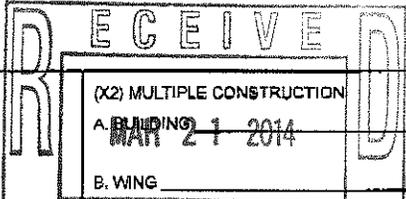


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 03/11/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185094	(X2) MULTIPLE CONSTRUCTION A. BUILDING <u>21</u> 2014 B. WING _____	(X3) DATE SURVEY COMPLETED C 02/25/2014
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	DIVISION OF HEALTH SERVICES Southern Enforcement Branch STREET ADDRESS, CITY, STATE, ZIP CODE 265 SOUTH MAYO TRAIL PIKEVILLE, KY 41601
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F 000 F 514 SS=E	<p>INITIAL COMMENTS</p> <p>An abbreviated standard survey (KY21309) was initiated on 02/24/14 and concluded on 02/25/14. The complaint was substantiated with deficient practice identified at "E" level.</p> <p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain clinical records for three of three sampled residents (Residents #1, #2, and #3) that were complete, accurate, and in accordance with accepted professional standards and practices. A review of the medical records for Residents #1, #2, and #3 revealed staff was to turn and reposition the residents "every two hours." However, a review of the facility's documentation revealed no evidence staff had turned and repositioned</p>	F 000 F 514	<p>Disclaimer:</p> <p>Signature Healthcare of Pikeville does not believe and does not admit that any deficiencies existed either, 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 be 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.</p>	4/4/14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE 3/21/14

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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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41501	
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F 514	<p>Continued From page 1</p> <p>Resident #1, Resident #2, and Resident #3 in October 2013, November 2013, and January 2014, as planned. In addition, a review of physicians orders dated 01/28/14, revealed Resident #1 was scheduled to have an outpatient procedure at a local hospital on 02/06/14 and was to have nothing "by mouth" after midnight on 02/05/14. In addition, the resident had physician orders for a pureed diet and one can of Jevity (dietary supplement) every six hours. However, a review the Medication Administration Record (MAR) for Resident #1, dated February 2014, revealed the resident received medications and tube feedings at 8:00 AM on 02/06/14. Continued review of the MAR for February 2014 revealed no documented evidence staff had administered feedings through Resident #1's gastrostomy tube at 8:00 PM on February 14th, 19th, and 22nd as ordered by the physician. In addition, the physician had requested staff to flush Resident #1's Gastrostomy tube with water every four hours. However, a review of the MAR revealed staff failed to document the administration of the water through the resident's gastrostomy tube on 02/13/14 at 8:00 PM.</p> <p>The findings include:</p> <p>A review of the facility policy titled Charting and Documentation, with a revision date of April 2008, revealed staff was required to document all services provided in the resident's clinical record including the administration of medications and services.</p> <p>1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 07/20/09 with diagnoses that included Alzheimer's, Dysphagia, and Failure to Thrive. A</p>	F 514	<p>F 514 Res Records- Complete/Accurate/Accessible</p> <p>The facility will maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record will maintain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>Resident's Affected:</p> <p>Residents 1, 2 and 3 were turned and repositioned, DON, ADONs, SDC, were provided with education by the Regional Nurse on 2/25/14 in regards to maintaining clinical records, documentation and expectations. Documentation now reflects care is being delivered to meet each residents care needs as outlined in their CNA care plans. Resident #1 was immediately assessed for any s/s of adverse effects of noted medication errors along with omission/erroneous documentation for Tube feeding and flushes. MD/POA notified of medication errors along with omission/erroneous documentation for tube feedings and flushes. Documentation now reflects that resident is receiving medications/tube feeding and flushes as per MD orders. All Nursing Staff will be educated/trained by the SDC on documentation to validate that residents received care as per MD orders and outlined in the care plan by 4/1/14. The facility will ensure residents are turned and repositioned every two hours and the facility will provide evidence and documentation that turning and repositioning is completed. Furthermore the facility will ensure resident's Medication</p>	

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F 514	<p>Continued From page 2</p> <p>review of an Annual Minimum Data Set Assessment dated 12/25/13 revealed Resident #1 required extensive assistance of two staff members with transferring and bed mobility. The assessment also revealed the resident was at high risk for the development of pressure sores.</p> <p>A review of the Comprehensive Care Plan for Resident #1, last revised on 01/07/14, revealed the resident was at risk for the development of skin breakdown. The Care Plan further revealed staff was to assist the resident to reposition in an effort to relieve pressure "as needed."</p> <p>A review of the Nurse Aide Care Plan for Resident #1 dated October 2013, November 2013, and January 2014 revealed staff was required to turn and reposition the resident every two hours. A review of the validation of care provided to Resident #1 as outlined in the Nurse Aide Care Plan revealed the resident should have been turned every two hours, on all three shifts (7AM-3PM, 3PM-11PM, and 11PM-7AM) in October 2013, November 2013, and January 2014.</p> <p>A review of the Nurse Aide Care Plan dated October 2013 revealed staff should have turned and repositioned Resident #1 every two hours, for a total of 93 shifts. However, a review of facility documentation revealed no evidence the resident was turned as required for 18 of the 93 shifts. A review of the Nurse Aide Care Plan dated November 2013 revealed staff should have turned and repositioned the resident every two hours for a total of 90 shifts. However, a review of facility documentation revealed no evidence the resident was turned as required for 28 of 90 shifts. Continued review of Resident #1's Nurse</p>	F 514	<p>Administration Records are complete and accurate.</p> <p>Resident's Potentially Affected: Residents have the potential to be affective by this practice. 100% audit will be completed by the DON, ADONs, SDC, MDS, by 4/1/14 on C.N.A. Care Plans and Medication Administration Records as it relates to: Medications, Tube Feedings, Tube feeding flushes and compliance with policy and procedure, state and federal regulations. 100% of clinical records, to include physician orders, MARs, TARs, and C.N.A. care plans, will be audited by nursing administration team for correctness and compliance by 4/1/14.</p> <p>Systemic Measures: CNA's will be educated/trained by the SDC by 4/1/14 on turning and repositioning residents and documenting on the C.N.A. care plans. Nursing licensed staff will be educated/trained by SDC by 4/1/14 on appropriate MAR documentation and compliance, Nasogastric/Gastromy Tube policy and procedures and medication administration policy and procedure. C.N.A.s will review C.N.A. Care Plans together at shift change to ensure turning and repositioning documentation is complete and accurate. Licensed staff will review Medication Administration Records, Tube Feedings and Flushes of Gastrostomy Tube Records at shift change to ensure compliance with policy and procedure, state and federal regulations. The ADONs on north and south wing nurses stations will review clinical records documentation, to include the physician orders, MARs, TARs, and C.N.A. care plans, at minimum 3 times a week to ensure documentation is complete and accurate.</p>	

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F 514	<p>Continued From page 3</p> <p>Aide Care Plan revealed staff should have turned and repositioned Resident #1 every two hours, for a total of 93 shifts, in January 2014. However, a review of documentation revealed no evidence the resident was turned and repositioned for 13 of 93 shifts.</p> <p>An interview with State Registered Nurse Aide (SRNA) #1 on 02/25/14 at 11:20 AM revealed she had not provided care to Resident #1 on the days the turns had not been documented. However, SRNA #1 stated she, and all CNAs at the facility, had been trained to review and sign the Nurse Aide Care Plans every shift to validate care had been provided. SRNA #1 stated she documented every shift as required.</p> <p>In addition, continued review of Resident #1's medical record revealed physician orders for the resident to receive a pureed diet and for staff to administer one can of Jevity to the resident every six hours. Continued review of the physician orders also revealed staff was to flush the resident's gastrostomy tube with 250 cubic centimeters (cc) of water every four hours.</p> <p>Review of the medical record revealed on 01/28/14, the resident's physician had requested the resident to have nothing "by mouth" "after midnight" on 02/05/14 due to an outpatient procedure scheduled for 02/06/14. However, a review of the resident's Medication Administration Record (MAR), dated February 2014, revealed the resident received Levothyroxine 75 micrograms (mcg), a thyroid medication, and tube feedings at 6:00 AM on 02/06/14.</p> <p>In addition, review of the MAR dated February 2014 revealed staff failed to document the</p>	F 514	<p>Monitoring Measures:</p> <p>The ADONs on north and south wing nurses stations will review clinical records documentation, to include the physician orders, MARS, TARs, and C.N.A. care plans, at minimum 3 times a week to ensure documentation is complete and accurate along with Tube Feedings and Flushes of Gastrostomy Tube Records, at minimum 3 times a week to ensure documentation is complete and accurate. Effective 4/1/14 the DON will audit 20% of resident's records for 4 weeks to ensure documentation is complete and accurate. The audit will include, C.N.A. Care Plans, Medication Administration Record, Tube Feedings and Flushes of Gastrostomy Tube documentation. Beginning 5/1/14 the DON will audit 10% of resident's records for 4 weeks to ensure documentation is complete and accurate. The audit will include, C.N.A. Care Plans, Medication Administration Record, Tube Feedings and Flushes of Gastrostomy Tube documentation. Beginning 6/1/14 the DON will audit 5% of resident's records for 4 weeks to ensure documentation is complete and accurate. The audit will include, C.N.A. Care Plans, Medication Administration Record, Tube Feedings and Flushes of Gastrostomy Tube documentation. Results from audits will be brought to the monthly QA Committee for review for 3 months or until deficient practice is corrected.</p>	

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41601		
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F 514	<p>Continued From page 4</p> <p>administration of tube feeding for Resident #1, as ordered by the physician, on February 14th, 19th, and 22nd at 8:00 PM. Continued review of the MAR revealed facility staff failed to document they had flushed the resident's gastrostomy with water on 02/13/14, at 8:00 PM, as ordered by the physician.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 02/24/14 at 7:10 PM revealed she had been assigned to provide care to Resident #1 on the morning of 02/06/14, when Resident #1 had physician orders to have "nothing by mouth." The LPN acknowledged she had signed Resident #1's MAR on 02/06/14 at 6:00 AM to acknowledge she had administered the resident's tube feeding and the 6:00 AM dose of 75 mcg of Levothyroxine, a thyroid medication. However, the LPN stated she had not administered the resident's medication or tube feeding at 6:00 AM on 02/06/14 and had forgotten to "circle" the 6:00 AM medication and feeding to indicate the medication and tube feeding had been "held." LPN #1 further stated she had been trained to document accurately when medications were administered or held but "forgot" to do so. Continued interview with LPN #1 revealed she had also been assigned to provide care to Resident #1 on February 14th, 19th, and 22nd, when there was no documented evidence the resident received tube feedings as ordered by the physician. LPN #1 stated she had administered the resident's tube feedings as ordered by the physician but acknowledged she had failed to accurately document in the resident's medical record. LPN #1 stated she should have documented the resident's feedings as administered when care was provided.</p> <p>2. Review of Resident #2's medical record</p>	F 514			

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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF PIKEVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 260 SOUTH MAYO TRAIL PIKEVILLE, KY 41601
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F 514	<p>Continued From page 5</p> <p>revealed the facility admitted the resident on 09/19/13 with diagnoses that included Aneurysm, Generalized Muscle Weakness, History of Cardiovascular Accident, and a History of a Craniotomy. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 12/18/13, revealed the facility assessed Resident #2 to be cognitively impaired with impaired decision-making skills. The assessment also revealed the resident required extensive assistance of two staff members with transferring and bed mobility.</p> <p>A review of Resident #2's medical record revealed staff had revised the Comprehensive Care Plan on 12/15/13 and noted the resident was at risk for the development of skin breakdown. The Care Plan further revealed staff was to assist the resident to turn and reposition to relieve pressure on an "as needed" basis.</p> <p>A review of Resident #2's Nurse Aide Care Plan for October 2013, November 2013, and January 2014 revealed staff was required to turn and reposition the resident every two hours. A review of the validation of care provided to Resident #2 as outlined in the Nurse Aide Care Plan revealed staff should have turned the resident every two hours on all three shifts (7 AM-3 PM, 3 PM-11 PM, and 11 PM-7 AM) in October 2013, November 2013, and January 2014.</p> <p>However, review of the Nurse Aide Care Plan for Resident #2 dated October 2013 revealed staff failed to document the resident was turned every two hours for 15 of the 93 shifts in October 2013. A review of the Nurse Aide Care Plan for Resident #2 dated November 2013 revealed staff failed to document the resident was turned every</p>	F 514		
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F 514	<p>Continued From page 6</p> <p>two hours for 21 of the 90 shifts in November 2013. A review of the Nurse Aide Care Plan for Resident #2 dated January 2014 revealed staff failed to document the resident was turned every two hours for 12 of the 93 shifts in January 2014.</p> <p>3. Review of Resident #3's medical record revealed the facility admitted the resident on 11/09/13 with diagnoses that included Atrial Fibrillation, Diabetes, Congestive Heart Failure, Coronary Artery Disease, Chronic Kidney Disease, Dysphagia, and a Percutaneous Endoscopic Gastronomy Tube (feeding tube). Review of the Minimum Data Set (MDS) assessment dated 12/22/13 revealed the facility assessed Resident #3 to be cognitively impaired and had impaired decision-making skills. The assessment also revealed the resident required extensive assistance of two staff members with transferring and bed mobility.</p> <p>A review of the Nurse Aide Care Plan for Resident #3 dated November 2013 revealed staff failed to document the resident was turned every two hours for 13 of the 90 shifts in November 2013. A review of the Nurse Aide Care Plan for Resident #3 dated January 2014 revealed staff failed to document the resident was turned every two hours for 25 of the 93 shifts.</p> <p>An interview with the Director of Nursing (DON) on 02/25/14 at 12:20 PM revealed staff had been trained to document medications, tube feedings, and flushes on the resident's MAR when the care was provided to the residents. Further interview with the DON revealed facility State Registered Nurse Aides (SRNAs) had been trained and were required to validate the residents' care had been provided as outlined in the Care Plan, by signing</p>	F 514		

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F 514	Continued From page 7 the Nurse Aide Care Plans every shift. The DON stated the residents' medical records should be accurate and complete, related to the care and services received while in the facility. The DON further stated she ensured medical records were complete and accurate by conducting random "spot checks." However, the DON had not identified any concerns with facility documentation. An interview with the Administrator on 02/25/14 at 12:35 PM revealed facility staff was required to accurately document when care was provided to facility residents. The Administrator stated the facility had not identified any concerns related to the failure of staff to document services provided.	F 514			