

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

PRINTED: 06/13/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 280	<p>Continued From page 31</p> <p>Dermasavers.</p> <p>Review of the Comprehensive Plan of Care dated 07/30/13 revealed there was no documented evidence of the intervention for the footboard to the wheelchair or for the Dermasavers to the lower extremities.</p> <p>Observation of Resident #11 on 05/06/14 at 2:00 PM revealed Resident #11 was in the wheelchair and there was no footboard on the wheelchair and no Dermasavers observed to the resident's lower extremities.</p> <p>Interview with CNA #14 on 05/06/14 at 2:00 PM, revealed she was assigned to Resident #11 the majority of the time. She observed Resident #11 and stated the resident did not have a footboard in place on the wheelchair and did not have Dermasavers in place on the lower extremities. She reviewed the "My Daily Care Plan" ("MDCP"), and stated the footboard was on the MDCP, but the Dermasavers was not indicated on it. She further stated the resident had not had Dermasavers for a while, and the "MDCP" was the reference the CNA's used to provide care for residents.</p> <p>Interview with CNA #13 on 05/06/14 at 2:05 PM, revealed she was assigned to Resident #11. She reviewed the "MDCP" and stated she was unaware the resident was to have Dermasavers on his/her lower extremities or there was supposed to be a footboard on the wheelchair. She stated she used the "MDCP" as a reference to provide care for the resident. Further interview revealed she was "agency" staff and did not know Resident #11 very well.</p>	F 280		
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Interview with Licensed Practical Nurse (LPN) #4 on 05/06/14 at 2:20 PM, revealed she was assigned to Resident #11, and after reviewing the resident's clinical record, stated the footboard on the wheelchair and the Derasavers to the resident's lower extremities were still current Physician's Order. She stated the footboard and Derasavers were on Resident #11's Treatment Administration Record (TAR) as an intervention to be signed off by the nurse as they provided treatments; however, she had not yet completed her treatments for the day shift. She indicated she was responsible for ensuring the Physician's Orders were followed related to the devices ordered and as per the care plan.

Review of the TAR dated May 2014, revealed the intervention for the Derasavers to Resident #11's bilateral lower extremities had not been signed off by the nurses for the month of May 2014. Further review revealed the footboard was being signed off each shift as being in place to Resident #11's wheelchair.

Interview with LPN #7/MDS Coordinator on 05/07/14 at 6:40 PM, revealed she was just hired on 04/11/14, and the last MDS Coordinator who completed Resident #11's care plan no longer worked at the facility. She stated there was a three (3) part Physician's Order Sheet which was completed when a Physician's Order was written. She stated the care plan update would automatically be written then. LPN #7/MDS Coordinator stated with every new MDS, either Admission, Quarterly, Annual or Significant Change, the MDS nurse was to go through the care plan update forms and transcribe those interventions still required to the Comprehensive Care Plan. She stated the Physician's Orders for

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F 280	<p>Continued From page 33</p> <p>the Derasavers to Resident #11's bilateral lower extremities and footboard to his/her wheelchair should have been on the Comprehensive Care Plan by now as the orders were written prior to the current MDS which was just done on 04/25/14.</p> <p>2. Further review of Resident #11's Quarterly Minimum Data Set (MDS) Assessment dated 04/25/14, revealed the facility assessed the resident as requiring extensive assistance of one (1) person for transfers and locomotion, and as ambulation not occurring.</p> <p>Review of the Comprehensive Care Plan dated 07/30/13, revealed a problem which stated the resident had the potential for falls and required the assistance of one (1) person for ambulation and use of a walker. Continued review of this problem revealed the goal stated Resident #11 was to maintain present his/her function and be free from injury of falls through the target date of March 2014. However, review of the interventions revealed the resident required the assistance of a full body lift and two (2) care givers for transfers.</p> <p>Interview on 05/06/14 at 8:40 AM with CNA #13 revealed, she was assigned to the resident, and the resident required the assistance of two (2) staff to transfer him/her with a stand up lift. She further stated the resident had no alarms in place and did not ambulate.</p> <p>Further interview on 05/07/14 at 7:00 PM with LPN #7/MDS Coordinator, revealed the care plan problem and intervention related to falls did not match. She stated the problem indicated the resident was able to ambulate with the assist of</p>	F 280		

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one (1) person and the interventions indicated the resident required a full body lift and two (2) persons for transfer. After review of the record, she stated the sensor alarm had been discontinued per Physician's Order and should have been discontinued on the Comprehensive Care Plan. She further stated the care plan target date had not been updated as it was dated March 2014. However, she indicated the Comprehensive Care Plan and target date should have been revised to ensure accuracy of the resident's needs.

3. Review of Resident #1's clinical record revealed diagnoses which included Cirrhosis of the Liver, Chronic Kidney Disease, Heart Failure, and Seizure Disorder. Review of the Quarterly MDS Assessment dated 03/29/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status score of fifteen (15) out of fifteen (15). Further review revealed the facility assessed the resident as transferring with the assistance of two (2) staff, as receiving an antidepressant seven (7) days out of the last seven (7) days, and as having a Seizure Disorder.

Review of the monthly Physician's Orders dated May 2014 revealed orders to weigh Resident #1 three (3) times a week on Monday, Wednesday and Friday at 6:00 AM, and to notify the Physician if there was a more than five (5) pound weight gain in three (3) days. Continued review of the May 2014 Orders revealed the orders for the weights and Physician notification were initially ordered on 02/12/14.

Further review of the Physician's Orders revealed orders for Lexapro (an antidepressant

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medication) 10 milligrams (mg) daily for Depression which was ordered on 02/12/14.

Review of the Comprehensive Care Plan dated 01/08/14, revealed no documented evidence of a care plan related to Resident #11's diagnosis of Cirrhosis of the Liver with interventions to include the orders to weigh the resident three (3) times a week and notify the Physician if there was greater than a five (5) pound weight gain in three (3) days.

Further review of the Care Plan dated 01/08/14, revealed there was documented evidence on the Comprehensive Care Plan in regards to Resident #11 receiving the antidepressant medication with interventions to monitor for side effects, risks and complications, as well as, effectiveness of the medication.

Interview on 05/07/14 at 2:15 PM with LPN #2/Unit Coordinator (UC) of the unit Resident #1 resided on, revealed there should have been a care plan in place related to Resident #11's diagnosis of Cirrhosis of the Liver with interventions in place to weigh him/her three (3) times a week and notify the Physician for weight changes and to measure the resident's abdominal girth as per the Physician's Orders. She stated however, she was unable to find a care plan related to this; however, it would be important to have this information on the Comprehensive Care Plan as the resident frequently required Paracentesis (removal of fluid in the abdominal cavity).

4. Further review of Resident #1's Quarterly MDS Assessment dated 03/29/14, revealed the facility assessed the resident as requiring extensive

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F 280	<p>Continued From page 36</p> <p>assistance of one (1) person for transfers.</p> <p>Review of the Comprehensive Care Plan dated 01/08/14, revealed a problem for Resident #11's potential for falls related to decreased mobility with a goal for the resident to be free from falls. Continued review revealed the interventions included to transfer Resident #11 with a mechanical lift and assist of one (1).</p> <p>Interview with the Restorative Nurse on 05/06/14 at 9:10 AM, revealed Resident #11 was in the Restorative Nursing Program for transfers and Active Range of Motion (AROM), and all the CNA's were Restorative trained. She stated Resident #1 just needed one (1) assist with transfer, and she had just observed the resident being transferred with the assist of one (1) last week.</p> <p>Interview with CNA #16 on 05/06/14 at 10:00 AM, revealed she was assigned to Resident #1 that day, and the resident was transferred with the assist of one (1) staff.</p> <p>Interview on 05/07/14 at 6:40 PM and 7:00 PM with LPN #6/MDS Coordinator, revealed the MDS nurse who was responsible for Resident #1's Comprehensive Care Plan no longer worked at the facility. She stated Resident #1's Comprehensive Care Plan should have been revised to include the resident's Cirrhosis of the Liver diagnosis and the Physician's Orders related to obtaining weights three (3) times a week and checking the resident's abdominal girth daily. LPN #6/MDS Coordinator stated Resident #1's Comprehensive Care Plan should also have been updated related to the resident's Seizure Disorder and psychotropic medication (Lexapro).</p>	F 280		
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Further interview revealed Resident #1's transfer status should have been revised on the Comprehensive Care Plan to reflect the resident was in the restorative nursing program and was being assisted with one (1) staff member for transfers.

Interview with the Director of Nursing (DON) on 05/07/14 at 7:30 PM, revealed there had been a big turnover in MDS nurses in facility during the past year. She stated two (2) MDS Coordinators had recently left their position and two (2) new MDS Coordinators had just been hired, as well as, a part time MDS Nurse. She stated she was aware the Comprehensive Care Plans had not been revised accurately and they were currently working on the problem.

5. Review of Resident #9's clinical record revealed diagnoses which included Diabetes, Hypertension, Anxiety, and Vascular Dementia.

Review of Resident #9's Quarterly MDS dated 04/16/14, revealed the resident was checked to need extensive assistance with toileting with a one (1) person assist. Continued review of the MDS revealed Resident #9 was assessed by the facility to have a BIMS score of three (3), which indicated severe cognitive impairment. Review of Resident #9's Bowel and Bladder Assessment, dated 01/31/14, revealed the resident was checked to have complete control of the bowel and had seven (7) or more incontinent episodes of urine or at least one (1) episode of urine continence. Continued review revealed Resident #9 was placed on a toileting program to toilet the resident one (1) hour before and after meals, and at bedtime, and every two (2) hours after bedtime.

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F 280	<p>Continued From page 38</p> <p>Review of Resident #9's Comprehensive Care Plan revealed it was last revised on 04/25/14. Review of the Activities of Daily Living (ADL) care plan revealed Resident #9 was continent of bowel and bladder and interventions included assistance of one (1) staff to assist the resident in transferring to the bathroom. Continued review of the ADL care plan, revealed an intervention dated 09/16/13, for Resident #9 to be transferred with a Vera Lift (mechanical stand up lift) with one (1) assist was to be used to "toilet transfer" the resident. Further review revealed no documented evidence of the toileting program or the interventions to toilet the resident one (1) hour before and after meals, and at bedtime, and every two (2) hours after bedtime.</p> <p>Review of "My Daily Care Plan" dated May 2014, which was utilized by the CNA when providing resident care, revealed Resident #9 was on a toileting schedule and staff were to offer to toilet the resident one (1) hour before and after meals, and at bedtime, and every two (2) hours after bedtime.</p> <p>Interview with LPN #8 on 05/07/14 at 4:30 PM, revealed Resident #9 should not toilet without assistance. LPN #8 revealed the CNAs had a care plan they were to follow which stated Resident #9 should be toileted before and after each meal with assist of one (1). He stated he was not certain if this information was on the Comprehensive Care Plan, but if it was not, the care plan should be revised to include the information. LPN #8 reported the MDS Coordinator was responsible for ensuring care plans were revised.</p>	F 280		

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F 280 Continued From page 39
Interview with the Restorative Nurse on 05/07/14 at 2:55 PM, revealed her last assessment of Resident #9 had indicated the resident could participate in a toileting program. She stated Resident #9 needed assistance with transfers to be toileted. She stated MDS should have revised Resident #9's care plan in regards to his/her toileting program.

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Interview with the LPN #7/MDS Coordinator on 05/07/14 at 7:19 PM, revealed MDS was responsible for ensuring residents' Comprehensive Care Plans were updated and revised. She reported Resident #9's Comprehensive Care Plan should have been revised to include the resident's toileting program and the interventions to toilet the resident one (1) hour before and after meals, and at bedtime, and every two (2) hours after bedtime. She stated it was important for the Comprehensive Care Plan to be revised with this information as it alerted staff to Resident #9's toileting need.

Interview with the DON on 05/07/14 at 8:35 PM, revealed Resident #9 should not toilet without assistance. She stated she was not certain if Resident #9's Comprehensive Care Plan should have been revised to reflect the resident's toileting program and interventions.

F 309 483.25 PROVIDE CARE/SERVICES FOR
SS=D HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Resident #1's physician was made aware of the weight gain on May 6, 2014.

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This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of facility policy, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical well being for one (1) of twenty-three (23) sampled residents (Resident #1).

Resident #1 had a Physician's Order to be weighed three (3) times a week, at 6:00 AM on Monday, Wednesday, and Friday. The Physician was to be notified if the resident had more than a five (5) pound weight gain in three (3) days. Review of the weights for April 2014 revealed no documented evidence a weight was obtained on 04/07/14. In addition, from 04/04/14 to 04/09/14 there was an eight (8) pound weight gain, from 04/28/14 to 04/30/14 there was a seven and a half (7.5) pound weight gain, and from 04/30/14 to 05/02/14 there was an eleven (11) pound weight gain. There was no documented evidence the Physician was notified of these weight gains.

The findings include:

Review of the facility policy titled "Resident Weights", revised 06/20/12, revealed it was the responsibility of the nurse assigned to a resident's care to ensure weights were obtained when ordered more often than weekly. Continued review revealed the weights were to be recorded on the Medication Administration Record (MAR).

1. Review of the medical record revealed the

F 309 All residents in the facility that were ordered weights per MD order for diagnosis other than weights obtained per facility policy and MD notification for weight loss/gain reports from dietary, were identified. Resident #1 was the only resident on this list.

Residents requiring weights for diagnoses other than Cardiac/Pulmonary Program will have a specific MAR written for the weighing process; MD ORDERED WEIGHT MAR, stating why the weights were initiated and when/what days the weights are to be obtained. The MAR also instructs the nurse what lift and sling will be utilized to weight the resident and any re-weight needed and when to notify the physician/ARNP if the weight exceeds parameters ordered. The licensed staff were in serviced on this new policy and procedure on May 28, 2014 and June 1, 2014 by the DON and ADON.

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facility admitted Resident #1 with diagnoses which included Portal Hypertension with Chronic Ascites (a condition characterized by an accumulation of fluid, with swelling, in the abdomen), Congestive Heart Failure, Chronic Kidney Disease, and Cirrhosis of the Liver. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/29/14, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of fifteen (15) which indicated no cognitive impairment.

Review of the Physician's Orders for May 2014 revealed an order for weights to be obtained three (3) times a week at 6:00 AM on Monday, Wednesday, and Friday. Continued review revealed an order to notify the Physician if the resident had more than a five (5) pound weight gain in three (3) days. In addition, the resident was to have a measure of abdominal girth every morning at 6:00 AM, related to the resident's history of Ascites. Further review revealed these orders were originally written on 02/12/14, and carried forward each month.

Review of Resident #1's MAR for April 2014 revealed there was no documented evidence a weight was obtained on 04/07/14 (a Monday) as ordered. Further review revealed the resident had a recorded weight of 175 pounds on 04/04/14, and 183 pounds on 04/09/14, which indicated an eight pound weight gain.

Review of the Report of Consultation dated 04/22/14 revealed Resident #1 was seen by Endoscopy and received a paracentesis (a procedure to remove excess fluid that has collected in the abdomen), with six and a half (6.5) liters of fluid removed.

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The Quality Assurance Nurse will complete an audit of MD ordered weights/MD notification weekly for four (4) weeks. If the audit is 100%, the DON will take the audit results to the QA committee meeting the next month and ask to change the audit to quarterly.

06/20/14

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F 309	<p>Continued From page 42</p> <p>Continued review of the MARs for April 2014 and May 2014 revealed a weight recorded on 04/28/14 of 173.5 pounds and a weight recorded on 04/30/14 of 181 pounds, indicating a 7.5 pound weight gain. Continued review revealed a documented weight on 04/30/14 of 181 pounds, and a weight on 05/02/14 of 192 pounds, which reflected an eleven (11) pound weight gain.</p> <p>Review of the Report of Consultation Form for Resident #1, dated 05/05/14, revealed the resident was seen by Endoscopy and Radiology, and another paracentesis was done, with seven (7) liters of fluid removed from the resident's abdomen.</p> <p>Review of the Nurse's Note, dated 05/05/14 at 4:00 PM, revealed Resident #1 had a paracentesis done, with seven (7) liters of fluid removed from the abdomen, and the resident reported it was much easier to breath after the procedure.</p> <p>Although Resident #1 underwent paracentesis on 04/22/14 and 05/05/14, there was no documented evidence the Physician was notified of the weight gains recorded on 04/09/14, 04/30/14, and 05/02/14 as ordered by the Physician.</p> <p>Interview with Licensed Practical Nurse (LPN) #2/Unit Coordinator (UC) where Resident #1 resided, on 05/07/14 at 2:15 PM, revealed the resident's weight should have been documented on 04/07/14; however, she stated she did not review the MARs or TARS on a regular basis and was unaware the weights were not being recorded. She further stated the Physician should have been notified of the weight gains on</p>	F 309		

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F 309	<p>Continued From page 43</p> <p>04/09/14, 04/30/14 and 05/02/14 and the nurse should have assessed the resident and documented any changes in condition related to the weight gains. Continued interview revealed the resident had a history of requiring periodic paracentesis procedures due to a build up of fluid associated with a diagnosis of Cirrhosis of the Liver.</p> <p>Interview with the Director of Nursing (DON), on 05/07/14 at 7:30 PM, revealed it was important for the staff to follow Physician's Orders for Resident #1 related to the resident's diagnoses of Congestive Heart Failure and Cirrhosis of the Liver with Ascites. Further interview revealed staff should be monitoring the weights and notifying the Physician of any changes in the resident's condition, and of any weight gain per the parameters set by the Physician.</p> <p>Interview with the Attending Physician, on 05/07/14 at 5:00 PM, revealed he could not say he was notified of the weight gains if there was no documentation. He stated Resident #1 had weight gains and losses from the abdomen and had required frequent paracentesis. He stated the reason weights were ordered three (3) times a week was to see if the abdomen was picking up fluid and to assess for Ascites due to Cirrhosis of the Liver. Continued interview revealed it was his expectation for the Physician's orders to be followed related to obtaining weights, and to be notified regarding weight gains, as ordered.</p>	F 309		
F 322 SS=D	<p>483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that --</p>	F 322		

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F 322 Continued From page 44

(1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and

(2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review and review of facility's policy, it was determined the facility failed to ensure a resident who received medication through a Gastrostomy Tube (g-tube) received appropriate treatment and services to prevent Aspiration Pneumonia for one (1) Unsampled Resident (Unsampled Resident A).

Observation during medication pass revealed the nurse failed to check for g-tube placement and residual prior to the administration of medication via the g-tube for Unsampled Resident A.

The findings include:

Review of the facility's policy titled, "Specific

F 322

Resident A was monitored by the nursing staff after Resident A received medication through the G tube. Resident A had no aspiration pneumonia, diarrhea, vomiting, dehydration, or metabolic abnormalities as a result of medication given through the G-tube. The tube had been checked for placement earlier by the nurse.

All residents with G-tubes have the potential to be affected by the same scenario.

An in service will be given to all licensed nursing staff by the Staff Development Nurse by June 1, 2014 with a post test. The post test will determine nurse competency with checking placement with auscultation or aspiration.

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F 322 Continued From page 45

Medication Administration Procedures, Enteral Tube Medication Administration", revised 12/07/12, revealed to safely and accurately administer oral medications through an enteral tube; a) verify placement by inserting a small amount of air into the tube with the syringe and listen to the stomach with a stethoscope for gurgling sounds, b) aspirate stomach contents with a syringe.

Review of Unsampled A's medical record revealed diagnoses which included Cerebral Vascular Disease (CVA), and Alzheimer's Disease. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 04/17/14, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of a three (3) indicating cognitive impairment. Further review revealed the facility assessed the resident as having a feeding tube.

Observation of medication pass for Unsampled Resident A on 05/05/14 at 8:20 AM, revealed Licensed Practical Nurse (LPN) #6 did not check for placement of the g-tube prior to the administration of water and medication by placing the stethoscope on the resident's stomach and listening for gurgling sounds while administering air through the g-tube. Additionally, observation revealed LPN #6 did not check for residual tube feeding by aspirating the resident's stomach contents with a syringe prior to the administration of the water or medication. LPN #6 administered thirty (30) milliliters (ml's) of water through a syringe into the resident's g-tube, then administered medications which had been crushed and mixed with water in separate medication cups. The nurse administered each medication separately with water in between each

F 322

New nurses will be specifically oriented to G-tube medication administration and placement verification during the orientation process. Each nurse will take post test to ensure competency.

Quality Assurance will audit two nurses per week checking placement of the tube and administering medications through the tube for four weeks. If 100% compliant the audit will be taken to the QA committee the next month by the DON and asked to be changed to audit new employees only.

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F 322	<p>Continued From page 46</p> <p>medication. The medications included; Aspirin 81 milligrams (mg's) (medication for pain and inflammation), Amlodipine 10 mg's (calcium channel blocker), Cranberry tablet 425 mg's, Donepezil 10 mg's (medication used in the treatment of Alzheimer's disease), folic acid 1 mg (type of B vitamin), Namenda XR 14 mg's (medication used in the treatment of Alzheimer's Disease), ferrous sulfate 220 mg/5 ml-5 ml's (used to treat iron deficiency), Sensipar 30 mg's (calcium sensing receptor agonist), Spironalactone 20 mg's (diuretic), Vitamin B 12 1000 micrograms, and Theravitamin with beta carotene.</p> <p>Interview, on 05/05/14 at 8:40 AM with LPN #6 revealed she had checked for placement of the g-tube and checked for residual tube feeding at 7:30 AM for this resident, but stated she should have checked again prior to administration of the medication since it had been almost an hour.</p> <p>Interview with the Director of Nursing (DON) on 05/06/14 at 8:30 AM, revealed the nurses were to assess for air in the stomach with a stethoscope to check g-tube placement and were to place the syringe in the g-tube and draw back to check for residual tube feeding. Shes stated it was good practice to check for placement of the g-tube and check for residual prior to any medication administration even if the nurse had checked an hour earlier.</p>	F 322		
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives</p>	F 323		

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F 323	<p>Continued From page 47</p> <p>adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the resident environment remained as free of accident hazards as possible and that each resident received adequate supervision and assistance devices to prevent accidents. Observation of residents' rooms, on Unit 2 during the initial tour, revealed toiletries in resident rooms including nail polish remover, deodorant, bath wash, aerosol hair spray, perfume, air freshener, mouth wash, lotions and creams were improperly stored and accessible to wandering and confused residents. In addition, hazardous chemicals were observed unsecured and accessible on the housekeeping cart.</p> <p>The findings include:</p> <p>1. Observations during the initial tour of the facility on 05/04/14 revealed the following accessible toiletries located in resident rooms: in Room 405 at 1:23 PM - Remedy Skin Cream, Cleansing Body Lotion and Mouthwash labeled "Caution Keep out of Reach of Children"; in room 407 at 1:38 PM - aerosol air freshener labeled "Caution Keep out of Reach of Children"; in Room 409 at 1:41 PM - mouthwash labeled "Caution Keep out of Reach of Children"; and in room 411 at 1:44 PM - skin repair cream labeled "Caution Keep out of Reach of Children".</p>	F 323	<p>Hazardous personal items were removed from the residents' rooms by facility staff May 5, 2014 The Virex 256 was placed in the locked box by the housekeeper on May 4, 2014 when it was discovered on the cart.</p> <p>All rooms in the facility were checked by facility personnel on May 6, 2014 to ensure no hazardous chemicals were left out in the residents' rooms or accessible on the housekeeping carts. The Housekeeper involved was in serviced immediately on May 4, 2014. All other Housekeeping staff were in serviced on May 5, 2014 by the Housekeeping Supervisor regarding chemical storage and the locks for cleaning carts.</p> <p>Continuous Quality Improvement Rounds were initiated on May 27, 2014. 7-3 facility staff members are assigned to 3 rooms each for a daily round. Areas reviewed during rounds include resident condition, the room condition, and care areas. Rounds are to be done daily Monday-Friday. For 3-11 and 11-7 Monday through Friday the shift supervisor will select 3 rooms from Unit 1 and 3 rooms from Unit 2 and complete a CQI round sheet. On weekends, supervisors will choose 3 rooms from each unit for each shift and complete a CQI Round sheet. Staff will focus attention to the</p>	

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F 323 Continued From page 48

Further observation on initial tour on 05/04/14 between 1:25 PM and 2:00 PM revealed in Room 501 a container of Lysol Wipes labeled "Hazardous to humans and domestic animals, causes eye irritation", and a bottle of Urea 10% lotion labeled "if swallowed contact poison control right away" were located on the bedside table. In room 502 a tube of Remedy Skin Repair Cream labeled "keep out of reach of children, if swallowed call poison control" was observed. In room 504-A a bottle of Dial Roll-on Deodorant labeled "if swallowed call poison control, two (2) tubes of Skin Repair Cream labeled "Caution keep out of reach of children", and Vita Aerosol Hair Spray labeled "Caution, flammable" were on the bedside stand. In room 504-B a bottle of nail polish remover labeled "call poison control if ingested", and a bottle of Red Door perfume were observed.

Interview with LPN #2/Unit Coordinator, on 05/05/14 at 3:30 PM and 4:00 PM, revealed resident toiletries were to be stored in a labeled bag in their personal drawer, and aerosol cans were not to be in the building. She stated toiletries were not to be left out and accessible to confused residents. Further interview revealed there were several wandering and confused residents on Unit 2, which consisted of the 400, 500 and 600 hallways.

2. Observation of the housekeeping cart, on 05/04/14 at 2:18 PM, revealed Virex II 256 cleaning chemical was open and accessible to residents.

Interview with the Administrator, on 05/04/14 at 2:19 PM, revealed she was in close proximity of the chemical on the housekeeping cart. She

F 323

residents' surroundings, particularly the bedside area and the sink area for hazardous chemicals and toiletries as part of the room condition portion of the CQI round. Completed CQI round sheets are submitted to the DON for review by DON/ADON. After review the forms will be given to the unit coordinators for follow up. Nurses have been educated by the DON and ADON on May 29, 2014 and will begin walking rounds for shift change over on June 1, 2014. Nurses have been educated to focus on resident condition, room condition, and special care areas during their walking round.

QA nurse will audit 5 round sheets from each unit coordinator monthly for 3 months. If 100% compliant the audit will be taken to the next monthly QA committee by the DON to ask that the audit be changed to quarterly. The QA Nurse will also audit housekeeping cleaning carts weekly for four weeks to ensure carts remain locked and no hazardous chemicals are left in resident reach. If audit is 100% compliant it will be taken to the next monthly QA committee meeting and asked to be changed to monthly.

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stated it was her expectation that all chemicals be stored in the lock box on top of the cart.

Interview with the Housekeeping Supervisor on 05/05/14 at 3:45 PM, revealed the Virex II was to be stored in a locked box on top of the housekeeping cart. She stated education on the storage of chemicals was done almost daily, because the chemicals could be harmful to residents if swallowed.

F 323

F 325 483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE
SS=D
Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

F 325

This REQUIREMENT is not met as evidenced by:
Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents maintained acceptable parameters of nutritional status for one (1) of twenty-three (23) sampled residents (Resident #14).

Resident #14 had a dietary recommendation, dated 02/10/14, to discontinue the resident's High Protein/High Calorie Diet; however, the resident

An order was received and noted on April 22, 2014 to change resident #14's diet order to the RD recommendations.

An audit was conducted on all residents' records on 5/29/14 to ensure that all current diet orders recommended by the RD match the physicians order and diet card. The dietary manager will receive a copy of the RD recommendations each week. The unit managers will receive a copy of the recommendations as well. As the unit coordinators get the recommendations approved by the physician, the unit coordinator will write the order and give a copy to the dietary manager. If the physician does not approve the

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continued to receive the diet until 04/21/14.

The findings include:

Review of the facility's policy titled, "Dietary Recommendations", revised 06/14/08, revealed all dietary recommendations were to be completed within seventy-two (72) hours of their receipt. Further review revealed the Dietician would ensure dietary recommendations were placed in the appropriate mailboxes for review, and the forms would contain the actual date the forms were placed in the box. Continued review revealed the Unit Coordinators or their designees were held responsible for contacting the Physician or the Advanced Registered Nurse Practitioner (ARNP) to inform them of the new dietary recommendations received.

Review of Resident #14's record revealed a "Consultant Dietician Weight Change Report: Gain/Loss" form, dated 02/10/14, review of the Nutrition Progress Notes, dated 02/10/14, revealed a new recommendation to discontinue Resident #14's High Protein/High Calorie diet. Continued record review revealed no documented evidence the Physician was notified of the recommendation and no documented evidence Resident #14's diet was changed as recommended. The resident continued to receive the diet until 04/21/14, without evidence of notification to the resident's Physician regarding the Registered Dietician's (RD's) recommendations. Further review of Resident #14's record revealed a Nutrition Progress Note dated 04/21/14, which noted the current RD made recommendations to discontinue the resident's High Calorie/High Protein diet. Review of Resident #14's "Diet

F 325 recommendation, the unit coordinators will notify the dietary manager. The unit coordinator will write a nurses note explaining why the physician chose not to follow the recommendation. The RD or dietary manager will attend weekly Standards of Care meetings to discuss the Weight Loss/Gain Report. The Weight Loss/Gain report is used to alert staff of significant weight gain or loss. It is formulated by the RD after the weights have been obtained by the nursing staff.

The Quality Assurance Nurse will complete an audit of MD ordered weights/MD notification weekly for One month. If 100% compliant, audit results will be taken to the Quality Assurance meeting the next month by the DON to reduce the audit to monthly. After four (4) months of 100% compliance, the DON will take the audit results to the QA committee to be discontinued to semi-annually.

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Order and Communication" report dated 04/22/14 revealed it contained the RD's recommended discontinuance of the resident's High Calorie/High Protein diet.

Interview with the current RD on 05/06/14 at 10:11 AM, revealed the process for making recommendations for residents was for the dietician to complete a recommendation on the Consultant Dietician Weight Change Report: Gain/Loss form. This form was to be submitted to the resident's Physician, to the nurses, and to the Dietary Manager. She further stated the report showed if or when a special diet should have been discontinued. Continued interview revealed, based on her review of Resident #14's dietary records, the resident's High Calorie - High Protein diet should have been discontinued in February 2014, as recommended. She was not sure if the Physician received the RD's recommendations in February 2014.

Interview with the Director of Nursing (DON), on 05/06/14 at 11:46 AM, revealed the facility's process for handling dietary recommendations was to attach the recommendation to the "Nutritional Recommendations Pine Meadows Health Care" Form. She stated it was her expectation when the dietician wrote a recommendation, the DON, Assistant DON and both Unit Coordinators got a copy, as well as the Dietary Manager. She stated distribution of the dietician's recommendation were missed on the Physician's Order recommendations, and the facility took their orders from the Physician.

Interview with Resident #14's Physician, on 05/07/14 at 5:00 PM, revealed if the resident had dietary orders, the facility should execute the

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F 325 Continued From page 52
order. He stated he did not have to see the order until the nurses reviewed the recommendations. Continued interview revealed he usually signed off on the recommendation unless he did not agree. He further stated the Dietician did her job; the disconnect happened between the Dietary Manager and the nurses.

F 325

F 328 483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS
SS=D

- The facility must ensure that residents receive proper treatment and care for the following special services:
- Injections;
 - Parenteral and enteral fluids;
 - Colostomy, ureterostomy, or ileostomy care;
 - Tracheostomy care;
 - Tracheal suctioning;
 - Respiratory care;
 - Foot care; and
 - Prostheses.

F 328

Resident #13's oxygen tubing was changed out on May 4, 2014.

All residents with oxygen tubing had their tubing changed out and new storage bags put in place and dated with a pink sticker on the tubing on May 6, 2014 by Central Supply Coordinator.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility's policy, it was determined the facility

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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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
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F 328 Continued From page 53
failed to ensure respiratory equipment was clean and stored appropriately in a manner to prevent the spread of infection for one (1) of twenty (20) sampled residents (Resident #13). The staff failed to ensure Resident #13's nasal cannula and oxygen tubing was not touching the floor and appropriate equipment to store the cannula was provided.

The findings include:

Review of the facility's "Oxygen Administration" policy, undated, revealed oxygen equipment, masks, tubing and cannulas, should be checked at regular intervals and cleaned. The policy did not address how oxygen tubing was to be stored when not in use or how often the oxygen tubing was to be changed.

Observation, on 05/04/14 at 4:28 PM, revealed Resident #13's oxygen tubing was on the floor under his/her bedside toilet. When the resident was asked if he/she had been educated on the proper storage of his/her oxygen tubing, the resident stated he/she had been educated and was told not to leave the tubing in the floor and to keep it in the bag provided. Resident #13 stated he/she did not know why the tubing was on the floor. Further observation revealed the oxygen tubing was undated, and the oxygen bag provided for the tubing was ripped.

Interview with Licensed Practical Nurse (LPN) #2/Unit Coordinator (UC), on 05/05/14 at 4:00 PM, revealed it was facility policy to store the oxygen tubing in a plastic bag with a label and date and she would find out how often the oxygen tubing was to be changed. Further interview with LPN #2/UC, on 05/05/14 at 4:35 PM, revealed the

F 328
All oxygen tubing will be changed out weekly by the Central Supply Coordinator with a new storage bag. Bags will be dated with a marker and tubing is dated with a pink sticker. If tubing is found on the floor, it will be changed immediately by the nurse and will be dated with a pink sticker. All nursing staff will be in serviced on oxygen tubing storage by June 1, 2014

QA Nurse will audit five (5) resident's oxygen tubing and bags for dates and that they have been changed at least weekly. This audit will be completed weekly for four weeks. If audits are 100% compliant for four weeks audit results will be taken to the next months QA meeting by the DON and ask to be changed to monthly.

06/30/14

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NAME OF PROVIDER OR SUPPLIER PROVIDENCE PINE MEADOWS	STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504
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F 328	<p>Continued From page 54</p> <p>oxygen tubing, filter and bag were to be changed every Tuesday or as needed.</p> <p>Interview with the Director of Nursing (DON), on 05/07/14 at 8:01 PM, revealed it was her expectation for oxygen tubing to be stored in the appropriate concentrator bag. She stated there should be a separate bag and tubing for the wheelchair. She further stated it was her expectation that the oxygen bags and oxygen tubing were changed weekly and dated. Continued interview revealed if the tubing was dropped on the floor, staff should change the tubing immediately.</p>	F 328		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Plan approval: 1989, 1996 Survey under: NFPA 101 (2000 Edition) Facility type: SNF/NF Type of structure: Type V (000) Smoke Compartments: Seven (7) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors and basement. Sprinkler System: Complete sprinkler system (dry). Generator: Type 2 generator powered by natural gas installed in 1989 A Standard Life Safety Code Survey was initiated and concluded on 05/07/14, for compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The facility was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 038	NFPA 101 LIFE SAFETY CODE STANDARD	K 038		

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MAY 30 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator (X6) DATE 5/29/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038 Continued From page 2
maintained
free of all obstructions or impediments to full instant use in the case of fire or other emergency.
7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.
7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.
Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.
Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.
Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.

K 038

K 064 SS=D CMS S&C letter 5-38
NFPA 101 LIFE SAFETY CODE STANDARD
Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10

This STANDARD is not met as evidenced by:

K 064 No residents were affected.

All extinguishers were checked May 13, 2014 to ensure this 6 year compliance inspection was completed.

On May 13, 2014 American Fire and Security inspected and updated all extinguishers to ensure 6 year compliance was completed.

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K 064 Continued From page 3
Based on observation and interview it was determined the facility failed to ensure fire extinguishers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of seven (7) smoke compartments, twenty-two (22) residents, staff and visitors.

The findings include:

Observation, on 05/07/2014 at 12:21 PM, revealed a fire extinguisher near room 312 which did not have a six (6) year service tag. Further observation revealed the fire extinguisher was dated 2008. Interview with the Maintenance Director, at the time of observation, revealed he relied on an outside contractor to perform maintenance and yearly inspection of fire extinguishers. He stated he was unaware the fire extinguishers were out of compliance for the six (6) year maintenance.

Reference: NFPA 10 (1998 Edition).

4-4.3* Six-Year Maintenance. Every 6 years, stored-pressure fire extinguishers that require a 12-year hydrostatic test shall be emptied and subjected to the applicable maintenance procedures. The removal of agent from halon agent fire extinguishers shall only be done using a listed halon closed recovery system. When the applicable maintenance procedures are performed during periodic recharging or hydrostatic testing, the 6-year requirement shall begin from that date.

Exception: Nonrechargeable fire extinguishers shall not be hydrostatically tested but shall be removed from service at a maximum interval of

K 064 A yearly inspection of all fire extinguishers will be completed by the Maintenance Director or assistant to ensure fire extinguishers have a six year compliance inspection.

5/14/14

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K 064	Continued From page 4 12 years from the date of manufacture. Nonrechargeable halon agent fire extinguishers shall be disposed of in accordance with 4-3.3.3. 4-4.4* Maintenance Recordkeeping. Each fire extinguisher shall have a tag or label securely attached that indicates the month and year the maintenance was performed and that identifies the person performing the service. 4-4.4.1* Fire extinguishers that pass the applicable 6-year requirement of 4-4.3 shall have the maintenance information recorded on a suitable metallic label or equally durable material having a minimum size of 2 in. x 3 1/2 in. (5.1 cm x 8.9 cm). The new label shall be affixed to the shell by a heatless process, and any old maintenance labels shall be removed. These labels shall be of the self-destructive type when removal from a fire extinguisher is attempted. The label shall include the following information: (a) Month and year the maintenance was performed, indicated by a perforation such as is done by a hand punch (b) Name or initials of person performing the maintenance and name of agency performing the maintenance. 4-4.4.2* Verification of Service (Maintenance or Recharging). Each extinguisher that has undergone maintenance that includes internal examination or that has been recharged (see 4-5.5) shall have a "Verification of Service" collar located around the neck of the container. The collar shall contain a single circular piece of uninterrupted material forming a hole of a size that will not permit the collar assembly to move	K 064		

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K 064 Continued From page 5
over the neck of the container unless the valve is completely removed. The collar shall not interfere with the operation of the fire extinguisher. The "Verification of Service" collar shall include the month and year the service was performed, indicated by a perforation such as is done by a hand punch.

Exception No. 1: Fire extinguishers undergoing maintenance before January 1, 1999.

Exception No. 2: Cartridge/cylinder-operated fire extinguishers do not require a "Verification of Service" collar.

K 064