated 11/01/11 revealed the facility assessed the resident's cognition as moderately impaired for decision-making and the resident required the assistance of one person for transfers, ambulation, and toileting. A review of nurse's notes dated 11/24/11, at 4:43 AM, revealed Certified Nurse Assistant (CNA) #10 informed Licensed Practical Nurse (LPN) #2 that Resident #1 had a bruise on the left hand. The nurse documented that the bruise would be monitored. At 11:28 AM on 11/24/11, documentation revealed the resident's left hand was purplish/blue in color and the resident's responsible party was notified of the bruise.</p> <p>A review of a Resident Incident Witness Statement dated 11/25/11 (no time given) obtained by the Social Worker (SW) revealed Resident #1 reported he/she did not have a bruise when the resident had gone to bed and that a nurse (unknown) had grabbed the resident's hand.</p> <p>Facility staff continued to monitor the bruising and on 11/29/11, documentation revealed the resident's physician requested a radiological examination of the resident's left hand. The radiology report revealed the resident had arthrosis, contracture, and osteoporosis, but there were no fractures or destructive processes noted.</p> <p>An interview conducted on 12/22/11, at 2:45 PM,</p>	F 225	<p>missappropriation, or injuries of unknown origin to the appropriate state agencies.</p> <p>The Administrator and DON were re-educated on 1/19/11 by the facility's Registered Nurse Consultant on conducting a thorough investigation of all allegations of abuse, neglect and misappropriation of property, documenting the findings of the investigation and immediately reporting an allegation of abuse to state agencies as required.</p> <p>All staff were re-educated on January 19, 2012 by the Staff Development Coordinator and DON to recognize allegations & events/allegations that must be reported to the Director of Nursing and the Administrator immediately according to the facility's policy for Abuse, Neglect, or Misappropriation of Resident Property and the actual policy itself. Any staff member unable to attend the scheduled mandatory inservice education will not be allowed to return to work until this is completed. All new employees will</p>	

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F 225	<p>Continued From page 3</p> <p>with CNA #10 revealed she had helped the resident to the bathroom when she noticed a "bad bruise" on the resident's left hand. CNA #10 stated she asked Resident #1 what had happened and although the resident would not tell her what happened the resident stated, "It hurts."</p> <p>An interview conducted on 12/22/11, at 10:00 AM, with LPN #2 confirmed CNA #10 had reported the resident's bruise and the LPN interviewed the resident. The LPN stated Resident #1 initially told her "a nurse did it" but later told conflicting stories about the bruise. LPN #2 stated she reported the resident's bruise to the Quality Improvement Nurse (QIN).</p> <p>An interview conducted on 12/22/11, at 9:20 AM, with the Quality Improvement Nurse (QIN) revealed she had interviewed Resident #1 and facility staff in an effort to determine the cause of the reported bruise on Resident #1's left hand. The QIN stated findings from the investigation revealed Resident #1 stated, "Someone came into the room and pinched" (him/her) but was unable to identify a staff person. The QIN stated the results of her investigation were recorded and reported to the Administrator.</p> <p>An interview conducted on 12/21/11, at 4:45 PM, with the Director of Nursing (DON) revealed the DON had the responsibility to review all investigation findings and report the findings to the Administrator. The DON stated that, based on information, it was determined the bruise to Resident #1's left hand was caused by staff when they transferred the resident. However, the DON was unable to provide evidence of an investigation to support the finding.</p>	F 225	<p>continue to receive this education during the orientation process.</p> <p>The completed investigation of any allegations of abuse will be reviewed daily Monday thru Friday during the Administrative Staff meeting to ensure that any allegation of abuse, neglect or misappropriation has been thoroughly investigated and is reported to state agencies as required. The results of any investigations of abuse, neglect or misappropriation will be reviewed monthly by the Executive QI committee consisting of the Administrator, DON, Medical Director, MDS Nurses, QI Nurse and SDC Nurse to ensure the investigation has been conducted thoroughly per the facility policy to include reporting to the appropriate state agencies with further action taken as necessary by the committee.</p> <p>February 5, 2012</p>	02-05-12	

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F 225	Continued From page 4 An interview conducted on 12/21/11, at 5:45 PM, with the Administrator revealed it was the facility's policy to report any allegations of abuse, neglect, misappropriation, or injuries of unknown origin to the appropriate state agencies. The Administrator stated the facility had not reported the bruise on Resident #1's hand because the findings of the investigation revealed the bruise occurred when staff transferred the resident and it had been determined there was no intent to harm the resident. However, it could not be determined by a review of the facility's investigation that the facility's conclusion had been determined as a result of the investigation of how the resident sustained the bruise.	F 225			



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
Division of Health Care
116 Commerce Avenue
London, Kentucky 40744
(606) 330-2030
Fax: (606) 330-2054
<http://chfs.ky.gov/os/oig>

Mary Reinle Begley
Inspector General

Audrey Tayse Haynes
Secretary

Connie Payne
Director

May 2, 2012

Ms. Shannon Fuston
Post Office Box 16
Four Mile, Kentucky 40939

Re: Mountain View Nursing and Rehabilitation Center - KY17495

Dear Ms. Fuston:

As discussed during a conversation on December 6, 2011, with a representative of the Office of Inspector General, Division of Health Care, an investigation of your concerns regarding the care provided by Mountain View Nursing and Rehabilitation Center was completed on December 22, 2011. The purpose of this letter is to summarize the findings and action taken by the agency.

The investigation was conducted in accordance with KRS 216B.042 (2), which states that the Cabinet for Health and Family Services may authorize its representatives to enter upon the premises of any health care facility for the purpose of inspection.

Observations, interviews, and/or record reviews were utilized to obtain information during the investigation. The purpose of the investigation was to determine if the facility was in compliance with regulatory requirements and to determine if the allegation was substantiated (the allegation was verified by evidence) or unsubstantiated (no evidence or insufficient evidence to verify the allegation).

The evidence obtained from the investigation verified that the allegation was substantiated with regulatory violations.

Ms. Shannon Fuston
May 2, 2012
Page Two

Thank you for bringing this matter to our attention. If you have any questions, please contact our office.

Sincerely,

A handwritten signature in black ink that reads "Sandy Goins R.P.M./P.M." The signature is written in a cursive style.

Sandy Goins
Regional Program Manager

SG:fh:lk



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Sandy Goins, Regional Program Manager
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Mary Reinle Begley
Inspector General

Audrey Tayse Haynes
Secretary

Connie Payne
Director

May 2, 2012

Ms. Kelly Goodin
Mountain View Nursing and Rehabilitation Center
39 Ferndale Apartments Road
Pineville, Kentucky 40977

Re: Complaint #KY17495

Dear Ms. Goodin:

Thank you for submitting your proposed plan of correction regarding the deficiencies identified during the abbreviated standard survey completed on December 22, 2011.

We are accepting your allegation of compliance and presume that substantial compliance was achieved by February 5, 2012, as alleged in your plan of correction. Therefore, we are not recommending the remedies referred to in the initial notice dated January 11, 2012, to the Centers for Medicare and Medicaid Services Regional Office at this time.

If you should have questions regarding this information, please contact our office.

Sincerely,

Sandy Goins /MH

Sandy Goins
Regional Program Manager

SG:fh:lk



CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL

Steven L. Beshear
Governor

Janie Miller
Secretary

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Mary Reinle Begley
Inspector General

Connie Payne
Director

January 11, 2012

ELECTRONIC MAIL (mtv72-admin@mountainviewnursingcenter.com)

Ms. Kelly Goodin
Mountain View Nursing and Rehabilitation Center
39 Ferndale Apartments Road
Pineville, Kentucky 40977

Dear Ms. Goodin:

On December 22, 2011, an abbreviated standard survey was completed at your facility by the Division of Health Care to determine if your facility was in compliance with federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This visit found that your facility was not in substantial compliance with the participation requirements. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy, as evidenced by the attached CMS-2567, whereby corrections are required (D).

All references to regulatory requirements contained in this letter are found in Title 42, Code of Federal Regulations.

Plan of Correction (POC)

A POC for the deficiencies must be submitted within ten (10) days of receipt of this letter. Failure to submit an acceptable POC may result in a recommendation that remedies be imposed immediately upon notification requirements being met. Your POC, as fully implemented, will serve as your allegation of compliance.

Ms. Kelly Goodin
January 11, 2012
Page Two

Your POC must:

- Address what corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to ensure that solutions are sustained; and
- **Include dates when corrective action will be completed. In the right column with the heading 'completion date,' include only one date for each corresponding deficiency with the heading 'ID Prefix Tag' listed in the left column.**

You are required to record your plan of correction in the appropriate column on the enclosed Form(s) CMS-2567. **Sign, date, and indicate your title in the blocks provided at the bottom of page one.**

Recommended Remedies

As a result of our finding that your facility was not in compliance with participation requirements, the State Agency reserves the right to recommend discretionary remedies to the Centers for Medicare and Medicaid Services (CMS) Regional Office if substantial compliance has not been achieved by February 5, 2012.

If you do not achieve substantial compliance **within three (3) months** from the last day of the survey identifying noncompliance, the CMS Regional Office must deny payments for new admissions.

Your provider agreement must be terminated if substantial compliance is not achieved **within six (6) months** from the last day of the survey identifying noncompliance.

Please note that this letter does not constitute formal notice of imposition of alternative sanctions or termination of your provider agreement. Should the Centers for Medicare and Medicaid Services determine that termination or any other sanction is warranted, it will provide you with a separate formal notification of that determination.

Ms. Kelly Goodin
January 11, 2012
Page Three

Informal Dispute Resolution

In accordance with 42 CFR 488.331 and 906 KAR 1:120, a provider shall have one informal opportunity to dispute a cited deficiency, or scope and severity assessment that constitutes Substandard Quality of Care or Immediate Jeopardy. You are required to send your request in writing to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621. Your request shall specify the format for the informal dispute resolution, specify the deficiency in dispute, explain the dispute, and provide a detailed basis for the dispute.

Documentation in support of the dispute shall be attached to the request. The request and attachments shall be delivered **on or before the tenth calendar day after receipt of the Statement of Deficiencies**. A request for informal dispute resolution shall not delay an enforcement action.

If you should have questions regarding this information, please contact our office.

Sincerely,



Sandy Goins
Regional Program Manager

SG:fh:lk

Enclosure



**CABINET FOR HEALTH AND FAMILY SERVICES
OFFICE OF INSPECTOR GENERAL**

Steven L. Beshear
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Mary Reinle Begley
Inspector General

Connie Payne
Director

January 11, 2012

Ms. Kelly Goodin
Mountain View Nursing and Rehabilitation Center
39 Ferndale Apartments Road
Pineville, Kentucky 40977

Dear Ms. Goodin:

The Division of Health Care completed a complaint investigation at your facility on December 22, 2011. This survey was conducted to determine compliance with state licensure requirements. The survey found that your facility failed to meet minimum state licensure requirements for operation of a nursing facility. The deficiencies cited are listed on the enclosed Statement of Deficiencies/Plan of Correction document.

As part of the investigation process, each facility is required to submit a written plan for the correction of all deficiencies noted during the survey. The Plan of Correction shall specify:

- The date by which the violation shall be corrected,
- The specific measures utilized to correct the violation, and
- The specific measures utilized to ensure the violation will not recur.

Ms. Kelly Goodin
January 11, 2012
Page Two

902 KAR 20:008 Section 2.(5)(b) requires that a plan of correction for licensure deficiencies be submitted to this agency within ten (10) days from receipt of this letter. The plan, outlining methods of correction and proposed completion dates for each deficiency, should be incorporated in the column provided on the enclosed form. The form should be signed by you or an authorized representative and received in this office within ten (10) days of receipt of this letter. You should make a copy of the form for your records and/or posting requirements. Continued failure to meet minimum state licensure requirements will result in a recommendation for revocation of a license to operate a nursing facility.

KRS 216.547 requires that all long-term care facilities shall retain, for public inspection in the office of the administrator and in the lobby of the facility, a complete copy of every inspection report of the facility received from the cabinet during the past three (3) years, including the most recent inspection report.

Informal Dispute Resolution (IDR): In accordance with 906 KAR 1:120, a long-term care facility shall have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send a written request which specifies the deficiency in dispute; explain the dispute and provide a detailed basis for the dispute; specify the format desired (refer to the enclosure) and attach the documentation in support of your position to the request. This written request and attachments shall be delivered to IDR Coordinator, Office of Inspector General, Division of Health Care, 275 East Main Street, 5E-A, Frankfort, Kentucky 40621 on or before the mandated return date for the plan of correction. Informal Dispute Resolution will be accomplished in accordance with 906 KAR 1:120. This process will not delay the effective date of any enforcement action.

IDR in no way is to be construed as a formal evidentiary hearing. It is an informal process to discuss deficiencies. If you will be accompanied by counsel, you must indicate this in your request for IDR so that we may also have counsel present. You will be advised verbally of your decision relative to the informal dispute, with written confirmation to follow.

If you should have questions regarding this information, please contact our office.

Sincerely,



Sandy Goins
Regional Program Manager

SG:fh:lk

Enclosure

RESIDENT CENSUS AND CONDITIONS OF RESIDENTS

Provider No. 185243	Medicare F75 8	Medicaid F76 77	Other F77 6	Total Residents F78 91
ADL	Independent	Assist of One or Two Staff	Dependent	
Bathing	F79 3	F80 47	F81 41	
Dressing	F82 3	F83 70	F84 18	
Transferring	F85 25	F86 38	F87 28	
Toilet Use	F88 10	F89 52	F90 29	
Eating	F91 55	F92 25	F93 11	

<p>A. Bowel/Bladder Status</p> <p>F94 <u>7</u> With indwelling or external catheter</p> <p>F95 Of total number of residents with catheters, <u>9</u> were present on admission</p> <p>F96 <u>57</u> Occasionally or frequently incontinent of bladder</p> <p>F97 <u>46</u> Occasionally or frequently incontinent of bowel</p> <p>F98 <u>7</u> On individually written bladder training program</p> <p>F99 <u>0</u> On individually written bowel training program</p>	<p>B. Mobility</p> <p>F100 <u>16</u> Bedfast all or most of the time</p> <p>F101 <u>31</u> In chair most of the time</p> <p>F102 <u>22</u> Independently ambulatory</p> <p>F103 <u>22</u> Ambulation with assistance or assistive device</p> <p>F104 <u>8</u> Physically restrained</p> <p>F105 Of total number of residents restrained, <u>0</u> were admitted with orders for restraints.</p> <p>F106 <u>10</u> With contractures</p> <p>F107 Of total number of residents with contractures, <u>6</u> had contractures on admission.</p>
---	--

<p>C. Mental Status</p> <p>F108 <u>5</u> With mental retardation</p> <p>F109 <u>46</u> With documented signs and symptoms of depression</p> <p>F110 <u>38</u> With documented psychiatric diagnosis (exclude dementias and depression)</p> <p>F111 <u>20</u> Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type</p> <p>F112 <u>19</u> With behavioral symptoms</p> <p>F113 Of the total number of residents with behavioral symptoms, the total number receiving a behavior management program <u>18</u>.</p> <p>F114 <u>0</u> Receiving health rehabilitative services for MI/MR</p>	<p>D. Skin Integrity</p> <p>F115 <u>7</u> With pressure sores (exclude Stage I)</p> <p>F116 Of the total number of residents with pressure sores excluding Stage I, how many resident had pressure sores on admission? <u>3</u></p> <p>F117 <u>65</u> Receiving preventive skin care</p> <p>F118 <u>10</u> With rashes</p>
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<p>E. Special Care</p> <p>F119 <u>2</u> Receiving hospice care benefit</p> <p>F120 <u>0</u> Receiving radiation therapy</p> <p>F121 <u>0</u> Receiving chemotherapy</p> <p>F122 <u>2</u> Receiving dialysis</p> <p>F123 <u>4</u> Receiving intravenous therapy, parental nutrition, and/or blood transfusion</p> <p>F124 <u>19</u> Receiving respiratory treatment</p> <p>F125 <u>1</u> Receiving tracheostomy care</p> <p>F126 <u>12</u> Receiving ostomy care</p>	<p>F127 <u>1</u> Receiving suctioning</p> <p>F128 <u>14</u> Receiving injections (exclude vitamin B12 injections)</p> <p>F129 <u>8</u> Receiving tube feedings</p> <p>F130 <u>34</u> Receiving mechanically altered diets including pureed and all chopped food (not only meat)</p> <p>F131 <u>36</u> Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy)</p> <p>F132 <u>4</u> Assistive devices while eating</p>
<p>F. Medications</p> <p>F133 <u>57</u> Receiving any psychoactive medication</p> <p>F134 <u>23</u> Receiving antipsychotic medications</p> <p>F135 <u>27</u> Receiving antianxiety medications</p> <p>F136 <u>44</u> Receiving antidepressant medication</p> <p>F137 <u>0</u> Receiving hypnotic medications</p> <p>F138 <u>6</u> Receiving antibiotics</p> <p>F139 <u>39</u> On pain management program</p>	<p>G. Other</p> <p>F140 <u>9</u> With unplanned significant weight loss/gain</p> <p>F141 <u>0</u> Who do not communicate in the dominant language of the facility (include those who use sign language)</p> <p>F142 <u>0</u> Who use non-oral communication devices</p> <p>F143 <u>14</u> With advance directives</p> <p>F144 <u>43</u> Received influenza immunization</p> <p>F145 <u>41</u> Received pneumococcal vaccine</p>

I certify that this information is accurate to the best of my knowledge.

Signature of Person Completing the Form 	Title RN	Date 12/21/2011
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TO BE COMPLETED BY SURVEY TEAM

- F146 Was ombudsman notified prior to survey? Yes No
- F147 Was ombudsman present during any portion of the survey? Yes No
- F148 Medication error rate __%