

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

PRINTED: 02/23/2011  
FORM APPROVED  
OMB NO. 0938-0391

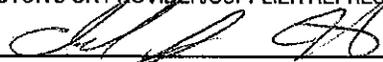
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185215	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C 02/10/2011
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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE	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)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS  A Standard Re-certification Survey and an Abbreviated Survey investigating ARO KY00015848 was initiated on 02/08/11 and concluded on 02/10/11. ARO ##KY00015848 was substantiated with deficiencies cited. Deficiencies were cited at 42 CFR 483.10 Resident Rights. The highest Scope and Severity of an "E". A Life Safety Code Survey was conducted on 02/10/11.	F 000	F159 1. All resident trust fund accounts underwent a forensic audit by an outside certified accounting firm. Any resident trust fund account found to be affected was refunded the amount of discrepancy.  2. An audit of all resident trust fund accounts was completed by a certified accounting firm to determine if other residents were affected.	
F 159 SS=D	483.10(c)(2)-(5) FACILITY MANAGEMENT OF PERSONAL FUNDS  Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section.  The facility must deposit any resident's personal funds in excess of \$50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.)  The facility must maintain a resident's personal funds that do not exceed \$50 in a non-interest bearing account, interest-bearing account, or petty cash fund.  The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf.	F 159	3. Beginning in August 2010, the accounting software for Pine Meadows Health Care was transferred to the corporate office to handle all postings of monthly resident trust transactions. As a result, copies of all deposits, check stubs, cash receipts and cash count logs are sent to the corporate office, which are then entered and reconciled against the bank statement on a monthly basis. The bank bank statement is sent directly to the corporate office along with scanned copies of check withdrawals. The representative at the corporate office does not have check writing capability, nor has access to cash funds at the facility. This process also allows additional monthly monitoring of transactions since the corporate representative sees the type of withdrawals that are occurring on a weekly/ monthly basis.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 3-8-11
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  PINE MEADOWS HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1608 HILL RISE DRIVE LEXINGTON, KY 40504		
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F 159	<p>Continued From page 1</p> <p>The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.</p> <p>The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative.</p> <p>The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches \$200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to have an effective system in place to hold, safeguard, manage, and account for the personal funds of residents in the facility as evidenced by a facility audit that uncovered misappropriation of residents' personal funds.</p> <p>The findings include: Review of the the facility's policy related to Abuse/Neglect/Misappropriation, updated 10/99, revealed "Misappropriation of resident property" is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's personal belongings or money without the resident's consent.</p>	F 159	<p>The quarterly Resident Trust Fund statements are generated from the corporate office and sent to Pine Meadows for distribution to residents and/or responsible parties. Effective July 2010, Pine Meadows ordered new Resident Trust Fund checks which require two-person signatures. The facility representative who is responsible for disbursing cash to residents is not permitted to be a signer on the account.</p> <p>4. The corporate billing manager will conduct an audit to ensure compliance every month for the first three months and every three months thereafter. This audit will include a review to ensure all policies and procedures are being followed. The audit will include a sampling of transactions to ensure accuracy of resident signatures on cash receipts and verification that withdrawals from resident trust are valid via interviews with staff and/or residents. Once determined via the audit process that policies and procedures are being followed then the audits will eventually decrease to bi-annual audits.</p> <p>Completion date:</p>	3/16/2011	

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F 159	<p>Continued From page 2</p> <p>During the review of the Residents' Personal Funds Accounts, it was noted the ledger with the accounting of residents' personal funds only went back to 07/10; and it was also noted the current bookkeeper had started in 07/10. Interview on 02/10/11, at 11:30 AM, with the Bookkeeper revealed the corporate office had all the ledgers for the residents' funds accounts prior to 07/10. She stated the corporate office took the information prior to 07/10 to do an audit due to the discovery of misappropriation of residents' personal funds.</p> <p>Interview with the Corporation President on 02/10/11 at 4:20 PM revealed the previous Administrator had discovered some discrepancies while doing an audit of the "petty cash" account at the facility and reported it to the corporation. He further stated, he went to the facility and could not find the residents' funds files. Further interview revealed he contacted the police and employed a firm to do the forensic accounting which discovered the residents' funds account had been misappropriated by the facility's bookkeeper, who no longer was employed, for more than \$50,000.00. Further interview revealed the facility failed to have an effective auditing system in place to identify the misappropriation during routine annual audits of the residents' funds account.</p> <p>These findings were referred to the Special Investigations Office, the Attorney General's Office, Department of Community Based Services, and the Police.</p>	F 159		
F 224 SS=D	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN	F 224		

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F 224	<p>Continued From page 3</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to implement the facility's policy that prohibits against misappropriation of resident property by failing to have an effective system in place to hold, safeguard, manage, and account for the personal funds of residents in the facility as evidenced by a facility audit that uncovered misappropriation of residents' personal funds.</p> <p>The findings include:</p> <p>Review of the the facility's policy related to Abuse/Neglect/Misappropriation, updated 10/99, revealed "Misappropriation of resident property" is defined as the patterned or deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's personal belongings or money without the resident's consent.</p> <p>During the review of the Residents' Personal Funds Accounts, it was noted the ledger with the accounting of residents' personal funds only went back to 07/10 and the current bookkeeper had started in 07/10. Interview on 02/10/11, at 11:30 AM, with the Bookkeeper revealed the corporate office had all the ledgers for the residents' funds accounts prior to 07/10. She stated the corporate</p>	F 224	<p>F224</p> <ol style="list-style-type: none"> <li>1. All Resident Trust Fund accounts underwent a forensic audit by an outside, certified accounting firm. Any Resident Trust fund account found to be affected was refunded the amount of discrepancy.</li> <li>2. An audit of all Resident trust Fund accounts was completed by a certified accounting firm to determine if other residents were affected.</li> <li>3. Beginning in August 2010, the accounting software for Pine Meadows Health Care was transferred to the corporate office to handle all postings of monthly resident trust transactions. As a result, copies of all deposits, check stubs, cash receipts and cash count logs are sent to the corporate office, which are then entered and reconciled against the bank statement on a monthly basis. The bank statement is sent directly to the corporate office along with scanned copies of check withdrawals. The representative at the corporate office does not have check writing capability, nor has access to cash funds at the facility. This process also allows additional monthly monitoring of transactions since the corporate representative sees the type of withdrawals that are occurring on a</li> </ol>	
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F 224	Continued From page 4 office took the information prior to 07/10 to do an audit due to the discovery of misappropriation of residents' personal funds.  Interview with the Corporation President on 02/10/11 at 4:20 PM revealed the previous Administrator discovered some discrepancies while doing an audit of the "petty cash" account at the facility and reported it to the corporation. He further stated, he went to the facility and could not find the residents' funds files. Interview further revealed he contacted the police and employed a firm to do the forensic accounting which discovered the residents' funds account had been misappropriated, by the facility's bookkeeper, who was no longer employed by the facility, for more than \$50,000.00. Further interview revealed the facility failed to have an effective auditing system in place to identify the misappropriation during routine annual audits of the residents' funds account.  These findings were referred to the Special Investigations Office, the Attorney General's Office, Department of Community Based Services, and the Police.	F 224	weekly/monthly basis. The quarterly Resident Trust Fund statements are generated from the corporate office and sent to Pine Meadows for distribution to residents and/or responsible parties. Effective July 2010, Pine Meadows ordered new Resident Trust fund checks which require two-person signatures. The facility representative who is responsible for disbursing cash to residents is not permitted to be a signer on the account.  4. The corporate billing manager will conduct an audit to ensure compliance every month for the first three months and every three months thereafter. This audit will include a sampling of transactions to ensure accuracy of resident signatures on cash receipts and verification that withdrawals from resident trust are valid via interviews with staff and/or residents.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225	Once determined via the audit process that policies and procedures are being followed then the audits will eventually decrease to bi-annual audits.  Completion date:	3/16/2011	

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F 225	<p>Continued From page 5 other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to follow its policy on reporting misappropriations to the State Agencies for one (1) of twenty three (23) sampled residents (Resident # 19).</p> <p>The findings include:  Review of Resident#19's Medical Record revealed he/she was admitted on 10/15/10 with</p>	F 225	<p>F225</p> <ol style="list-style-type: none"> <li>The article that resident #19 allegedly had missing was reported to Senior Crime Stoppers, to the resident's family and the alleged missing amount was reimbursed to resident #19.</li> <li>There are no other reportable instances at this time involving other residents.</li> <li>The facility policy on misappropriations of resident property was revised to state that any alleged misappropriation of property will be reported to the appropriate state agencies immediately. The facility will then report the findings of the investigation within five (5) working days. The administration and all facility staff will be in-serviced by Crime Stoppers on 3/21/2011 on the topic of deterring any and all theft in the facility. The corporate Director of Operations in-serviced the facility Administrator on 2/20/2011 on facility Abuse, Neglect and Misappropriation of Resident Property. All other staff will be in-serviced on the policy revision on 3/21/2011.</li> <li>The Administrator will receive all missing article reports from Social Services to ensure appropriate agencies are notified if the items cannot be located within the time frame stipulated by policy revision.</li> </ol>	
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F 225	<p>Continued From page 6</p> <p>diagnoses which included Atrial Fibrillation, Deep Vein Thrombosis, Hypertension and Coronary Artery Disease.</p> <p>Review of the facility's "Missing Item Report" dated 01/13/11, revealed Resident #19 reported forty (\$40.00) dollars missing from his/her locked box between bedtime on 01/12/11 and 1:00 PM on 01/13/11. Further review revealed the resident was interviewed, the Administrator and Resident #19's niece were notified. However, the appropriate State agencies were not notified.</p> <p>Interview with the Social Services Director on 02/10/11 at 11:45 AM revealed she had no answer as to why the appropriate State Agencies were not notified.</p> <p>Interview with the Director of Nursing, on 02/10/11 at 4:25 PM, revealed the Administrator and Social Services Director were responsible for reporting misappropriations to the State Agencies.</p> <p>Interview with the Administrator, on 02/10/11 at 4:45 PM revealed he was unsure of the facility's policy or why he did not follow the policy in reporting misappropriations.</p> <p>Review of the facility's policy regarding reporting theft/misappropriations revealed the appropriate State Agencies should be notified. Further review of the facility's policy revealed it failed to identify when the State Agencies should be notified.</p>	F 225	<p>The Administrator will be responsible for compliance.</p> <p>Completion date:</p>	3/22/2011	

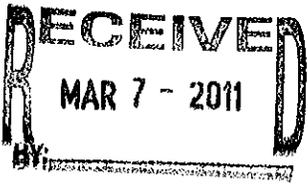
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K 000	<p><b>INITIAL COMMENTS</b></p> <p>A Life Safety Code survey was initiated and concluded on February 10, 2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was at an "E" level.</p>	K 000		
K 018 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <div data-bbox="379 1280 687 1466" style="text-align: center;">  </div> <p>This STANDARD is not met as evidenced by: Based on observation and interview on 2/10/2011, it was determined the facility failed to ensure the corridor doors were capable of resisting the passage of smoke. This deficiency has the potential to affect all residents and staff in Zone 2</p>	K 018	<p><b>K018</b></p> <ol style="list-style-type: none"> <li>The fire doors on zone 2 &amp; 3 of facility were brought to compliance by our maintenance department the day of survey, 2/10/11.</li> <li>All fire doors in the facility were checked by facility maintenance department to ensure they closed properly to prevent smoke from passing through gap.</li> <li>The maintenance department will conduct smoke gap checks on all fire doors monthly x 6 months and quarterly thereafter to ensure proper closure. Results will be logged and problems found will be corrected.</li> <li>Records will be reviewed by Quality Assurance during Quality Assurance audits. The facility Administrator will be responsible for overseeing compliance.</li> </ol> <p>Completion date:</p>	2/14/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER/REPRESENTATIVE'S SIGNATURE  	TITLE  <i>Administrator</i>	(X8) DATE  <i>3-8-11</i>
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K 018	Continued From page 1 and Zone 3. The facility is licensed for one hundred twenty beds (120) beds and the census on the day of the survey was one hundred thirteen (113) residents.  The findings include:  Observation on 2/10/2011 at 10:25 AM with the Maintenance Director, revealed the fire doors between Zone 2 and Zone 3 failed to close all the way to resist the passage of smoke.  Interview with the Maintenance Director on 2/10/2011 at 10:25 AM, indicated that he was unaware that the doors were not closing properly.	K 018		
K 073 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview on 2/10/2011, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards. The deficiency has the potential to affect all residents and staff in Zone 5. The facility is licensed for one hundred twenty beds (120) and the census on the day of the survey was one hundred thirteen (113).  The findings include:  Observation on 2/10/2011 at 10:00 AM with the Maintenance Director, revealed three resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 503, 504, and 506.	K 073	K073  1. The door decorations on the doors to 503, 504 & 506 were removed by facility maintenance department the day of survey, 2/10/11.  2. All resident rooms were checked by facility maintenance department to ensure no other hanging decorations on resident doors were placed without being properly treated to make decorations flame retardant.  3. A letter will be provided to all current residents & added to the admission packet for all future residents, explaining the Policy & Procedure for fireproofing door decorations.	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185215</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>02/10/2011</b>
NAME OF PROVIDER OR SUPPLIER  <b>PINE MEADOWS HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1608 HILL RISE DRIVE LEXINGTON, KY 40504</b>	
(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)	(X6) COMPLETION DATE
K 073	Continued From page 2  Interview with the Maintenance Director on 2/10/2011 at 10:00 AM, revealed they did not have a written policy for treating the decorations with a flame-retardant material.  Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	All department heads were in-serviced on this practice.  4. The safety committee will audit compliance of the regulation monthly. The facility Administrator will oversee compliance.  Completion date:	2/14/2011