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JUL 23 2010
Division of Health Care
Southern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185094	A. BUILDING _____ B. WING _____	C 07/22/2010

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS An abbreviated standard survey (KY14944 and KY14964) was conducted on June 30, 2010 - July 2, 2010. Deficient practice was identified to exist with the highest scope and severity at a "G" level.	F 000		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by:	F 164	**Signature Health Care of Pikeville does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Administrator (X6) DATE: 7/22/10

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.

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

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F 164	Continued From page 1 Based on observation, interview and record review, it was determined the facility failed to provide full visual privacy, during incontinence care, for two (2) of nineteen (19) sampled residents. Observations of incontinence care revealed the staff failed to pull the resident's privacy curtain completely around the bed and other facility staff entered the room exposing the resident to any residents/visitors in the hallway. The findings include: On June 30, 2010, at 2:17 p.m., SRNA #1 and SRNA #2 were observed to prepare to perform incontinence care for resident #17. The SRNAs transferred resident #17 back to the bed, closed the door, and pulled the curtain between the two residents' beds. However, the curtain was not pulled completely around the bed to provide full visual privacy for resident #17. During the observation of incontinence care, another staff member opened the door, exposing resident #17 to any residents/visitors in the hallway. An interview conducted on June 30, 2010, at 2:17 p.m., during resident #17's incontinence care, with SRNA #2 revealed the SRNA was required to pull the privacy curtain completely around the bed to provide full visual privacy. On June 30, 2010, at 7:24 p.m., SRNA #4 and SRNA #5 were observed to perform incontinence care for resident #8. The observation revealed the staff removed resident #8's shirt while still in the wheelchair and placed a gown on the resident, during which time the resident's curtain was not pulled to provide full visual privacy for the resident. Resident #8 was observed to be transferred back to the bed and the SRNAs	F 164	**F164 483.10 (e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS** **Corrective Action for Resident(s) Affected:** Resident #17 and #8 were assessed by nursing and social services on 7/21/10 for any signs of psychosocial harm related to the cubicle curtain not being pulled all the way around allowing for complete privacy. No signs of psychosocial harm were identified. **How the facility will act to protect residents in similar situations:** Walking rounds was conducted by Nursing Administration on 7/22/10 to observe, educate, and speak to residents in regards to privacy and curtains being pulled completely around bed. No concerns were identified with the residents. **Measures to prevent reoccurrence:** All licensed staff will be in serviced by Staff Development on the policy on dignity, to include closing curtains while providing resident care by 7/26/10. All nursing staff and department heads (during working hours) have initiated every two hour rounding to observe for any signs of privacy not being provided. Education will be given to any staff not following the dignity policy. All new employees during orientation will receive education on privacy and dignity. **Monitoring of Corrective Action:** The DON or nursing administration will review 20% of residents monthly to ensure compliance with dignity. Any concerns identified will be brought to the administrator and addressed immediately. The results of the every two hour rounding and of the 20% of residents monitored monthly will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. **Completion date: 8/11/2010**	

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F 164	Continued From page 2 closed the door and pulled the curtain between the two residents' beds. However, the curtain was not pulled completely around the resident's bed to provide full visual privacy for resident #8. During the observation of incontinence care, the resident's door was opened twice by another staff member, exposing resident #8 to any residents/visitors in the hallway. An interview conducted on July 1, 2010, at 4:30 p.m., with SRNA #5 revealed the SRNA did not notice the curtain was not pulled completely around the resident's bed to provide full visual privacy for the resident. SRNA #5 stated the policy required staff to pull the privacy curtain completely around the resident's bed. A review of the facility's Perineal Care policy dated April 2007 revealed privacy was required to be provided for each resident during incontinence care by staff closing the door, closing the blinds, and pulling the privacy curtain. An interview conducted on June 30, 2010, at 8:15 p.m., with the DON revealed staff was required to provide privacy during incontinence care by closing the resident's door, closing the blinds, and pulling the privacy curtain completely around the resident's bed.	F 164		
F 282 SS=G	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced	F 282		

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F 282	Continued From page 3 by: Based on observation, interview, and record review, it was determined the facility failed to provide services to nine (9) of nineteen (19) sampled residents (residents #3, #7, #8, #9, #10, #13, #16, #17, and #19) in accordance with each resident's written plan of care. The residents were care planned to require incontinence care and/or turned/repositioned every two (2) hours. However, staff failed to provide the required care every two (2) hours as care planned. Two (2) of the nine (9) residents (residents #3 and #8) developed Stage II pressure ulcers. The findings include: 1. Review of resident #3's Resident Assessment Protocol Summary (RAPS) dated April 21, 2010, revealed the resident required total assistance with most Activities of Daily Living (ADLs), did not understand the use of a call light, did not recognize the importance of turning/repositioning and had two Stage II pressure ulcers. Review of resident #3's care plan dated April 21, 2010, revealed staff was required to provide incontinence care and turn/reposition this resident every two hours. Review of resident #3's medical record revealed the resident's Foley catheter was discontinued on June 11, 2010. The record revealed the resident had a Stage II pressure ulcer measuring 1.5 centimeter (cm) by 0.9 cm by <0.1 cm, which was identified on June 28, 2010. An observation conducted during the initial tour on June 30, 2010, at 2:42 p.m., revealed incontinence care was performed for resident #3 by SRNA #7 and SRNA #8. Upon completion of	F 282	**F282 483.20(k) (3)(ii)SERVICES BY QUALIFIED PERSONS/PER CARE PLAN** **Corrective Action for Resident(s) Affected:** Bowel and bladder assessments and head to toe skin assessments were completed on Residents #3, #7, #8, #9, #10, #13, #16 #17, and #19 by 7/22/10. Care plans for those residents were updated as needed. **How the facility will act to protect residents in similar situations:** Head to toe skin assessments were completed on all residents by 7/9/2010 and bowel bladder assessments that were completed by 6/25/10 were reviewed by nursing administration on 7/9/2010 with no changes identified. **Measures to prevent reoccurrence:** All licensed staff and C.N.A.'s will be in serviced by Staff Development on turning and repositioning, incontinence care, dignity, and following the plan of care by 7/26/10. All nursing staff and department heads (during working hours) have initiated every two hour rounding to observe for provided services to include incontinence care, turning and repositioning, dignity. Concerns identified will be brought to the attention of the director of nursing or designee and will be addressed immediately. All new employees during orientation will receive education on turning and repositioning, incontinence care, dignity, and following the plan of care.	

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F 282	Continued From page 4 the incontinence care resident #3 was positioned onto the resident's left side. Further observations conducted on June 30, 2010, from 2:42 p.m. through 7:00 p.m. (4 hours and 18 minutes), revealed resident #3 remained positioned on the left side. An interview conducted on June 30, 2010, at 7:00 p.m., with SRNA #7 revealed resident #3 had not been turned/repositioned and had not received incontinence care since 2:42 p.m. 2. Review of resident #8's RAPS dated December 8, 2009, revealed the resident was alert and oriented to person, place, and time and was able to make his/her needs known. The RAPS stated the resident was incontinent of bowel/bladder and the resident required supervision from staff in planning/organizing their daily routines. The review revealed the resident required extensive assistance with ADLs, except for eating. Review of resident #8's care plan dated February 15, 2010, revealed staff was required to provide scheduled toileting for the resident upon rising in the morning, before/after each meal, at bedtime, and as needed. The falls and skin breakdown care plans dated February 9, 2009, revealed staff was required to perform incontinence care and turn/reposition the resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:32 p.m., revealed resident #8 in a wheelchair in the hallway waiting for staff to provide incontinence care. Resident #8 reported it took staff 30 to 45 minutes to answer the resident's call light. The resident pointed to the watch on the resident's wrist when asked how the resident monitored how long the resident had	F 282	**Monitoring of Corrective Action:** The DON or nursing administration will review 20% of residents monthly to ensure compliance with incontinence care, turning and repositioning, and dignity. Any concerns identified will be brought to the administrator and addressed immediately. The results of the every two hour rounding and of the 20% of residents monitored monthly will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. **Completion date: 8/11/2010**	

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F 282	Continued From page 5 to wait. The resident interview revealed the resident had not been provided with incontinence care since 5:20 a.m. on June 30, 2010, when the resident was provided with morning care and transferred to the wheelchair. At 1:35 p.m., LPN #2 and SRNA #3 took the resident into the resident's room to provide incontinence care. The staff stood resident #8 to transfer the resident to the toilet. A strong urine odor was noted and the resident's pants were observed to be soaked with urine along with the resident's wheelchair cushion. The resident's brief was totally saturated with urine. The observation revealed staff removed the resident's clothing, provided incontinence care, and applied a new brief and clean/dry pants. While the staff was washing the resident's buttocks, the resident asked SRNA #3 not to rub hard because the resident's buttock was sore. The observation revealed a small opened area to the right side of the resident's coccyx. SRNA #3 stated the SRNA was not assigned to resident #8 and was unsure when the resident received incontinence care previously. LPN #3 had not assisted with incontinence care for resident #8 previously and was unsure when the resident had received incontinence care. An interview conducted on July 1, 2010, at 2:30 p.m., with SRNA #10 revealed resident #8 was already dressed and in the wheelchair when SRNA #10 started the shift at 7:00 a.m. on June 30, 2010. SRNA #10 reported the SRNA had not offered incontinence care to resident #8 or turned/repositioned the resident at all on June 30, 2010. An interview conducted on July 1, 2010, at 2:07 p.m., with SRNA #9 revealed resident #8 was	F 282		

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F 282	Continued From page 6 already dressed and in the wheelchair when SRNA #9 started the shift at 7:00 a.m. on June 30, 2010. SRNA #9 reported the SRNA had not offered incontinence care or turned/repositioned resident #8 at all on June 30, 2010. SRNA #9 stated residents were frequently found saturated with urine. Observation and interview conducted on June 30, 2010, at 7:24 p.m., revealed resident #8 complained of the resident's peri area burning from only being provided incontinence care one time this day. The observation revealed a strong urine odor and the resident's brief/pants were observed to be saturated with urine. Resident #8's peri area and buttocks were observed to be very red in color. Further observation revealed a 1.5-cm diameter area to the resident's right buttock/coccyx which was hard, red, and very tender to touch, with a 0.4 cm diameter and <0.1 cm depth open area to the buttock/coccyx area. Record review revealed the open area had not been identified by the facility; therefore, no treatment had been provided to this area of skin breakdown. An interview conducted on June 30, 2010, at 7:24 p.m., during resident #8's incontinence care, with SRNA #4 and SRNA #5, revealed both staff members arrived at the facility for their scheduled shift at 3:00 p.m., and had not offered/provided incontinence care to resident #8 until 7:24 p.m. Review of resident #8's comprehensive care plan revealed resident #8 was to be turned/repositioned and provided with incontinence care every two hours. However, interview and observation revealed the resident was only provided with incontinence care three	F 282		

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F 282	Continued From page 7 times in 14 hours and resident #8 developed an open area to the right buttock/coccyx that was identified on June 30, 2010, during incontinence care. 3. Review of resident #7's RAPS dated December 30, 2009, revealed the resident was alert and oriented to person, place, and time, however, required supervision from staff in planning and organizing their daily routine. The RAPS revealed resident #7 required assistance with most ADLs and was incontinent of bowel/bladder. The RAPS stated the resident was to be turned/repositioned by staff every two hours. Review of resident #7's care plan dated February 20, 2009, revealed staff was required to turn/reposition and provide incontinence care to resident #7 every two hours. Observations conducted on June 30, 2010, at 1:30 p.m., during the initial tour, revealed resident #7 lying on the resident's back looking out the doorway. Further observations conducted on June 30, 2010, from 1:30 p.m. through 8:36 p.m., revealed resident #7 remained positioned on the resident's back. 4. Review of resident #9's RAPS dated May 10, 2010, revealed the resident was alert and oriented to person, place, and time, and the resident was able to make consistent, reasonable decisions. The RAPS stated resident #9 required total assistance with all ADLs due to progression of Multiple Sclerosis (MS). The RAPS revealed staff was required to turn/reposition and provide incontinence care every two hours for resident #9. Review of resident #9's care plan dated May 27, 2009, revealed staff was required to provide incontinence care for this resident every two	F 282		

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F 282	Continued From page 8 hours. An interview conducted on June 30, 2010, at 1:48 p.m., during the initial tour, with resident #9, revealed it took two staff members to provide care to the resident. The interview revealed the resident did not receive incontinence care or turns/repositioning every two hours as required. Additional interview conducted from 4:50 p.m. until 8:33 p.m., with resident #9 revealed on the evening shift the resident did not receive incontinence care for up to five hours. Further interview with resident #9 at 7:11 p.m., revealed the resident had not received incontinence care since 3:00 p.m. on June 30, 2010. An observation of resident #9 conducted on June 30, 2010, from 4:50 p.m. until 7:42 p.m., revealed the resident remained in the same position, on the resident's back with the head of the bed elevated approximately 45 degrees. 5. Review of resident #10's RAPS dated January 17, 2010, revealed the resident was alert and oriented with intermittent confusion, however, required supervision from staff in planning and organizing their daily routine. The RAPS stated resident #10 required assistance with most ADLs, and was to be turned/repositioned and provided incontinence care every two hours. Review of resident #10's care plan dated January 19, 2010, revealed the resident was to be turned/repositioned and provided with incontinence care every two hours. Interviews conducted on June 30, 2010, from 1:10 p.m. until 3:10 p.m., during the initial tour, with resident #10, revealed staff was required to provide incontinence care for the resident every	F 282		

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F 282	Continued From page 9 two hours. However, according to resident #10, the staff actually provides incontinence care every three to five hours. Observations conducted on June 30, 2010, from 1:10 p.m. until 8:38 p.m., revealed resident #10 was lying on the resident's back in bed with the head of bed elevated. 6. Review of resident #13's RAPS dated December 21, 2009, revealed the resident was alert and oriented to person, place, and time, however, required supervision from staff in planning and organizing their daily routine. The RAPS stated staff was required to assist the resident with turning/repositioning every two hours. Review of resident #13's care plan dated May 31, 2010, revealed staff was required to assist the resident with toileting upon rising in the morning, before/after each meal, and at bedtime. Review of resident #13's care plan updated on March 10, 2010, revealed incontinence care was to be provided for this resident every two hours. The resident's care plan dated December 22, 2009, required staff to turn/reposition the resident every two hours. An interview conducted on June 30, 2010, with resident #13 revealed the resident had to wait a long time for staff to assist the resident to the toilet. Interview with resident #13's family member revealed the resident had been incontinent twice due to staff not assisting the resident in a timely manner. The family member reported observing the resident's bed linens soaked with urine twice due to staff not assisting the resident to the toilet in a timely manner. Observations conducted on June 30, 2010, from	F 282		

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F 282	Continued From page 10 4:41 p.m. until 8:29 p.m., revealed resident #13 remained on his/her back in bed during this timeframe. 7. Review of resident #16's RAPS dated November 19, 2009, revealed the resident was alert and oriented to person and place with confusion, and required staff supervision in planning and organizing their daily routine. The RAPS revealed the resident required the extensive assistance of staff with most ADLs and was incontinent of bowel/bladder. The RAPS further stated staff was required to provide turns/repositioning and incontinence care every two hours for this resident. Review of resident #16's care plan dated November 20, 2009, revealed staff was required to provide incontinence care and turns/repositioning for resident #16 every two hours. An interview conducted on June 30, 2010, at 2:05 p.m., with resident #16's family member revealed the facility often had a pervasive urine odor due to the lack of incontinence care. The interview revealed the family member had to go get staff to come and provide incontinence care to the resident after ringing the call light when no assistance was given. An observation conducted on June 30, 2010, at 2:38 p.m., revealed resident #16's family member requested resident #16 be transferred to bed and incontinence care provided. The observation revealed resident #16's brief was saturated with urine and soiled with stool and the Chux under the resident was also saturated with urine. 8. Review of resident #17's RAPS dated March 19, 2010, revealed resident #17 was alert and	F 282		

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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 282	Continued From page 11 oriented to self and required staff supervision in planning and organizing their daily routine. The RAPS stated the resident was totally incontinent of bowel and bladder. Review of resident #17's care plan dated March 19, 2010, revealed staff was required to provide incontinence care for this resident every two hours. Observation on June 30, 2010, at 2:17 p.m., revealed SRNA #2 and SRNA #3 providing incontinence care for resident #17. The observation revealed the resident's brief and Chux, which were under the resident, to be saturated with urine. An interview conducted on July 1, 2010, at 2:15 p.m., with SRNA #3 confirmed resident #17's brief and Chux were saturated with urine. An interview conducted on June 30, 2010, at 2:17 p.m., during the incontinence care, with SRNA #2, revealed staff was to provide incontinence care every two hours to incontinent residents. SRNA #2 stated the SRNA documented the incontinence care at the end of shift. 9. Review of resident #19's RAPS dated March 27, 2010, revealed the resident was alert and oriented to self only. The RAPS stated staff was required to provide incontinence care and turning/repositioning for this resident every two hours. Review of resident #19's care plan dated June 2, 2008, revealed staff was required to provide incontinence care and turn/reposition this resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:33 p.m., revealed incontinence care was being performed for	F 282		

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	185094	A. BUILDING _____ B. WING _____	C 07/02/2010

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F 282	Continued From page 12 resident #19 by SRNA #8. The observation revealed the resident's brief and draw sheet were soaked with urine. An interview conducted on June 30, 2010, at 5:25 p.m., with SRNA #6 revealed the SRNAs have a "Care Book" that informs the SRNAs which residents are to be turned/repositioned and provided with incontinence care every two hours.	F 282		
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure residents who were at high risk for developing pressure ulcers and/or had a history of pressure ulcers received the necessary treatment/services to prevent new pressure ulcers from developing for two (2) of nineteen (19) sampled residents. Resident #3 and resident #8 were assessed to be at risk for skin breakdown and care plan interventions were developed for the residents to be turned/repositioned and provided with incontinence care every two (2) hours. However, residents #3 and #8 developed pressure sores	F 314	**F314 483.25 (c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE ULCERS** **Corrective Action for Resident(s) Affected:** Resident #8 was evaluated by the ADON on 6/30/10 and treatment was initiated by the physician and responsible parties were notified. Resident #8 was healed on 7/5/2010. Current treatment order was continued for resident #3. Resident #3 was healed on 7/20/2010. Care plans were reviewed and/or revised to reflect current plans. **How the facility will act to protect residents in similar situations:** Head to toe skin assessments were completed by the treatment nurse on all residents by 7/9/2010. No new areas were identified. **Measures to prevent reoccurrence:** All nursing staff will be in serviced by Staff Development on the skin care policy, turning and repositioning, and incontinence care by 7/25/2010. Weekly head to toe skin assessments are completed by the licensed nurse and C.N.A.'s will report any skin changes identified during routine care to their nurse immediately. Orders will be obtained from the physician for any newly identified areas and responsible parties will be notified. Changes will be communicated per the 24 hour report and care plan.	

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F 314	Continued From page 13 due to the facility's failure to provide the required care/services. The findings include: 1. Review of resident #3's Resident Assessment Protocol Summary (RAPS) dated April 21, 2010, revealed the resident required total assistance from staff with most Activities of Daily Living (ADLs). The RAPS further revealed resident #3 did not understand the use of a call light, did not recognize the importance of turning/repositioning, and had developed two Stage II pressure ulcers. Review of resident #3's care plan dated April 21, 2010, revealed the resident had a Stage II pressure ulcer to the resident's buttocks. The care plan revealed the resident was at risk for developing further skin breakdown due to incontinence, CVA, impaired mobility, a history of weight loss, and noncompliance. Review of the care plan interventions revealed staff was required to provide incontinence care and turning/repositioning for resident #3 every two hours. The care plan further revealed resident #3 had an open area (Stage II pressure ulcer) to the left buttock identified on May 1, 2010. The care plan revealed the area to resident #3's left buttock had healed on June 10, 2010. However, another Stage II pressure ulcer was identified to resident #3's left buttock on June 28, 2010. Review of resident #3's physician's orders revealed the resident's Foley catheter had been discontinued on June 11, 2010. The review of a Skin Ulcer Change in Condition Evaluation form dated June 28, 2010, revealed resident #3 had a new Stage II pressure ulcer to the left buttock measuring 1.5 cm by 0.9 cm by <0.1 cm.	F 314	All nursing staff and department heads (during working hours) have initiated every two hour rounding to observe for provided services to include incontinence care, turning and repositioning, dignity. Concerns identified will be brought to the attention of the director of nursing or designee and will be addressed immediately. All new employees during orientation will receive education on turning and repositioning, incontinence care, dignity, and following the plan of care. **Monitoring of Corrective Action:** The DON or nursing administration will review 20% of residents monthly to ensure compliance with incontinence care, turning and repositioning, and dignity. Any concerns identified will be brought to the administrator and addressed immediately. The results of the every two hour rounding and of the 20% of residents monitored monthly will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. **Completion date: 8/11/2010**	

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F 314	Continued From page 14 Observation during the initial tour on June 30, 2010, at 2:42 p.m., revealed incontinence care was provided for resident #3 by SRNA #7 and SRNA #8. Upon completion of the incontinence care, resident #3 was positioned onto the resident's left side in bed. Further observations conducted on June 30, 2010, from 2:42 p.m. through 7:00 p.m., revealed resident #3 remained positioned on the resident's left side in bed. An interview conducted on June 30, 2010, at 7:00 p.m., with SRNA #7 revealed resident #3 had not been turned/repositioned and had not received incontinence care since 2:42 p.m. on June 30, 2010. 2. Review of resident #8's RAPS dated December 8, 2009, revealed the resident was alert and oriented to person, place, and time and was able to make his/her needs known. The RAPS stated the resident required staff supervision in planning and organizing the resident's daily routine. The RAPS revealed the resident required extensive assistance from staff with ADLs, except for eating, and was incontinent of bowel/bladder. The Pressure Ulcer RAP revealed resident #8 was at risk for developing a pressure ulcer due to decreased bed mobility, incontinence, and peripheral vascular disease. The RAP stated the resident was to receive incontinence care and turning/repositioning every two hours by staff. Review of resident #8's care plan dated February 15, 2010, revealed staff was required to provide scheduled toileting for this resident upon rising in the morning, before/after each meal, at bedtime, and as needed. Review of the care plan	F 314		

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F 314	Continued From page 15 regarding the resident's risk for skin breakdown dated February 9, 2009, revealed the resident was at risk for skin breakdown due to incontinence, impaired mobility, and peripheral vascular disease. Interventions included that staff was required to perform incontinence care and turn/reposition the resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:32 p.m., revealed resident #8 in a wheelchair in the hallway waiting for staff to provide incontinence care. Resident #8 reported it takes staff 30 to 45 minutes to answer the resident's call light. The resident pointed to the watch on the resident's wrist when asked how the resident monitored how long the resident had to wait. The interview revealed the resident had not been provided with incontinence care since 5:20 a.m. on June 30, 2010, when the resident was provided with morning care and transferred to the wheelchair. At 1:35 p.m. on June 30, 2010, LPN #2 and SRNA #3 took the resident into the resident's room to provide incontinence care. When staff stood resident #8 to transfer the resident to the toilet a strong urine odor was noted and the resident's pants were observed to be soaked with urine. The resident's wheelchair cushion was also soaked with urine and the resident's brief was totally saturated with urine. The observation revealed staff removed the resident's clothing and provided incontinence care, and applied a new brief and clean/dry pants. While the staff was washing the resident's buttocks, the resident asked SRNA #3 not to rub hard because the resident's buttock was sore. The observation revealed a small opened area to the right side of the resident's coccyx. SRNA #3 stated the SRNA was not assigned to resident #8 and was unsure when the resident received	F 314		

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F 314	Continued From page 16 incontinence care previously. LPN #3 had not assisted with incontinence care for resident #8 previously and was unsure when the resident had received incontinence care. An interview conducted on July 1, 2010, at 2:30 p.m., with SRNA #10 revealed resident #8 was already dressed and in the wheelchair when SRNA #10 started the scheduled shift at 7:00 a.m. on June 30, 2010. SRNA #10 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. An interview conducted on July 1, 2010, at 2:07 p.m., with SRNA #9 revealed resident #8 was already dressed and in the wheelchair when SRNA #9 started the shift at 7:00 a.m. on June 20, 2010. SRNA #9 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. SRNA #9 stated residents were frequently found saturated with urine. Observation and interview conducted on June 30, 2010, at 7:24 p.m., revealed resident #8 complained of the resident's peri area burning from only being provided with incontinence care one time on June 30, 2010. The observation revealed a strong urine odor noted and the resident's brief/pants were saturated with urine. Resident #8's peri area and buttocks were observed to be very red in color. Further observation revealed a 1.5-cm diameter area to the resident's right buttocks/coccyx which was hard, red, and very tender to touch, with a 0.4 cm diameter with <0.1 cm depth open area. Record review revealed the open area had not been identified by the facility; therefore, no treatment	F 314		

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F 314	Continued From page 17 had been provided. An interview conducted on June 30, 2010, at 7:24 p.m., during resident #8's incontinence care, with SRNA #4 and SRNA #5, revealed both staff members came in at 3:00 p.m. on June 30, 2010, and were unable to offer or provide incontinence care for resident #8 until 7:24 p.m. Record review revealed resident #8 was required to be turned/repositioned by staff with incontinence care provided every two hours. However, interview and observation revealed the resident was only provided with incontinence care three times in fourteen hours and resident #8 developed an open area to the buttocks/coccyx.	F 314		
F 315 SS=E	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, and record review, it was determined the facility failed to ensure residents who were incontinent of bladder received appropriate treatment/services to prevent urinary tract infections and to restore as much normal bladder function as possible for ten	F 315	**F 315 483.25 (d) NO CATHETER, PREVENT UTI, RESTORE BLADDER** **Corrective Action for Resident(s) Affected:** Bowel and bladder assessments and head to toe skin assessments were completed on Residents #3, #7, #8, #9, #10, #13, #16 #17, and #19 by 7/22/10. Care plans for those residents were updated as needed. **How the facility will act to protect residents in similar situations:** Head to toe skin assessments were completed on all residents by 7/9/2010 and bowel bladder assessments that were completed by 6/25/2010 were reviewed by nursing administration on 7/9/2010 with no changes identified.	

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F 315	Continued From page 18 (10) of nineteen (19) sampled residents (residents #3, #8, #9, #10, #11, #12, #13, #16, #17, and #19). The residents were assessed and care planned to required incontinence care to be provided every two (2) hours. However, staff failed to provide the required incontinence care every two (2) hours. The findings include: 1. Review of resident #3's Resident Assessment Protocol Summary (RAPS) dated April 21, 2010, revealed the resident required total assistance with most Activities of Daily Living (ADLs), did not understand the use of a call light, and was incontinent of bowel. Review of resident #3's care plan dated April 21, 2010, revealed staff was required to provide incontinence care to this resident every two hours. Review of resident #3's medical record revealed the resident's Foley catheter was discontinued on June 11, 2010. Observation conducted during the initial tour on June 30, 2010, at 2:42 p.m., revealed incontinence care was provided for resident #3 by SRNA #7 and SRNA #8. Further observations conducted on June 30, 2010, from 2:42 p.m. through 7:00 p.m., revealed staff did not provide incontinence care to resident #3 during this time period (4 hours and 18 minutes). An interview conducted on June 30, 2010, at 7:00 p.m., with SRNA #7 revealed resident #3 had not received incontinence care since 2:42 p.m. 2. Review of resident #8's RAPS dated December 8, 2009, revealed the resident was incontinent of bowel/bladder. The review revealed the resident required extensive	F 315	**Measures to prevent reoccurrence:** All licensed staff and C.N.A.'s will be in serviced by Staff Development on turning and repositioning, incontinence care, dignity, and following the plan of care by 7/26/2010. All nursing staff and department heads (during working hours) have initiated every two hour rounding to observe for provided services to include incontinence care, turning and repositioning, dignity. Concerns identified will be brought to the attention of the director of nursing or designee and will be addressed immediately. All new employees during orientation will receive education on turning and repositioning, incontinence care, dignity, and following the plan of care. **Monitoring of Corrective Action:** The DON or nursing administration will review 20% of residents monthly to ensure compliance with incontinence care, turning and repositioning, and dignity. Any concerns identified will be brought to the administrator and addressed immediately. The results of the every two hour rounding and of the 20% of residents monitored monthly will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as indicated. **Completion date: 8/11/2010**	

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F 315	Continued From page 19 assistance with ADLs, except for eating. Review of resident #8's care plan dated February 15, 2010, revealed staff was required to provide scheduled toileting for the resident upon rising in the morning, before/after each meal, at bedtime, and as needed. The falls and skin breakdown care plans dated February 9, 2009, revealed staff was required to perform incontinence care to the resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:32 p.m., revealed resident #8 in a wheelchair in the hallway waiting for staff to provide incontinence care. The resident interview revealed the resident had not been provided with incontinence care since 5:20 a.m. on June 30, 2010, when the resident was provided with morning care and transferred to the wheelchair. At 1:35 p.m., LPN #2 and SRNA #3 took resident #8 into the resident's room to provide incontinence care. When the staff stood resident #8 to transfer the resident to the toilet a strong urine odor was noted, and the resident's pants and wheelchair cushion were observed to be soaked with urine. The resident's brief was also observed to be totally saturated with urine. The observation revealed staff removed the resident's clothing, provided incontinence care, and applied a new brief and clean/dry pants. SRNA #3 stated the SRNA was not assigned to resident #8 and was unsure when the resident received incontinence care previously. LPN #3 had not assisted with incontinence care for resident #8 previously and was unsure when the resident had received incontinence care. An interview conducted on July 1, 2010, at 2:30 p.m., with SRNA #10 revealed resident #8 was already dressed and in the wheelchair when	F 315		

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F 315	Continued From page 20 SRNA #10 started the shift at 7:00 a.m. on June 30, 2010. SRNA #10 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. An interview conducted on July 1, 2010, at 2:07 p.m., with SRNA #9 revealed resident #8 was already dressed and in the wheelchair when SRNA #9 started the shift at 7:00 a.m. on June 20, 2010. SRNA #9 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. SRNA #9 stated residents were frequently found saturated with urine. Observation and interview conducted on June 30, 2010, at 7:24 p.m., revealed resident #8 complained of the resident's peri area burning from only being provided with incontinence care one time on June 30, 2010. The observation revealed a strong urine odor and the resident's brief/pants were saturated with urine. An interview conducted on June 30, 2010, at 7:24 p.m., during resident #8's incontinence care, with SRNA #4 and SRNA #5, revealed both staff members started the scheduled shift at 3:00 p.m. on June 30, 2010, and had not offered/provided incontinence care to resident #8 until 7:24 p.m. 3. Review of resident #9's RAPS dated May 10, 2010, revealed the resident required total assistance with all ADLs due to progression of Multiple Sclerosis (MS). The RAPS revealed staff was required to provide incontinence care every two hours for resident #9. Review of resident #9's care plan dated May 27, 2009, revealed staff was required to provide incontinence care for this	F 315		

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F 315	Continued From page 21 resident every two hours. An interview conducted on June 30, 2010, at 1:48 p.m., during the initial tour, with resident #9, revealed it took two staff members to provide care to the resident. The interview revealed the resident did not receive incontinence care every two hours as required. Additional interview conducted on June 30, 2010, at 4:50 p.m., with resident #9 revealed on the evening shift the resident did not receive incontinence care for up to five hours. Further interview with resident #9 at 7:11 p.m. on June 30, 2010, revealed the resident had not received incontinence care since 3:00 p.m. 4. Review of resident #10's RAPS dated January 17, 2010, revealed resident #10 required assistance with most ADLs and was to be provided incontinence care every two hours. Review of resident #10's care plan dated January 19, 2010, revealed the resident was to be provided with incontinence care every two hours. An interview with resident #10 during the initial tour on June 30, 2010, from 1:10 p.m. until 3:10 p.m., revealed staff was required to provide incontinence care for this resident every two hours. However, according to resident #10, staff actually provided incontinence care every three to five hours. 5. Review of resident #11's RAPS dated January 11, 2010, revealed the resident required extensive assistance from staff with most ADLs. Review of resident #11's care plan dated January 14, 2010, revealed staff was required to provide incontinence care for this resident every two hours.	F 315		

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F 315	Continued From page 22 An interview conducted on June 30, 2010, with resident #11 during the initial tour from 1:10 p.m. until 3:10 p.m., revealed sometimes when the resident activated the nurse call system for assistance to the restroom, staff instructed the resident to void in the brief because there was not enough staff to help get the resident to the toilet. 6. Review of resident #12's RAPS dated March 1, 2010, revealed the resident had some episodes of bladder incontinence and requested the use of a brief. An interview conducted on June 30, 2010, at 1:16 p.m., with resident #12 revealed the resident had soiled her/himself on a daily basis due to staff failing to answer the call light timely. The interview revealed the resident did not soil her/himself before being admitted to the facility. The resident stated on June 29, 2010, the resident utilized the call light for assistance to the restroom, however, was incontinent of stool because no staff came to assist the resident to the restroom. Resident #12 stated the resident had fallen three times since admission to the facility in March 2010, due to trying to get up to go to the toilet unassisted. The resident asked what the resident was supposed to do when the resident cannot get any staff to assist the resident to toilet. 7. Review of resident #13's care plan dated May 31, 2010, revealed staff was required to assist the resident with toileting upon rising in the morning, before/after each meal, and at bedtime. Review of resident #13's care plan updated on March 10, 2010, revealed incontinence care was to be provided for this resident every two hours.	F 315		

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F 315	Continued From page 23 An interview conducted on June 30, 2010, with resident #13 revealed the resident had to wait a long time for staff to assist the resident to the toilet. Interview with resident #13's family member revealed the resident had been incontinent twice due to staff not being able to assist the resident in a timely manner. The family member reported observing the resident's bed linens soaked with urine twice due to failure of staff to assist the resident to the toilet in a timely manner. 8. Review of resident #16's RAPS dated November 19, 2009, revealed the resident required the extensive assistance of staff with most ADLs and was incontinent of bowel/bladder. The RAPS further stated staff was required to provide incontinence care every two hours for this resident. Review of resident #16's care plan dated November 20, 2009, revealed staff was required to provide incontinence care for resident #16 every two hours. An interview conducted on June 30, 2010, at 2:05 p.m., with resident #16's family member revealed the facility often had a pervasive urine odor due to the lack of incontinence care. The interview revealed the family member had to go get staff to come and provide incontinence care to the resident after ringing the call light when no assistance was given. An observation conducted on June 30, 2010, at 2:38 p.m., revealed resident #16's family member had requested that staff transfer resident #16 to bed and provide incontinence care to the resident. The observation revealed resident #16's brief and Chux under the resident was	F 315		

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F 315	Continued From page 24 saturated with urine and soiled with stool. 9. Review of resident #17's RAPS dated March 19, 2010, revealed the resident was totally incontinent of bowel and bladder. Review of resident #17's care plan dated March 19, 2010, revealed staff was required to provide incontinence care for this resident every two hours. An observation of incontinence care conducted on June 30, 2010, at 2:17 p.m., revealed SRNA #3 and SRNA #2 conducted incontinence care for resident #17. The observation revealed the resident's brief and Chux, which was under the resident, were saturated with urine. An interview conducted on June 30, 2010, at 2:17 p.m., during the incontinence care, with SRNA #2, revealed staff was required to provide incontinence care every two hours to incontinent residents. SRNA #2 stated the SRNA documented the incontinence care at the end of shift. An interview conducted on July 1, 2010, at 2:15 p.m., with SRNA #3 confirmed resident #17's brief and Chux were saturated with urine. 10. Review of resident #19's RAPS dated March 27, 2010, revealed the staff was required to provide incontinence care for this resident every two hours. Review of resident #19's care plan dated June 2, 2008, revealed staff was required to provide incontinence care to this resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:33 p.m., revealed	F 315		

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F 315	Continued From page 25 incontinence care was conducted for resident #19 by SRNA #8. The observation revealed the resident's brief and the draw sheet were soaked with urine. An interview conducted on June 30, 2010, at 8:15 p.m., with the DON revealed staff was required to provide "check and change" or incontinence care every two hours for residents that were incontinent.	F 315		
F 353 SS=G	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 353	**F353 483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS** **Corrective Action for Resident(s) Affected:** Residents #3, #7, #8, #9, #10, #11, #12, #13, #16, #17, and #19 are currently receiving the necessary services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident's assessments and individual plans of care. Residents are maintaining personal hygiene, through timely incontinence care provided by nursing staff, as indicated by the interventions established in the individual care plan of care for #3, #7, #8, #9, #10, #11, #12, #13, #16, #17, and #19. Resident #8 was evaluated by the ADON on 6/30/10 and treatment was initiated by the physician and responsible parties were notified. Resident #8 was healed on 7/5/2010. Current treatment order was continued for resident #3. Resident #3 was healed on 7/20/2010. Care plans were reviewed and/or revised to reflect current plans.	

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F 353	Continued From page 26 review, it was determined the facility failed to ensure there was sufficient nursing staff to provide nursing services to maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by the resident assessments and care plan for eleven (11) of nineteen (19) sampled residents (residents #3, #8, #7, #9, #10, #11, #12, #13, #16, #17, and #19). The residents' care plans required nursing staff to provide incontinence care and/or turned/repositioned these residents every two hours. However, staff was unable to provide the required care every two hours due to an insufficient number of staff. Two (2) of the eleven (11) residents (residents #3 and #8) developed Stage II pressure ulcers. The findings include: 1. Review of resident #3's Resident Assessment Protocol Summary (RAPS) dated April 21, 2010, revealed the resident required total assistance with most Activities of Daily Living (ADLs), did not understand the use of a call light, did not recognize the importance of turning/repositioning, and had two Stage II pressure ulcers. Review of resident #3's care plan dated April 21, 2010, revealed staff was required to provide incontinence care and turns/repositioning for this resident every two hours. Review of resident #3's medical record revealed the resident's Foley catheter had been discontinued on June 11, 2010, and on June 28, 2010, resident #3 developed a Stage II pressure ulcer measuring 1.5 centimeter (cm) by 0.9 cm by <0.1 cm. An observation conducted during the initial tour	F 353	**How the facility will act to protect residents in similar situations:** The facility will ensure that there is sufficient nursing staff to provide nursing and related services as determined by resident assessments and individual plan of care. In reviewing C.N.A. assignments, if assigned staff is unable to provide services according to plan of care, the C.N.A. will report to licensed nurse, at anytime during the shift that an issue is identified. The licensed nurse will facilitate immediate assistance by actively assisting with care and/or alerting administrative staff who will ensure that sufficient nursing staff is allocated to provide care. Head to toe skin assessments were completed on all residents by 7/9/2010 and bowel bladder assessments that were completed by 6/25/2010 were reviewed by nursing administration on 7/9/2010 with no changes identified. The interdisciplinary team will interview all residents who are interviewable and the responsible party for all residents in regards to care concerns and care needs. This review will be completed by 7/31/10. Any concerns will be addressed immediately. **Measures to prevent reoccurrence:** All licensed staff and C.N.A.'s will be in serviced by Staff Development regarding the process for maintaining personal hygiene, incontinence care, turning and repositioning, dignity and providing care according to care plan and resident needs to be completed by 7/26/2010.	

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F 353	Continued From page 27 on June 30, 2010, at 2:42 p.m., revealed incontinence care was conducted for resident #3 by SRNA #7 and SRNA #8. Upon completion of the incontinence care resident #3 was positioned onto the resident's left side in bed. Further observations conducted on June 30, 2010, from 2:42 p.m. through 7:00 p.m., revealed resident #3 remained positioned on the resident's left side in bed. An interview conducted on June 30, 2010, at 7:00 p.m., with SRNA #7 revealed resident #3 had not been turned/repositioned and had not received incontinence care since 2:42 p.m. on June 30, 2010. SRNA #7 reported the staff does not have enough time to answer call bells, turn/reposition, and provide incontinence care to residents every two hours. 2. Review of resident #8's RAPS dated December 8, 2009, revealed the resident was incontinent of bowel/bladder. The RAPS further revealed the resident required extensive assistance with ADLs, except for eating. Review of resident #8's care plan dated February 15, 2010, revealed staff was required to provide scheduled toileting for this resident upon rising in the morning, before/after each meal, at bedtime, and as needed. The falls and skin breakdown care plans dated February 9, 2009, for resident #8 revealed staff was required to perform incontinence care and turn/reposition the resident every two hours. An observation conducted during the initial tour on June 30, 2010, at 1:32 p.m., revealed resident #8 in a wheelchair in the hallway waiting for staff to provide incontinence care. Resident #8 reported it took staff 30 to 45 minutes to answer	F 353	All nursing staff and department heads (during working hours) have initiated every two hour rounding to observe for provided services to include incontinence care, turning and repositioning, dignity. Concerns identified will be brought to the attention of the director of nursing or designee and will be addressed immediately. All new employees during orientation will receive education on personal hygiene, turning and repositioning, incontinence care, dignity, and following the plan of care. **Monitoring of Corrective Action:** The DON or nursing administration will review 20% of residents monthly to ensure compliance with incontinence care, turning and repositioning, and dignity. Any concerns identified will be brought to the administrator and addressed immediately. The results of the every two hour rounding and of the 20% of residents monitored monthly will be reported to the quality assurance committee monthly for three months for recommendations and follow-up as needed. **Completion date: 8/11/2010**	

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F 353	Continued From page 28 the resident's call light. The resident pointed to the watch on the resident's wrist when asked how the resident monitored how long the resident had to wait. The resident interview revealed the resident had not been provided with incontinence care since 5:20 a.m. on June 30, 2010, when the resident was provided with morning care and transferred to the wheelchair. At 1:35 p.m., LPN #2 and SRNA #3 took resident #8 into the resident's room to provided incontinence care. When the staff stood resident #8 to transfer the resident to the toilet a strong urine odor was noted, and the resident's pants were observed to be soaked with urine along with the resident's wheelchair cushion. The resident's brief was also totally saturated with urine. The observation revealed staff removed the resident's clothing, provided incontinence care, and applied a new brief and clean/dry pants. While the staff was washing the resident's buttocks, the resident asked SRNA #3 not to rub hard because the resident's buttock was sore. Resident #8 was observed to have a small opened area to the right side of the resident's coccyx/buttock. SRNA #3 stated the SRNA was not assigned to resident #8 and was unsure when the resident received incontinence care previously. LPN #3 had not assisted with incontinence care for resident #8 previously and was unsure when the resident had last received incontinence care. An interview conducted on July 1, 2010, at 2:30 p.m., with SRNA #10 revealed resident #8 was already dressed and in the wheelchair when SRNA #10 started the shift at 7:00 a.m. on June 30, 2010. SRNA #10 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. SRNA #10 stated there was not enough	F 353		

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F 353	Continued From page 29 staff to answer call bells, turn/reposition, and provide incontinence care to residents every two hours. An interview conducted on July 1, 2010, at 2:07 p.m., with SRNA #9 revealed resident #8 was already dressed and in the wheelchair when SRNA #9 started the shift at 7:00 a.m. on June 30, 2010. SRNA #9 reported the SRNA had not offered or provided turning/repositioning or incontinence care to resident #8 at all on June 30, 2010. SRNA #9 stated there was not enough staff to provide all the care the residents required and the nurses only helped with resident care when the state surveyors were in the facility. The interview revealed residents were frequently found saturated with urine. Observation and interview conducted on June 30, 2010, at 7:24 p.m., revealed resident #8 complained of the resident's peri area burning from only being provided incontinence care one time on June 30, 2010. A strong urine odor was noted and the resident's brief/pants were observed to be saturated with urine. The observation revealed resident #8's peri area and buttocks to be very red in color. Further observation revealed a 1.5-cm diameter area, which was hard, red, and very tender to touch, with a 0.4 cm diameter and <0.1 cm depth open area to resident #8's coccyx/buttocks. Record review revealed the open area had not been identified by the facility; therefore, no treatment had been provided. An interview conducted on June 30, 2010, at 7:24 p.m., during resident #8's incontinence care, with SRNA #4 and SRNA #5, revealed there was not enough staff to provide the required care to all	F 353		

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F 353	Continued From page 30 residents. The interviews revealed both staff members came in at 3:00 p.m. on June 30, 2010, to work their scheduled shifts and were unable to offer or provide incontinence care to resident #8 until 7:24 p.m. Record review revealed staff was required to turn/reposition and provide resident #8 with incontinence care every two hours. However, interview and observation revealed the resident was only provided with incontinence care three times in 14 hours and resident #8 developed an open area to the coccyx/buttocks. 3. Review of resident #7's RAPS dated December 30, 2009, revealed the resident required staff assistance with most ADLs and was incontinent of bowel/bladder. The RAPS stated the resident was to be turned/repositioned by staff every two hours. Review of resident #7's care plan dated February 20, 2009, revealed staff was required to turn/reposition and provide incontinence care for resident #7 every two hours. Observations conducted on June 30, 2010, at 1:30 p.m., during the initial tour revealed resident #7 lying on the resident's back in bed looking out the doorway. Further observations conducted on June 30, 2010, from 1:30 p.m. through 8:36 p.m., revealed resident #7 remained positioned on the resident's back in bed. 4. Review of resident #9's RAPS dated May 10, 2010, revealed the resident required total assistance from staff with all ADLs due to progression of Multiple Sclerosis (MS). The RAPS revealed staff was required to turn/reposition resident #9 and provide incontinence care for this resident every two	F 353		

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F 353	Continued From page 31 hours. Review of resident #9's care plan dated May 27, 2009, revealed staff was required to provide incontinence care every two hours. An interview conducted on June 30, 2010, at 1:48 p.m., during the initial tour, with resident #9, revealed there was not enough staff to provide incontinence care and turns/repositioning every two hours as required. Resident #9 reported it took two staff members to provide care to the resident and there was not enough staff to provide the care. The interview revealed the resident did not receive incontinence care or turns/repositioning every two hours as required. The resident informed the ADON there was not enough staff to provide the care and the ADON informed resident #9 that staff "have to get it done." Resident #9 stated the resident requested three showers a week; however, due to not enough staff resident #9 only receives two showers per week. The interview revealed the resident was routinely provided with incontinence care at 5:30 a.m., before lunch, at 3:00 p.m., and then between 8:00 p.m. and 9:00 p.m. (four times in a 16-hour time span). Additional interview conducted from 4:50 p.m. until 8:33 p.m., with resident #9 revealed on the evening shift the resident did not receive incontinence care for up to five hours. Further interview with resident #9 at 7:11 p.m. on June 30, 2010, revealed the resident had not received incontinence care since 3:00 p.m. on June 30, 2010. The interview revealed resident #9 was wet with urine at the time of the interview; however, the resident would not utilize the call light to request incontinence care due to the fact staff was busy feeding the evening meal to other residents. The resident complained of receiving cold food almost every meal due to not enough staff to pass the trays in a timely manner.	F 353		

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F 353	Continued From page 32 Resident #9 stated the French fries were cold, the ice cream melted, and the milk was warm. An observation of resident #9 conducted on June 30, 2010, from 4:50 p.m. until 7:42 p.m., revealed the resident remained in the same position, on the resident's back with the head of the bed elevated approximately 45 degrees. 5. Review of resident #10's RAPS dated January 17, 2010, revealed the resident required staff assistance with most ADLs and was to be turned/repositioned and provided incontinence care every two hours. Review of resident #10's care plan dated January 19, 2010, revealed the resident was to be turned/repositioned and provided with incontinence care every two hours. An interview conducted on June 30, 2010, from 1:10 p.m. until 3:10 p.m., during the initial tour, with resident #10, revealed staff was required to provide this resident with incontinence care every two hours. However, staff actually provided incontinence care every three to five hours due to not enough staff to provide care every two hours. Observations conducted on June 30, 2010, from 1:10 p.m. until 8:38 p.m., revealed resident #10 was lying on the resident's back in bed with the head of bed elevated. 6. Review of resident #11's RAPS dated January 11, 2010, revealed the resident required extensive assistance from staff with most ADLs and was to be turned/repositioned every two hours. Review of resident #11's care plan dated January 14, 2010, revealed staff was required to provide incontinence care for this resident every two hours.	F 353		

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F 353	Continued From page 33 An interview conducted on June 30, 2010, from 1:10 p.m. until 3:10 p.m., during the initial tour, with resident #11, revealed sometimes when the resident rings for assistance the staff instructed the resident to void in the resident's brief because there was not enough staff to help get the resident to the toilet. Resident #11 further stated the resident was only turned/repositioned two times at night. 7. Review of resident #12's RAPS dated March 1, 2010, revealed the resident had some episodes of bladder incontinence, requested the use of a brief, and was to be turned/repositioned every two hours. Review of resident #12's care plan dated March 2, 2010, revealed staff was required to assist this resident with turns/repositioning every two hours.	F 353		
	An interview conducted on June 30, 2010, at 1:16 p.m., with resident #12 revealed the resident had soiled her/himself on a daily basis due to staff failing to answer the call light timely. The interview revealed the resident did not soil her/himself before being admitted to the facility. The resident stated on June 29, 2010, the resident utilized the call light for assistance to the restroom, however, was incontinent of stool because no staff came to assist the resident to the restroom. Resident #12 stated the resident had fallen three times since the resident's admission to the facility in March 2010 due to trying to get up to go to the toilet unassisted. The resident asked what the resident was supposed to do when the resident could not get any staff to assist the resident to toilet. The resident stated the falls occurred when the resident got up unassisted. The interview revealed staff comes			

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	185094	A. BUILDING _____ B. WING _____	C 07/02/2010

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

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F 353	Continued From page 34 in and tells the resident, "We are feeding someone," and staff does not assist the resident to the bathroom. 8. Review of resident #13's RAPS dated December 21, 2009, revealed the resident required assistance with turning/repositioning every two hours. Review of resident #13's care plan dated May 31, 2010, revealed staff was required to assist the resident with toileting upon rising in the morning, before/after each meal, and at bedtime. The review revealed a care plan updated on March 10, 2010, which included incontinence care every two hours for this resident. Further review revealed a care plan dated December 22, 2010, that required staff to turn/reposition the resident every two hours. An interview conducted on June 30, 2010, with resident #13 revealed the resident had to wait a long time for staff to assist the resident to the toilet. Interview with resident #13's family member revealed the resident had been incontinent twice due to no staff available to assist the resident in a timely manner. The family member reported observing the resident's linens soaked with urine twice due to staff not assisting the resident to the toilet in a timely manner. Observations conducted on June 30, 2010, from 4:41 p.m. until 8:29 p.m., revealed resident #13 was lying in bed on the resident's back. 9. Review of resident #16's RAPS dated November 19, 2009, revealed the resident required extensive assistance from staff with most ADLs and was incontinent of bowel/bladder. The RAPS further stated staff was required to provide the resident with turns/repositioning and	F 353		

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F 353	Continued From page 35 incontinence care every two hours. Review of resident #16's care plan dated November 20, 2009, revealed staff was required to provide incontinence care and turns/repositioning for this resident every two hours. An interview conducted on June 30, 2010, at 2:05 p.m., with resident #16's family member revealed the facility often had a pervasive urine odor due to the lack of incontinence care. The family member stated staff was slow to answer the call lights and when staff did answer, staff would say they were busy and would be back later. The interview revealed the family member had to go get staff to come and provide incontinence care to the resident after ringing the call light when no assistance was given. The family member stated when the staff did not come back to provide the care requested the family member would have to go find staff and make the staff provide incontinence care to the resident. An observation conducted on June 30, 2010, at 2:38 p.m., revealed resident #16's family member requested that resident #16 be transferred to bed and incontinence care provided. The observation revealed resident #16's brief was saturated with urine and stool and the Chux under the resident was also saturated with urine. 10. Review of resident #17's RAPS dated March 19, 2010, revealed the resident was totally incontinent of bowel and bladder. Review of resident #17's care plan dated March 19, 2010, revealed staff was required to provide incontinence care for the resident every two hours. An observation of incontinence care conducted	F 353		

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F 353	Continued From page 36 on June 30, 2010, at 2:17 p.m., revealed SRNA #2 and SRNA #3 provided incontinence care for resident #17. The observation revealed the resident's brief and Chux, which was under the resident, to be saturated with urine. An interview conducted on July 1, 2010, at 2:15 p.m., with SRNA #3 confirmed resident #17's brief and Chux were saturated with urine. SRNA #3 reported staff was not able to provide incontinence care for residents every two hours as required due to not enough staff. 11. Review of resident #19's RAPS dated March 27, 2010, revealed the resident required incontinence care and turns/repositioning every two hours. Review of resident #19's care plan dated June 2, 2008, revealed staff was required to provide incontinence care and turning/repositioning for this resident every two hours. A care plan update on July 31, 2008, revealed staff was required to reposition the resident every one to two hours while in a chair. An observation conducted during the initial tour on June 30, 2010, at 1:33 p.m., revealed incontinence care being performed for resident #19 by SRNA #8. The observation revealed the resident's brief and draw sheet were soaked with urine. An interview conducted on June 30, 2010, at 4:55 p.m., with SRNA #1 revealed staff was required to provide turns/repositioning and incontinence care to incontinent residents every two hours, which would be four times per shift. However, the staff usually provided two incontinence care rounds per shift due to not enough staff available to provide the care and conduct meal service too.	F 353		

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F 353	Continued From page 37 The interview revealed SRNA #1 had found residents soaked with urine due to lack of incontinence care. An interview conducted on July 1, 2010, at 2:07 p.m., with SRNA #7 revealed the SRNA was working on June 30, 2010, and the unit was short one SRNA and SRNA #7 floated from one hall to the other due to only one SRNA on each hall. The interview revealed the SRNAs usually provided two incontinence care rounds per shift due to multiple residents requiring two staff members for care and meal service; according to SRNA #7, there was not enough staff to complete all the tasks. An interview conducted on July 1, 2010, at 2:15 p.m., with SRNA #3 revealed the SRNAs were only able to provide two or three incontinence rounds per shift due to not enough staff available to provide the care. An interview conducted on July 1, 2010, at 2:30 p.m., with SRNA #10 revealed the SRNAs usually provided two incontinence care rounds per shift due to not enough staff available to complete all the tasks. SRNA #10 stated the residents did not receive proper care due to the staffing shortage. The interview revealed a group of staff confronted Administrative staff about the concerns with the staffing shortage and no action was taken to resolve the problem. An interview conducted on July 1, 2010, at 4:15 p.m., with SRNA #4 revealed the staff was required to provide incontinence care rounds every two hours. However, due to not having enough staff, the residents were only provided with two or three incontinence care rounds per	F 353		

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F 353	Continued From page 38 shift. SRNA #4 reported finding multiple residents with urine-soaked clothing. An interview conducted on July 1, 2010, at 4:30 p.m., with SRNA #5 revealed the staff was required to provide four incontinence care rounds per shift. However, staff was lucky to be able to provide three incontinence care rounds per shift, according to SRNA #5, due to not having enough staff. An interview conducted on June 30, 2010, at 8:15 p.m., with the DON, revealed staff was required to perform "check and change" (incontinence care) every two hours and as needed. The DON stated the DON, Unit Managers (UMs), and ADON monitored turns/repositioning and incontinence care by making rounds every one and one-half to two hours. The interview revealed the DON physically checked the resident and if the resident was not provided incontinence care or turns then staff was questioned. The DON denied having any problems with staff completing incontinence care or turns as required. The DON denied any staff had reported a problem with not having enough staff to provide incontinence care or turns for residents every two hours.	F 353		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it -	F 441		