	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100020	A. BUILDING; B. WING	COMPLE R-C	TED
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OUTHEA	STERN KY MEDICAL C	ENTER		Division of Health Care	
			.E, KY 40977	Southern Enforcement Branch	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	FROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)	(X5) COMPLE DATE
{E 000}	Initial Comments		{E 000}		
7		d complaint investigation ducted on 05/07-09/19. The			
	complaint was subst continued to be out of E0041 and E2340, a			The governing board met 5/30/19, appointing a Vice Chairman. The current chairman of the board and owner of Southeastern KY Medical Center will no longer have authority or voting ability r/t day to day operations of the facility. The owner/chairman will only be involved for the sale or liquidation of assets.	6/11/1
E 020	902 KAR 20:016 3(1 and Operation (1) Governing author	-2) Section 3. Administration rity licensee.	E 020	A new entity was engaged two weeks ago for the transfer of ownership of the assets, including the CON, license, and other assets within the facility. A change of ownership is expected to be finalized by early next week. (See attached board minutes)	
	for: 1. The manager hospital; and	hat has overall responsi-bility ment and operation of the with federal, state, and local		A 90-day budget was developed to reflect how the facility will meet the needs for operational cost, payroll, pharmacy needs, ED provider coverage, and supplies. (See attached budget). An understanding with the ED provider vendor, pharmacy vendor, EMR vendor, and supply vendor has been established to continue a relationship with the facility with the involvement of a new entity along with the	6/11/1
	Based on interview, Governing Body Mer Daily Operating Bud Correction the facility of Deficiencies dated was determined that the Chief Executive responsible for manaimplementing the Pla 01/30/19, Immediate the facility. The facility Correction (POC) and However, a revisit or non-compliance with Participation (COP)	aging the hospital budget and an of Correction. On a Jeopardy was identified at all submitted a Plan of and alleged compliance. In 03/12/19 revealed at the Conditions of at Governing Body, Quality aformance improvement, and		impending transfer of ownership next week. The facility is purchasing supplies without interruption. A copy of the pharmacy transaction is attached showing the facility's ability to order medications from the pharmacy vendor. To show no lapse in coverage for the ED, the provider group is attached. The ED vendor has received a daily amount agreed upon and will continue with ED coverage. There has been no in interruption of Emergency Department coverage see Emergency Department provider schedule and vendor contact information if verification is needed. Payment plan will be in place with all lab vendors which will give the facility the ability to order supplies needed to perform in-house test.6/11/19	

STATE FORM

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE **DEFICIENCY**) E 020 Continued From page 1 E 020 submitted a second Plan of Correction (POC) and alleged compliance effective 04/14/19. However, a second revisit on 05/09/19 revealed non-compliance continued at the COPs and Immediate Jeopardy was identified. In addition. Immediate Jeopardy was identified at the COPs for Laboratory Services and Infection Control. The findings include: Review of the Chief Executive Officer's (CEO) Job Description and Performance Standards, undated, revealed the CEO/Administrator shall be the Governing Board's representative in the management of the facility. The CEO shall be given the necessary authority and responsibility to operate the facility in all its activities and departments, subject only to such policies as may be issued by the Governing Board or by any of its committees to which it has delegated power for such action. The CEO shall act as the duly authorized representative of the Governing Board had not formally designated some other person to act. Review of a Statement of Deficiencies dated 01/30/19 revealed Immediate Jeopardy was identified at the Conditions of Participation (COP) for Governing Body (CEO and Budget); Patient Rights; Quality Assurance and Performance Improvement; Nursing Services: Discharge Planning; Surgical Services; and Emergency Department Services. The facility submitted a Plan of Correction and alleged compliance with the COPs effective 03/08/19. However, a revisit conducted on 03/12/19 revealed the facility continued to have noncompliance with the COPs at Governing Body; Quality Assurance and Performance

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG **DEFICIENCY**) E 020 Continued From page 2 E 020 Improvement; and Nursing Services. **Review of Board of Directors Meeting Minutes** dated 04/02/19 revealed the board met to discuss the current "J" (Immediate Jeopardy) tags and the Corrective Action plan submitted on 03/29/19. Continued review of the Board of Directors Meeting Minutes revealed the CEO reported that he was working to amend the budget to include repayment of outstanding debt, which included all vendor debt and the repayment schedule for tax liabilities. The CEO requested Board approval for the addendum to the budget, and the motion passed unanimously. The meeting minutes also indicated a Quality Improvement Director had been hired and the facility was working to improve Quality Assessment. Quality Meetings were being held weekly with a Board member and physician in attendance. According to the minutes, quality reports and information that were shared with the Board had shown improvement. The CNO reported that daily chart audit tools had been revised to include detail to better capture medication errors. The minutes stated the CNO also indicated that in-services and education were continuing with Nursing Staff regarding the nursing "J" (jeopardy) tags. Review of the Board of Directors Meeting Minutes dated 04/11/19 revealed the CEO amended the facility's budget to include the outstanding debt as required by the "state" for the corrective action plan. The Minutes revealed that the CEO had "prepared a repayment schedule for the tax liabilities and [pharmacy vendor]." The meeting minutes stated a discussion ensued regarding the current "liabilities and the payroll issues." The owner of the facility stated the pharmacy vendor "would be paid within six months and the funds would come from [Americore] and [St. Alexius, a

PRINTED: 05/29/2019 **FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C **B. WING** 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION ID. (X5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) E 020 Continued From page 3 E 020 facility in another state], he indicated the plan would be to pay the tax liabilities from the RHC (Rural Health Clinic) Medicaid rate adjustment. Responding to the payroll issue [the owner] stated we will work to improve business operations to ensure payroll is stable." The facility submitted a second POC and alleged compliance effective 04/14/19. However, during a revisit on 05/07/19, interviews with staff and review of medical records, facility policies, audit tools, and Performance Improvement Minutes revealed the facility failed to implement the Plan of Correction and Immediate Jeopardy was identified again at Governing Body; Quality Assurance and Performance Improvement; and Nursing Services. In addition, Immediate Jeopardy was also identified at Infection Control and Laboratory Services. Interview with the CEO on 05/08/19 at 5:30 PM revealed he did not have funds to make payments on outstanding debt and to fund the daily operations of the facility. Currently, the CEO stated he could not pay the Emergency Department physician vendor on 05/10/19 and there was the possibility that the facility would not have physician coverage for the ED. Further interview with the CEO revealed the facility had not met payroll for the pay period ending on 04/26/19 and at the time of the interview, he did not have the funds to meet pay roll on 05/10/19. The CEO stated the facility still owed the health insurance vendor, but was attempting to negotiate a settlement for continued coverage for

employee health benefits. Continued interview with the CEO revealed the facility had discussed the fact that some laboratory supplies could not be re-purchased and some laboratory services were being "out sourced" to another laboratory.

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** E 020 Continued From page 4 E 020 The CEO stated he was aware that the procedure had resulted in a delay in obtaining results of tests, which in turn delayed treatment for facility patients. Continued interview with the CEO revealed he could not access any funds for the facility without approval from the owner of the facility. The CEO stated that the owner had applied for a "bridge" loan to assist with funding the facility; however, the loan was not approved and the facility did not have adequate funds to operate on a day to day basis. Further interview with the CEO revealed he did not know how the facility planned to continue to operate without funds. According to the interview with the CEO, he was not aware that the facility was not conducting audits as stated in the facility's Plan of Correction and was not aware that audits were not effective in identifying quality of care issues. Review of Board of Directors Meeting Minutes (Special Called Conference Call) dated 05/02/19 revealed a special meeting was called to discuss the election of a new board member (Physician #5), to inquire whether the State Agency had returned for a revisit, and to question if the facility Geriatric Psychiatric Unit had reopened. Continued review of the minutes revealed another meeting was set for 05/07/19 at 5:00 PM. Further review of the minutes revealed no documented evidence the facility discussed the facility's budget and/or the inability to pay for continued operation, that payroll could not be met on 04/26/19, or the progress of the facility's compliance with the Conditions of Participation. Post survey interviews with the ED contract

vendor on 05/13/19 at 2:55 PM 3:45 PM revealed the vendor received payment from the facility on

Office of Inspector General STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY		
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		100020	B, WING		05/0	9/2019	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	NTE, ZIP CODE			
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SOUTHER	STERM RT MEDICAL C		.E, KY 40977				
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E 020	Continued From pag	e 5	E 020				
£0	05/10/19 and continucoverage for the facili weekend; however, to facility on 05/13/19 so coverage of the ED to been made.  A post survey intervices: 15 PM revealed the	lity's ED through the he vendor sent a letter to the uspending physician because payment had not lew with CNO on 05/13/19 at a facility did not have the lagain on 05/10/19, resulting			2	V.	
	vendor on 05/14/19 a facility currently had \$481,754.86 in the "p \$23,335.79 in the "m Pharmacy Supply Ve account was evaluate month to review payr and to determine if the would continue to su medications/supplies the pharmacy vendor "account is now flagg [they] "will not be account in the payments were made stated the facility had vendor] for the 20th of stopped as well as a [had] also not worked.	edical" account. The endor stated the facility's ed on the 20th of every ments made on the account he Pharmacy Supply Vendor poly the facility with a Continued interview with a revealed the facility's ged for a hold" - meaning septing any more orders from bing product to them." ealed the vendor had "shut by times in the past until a. The Pharmacy Vendor I "set up payments with [the of each month which have pre-payment option, which is."					
(E 041)	902 KAR 20:016 3(2) Administration and O	)(a)2 Section 3. peration	{E 041}				
	(2) Administrator.		90				
			1				

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A BUILDING:		
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		100020	B. WING	<u> </u>	R- 05/0	C 19/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, S	TATE, ZIP CODE	12	
POLITHE	STEDN VV MEDICAL	SENTER 850 RIVE	RVIEW AVEN	JE		
SOUTHER	STERN KY MEDICAL		LE, KY 40977			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	ON	(XS)
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{E 041}	Continued From pa	ge 6	(E 041)	Completion of the CHOW is pending. A completion of the transaction a new hospi administrator will be appointed to overset	ital	6/11/19
	(a) The administrate	or shall:		operations and implementation of the plan correction as well as ensure that quality o	nof	
	2. Be responsible for	or the management of the		maintained.		
	hospital;			A hospital wide policy implementation w May 30th, 2019 from QAPI Council (see	attached	6/11/19
	This requirement is	not met as evidenced by:	-	policy) which will ensure appropriate acti when policy violation occurs. Sent to MI	On is taken	
	Based on interview	, review of the facility's Budget	:	Governing Board for approval. Education	of staff	
	policy, review of the	e facility's vendor balances,	1	will occur with each violation, with docu-	mentation	
		ts of Deficiencies (SOD)		available to support the identified occurre	nce as	- 8
	issued to the facility			required.		
		s of Correction (POC), it was	ľ	The owner of Southeastern KY Medical ( been removed from the day to day operati		6/11/19
		lity failed to ensure an annual		facility, (see attachment of court order an	d from the	
		as prepared according to accounting principles.		Governing Board as a voting member). T	he owner's	
		accounting principles.  as identified at the facility on		input to the board is only regarding assets	and	
	01/30/19 related to	the facility's failure to develop		liquidation of the facility. A Vice Chairm	ian of the	
		conducted on 03/12/19		board was appointed 5/29/19 (see board nattached).	ninutes	=
j		liance continued related to the		attacheu).		
		nsure the budget was				
	prepared in accorda	ance with generally accepted	ő			
	accounting principle	es. The facility submitted a		1		•
	second POC and a	lleged compliance with the		1		
		pation effective 04/14/19.	1			
	However, non-comp	pliance was determined to				
	budget to Institute	igh the facility revised the		(4		
		ayment toward outstanding			70	
	the CEO revealed	budget and an interview with he facility did not have the	10			
	funds to cover outs	landing debt and day to day				79.
	operation. Review of	of the facility's Vendor		All and a second	- 23	
	Balances revealed	the facility owed vendors				
271	\$4,762,937.88; sub	sequently, the vendor that				
	provided physicians	for the Emergency				
	Department and the	evendor who provided				
	pharmaceutical sup	plies terminated their		X a		
	contracts with the fa	acility. In addition, the facility				
	nad an outstanding	tax debt of \$1,189,274.97 and				
	ald not meet employ	yee payroll on 04/26/19 or				
	not to the due to the	unavailability of funds.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		100020	9. WING		R-0	C 9/2019
- 54	ROVIDER OR SUPPLIER  STERN KY MEDICAL C	STREET A	DDRESS, CITY, S RVIEW AVENU LE, KY 40977			(X5)
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{E 041}	The findings include:		{E 041}	Attached is an ED Physician Schedule whi no lapse of coverage has occurred at any ti ED. The ED Physician vendor and the Facmanagement has agreed upon financial reimbursement to satisfy the coverage requirements of the	me in our cility sired to	6/11/19
	Expense Budget," da the Hospital Adminis develop, and comple operation budget, an	ete an annual strategic plan, id three-year capital expense	E	Payment plan will be in place with all lab which will give the facility the ability to or supplies needed to perform in-house test if	rder f needed.	6/11/19
		o forwarded to the Medical e and Board of Directors for		The health insurance vendor is current, and employees have continued coverage (see a receipt of payments for May 2019.		6/11/19
	dated 01/30/19 reversions identified at the Participation becaus overall institutional pudget that included expenses, and contate a three-year period. revealed observation revealed the facility supplies, equipment adequately care for constraints and the facility supplies and the facility supplies, equipment adequately care for constraints and the facility of the cash flow to purchase o1/30/19 SOD reveas supplying pharmacy million dollars, and the records vendor appropriate the constraints and the records vendor appropriate of the constraints and the facility were refusing goods without prepasubmitted a Plan of effective 03/06/19 the compliance.	ant of Deficiencies (SOD) aled Immediate Jeopardy Governing Body Condition of e the facility failed to have an lan with an annual operating all anticipated income and all expenditures for Further review of the SOD as and interviews with staff failed to have adequate and or medications to patients due to budgetary facility's inability to obtain the needed items. The alled the facility owed their approximately one-half aneir electronic medical oximately six hundred d all vendors supplying the to provide services and yment payments. The facility Correction and alleged e facility would be back in a SOD dated 03/12/19 failed to achieve compliance				

NS8G13

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	(X3) DATE SURVEY COMPLETED	
100020 B. WING	R-C 05/09/2019	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEASTERN KY MEDICAL CENTER  850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
(E 041)  Continued From page 8  effective 03/08/19 and non-compliance continued due to the facility's failure to ensure the annual operating budget was prepared according to generally accepted accounting principles. Review of the facility's budget revealed the facility failed to ensure the budget included repayment of outstanding debt and failed to fully disclose the hospital's monetary situation. The facility failed to pay employee taxes (federal, state, and city) for the 4th quarter of 2018; employee taxes for February 2019; and owed \$377,000 to the Pharmacy Supplier. However, the facility failed to include the debt in their budget. Further, as of 03/12/19, finds were not available to meet payroll due on 03/15/19. In addition, the budget included revenue (\$99,000 per month from January through June 2019) for income that will not be received until November 2019 (the next fiscal year). The facility's velocitied a Plan of Correction in response to the SOD and alleged the facility would be in compliance with a correction date of 04/14/19. The facility's PoC stated, "The budget was approved by the Governing Board on 02/28/19. An addendum will be added to include repayment of outstanding debt, which includes all vendor debt and the repayment schedule for tax liabilities. The Board has approved agreements with taxing authorities to ensure liabilities are met, see board minutes."  Review of the "Operating Budget" for the period ending 08/30/19, "as a Preliminary Draft as of 8/3/18", revealed the facility revised the budget to include \$200,000-\$300,000 each month for the "Provision for Bad Debt" as stated in the facility's POC. In addition, the facility's budget revealed allowances were made for salaries and wages, employee benefits, physician fees, and supplies. However, according to the budget, the facility had a "Net Operating" toss each month from July		

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **860 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY (E 041) Continued From page 9 (E 041) 2018 through April 2019 that ranged from \$13,495 in April 2019 to \$435,277 in July 2018. Review of the "Vendor Balances" spreadsheet dated 05/07/19 revealed the facility had outstanding balances to the pharmacy vendor in the amount of \$469,564.15 for one account, a second account in the amount of \$27,584.54, a third account in the amount of \$18,428.40, and a fourth account in the amount of \$97,444.81; Kentucky Unemployment Insurance Fund in the amount of \$9,474.83, and a second account in the amount of \$328,442.58; Electronic Medical Record Vendor in the amount of \$795,950.01: Laboratory Corp of America in the amount of \$51,612.75; Baxter Health Care (a medical and pharmaceutical vendor for intravenous medication supplies) in the amount of \$41,756.90; Kentucky State Treasurer in the amount of \$859,837.17, and a second account in amount of \$109,015.50; Omniceli (medication vendor) Inc. in the amount of \$174,181.51; the Emergency Department (ED) physician group in amount of \$85,109.67; and Medius Radiology Services in the amount of \$26,600,00. Further review of the vendor balance sheet revealed the total balance owed to all vendors was \$4,762,937.88. Review of the Gross Wages and Tax Liability for fiscal year 2019 revealed the facility had not paid federal taxes for fourth quarter of 2018 and had an outstanding debt of \$356,706.79, and had an outstanding debt of \$401,738.14 for federal taxes for the first quarter of 2019, for a total debt of \$933,052. Continued review revealed the facility owed Total Withholding Taxes in the amount of \$1,189,274.97. Interview with the Chief Executive Officer (CEO)

Office of Inspector General STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C **B. WING** 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 (X4) ID **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY (E 041) Continued From page 10 {E 041} on 05/08/19 at 5:20 and 5:50 PM revealed he had been making minimum payments on the tax liabilities debt; however, when he paid the tax debt, he could not continue to pay a \$5,000 per day debt to the vendor who staffed the facility's Emergency Department with physicians, The CEO stated if he could not pay the Emergency Department physician vendor \$30,000 by the close of business on 05/10/19, the vendor would not provide a physician for the facility's ED beginning at 7:00 PM on 05/10/19. Further interview with the CEO revealed the facility had not met payroll for the pay period ending on 04/26/19 and at the time of the interview, he did not have the funds to meet pay roll on 05/10/19. The CEO also stated even though the facility had taken money from employees' wages to pay for health benefits, the facility employees had no health benefits for the months of November and December 2018 because the facility had not paid the health insurance company for the employees' premiums. The CEO stated the facility still owed the health insurance vendor, but was attempting to negotiate a settlement for continued coverage for employee health benefits. Continued interview with the CEO revealed the facility had discussed the fact that some laboratory supplies could not be re-purchased and some laboratory services were being out sourced to another laboratory facility. The CEO stated he was aware that the procedure had resulted in a delay in obtaining results of tests, which in turn delayed treatment for facility patients. Further interview revealed out of state taxes for two (2) employees had not been paid for 2018 and the CEO was assisting those employees with personal audits due to the facility's non-payment of their taxes.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
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			(===,				
		the CEO revealed he did	1			İ	
		ny funds for the facility		2.			
		n the owner of the facility. the owner had applied for a	1				
		it with funding the facility;					
		as not approved and the					
		idequate funds to operate on					
		addition, the CEO stated					
y.	the facility had little re	evenue because for an				•	
15.0		facility had not received any					
7	reimbursements from						
1		eks. The CEO did not					
,	Comment on a plan to	o repay the \$4,762,937.88					
	listed on the facility's spreadsheet.	vendor balance				!	
	opreausticet.						
	Post-survey interviey	vs with the ED contract					
		at 2:55 PM and 3:45 PM					
		provide physician coverage					
		he facility had to pay the					
,		r day. Failure to receive	-				
	payment would resul	t in suspension of physician					
		or representative stated the					
		nyment from the facility on different to the temperature of temperature of the temperature of temperature of temperature of temperature of tempera	}				
		verage for the facility's ED		*		'	
	through the weekend	i; however, the vendor sent a					
	letter to the facility or	1 05/13/19 suspending		(c)			
		of the ED due to the facility's	1				
		000.00 payment. Continued			ă.		
	interview revealed pl	nysician coverage of the ED					
	had been suspended	l in the past on 11/08/18	1				
		11:00 AM, on 11/27/18					
	through 11/28/18 at 1	1:00 PM, and on 12/29/18				'	
	through 12/31/18 at	12:15 PM,			I		
	A post-survey intervi-	ew with the Chief Nursing					
		13/19 at 3:15 PM revealed					
	the facility planned to	continue to provide ED					
	services, despite bei	ng unable to pay the vendor					

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE. KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (XS) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY (E 041) Continued From page 12 (E 041) for physician coverage. The CNO stated a staff physician planned to stay at the facility and provide ED services if a "deal" could not be worked out with the current vendor. Further interview with the CNO revealed the facility did not have the funds to meet payroll again on 05/10/19, resulting in staff not being paid for one month. A post-survey interview with the Pharmacy Supply Vendor on 05/14/19 at 11:25 AM revealed the facility had an outstanding debt of \$481,754.86 in one account ("pharma") and \$23,335.79 in a "medical" account. The Pharmacy Supply Vendor stated the facility's account was evaluated on the 20th of every month to review payments made on the account and to determine if the Pharmacy Supply Vendor would continue to supply the facility with medications/supplies. Continued interview with the pharmacy vendor revealed the facility's "account is now flagged for a hold" meaning [the vendor] "will not be accepting any more orders from (the facility) nor shipping product to them." Further interview revealed the vendor had "shut them" off briefly a few times in the past until payments were made. The Pharmacy Vendor stated the facility had "set up payments with [the vendor] for the 20th of each month which have stopped as well as a pre-payment option, which [had] also not worked." A post-survey interview with the Pharmacy Supply Vendor on 05/15/19 at 4:47 PM revealed the Pharmacy vendor confirmed the facility "still is on hold and [the Pharmacy Vendor was] not accepting any more payment arrangements or orders at this point."

Office of Inspector General STATEMENT OF DEFICIENCIES

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SI			
AND PLAN (	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
				·	R-C	,	
		100020	B. WING			9/2019	
		100020					
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, S	·			
SOUTHEA	STERN KY MEDICAL C		VIEW AVENU	)E			
			E, KY 40977				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE	
TAG	REGODATORTOR	LEGS IDENTIFY THIS IN CHIMATION,	TAG	DEFICIENCY)			
				A QAPI chart audit tool was developed aft	er the	6/11/19	
E 330	Continued From pag	e 13	E 330	1/30/2019 survey. The lack of measuring			
E 330	902 KAR 20:016 3(8	)(b)1-2 Section 3.	E 330	on the original tool utilized did not effective	ely capture		
	Administration and C			the entire record. A QAPI consultant was			
				3/19/2019 and a QAPI plan was developed			
	(8) Medical staff.			implemented at that time. Weekly PI mee held. Audits were completed on 4/29/2019			
8				4/30/2019, and 5/02/2019. See the attache			
	(b) The medical staff	f shall be responsible:		confirmation to the OIG for chart audits.			
	4 77-11-11					,,,,,,	
- 6		authority for the quality of		On 3/9/2019, a revised tool was implemen		6/11/19	
		ed to the patients; and d professional practice of its		The revised tool was also found to be ineff	pture data for the 24-hour time frame.		
	z. For the ethical and members.	o professional practice of its	9	based on the re-survey in May of 2019.	ective		
	members.		1.01	Justice on the re-survey in thing of 2012.	2.99		
	This requirement is a	not met as evidenced by:		The QAPI committee met on 5/30/2019 to		6/11/19 ·	
		record review, and review of	i	SOD from CMS. Based on the findings, a			
		ents of Deficiencies and Plans		wide policy was developed to address issu			
		urvey visits on 01/30/19 and	1	employees where not following specific po (This policy will address issues with nursing			
	03/12/19, the facility	's Quality Improvement Plan,	1	documentation, medication administration			
		lits and Performance		any other quality of care concerns. A revi			
		inutes, it was determined the	1	chart audit tool has been completed. The			
		luct audits as required by the	1	audit tool has been improved to be more in			
		rovement Plan and Plan of	1	of the overall documentation and has elim inconsistencies in previous chart audits. P			
		t practice related to the		will utilize a tracking tool for all medication			
(6)		plement and maintain an		See attached QAPI minutes for the new po			
13		surance and Performance am (QAPI) was identified on		pharmacy tracking tool.	•		
		119. The facility submitted two		l			
		and alleged compliance on		On 5/30/2019, the Medical Executive Con		6/11/19	
		continued non-compliance		and discussed the SOD and the CAP in procommittee reviewed the QAPI's plan to in			
		d to the facility's failure to		new chart auditing tool and discussed and			
		eness of the quality of care		new policy for discipline for all employee			
[		evise action plans to address		not follow policy. With the implementation	on of this		
		erns that were identified		policy, Human Resources and Managers v			
		ram, and failed to ensure		effectively be able to hold employees according their actions.	untable for	0	
		e in identifying quality of care		men actions.			
	concerns related to	Patients #25 and #27.					
	The findings include	:					
	Daview of the facility	ule 2019 Orgality Improvement					
		y's 2019 Quality Improvement 9 revealed the areas included					
L	I fair aigned baroor i		1				

PRINTED: 05/29/2019 **FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES** (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) 6/11/19 To address and correct the issue of nursing not being E 330 Continued From page 14 E 330 aware of urine culture results, licensed nursing staff in the Scope of the program were high risk, high will review their specific patient's labs each shift and check for abnormal or pending lab results. The volume or problem prone processes; infection Infection Control Nurse will perform surveillance to control; restraint and seclusion use; mortality ensure that the nurse is checking for lab results and review; blood and blood product use; organ she will keep a log of compliance. See copy of procurement; utilization review: data surveillance log attached. management; measures related to regulatory requirements, etc. The plan also listed the To address the nursing staff failing to identify and 6/11/19 committee members, the process improvement treat the patients diabetic foot ulcer and follow framework and reporting format. hospital nursing assessment policy, the QAPI committee has developed a new policy that will take 1. Review of a Statement of Deficiencies (SOD) appropriate action for nursing staff for not following dated 01/30/19, revealed Immediate Jeopardy policies. Upon approval of this policy, nursing staff will be in-serviced on the new policy and the actions was identified due to the facility's failure to that will be taken if policies are not followed. implement and maintain an effective ongoing, hospital-wide, data-driven Quality Assurance and To address patient #26 who was admitted on 6/11/19 Performance Improvement (QAPI) Program. 5/07/2019 at 10:30am, patient had labored breathing Interviews with staff revealed the facility had not with no oxygen administered. The SOD stated, the conducted any QAPI activities since July 2018. patient had been there for awhile and the patient had Subsequently, review of patient records and not been evaluated by the nursing staff. The patient interviews with staff revealed the facility failed to was in the facility on the in-patient medical-surgical identify patient care and patient safety concerns floor because this is where the facility places all outpatients or (OPD patients). The MD order states and failed to develop action plans to address the the patient was admitted to an OPD bed. Because concerns. this patient was for an OPD bed and not an observation patient nor an inpatient, the Initial The facility submitted a Plan of Correction (POC) Physical Assessment was not required, instead an and alleged compliance with the QAPI Condition OPD flowchart was required and initiated. See of Participation effective 03/06/19. However, attached MD order. The nurse contacted the MD and a MD telephone order was obtained for oxygen at

and alleged compliance with the QAPI Condition of Participation effective 03/06/19. However, review of a SOD dated 03/12/19 revealed non-compliance continued due to the facility's failure to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction. The 03/12/19 SOD revealed the facility did not conduct audits as stated in the plan and did not identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13.

Review of a second Plan of Correction submitted for the 03/12/19 revealed the facility alleged that

11:15am. Later that evening, the patient was

converted from an OPD status to an observation status, see attached MD telephone order. After the

physical assessment and initial interview were

and patient admission policy.

completed per policy guidelines at 5:48pm. See

attached copy of nursing admission documentation

patient was converted to observation status, the initial

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ R-C a. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E 330 Continued From page 15 E 330 they would be in compliance with the QAPI Condition of Participation effective 04/14/19. Review of the POC revealed, "The chart audit tool was revised to include more detail and better capture medication errors. Chart audits were being done daily but were not capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from the same time each day to the next day ... Medication errors will be reported [through] a paper report to the Risk Management committee to monitor patterns or trends." The facility alleged in the Plan of Correction that compliance would be achieved effective 04/14/19. However, review of the facility's Nursing Medical-Surgical Audit Tool (24 hour) revealed there was no documented evidence that the facility completed an audit as stated in the Plan of Correction on 04/29/19, 04/30/19, 05/01/19, or 05/02/19 to ensure compliance was maintained. Review of the facility's Performance Improvement (PI) Minutes dated 04/30/19 revealed no documented evidence that the facility discussed the daily audits not being conducted as planned. Further review revealed 35 medical record audits had been conducted and 26% of the records had an omission medication error, and 6% of medications were administered at the wrong time. Further review revealed the physician had not been notified of any of the omission medication errors. Continued review of the PI minutes revealed there were 34 nursing errors that included the following: 11% of the records revealed an initial interview was not completed within 1 hour of admission, a pain assessment not completed 32% of the time, critical laboratory results were not reported in a timely manner 5.26 % of the time, nutrition screening not completed

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL COMPLETE PREFIX PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC (DENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG **DEFICIENCY**) E 330 Continued From page 16 E 330 11%, physician not notified of a change of status 42% of time. However, there was no documented evidence the facility developed a plan of action to address the concerns identified during the PI Meeting. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed she was "not sure" why chart audits had not been completed as stated in the facility's Plan of Correction. Continued interview with the CNO revealed the facility did not develop any type of action plan after the PI meeting, other than to educate which was not a new intervention. However, review of the minutes revealed that education had not been effective in ensuring compliance with medications errors and critical laboratory results, notification of change in condition, nor nursing documentation. 2. Review of the facility policy titled, "Medication Administration" approved August 2017, revealed antibiotic medications were time-critical scheduled medications and early or late administration could have a significant negative impact on the intended pharmacological or therapeutic effect of the medication. The policy stated antibiotics would be administered to the patient within thirty minutes before or after the scheduled dosing time, for a total window of one hour. Review of the medical record for Patient #27 revealed the facility admitted the patient on 05/02/19 with a diagnosis of Dyssomnia, Sleepless, Exhaustion, Pale, Orthostatic, and Generally not well.

NS6G13

Review of Physician Orders for Patient #27 dated 05/03/19 at 4:40 PM revealed the patient had an

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: R-C **B. WING** 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 330 E 330 Continued From page 17 order for intravenous (IV) Ampicillin (antibiotic) every six (6) hours. Review of Patient #27's Medication Record revealed staff administered IV Ampicillin on 05/04/19 at 8:00 PM, and again on 05/05/19 at 12:56 AM, (34 minutes before the dose could be given according to the facility's policy). Review of the facility's audit tool titled, "Nursing Medical-Surgical Audit Tool (24 hour)" dated 05/04/19 to 05/05/19 revealed the facility reviewed Patient #27's medical record and documented there were "no Issues" with the patient's medication. There was no documented evidence the facility identified that staff administered Patient #27's medication prior to time the dosage was due to be administered. 3. Continued review of the facility's "Nursing Medical-Surgical Audit Tool revealed the facility was monitoring to ensure the physician was notified timely of critical tests/results and any change in a patient's condition. Review of the Plan of Correction (POC) the facility submitted for the Statement of Deficiencies (SOD) dated 03/12/19 revealed "The chart audit tool was revised to include more detail and better capture medication errors ..." According to the Nursing Medical-Surgical Audit Tool, the facility was monitoring the types of medication errors, which included wrong dose, wrong medication, etc. and "diagnostic/treatment measures required". Review of Patient #25's medical record revealed the facility admitted the patient on 05/01/19 under the services of MD#5 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C **B. WING** 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY**) E 330 E 330 Continued From page 18 in urine), uncontrolled Diabetes, and Hypertension. Review of Patient #25 Admitting physician orders revealed staff were directed to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered Levaquin (or Levofloxacin, an antibiotic) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 mg one tablet daily. Review of Patient #25's laboratory reports revealed the facility collected a urine culture on 05/02/19 at 2:49 AM, and the final report dated 05/05/19 at 3:35 PM, revealed the patient had a Multidrug-Resistant organism (MDRO). Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levaquin or Bactrim antibiotics that the patient was receiving at the facility. However, further review of Patient #25's medical record revealed no evidence that the urine culture report had been reviewed or any action had been taken based on the report to ensure the patient was receiving a medication that was susceptible to the patient's infection. 3. b. Further review of the facility's Nursing Medical-Surgical Audit Tool revealed the facility was monitoring to determine whether a decubitus ulcer was present on admission and if so, the decubitus ulcer performance improvement form was required.

Continued review of Patient #25's medical record revealed prior to admission to the facility on 05/01/19, MD #5 evaluated the patient in his

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ R-C 9. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG **TAG DEFICIENCY**) E 330 Continued From page 19 E 330 office. MD #5 documented that the patient had burning pain and numbness to both feet and an ulcer to the right foot that had been previously debrided. The progress notes also revealed Patient #25 was status post amputation to his/her great and second toe on the left foot. However, review of Patient #25's Admission Nursing Assessment dated 05/01/19 at 3:56 PM revealed Registered Nurse (RN) #7 documented that the patient had no abnormal skin integrity impairments and the patient's neurological system and pulses were within normal limits. There was no documented evidence the facility identified and/or assessed the ulcer to Patient #25's left foot until 05/03/19, two days after admission to the facility. Review of the nurse's notes dated 05/03/19 (two days after admission) at 11:56 AM revealed RN #4, documented that Patient #25 had an "old debridement area, open round area surrounded by extremely thick dry skin noted white/pale yellow area noted with dark area on the side, small amount of clear yellow drainage noted," to his/her right foot. Review of Physician #3's documentation (the facility surgeon) revealed he evaluated Patient #25 on 05/07/19 and the patient had "ongoing open wound" to his/her right foot with a osteomyelitis (infection of the bone), which appeared to be "settling down" In addition, according to the documentation, even though

staff documented the Patient #25's pulses were within normal limits on admission, the surgeon documented that the patient did not have a pulse

in the patient's right foot (dorsalis pedis).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
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SOUTHEA	STERN KY MEDICAL C	ENTER	RVIEW AVENU .E, KY 40977	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(XS) COMPLETÉ DATE
E 330	Continued From page	e 20	E 330		-	
	facility reviewed Patie 05/02/19, 05/03/19, 0 the facility identified a skin integrity, medica	the Audit tools revealed the ent #25's medical record on 15/04/19 and 05/05/19, and no issues with the patient's tions, nor physician critical tests/results and/or	8	- V	-,	
	(CNO) on 05/13/19 a thought the facility we medical records and identified concerns. It was unsure why the during the audits of the because she was uneverything in the records.	The CNO also stated she concerns were not identified the patients' medical records der the impression that ords were being reviewed.				39 40
E 610	Administration and C (10) Physical and sar	peration	E 610	To address the infection control issue with #25, upon obtaining any results, including received through an electronic file form are outsourced laboratory, results will then be from the laboratory personnel to the Infect nurse and the patient's primary nurse and The infection control nurse will then place	results I forwarded lion Control physician. I results on	6/11/19
	h. Reporting, investig outbreaks of healthca This requirement is n	ase transmission to and from demployees, including:  pating, and controlling are-associated infections;  not met as evidenced by:		the tracking log. The infection control nureview the inpatient or observation patient ensure that the patient is on the appropriatin the event that an outpatient result requiphysician notification, the infection control do a follow-up with the physician's office determine and ensure that the patient has appropriate treatment.	records to e antibiotic. res Il nurse will to	
	review of facility police Infection Control Log facility falled to ensure officer had a system	n, interview, record review, by, and review of the facility , it was determined the re that the infection control for identifying, reporting, and of patients and personnel for				

**FORM APPROVED** Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) To correct the issue of the facility failing to prevent 6/11/19 E 610 Continued From page 21 the spread of infection, nursing staff will be educated one (1) of twelve (12) sampled patients (Patient on all types of isolation precautions and evaluation of the nurse's knowledge will be demonstrated through a #25). Review of the medical record revealed written test. Patient #25 was admitted to the facility on 05/01/19, with a diagnoses of Urinary Tract To address the infection control issue with patient 6/11/19 Infection (UTI) with gross hematuria (blood in #25, after the lab results are received by the lab staff, urine). Review of Patient #25's lab results, dated a copy will be sent to the infection control nurse and 05/05/19 revealed the patient had a the patient's primary nurse and physician. The Multidrug-Resistant organism (MDRO), infection control nurse will then review the results for Extended-spectrum beta-lactamase (ESBL) in any MDRO's and place results on the tracking log his/her urine (ESBL is an infection that is resistant and will also follow the guidelines for the reportable diseases. The infection control nurse will then review to many antibiotics and is spread by contact with the inpatient or observation patient records to ensure infected person or by contact with contaminated that the patient is on the appropriate antibiotic. In the surfaces). However, review of the medical record event that an outpatient result requires physician on 05/07/19 revealed no evidence the patient's notification, the infection control nurse will do a Physician had been notified of the lab results and follow-up with the physician's office to determine and no evidence that action had been taken to ensure that the patient has received the appropriate prevent the spread of the infection to other treatment. (See attached tracking log) patients. In addition, further review of Patient 6/11/19 #25's medical record revealed he/she had a To correct the issue of the facility failing to prevent history of ESBL infection of a wound that was the spread of infection, nursing staff will be educated on all types of isolation precautions and evaluation of diagnosed on 03/29/19; however, interview with nurse's knowledge will be demonstrated through a the Infection Control Nurse on 05/08/19 at 3:00 written test. PM, and review of the facility's Infection Control Tracking Log revealed no evidence Patient #25's 8/22/19 Lab Dept is now staffed 24/7. After culture results abnormal culture results were included on the have been received through the electronic portal the tracking log. lab technician will immediately take the paper culture results to the inpatient nurse and the Infection Control The Findings Include: Nurse. The nurse will verify the report by placing initials with the date, time, on the report and MD notification in the electronic medical record. Review of the facility policy titled, "Transmission Based Isolation Precautions," approved February To ensure and monitor that culture result notification 8/22/19 2017 revealed all patients suspected of/or known is reported the Lab will do a quality Focus Review to have a communicable disease will be placed in regarding notification to the primary nurse and the the proper category of isolation based on Infection Control nurse this will be report through transmission mode of the disease. A Physician, QAPI. Charge Nurse or Infection Control Nurse has the authority to order and place the patient in isolation. The policy stated that signage would be

universal within the acute care areas and that signs would be place on the door of the patient

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leadership on a routine and emergency basis.  Further review of the facility policy revealed  Multi-drug resistant organisms are a major facility		supplies relative to c	ontrol infections, and				
Further review of the facility policy revealed  Multi-drug resistant organisms are a major facility							
Further review of the facility policy revealed  Multi-drug resistant organisms are a major facility		leadership on a routi	ne and emergency basis.	1			
I and approvable adults are set to the set of the set o		Multi-drug resistant of	organisms are a major facility				
and community safety concern including							
colonization of MDRO, which have the potential to							
proliferate, invade and infect susceptible,		proliferate, invade ar	nd infect susceptible,				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		100020	B. WING	B. WING	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
SOUTHE	STERN KY MEDICAL C	ENTER	VIEW AVENUE		
			E, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
E 610	Continued From page	⇒ 23	E 610		
		l individuals. Factors that			
		patient to acquiring MDRO's			j
		mited to broad-spectrum tion, and immune-deficiency.		00	j
		gies related to reducing			
		the facility include but are			
		initiatives, hand hygiene	-		
	practices, and infection	on prevention education.			
	Observation of Patier	nt #25 on 05/07/19 at 11:05			
		our of the facility revealed	1		
	the patient was lying	in bed with eyes closed.			
	Review of the medica	al record for Patient #25			1
		idmitted the patient on			
		ervices of MD #5 with			
		Tract Infection (UTI) with od in urine), uncontrolled			
8		tension. Review of the		9.5	ļ
	Physician's Orders d	ated 05/01/19 revealed an			
		ect a urine culture with			
		9. Further review of Patient revealed Physician #5			
		antibiotics (medications to			
		administered: Levaquin			
		illigrams (mg) intravenous	•		
		n (antibiotic combination of	]		
	tablet daily.	d trimethoprim) 400-80 one		77	
!	Review of Patient #2	5 admitting physician orders	- 6		
	revealed staff were d	lirected to collect a urine			
-	culture with sensitivit	y on 05/01/19.			
		i's record revealed a urine			
		on 05/02/19 at 2:49 AM,			ļ
		urine culture report revealed			
	PM, which indicated	orted on 05/05/19 at 3:35			
	Multidrug-Resistant				
		<del></del>	<u> </u>	<u> </u>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) OATE SURVEY COMPLETED	
					R-	С
		100020	B. WING		05/0	9/2019
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
SOUTHEA	STERN KY MEDICAL C	ENTER 850 RIVE	RVIEW AVENUE			
			LE, KY 40977			
(XA) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(XS) COMPLETE DATE
E 610	Continued From page	e 24	E 610			
	his/her urine. Review revealed the organist respond) to Levaquir Further review of Pat	peta-lactamase (ESBL) in of the sensitivity report m was resistant (would not or Septra antibiotics. ient #25's culture report in was effective to treat the ganism.				80
10 No.	that the urine culture any action had been Continued observation at 11:05 AM revealed contact precautions to observation revealed patients on the unit, i observed to be in the Patient #25. In additinurse were observed Patient #25 and were	there were two other ncluding Patient #26 was room across the hall from on, two nurse aides and a l on the unit caring for a not wearing protective t the spread of infection to				
	revealed she was recare on 05/07/19. The aware that the culture therefore no action we notified the nurse of Observation of Paties PM revealed an "infection; however, there the type of precaution Interview with Labora 05/08/19 at 4:05 PM cultures" had been seapproximately one medium of the care of the type of the cultures.	5 on 05/07/19 at 5:00 PM sponsible for Patient #25's e nurse stated she was not e results were back and ras taken until the surveyor the test results.  Int #25 on 05/08/19 at 1:22 ction control box" on the was no signage to indicate his the patient required.  Intervaled she stated "all ent out of the facility for onth, because the facility ase the needed supplies, to				

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	TED
	m	100020	8. WING		R-I 05/0	9/2019
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
SOUTHEA	STERN KY MEDICAL	CENTER	RVIEW AVENUE LE, KY 40977			2
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
E 610	the only lab personner the day shift, 7:00 A have access to the obtain lab results, from the trained to track labs was unaware of wheresults were obtained processing from the Interview with LT #2 supervisor gave lab (Monday-Friday) and them to the ordering stated she had faxed results to MD #5's of was not aware the patherefore direct care the abnormal lab respoken to Patient #2 received the abnormal lab respoken to Patient #3 received the abnormal lab respoken to Patient #	se. The LT stated she was nel working on 05/05/19 during M-7:00 PM, and she did not system the facility utilizes to rom labs sent out for a facility. She had not been in the facility, and stated she to was monitoring to ensure ad of labs sent out for a facility.  2 on 05/08/19 revealed the lab results to her ad she had been trained to fax a physician's office. She ad Patient #25's abnormal lab office on 05/07/19; however, the patient remained in the facility, a staff had not been notified of sults. She stated she had not 25's physician to ensure he mal labs, because she had not so.  aboratory Supervisor on the facility "because of money." the plan had to be worked out a pany, because administration alance due on the account, so wild not be obtained to run the labs in the facility. She stated sing sent out to be resulted, elve the lab results, she had to kt" and acknowledged not have access to track labs out, and also stated "we're not"	E 610	DEFICIENT	en)	
	weekends." She str	at lab results on the ated she was required to track Monday-Friday; however, had	<u></u>			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED							
	100020		B. WING	Λ	R-C 05/09/2019							
NAME OF PROVIDER OR SUPPLIER . STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE												
SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977												
(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) COMPLETE DATE						
E 610			E 610									
	not tracked send out lab results from the previous week, on 05/06/19 (Monday) as required, because she "had other things to do."				m <sup>1</sup>							
	Continued review of Patient #25's medical record revealed the patient had previously been admitted to the facility on 03/27/19 under services of			Œ	- a	•						
	Gangrene to his/her Vascular Disease and	d Brittle Diabetes.		# #		V						
	previous admission r facility surgeon) eval	5's physician orders from the evealed Physician #3 (the uated Patient #25 on discount culture, which was		2 14								
9	collected on 03/27/19 patients record revea Patient #25's wound	9. Further review of the aled the final results of culture dated 03/29/19 had ESBL identified in			N							
	Infection Control Tra ninety days, revealed abnormal culture res identified in the patie	at 3:00 PM of the facility's cking Log for the previous d no evidence Patient #25's sults for the MDRO, ESBL ent's wound on 03/29/19 or in 5/19 was included on the		45		* 0						
	05/07/19 at 4:30 PM required to notify her however, they had fa #25's urine was Iden ESBL on 05/05/19. Sphysician should had	fection Control (IC) Nurse on revealed lab staff were r with abnormal cultures; ailed to inform her that Patient tified to have an MDRO, She stated the patient's re been notified of the on 05/05/19, and staff should										
	have ensured the pa antibiotic to treat the	itient was on the appropriate										

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
		IDENTIFICATION NUMBER:	A. BUILDING: _		COMP							
		100020	B. WING			R-C 09/2019						
		10020			00/	03/2013						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE												
SOUTHEASTERN KY MEDICAL CENTER 850 RIVERVIEW AVENUE												
PINEVILLE, KY 40977												
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE						
E 610	Continued From page	9 27	E 610									
	Continued From page 27		1 2010									
		living in in the facility, was										
. 5		lment for the patient's				1						
		The IC nurse also stated	1	- 8		]						
	contact precautions :											
		ect staff and other patients the infectious organism.				1						
	Continued interview											
		nt #25 was previously		88								
	diagnosed with an ESBL organism in his/her diabetic foot ulcer, during a previous hospital stay in March 2019. However, she was unsure why the patient information had not been included on the facility infection control tracking log. She also stated, because the electronic record system had not been updated due to outstanding debt, "nothing flags staff" that patients had been					1						
				(0)								
	-	RO during previous hospital										
	stays.					1						
	A ==== = =============================	and the the Objection										
		ew with the Chief Nursing 13/19 at 3:15 PM revealed										
		have been notified of Patient										
		esults on 05/05/19. She also										
6	stated laboratory per					äξ.						
55		ve system, since cultures										
		of the facility for processing	K.									
		ults were received in a timely		-24								
<i>V</i> ),	manner. The CNO a	lso stated patients should be	ì	1.67								
	placed in contact pre	cautions when MDRO's were										
		taff and other patients from										
		. Continued interview with	- 01			1						
		e facility infection control				,53						
		e accurate and should				1						
		ganisms identified in the	1									
	facility.											
(E2340)		)(g) Section 4 Provision of	(E2340)			1						
	Services											
			1			1						

Office of Inspector General (X1) PROVIDER/SUPPLIER/CLIA STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C **B. WING** 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY STATE ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY To correct the issue of nursing not being aware of 6/11/19 (E2340) Continued From page 28 {E2340} urine culture results, each RN will review their (2) Nursing service. specific patient labs each shift and check for abnormal or pending lab results. The Infection Control nurse will perform surveillance that the nurse (g) A registered nurse shall assign staff and is checking for lab results and keep a log of evaluate the nursing care of each patient in compliance. accordance with the patient's need and the nursing staff available. To address the nursing staff failing to identify and 6/11/19 treat the patient's diabetic foot ulcer and follow This requirement is not met as evidenced by: hospital nursing assessment policy, the QAPI Based on observation, interview, record review. committee has developed a new policy that will take review of facility policy, and review of Statements appropriate action for nursing staff not following any policy. Upon approval of this policy, nursing staff of Deficiencies and Plans of Correction for survey will be in-serviced on the new policy and the actions visits on 01/30/19 and 03/12/19, it was that will be taken if policies are not followed. determined the facility failed to ensure a To address the patient #26, who was admitted on registered nurse supervised and evaluated the 5/7/19 at 10:30am and patient having labored nursing care for two (2) of twelve (12) sampled breathing with no oxygen administered. The SOD patients (Patients #25 and #26). The facility stated the patient had been there for a while and the failed to ensure urine culture results were patient had not been evaluated by the nursing staff. monitored and addressed timely for Patient #25. The patient was in the facility on the inpatient The results of the patient's urine culture were medical surgical floor because this is where the available on 05/05/19 and revealed that the facility places all outpatient (called OPD bed). The patient had Extended-spectrum beta-lactamase MD order states patient is an OPD. Because this patient was an OPD bed, not an Observation Patient (ESBL) (a multi-drug resistant organism [MDRO]) nor an inpatient, the Initial Physical Assessment was in the urine. However, staff failed to notify the not required, instead an OPD flowchart was required patient's physician timely of the laboratory results: and initiated, see attached MD order. The nurse subsequently, the patient did not receive timely contacted the MD and a MD Telephone Order was treatment for the infection. In addition, the facility obtained for oxygen at 11:15am. Later that evening, failed to take action to prevent the spread of the the patient was converted from an OPD status to an patient's infection to others. Observation status, see attached MD telephone order. After the patient was converted to observation status, Further, when Patient #25 was admitted to the the Initial Physical Assessment and Initial Interview facility on 05/01/19, the physician progress notes were completed per policy guidelines at 5:48pm. Copy of Nursing Admission Documentation and revealed the patient had an ulcer present to Patient Admission Policy are attached his/her right foot, which had previously been debrided. However, review of the nursing admission assessment dated 05/01/19 revealed the nurse documented that the patient had no skin abnormalities. Further review of the record revealed nursing staff failed to identify, assess, or treat the patient's diabetic foot ulcer until

05/03/19, two days after admission.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **860 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) DATE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG **DEFICIENCY**) 6/11/19 To correct the issue of nursing not being aware of (E2340) {E2340} Continued From page 29 urine culture results, each RN will review their specific patient labs each shift and check for abnormal or pending lab results. The Infection In addition, on 05/07/19 at 11:05 AM, observation Control nurse will perform surveillance that the nurse and interview with Patient #26 revealed the is checking for lab results and keep a log of patient had labored breathing. The patient stated compliance. Copy attached of surveillance tracking he/she had there "awhile" and had not been sheet evaluated by nursing staff. At 11:15 AM, the surveyor notified nursing staff that the patient was To correct the issue of staff failing to notify the 6/11/19 in distress; however, the nurse did not assess or patient's physician timely of laboratory results, evaluate the patient, but called respiratory resulting in the patient not receiving timely treatment and not following polices for assessments of patient # services to assess and treat the patient, Review 5, the QAPI committee has developed a new policy of the medical record revealed that a nursing that will take appropriate action to address the quality assessment was not completed for the patient care concerns, specifically in this incident for nursing until 5:48 PM (approximately 7 hours and 17 staff not following facility policy for MD notification. minutes after admission). Upon approval of this policy, staff will be educated on the new policy and the actions that will be taken if The findings include: polices are not followed. Review of a Statement of Deficiencies (SOD) To correct the issue of the facility failing to take 6/11/19 issued to the facility on 01/30/19 revealed action to prevent the spread of the patient's infection to others in the facility, licensed nursing staff will be deficient practice was issued because the facility educated on all types of Isolation Precautions and failed to have a system for consulting the evaluation of nurses' knowledge will be demonstrated Registered Dietitian (RD) when patients had through a written test. feeding tubes, pressure ulcers/wounds, or Patient # 25 had a diagnosis of a Diabetic Foot Diabetes; failed to have an effective system to Ulcers, which according to policy does not require a ensure patients received physician ordered diets; photo, whereas Pressure Ulcers do require a failed to have effective system for ensuring Social photograph. Services was consulted; failed to administer To ensure that timely assessment and monitoring of medications as ordered by physicians; and failed 8/22/19 OPD patients a quality Focus Review will be done on to monitor and notify a physician of a patient's all OPD patients and reports through QAPI. urinary output as ordered. The facility submitted a Plan of Correction and alleged compliance with nursing services on 03/06/19. However, review of a SOD issued to the facility on 03/12/19, revealed facility failed to implement the POC and continued non-compliance was identified. The facility continued to fail to administer medications as prescribed by the patient's physicians. The Plan of Correction

stated daily chart audits, which included ensuring

Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ R-C B. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE. KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY 8/22/19 Lab Dept is now staffed 24/7. After culture results (E2340) {E2340} Continued From page 30 have been received through the electronic portal the lab technician will immediately take the paper culture physician orders were completed correctly and results immediately to the inpatient nurse and the monitoring for medication administration were Infection Control Nurse. The nurse will verify the completed. However, review of the chart audits report by placing initials with the date, time, on the revealed the facility failed to identify any concerns report and MD notification in the electronic medical with medication administration. record. To ensure and monitor that culture result notification is reported the Lab will do a quality Focus Review regarding notification to the primary 1. a. Review of the facility policy titled, "Priority nurse and the Infection Control nurse this will be List for Laboratory," last revised April 2001, revealed the policy did not address the process report through QAPI. lab was required to follow when labs were sent To ensure patients with Diabetic Foot Ulcers will be out to other labs for processing. 8/22/19 assessed and treated per policy (see attached policy). A quality Focus Review will be done to monitor this Review of the facility policy titled, "Transmission and reported through QAPI. Based Isolation Precautions," approved February 2017 revealed all patients suspected of/or known to have a communicable disease will be placed in the proper category of isolation based on transmission mode of the disease. A Physician, Charge Nurse or Infection Control Nurse has the authority to order and place the patient in isolation. Signage will be universal within the acute care areas. Signs will be place on the door of the patient rooms. Continued review of the policy revealed contact precautions requires gloves and handwashing, wearing of a gown in the patient's room, patient placed in a private room if possible or cohorted as necessary, use disposable patient care equipment whenever possible and all items in the patient's room should be cleaned daily. Visitors are required to use gowns and gloves. Review of the facility policy titled, "Infection Prevention Plan," approved February 2017, revealed the facility had systems in place for the reporting of infection surveillance, prevention, and control information to the following: appropriate staff within the facility, federal, state and local public health authorities, Accrediting bodies including infection control related adverse event

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_\_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC (DENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) (E2340) {E2340} Continued From page 31 reporting, and the referring or receiving organization when a patient was transferred. Continued review of the policy revealed the Infection Prevention Chairperson and the Infection Prevention Manager/Professional were responsible for overall monitoring and evaluation of the Infection Prevention Program. The Infection Prevention Manager was responsible for employee health and safety including identifying infection prevention and control risks, monitoring of patient care activities and the implementation of applicable precautions, environmental conditions related to control of infections, safety consulting in the selection of equipment and supplies relative to control infections. communication of infection date, to administrative leadership on a routine and emergency basis. Further review of the facility policy revealed Multi-drug resistant organisms are a major facility and community safety concern including colonization of MDRO which have the potential to proliferate, invade and infect susceptible, immunocompromised individuals. Factors, which may predispose the patient to acquiring MDRO's, include, but are not limited to: broad spectrum antibiotics administration, and immune-deficiency. Risk reduction strategies related to reducing MDRO's acquisition at the facility include but are not limited to MDRO initiatives, hand hygiene practices, and infection prevention education. Observation of Patient #25 on 05/07/19 at 11:05 AM during the initial tour of the facility revealed the patient was lying on the bed with eyes closed. Continued observation revealed there was no evidence that contact precautions were in place. Further observation revealed there were two other patients on the unit, including Patient #26 was observed to be in the room across the hall from Patient #25.

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED **IDENTIFICATION NUMBER:** A. BUILDING: \_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** (E2340) Continued From page 32 (E2340) Observation of Patient #25 on 05/08/19 at 1:22 PM revealed an "infection control box" on the door; however, there was no signage to indicate the type of precautions the patient required. Review of the medical record for Patient #25 revealed the patient was admitted to the facility on 05/01/19 under the services of MD #5 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine), uncontrolled Diabetes, and Hypertension. Review of Physician's Orders dated 05/01/19 revealed an order for staff to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered the following antibiotics (treats infection) to be administered: Levaquin (Levofloxacin) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 one tablet daily. Review of the patient's record revealed a urine culture was collected on 05/02/19 at 2:49 AM. Further review of the urine culture report revealed final results were reported on 05/05/19 at 3:35 PM, which indicated the patient had a Multidrug-Resistant organism (MDRO), Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levaquin or Septra antibiotics. Further review of Patient #25's culture report revealed Nitrofurantoin (an antibiotic) was effective to treat the patient's infectious organism. Further review of the record revealed no evidence that the urine culture report had been reviewed or any action had been taken based on the report.

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Office of Inspector General STATEMENT OF DEFICIENCIES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) [E2340] Continued From page 33 (E2340) Interview with Registered Nurse (RN) #25 on 05/07/19 at 5:00 PM revealed she was responsible for Patient #25's care on 05/07/19. The nurse stated she was not aware that the culture results were back and therefore no action was taken to notify the patient's physician of the results or to initiate infection control precautions to prevent the spread of the patient's infection. Interview with Laboratory Technician (LT) #1 on 05/08/19 at 4:05 PM revealed she stated "all cultures" had been sent out of the facility for approximately one month, because the facility was unable to purchase the needed supplies to run the tests in the facility. The LT stated she was the only lab personnel working on 05/05/19 during the day shift, 7:00 AM-7:00 PM, and she did not have access to the system the facility utilized to obtain lab results from labs that were sent out for processing. She had not been trained to track labs in the facility, and stated she was unaware of who was monitoring to ensure results were obtained of labs sent out for processing from the facility. Interview with LT #2 on 05/08/19 at 11:25 AM revealed the lab supervisor gave lab results to her (Monday-Friday) and she had been trained to fax them to the ordering physician's office. She stated she had faxed Patient #25's abnormal lab results to MD #5's office on 05/07/19; however, was not aware the patient remained in the facility. LT#2 stated that direct care staff had not been notified of the abnormal lab results. She stated she had not spoken to Patient #25's physician to ensure he received the abnormal labs, because she had not been trained to do so. Interview with the Laboratory Supervisor on

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: \_\_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE **860 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 **SUMMARY STATEMENT OF DEFICIENCIES** PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** DATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY) (E2340) Continued From page 34 (E2340) 05/08/19 at 1:50 PM revealed the facility was not doing cultures in the facility "because of money." She stated a payment plan had to be worked out with the supply company because administration had not paid the balance due on the account: therefore, needed supplies could not be obtained to run the physician ordered labs in the facility. She stated all cultures were being sent out to be resulted, and in order to receive the lab results. she had to "login to a direct link" and acknowledged that weekend staff did not have access to track labs that had been sent out. The Laboratory Supervisor also stated, "We're not necessarily looking at lab results on the weekends." She stated she was required to track patient lab results Monday-Friday; however, had not tracked lab results for labs that were sent out of the facility from the previous week, on 05/06/19 (Monday) as required, because she "had other things to do." Interview with the infection Control (IC) Nurse on 05/07/19 at 4:30 PM revealed laboratory staff were required to notify her of any abnormal cultures; however, they had failed to inform her that Patient #25's urine was identified to have ESBL (an MDRO) on 05/05/19. She stated the patient's physician should have been notified of the abnormal laboratory result on 05/05/19, and staff should have ensured the patient was on the appropriate antiblotic to treat the identified infectious organism. She acknowledged the antibiotics that Patient #25 was receiving were not the effective treatment for the patient's infectious organism. The IC nurse also stated contact precautions should have been implemented to protect staff and other patients from transmission of the infectious organism. The IC nurse stated that Patient #25 was previously diagnosed with an ESBL organism in

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **860 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG **DEFICIENCY** {E2340} Continued From page 35 (E2340) his/her diabetic foot ulcer, during a previous hospital stay in March 2019. However, because the electronic record system had not been updated due to outstanding debt, "nothing flags staff" that patients had been diagnosed with an MDRO during previous hospital stays. 1.b. Review of the facility policy titled, "Skin Integrity/Pressure Ulcer," approved August 2018, revealed all patients admitted to the facility are assessed for skin integrity and the presence of a pressure ulcer or the potential for development of a pressure ulcer, to ensure that patients admitted with intact skin and without a pressure ulcer are assessed for risk factors that may potentially lead to the development of a pressure ulcer. If a pressure ulcer is present at time of admission. staffing and measurement will be done, and will be photographed and attached to the medical record. Continued review of the policy revealed all patients with a Braden score of less than 9 are considered a high risk and will be considered as having the potential for impaired skin and preventative measures will be implemented. Patients who are admitted with a pressure ulcer and those who are admitted and are identified to have potential for impaired skin integrity will have a plan of care developed addressing this area. Continued review of Patient #25's medical record revealed prior to admission to the facility on 05/01/19, MD #5 evaluated the patient in his office. MD #5 documented that the patient had burning pain and numbness to both feet and an ulcer to the right foot that had been previously debrided. The progress notes also revealed Patient #25 was status post amputation to his/her great and second toe on the left foot.

However, review of Patient #25's Admission

Office of Inspector General (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION DENTIFICATION NUMBER: A. BUILDING: \_ R-C 05/09/2019 B. WING 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY** {E2340} (E2340) Continued From page 36 nursing assessment, completed by RN #7, revealed the patient was admitted to the facility at 3:56 PM on 05/01/19 and no abnormal skin integrity impairments were identified. RN #7 also documented the patients neurological and pulses were within normal limits. Review of the nurses notes dated 05/03/19 (2) days after admission) at 11:56 AM revealed RN #4 documented that Patient #25 had an "old debridement area, open round area surrounded by extremely thick dry skin noted white/pale yellow area noted with dark area on the side. small amount of clear yellow drainage noted," to his/her right foot. Review of the patient's record revealed no evidence the patient's diabetic foot ulcer was Identified, assessed, and/or treated until 05/03/19 at 11:56 AM. Continued review of the record revealed the first measurement of the patient's diabetic ulcer was not completed until 05/04/19 (2 days after admission) at 6:00 PM by the Chief Nursing Officer (CNO). Review of the CNO's documentation revealed the patient's ulcer was "3 centimeters (cm), X 3 cms and was 0.3 cms deep with a callus present." In addition, review of Patient #25's physician orders revealed an order was not entered to treat the patient's wound to the foot until 05/03/19 (2 days after admission) at 12:02 PM for "daily betadine dressing changes". Further review of Patient #25's nursing documentation revealed RN #6 documented on 05/06/19 at 12:53 PM that the patient's wound had a moderate amount of serous (clear) drainage and an odor was noted. However, there was no evidence the patient's physician was

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_ R-C B. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) {E2340} Continued From page 37 {E2340} notified of the foul odor to the patient's wound. Continued review of Patient #25's physician orders revealed Nurse Practitioner (NP) #1 ordered a surgical consult for the patient on 05/05/19 at 10:44 AM related to his/her diabetic ulcer. Review of Physician #3's (the facility surgeon) consultation report revealed he evaluated Patient #25 on 05/07/19 (2 days after the surgical consult was requested) and documented that the patient had an "ongoing open wound" to his/her right foot. Physician #3's documentation also revealed the patient had a history of osteomyelitis (infection of the bone), which appeared to be "settling down," and had Peripheral Vascular Disease, Diabetes, Coronary Artery Disease, Multiple Debridement, and foot surgery. Continued review of Physician #3's assessment of Patient #25 revealed there was no pulse on the dorsalis pedis (artery that carries oxygenated blood to that area of the foot) on the patient's right side, and he/she also had a 3 cm by 5 cm area of ulceration, with some cellulitis and hyperkeratotic (thickening of the outer layer of skin) skin around the patients diabetic ulcer. Interviews with RN #4 and RN #7, who provided care for Patient #25, were attempted on 05/07/19 and 05/08/19; however, no return calls were received. Interview with the Infection Control Nurse on 05/07/19 at 4:30 PM revealed if staff had observed/documented that Patient #25's wound had odorous drainage during the current hospital stay, the physician should have been notified.

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **860 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (E2340) Continued From page 38 (E2340) A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed she expected staff to complete head to toe assessments on patients when they were admitted to the facility. She also stated staff should have identified Patient #25's diabetic ulcer on admission and notified the patient's physician and obtained orders to treat the patient's ulcer. She also stated Patient #25's ulcer should have been photographed and measured as directed in the facility policy. The CNO also stated she was unsure why staff who conducted daily chart audits had not identified the concerns with Patient #25's care. She also said staff that identified odorous drainage to Patient #25's wound should have contacted the patient's physician. She also stated the laboratory department should have implemented processes to ensure labs that had been sent out of the facility for processing, and were tracked timely to ensure timely physician notification. A post-survey interview with Physician #5 on 05/13/19 at 3:35 PM revealed staff should have notified him timely of the patient's final urine culture results to ensure proper treatment. 2. Review of the facility policy titled, "Assessment and Reassessment of Patients Plan" revised February 2019 revealed Patient assessments are initiated by qualified individuals upon admission to the facility. Assessments and reassessments continued throughout the patient's stay in the facility. Continued review revealed an assessment was required to be completed on patients admitted to the facility. Each patient would have his/her needs initially assessed by a registered nurse. According to the policy, care needs are evaluated periodically and reassessed by a RN as the condition warrants. Maximum

Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_\_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5)(X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) {E2340} {E2340} Continued From page 39 time frames for the initial assessment to be completed and for the reassessment are upon admission to the medical/surgical floor. Further review of the policy revealed the RN was responsible for initiating and individualizing the Plan of Care for each patient. The RN prioritizes the identified patient needs and this included collaboration with involved disciplines when appropriate. Record review revealed the facility admitted Patient #26 on 05/07/19 at approximately 10:30 AM with diagnoses that included Asthmatic Bronchitis and Chronic Obstructive Pulmonary Disease Exacerbation. Observation of Patient #26 on 05/07/19 at 11:05 AM revealed Patient #26 was found lying in bed with the head of the bed raised. The patient was dressed in street clothing and was observed to have labored breathing. Further observation revealed Patient #26 had no Intravenous (IV) access or Oxygen in place at that time. Continued observation revealed the facility had three (3) patients admitted in the facility at the time of observation, staffed with two (2) CAN's and one (1) Registered Nurse. All nursing staff were seated at the nursing station at the time of the observation. Interview with Patient #26 on 05/07/19 at 11:05 AM revealed the patient stated, "I'm terrible." Patient #26 stated Physician #2 sent him/her over from the doctor's office for admission to the facility. Patient #26 stated "I can't breathe" and that only a "Nurse Aide" has been in the room to get a weight and someone from the kitchen had brought him/her something to eat. Continued interview revealed the patient stated "no nurse" had been in to check on the patient or to assess

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED AND PLAN OF CORRECTION A. BUILDING: 8. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES COMPLETE FACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) {E2340} {E2340} Continued From page 40 the patient's difficulty breathing. Patient #26 stated the CAN had told him/her the nurse would be in to give him/her some medication. Interview with Registered Nurse #25 on 05/07/19 at 11:15 AM revealed that she was Patient #26's nurse for that shift. RN #25 was informed by the surveyor that Patient #26 said she was in distress and the RN said she was unaware that the patient was in distress. RN #25 contacted Respiratory Services to assess and treat Patient #26's respiratory difficulty at that time; however, observation revealed that RN #25 did not go and assess or evaluate the patient. Review of Patient #26's History and Physical dated 05/08/19 revealed Physician #2 documented the patient presented to her office as an acute walk in with increased periods of shortness of breath and dyspnea. "The respiratory difficulty is impairing [his/her] speech today. [The Patient] is having some mild respiratory distress while in the office. [The Patient] is to be admitted for further evaluation [and] treatment." Continued review revealed "The Plan" was to "Admit to medical floor, pulse doses of Medrol, IV Rocephin, IV Zithromax and DuoNeb treatments.\* Review of the "Initial Physical Assessment" dated 05/07/19 revealed at 10:30 AM, Nurse Aide (NA) #1 documented Patient #26's vital signs as the following: Temperature 99.2, Pulse 80, Respirations 20, Blood Pressure 131/83, Oxygen Saturation was 94 % on room air. Continued review of Patient #26's Initial Physical revealed the patient's physical assessment was conducted on 05/07/19 at 5:48 PM (seven (7) hours and seventeen (17) minutes after admission.)

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_\_\_ R-C B. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE. KY 40977** PROVIDER'S PLAN OF CORRECTION DGS SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) (E2340) (E2340) Continued From page 41 Review of "Patient Progress Notes" dated 05/07/19 at 11:00 AM revealed an IV was placed in Patient #26's right upper arm with a #22 gauge. Review of "Patient Progress Notes" dated 05/07/19 at 11:23 AM revealed RN #25 administered Solu-Medrol 80 mg (milligrams) IV Push. Interview with the Chief Nursing Officer on 05/09/19 at 3:00 PM revealed the reason Patient #26's nursing assessment was completed seven hours after admission was because the nursing staff thought the patient was being admitted to outpatient services. The CNO offered no explanation as to why Patient #26 was placed in a bed on the Medical Surgical floor, why the physician orders were written as if the patient was staying the night, why the History and Physical indicated the patient was to be admitted to the facility, or why it was acceptable not to conduct a timely nursing assessment if the patient was admitted to outpatient services. F2920 902 KAR 20:016 4(4)(b)2m Section 4. Provision 6/11/19 of Services To correct the issue of having adequate laboratory services to meet the needs of patients #25 and #31, aboratory staff have been educated on the procedure (4) Laboratory services. to access an electronic file to retrieve timely receipt of lab results. Result will then be forwarded to the Anatomical pathology services and blood Infection Control nurse and the patient's primary bank services shall be available in the nurse and physician. hospital or by arrangement with other facilities. An agreement between the facility and the vendor has 6/11/19 been reached to order supplies to perform lab test and 2. Anatomical pathology. Anatomical pathology to maintain inhouse microbiology testing. (see services shall be provided as indicated by the attached agreement) needs of the hospital, either in the hospital or under arrangement as specified in subparagraph 1.d. of this paragraph. m. The medical staff member requesting the

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) 1D (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY 6/11/19 To correct the issue of a 'stat' blood culture on E2920 E2920 Continued From page 42 4/15/19 and the facility failed to ensure the lab specimen reached the outside lab for 2 days. The examination shall be notified promptly. specimen was collected on 4/15 at 830pm and the lab courier picked the specimen up the following day This requirement is not met as evidenced by: 4/16/19. The specimen then went to the receiving lab Based on interview, record review, and review of and they followed their procedure for blood culture facility policy, it was determined that the facility intubating and reporting. On 4/17/19, we received failed to provide a written description of services verbal and written notification of blood culture results provided to medical staff. An interview with the via fax. (see attached) Laboratory Supervisor revealed the facility did not To correct the issue where the facility failed to have the supplies to conduct cultures and had 6/11/19 develop a written description of the services the been sending the specimens to an outside, contracted laboratory will provide. A written list of contracted laboratory for approximately one services is attached. month. However, the facility failed to develop a written description of the services that the To correct the issue of having adequate laboratory 6/11/19 contracted laboratory would provide and failed to services to meet the needs of patients #25 and #31. develop a policy/procedure to ensure the facility the LT #1 and other laboratory staff have been obtained the laboratory results and acted upon educated on the procedure to access an electronic file the results timely. to retrieve timely receipt of lab results. Results will then be forwarded to the Infection Control nurse and the patient's primary nurse and physician. Review of Patient #25's urine culture results from the contracted laboratory dated 05/05/19 revealed An agreement between the facility and the vendor has the patient's urine contained bacteria that was 6/11/19 been reached to order supplies to perform lab test and resistant to the antibiotics prescribed for the to maintain inhouse microbiology testing. (see patient. However, there was no documented attached agreement) evidence the facility notified the patient's physician of the test results timely. The lab is now staffed 24/7 and Stat Labs will be 8/22/19 done per policy. A quality Focus Review to monitor The physician ordered a blood culture for Patient this will be done by the lab regarding following policy on STAT labs and will be reported through #31 "stat" on 04/15/19. The facility obtained the OAPI. blood specimen for the culture; however, the facility failed to ensure the blood specimen reached the contracted facility's laboratory until 04/17/19, two days later. The findings include: Review of the facility policy titled, "Priority List for Laboratory," last revised April 2001, revealed the policy did not address the process the laboratory was required to follow when lab tests were sent out to other laboratories for processing.

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY E2920 E2920 Continued From page 43 1. Review of the Patient #25's medical record revealed Physician #5 admitted Patient #25 directly to the facility on 05/01/19 with diagnoses of Urinary Tract Infection (UTI) with gross hematuria (blood in urine), uncontrolled Diabetes, and Hypertension. Review of Patient #25 Admitting physician orders revealed staff were directed to collect a urine culture with sensitivity on 05/01/19. Further review of Patient #25's medical record revealed Physician #5 ordered the following antibiotics (treats infection) to be administered: Levaquin (Levofloxacin) 250 milligrams (mg) intravenous (IV) daily and Bactrim (antibiotic combination of sulfamethoxazole and trimethoprim) 400-80 mg one tablet daily. Further review of Patient #25's medical record revealed a urine culture was collected on 05/02/19 at 2:49 AM and the final urine culture results were reported on 05/05/19 at 3:35 PM. Review of the final results indicated the patient had a Multidrug-Resistant Organism (MDRO) called Extended-spectrum beta-lactamase (ESBL) in his/her urine. Review of the sensitivity report revealed the organism was resistant (would not respond) to Levofloxacin and sulfamethoxazole/trimethoprim antibiotic medications that the patient was receiving at the facility. There was no documented evidence the facility had notified the patient's physician that the medications that the patient was receiving would not treat the patient's infection. Interview with RN #25 on 05/07/19 at 5:05 PM revealed she had been assigned to care for Patient #25 on 05/07/19 since 7:00 AM. Even though the patient's lab results were observed in

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 100020 05/09/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **(EACH CORRECTIVE ACTION SHOULD BE** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY E2920 E2920 Continued From page 44 the patient's medical record, the RN was not aware that the patient had laboratory results dated 05/05/19 (two days prior) that showed the patient had ESBL (an MDRO) in his/her urine. The RN acknowledged staff had not implemented contact precautions to protect staff and other patients from the MDRO and no action was taken until the facility was made aware by the surveyor. Interview with Laboratory Technician (LT) #1 on 05/08/19 at 4:05 PM revealed "all cultures" were being sent to another facility laboratory to be processed because the facility was unable to purchase the needed supplies to run the tests in-house. She stated that had been the practice for approximately one month. The LT stated she was the only staff member working in the laboratory on 05/05/19 (when Patient #25's urine culture results were available) during the day shift (7:00 AM-7:00 PM). However, the LT stated she did not have access to the computer system to obtain laboratory results from the outside facility laboratory, nor was she trained to obtain the laboratory results. LT #1 stated she was unaware who was monitoring to ensure results from the outside laboratory were obtained timely. Interview with LT #2 on 05/08/19 revealed the lab supervisor gave her laboratory results (Monday-Friday) and she faxed the results to the ordering physician's office. She stated she faxed Patient #25's abnormal lab results to MD #5's office on 05/07/19 (two days after the results were available). LT #2 stated she was not aware the patient remained an inpatient at the facility; therefore, she did not notify direct care staff of the abnormal lab results. In addition, LT#2 stated she had not spoken to Patient #25's physician to ensure he received the abnormal laboratory results because she had not been trained to do

Office of Inspector General (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: \_ R-C B. WING 05/09/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) E2920 E2920 Continued From page 45 Interview with the Laboratory Supervisor on 05/08/19 at 1:50 PM revealed the facility was not doing any type of cultures "because of money" and the cultures were being sent to an outside facility. She stated the facility did not have supplies needed to analyze blood cultures because facility administration had not paid the balance on the account with the company that provided supplies. She stated a payment plan had to be worked out with the supply company before needed supplies could be obtained to process the laboratory testing at the facility. The Laboratory Supervisor stated to obtain the results of laboratory tests that were sent to another facility, she had to "login to a direct link": however, only she and one other staff member had access to the account. She acknowledged staff who worked on weekends did not have access to account to obtain laboratory results and stated, "We're not necessarily looking at lab results on the weekends." She stated she was required to track patient laboratory results Monday through Friday; however, she did not have a system to review/track laboratory results from the previous week because she "had other things to do." 2. Review of Patient #31's medical record for revealed the facility admitted the patient on 04/15/19 with a diagnosis of Atrial Fibrillation with Rapid Ventricular Rate (an irregular heart rate that commonly causes poor blood flow). Review of the Physician Orders for Patient#31 revealed the physician ordered a Blood Culture on 04/15/19 at 8:24 PM STAT. Review of the Laboratory Results for Patient #31

Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING: \_\_ R-C B. WING 05/09/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) E2920 Continued From page 46 E2920 revealed the facility collected a blood specimen for a blood culture on 04/15/19 at 8:30 PM. However, further review revealed the facility did not send the blood specimen to another laboratory "Out Sourced Lab" until 04/17/19 at 5:03 AM, two days after the physician's order for the laboratory was written and the blood specimen was obtained. Review of the final report revealed the patient's blood culture was positive for Gram Negative Bacilli (bacteria In the blood). Continued interview with the Laboratory Supervisor on 05/08/19 at 1:50 PM revealed Patient #31's blood specimen did not go to the "Out Sourced Lab" on 04/15/19 because the laboratory service had already picked up specimens when the blood specimen for the patient was obtained. The supervisor stated the specimen was picked up on 04/16/19, and did not arrive to the outside laboratory until 04/17/19, two davs later. A post-survey interview with the Chief Nursing Officer (CNO) on 05/13/19 at 3:15 PM revealed the laboratory department should have implemented processes to ensure laboratory tests that were sent out of the facility for processing were tracked to ensure timely physician notification.

PRINTED: 03/29/2019 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X1) PROVIDERS LIPLIER CLIA (X3) DATE SURVEY STATEMENT OF DEFICIENCIES NSTRUCTION AND PLAN OF CORRECTION COMPLETED A. BUILDII 0021 03/12/2019 NAME OF PROVIDER OR SUPPLIER ADDRESS, CITY, STATE, ZIP CODE TREE ERVIEW AVENUE Blanch LE, KY 40977 SOUTHEASTERN KY MEDICAL CENTER Division of Health Care PROVIDER'S PLAN OF CORRECTION (215) (CEP LET ION (X4) ID PREFIX ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) **GOVERNING BODY** 4/14/19 {A 043} (A 043) The Governing Board appointed a new CEO CFR(s): 482.12 who is providing oversight to ensure quality care is being provided. Presently the PI committee is meeting weekly at which time performance There must be an effective governing body that is indicator's and audit findings are being reported. legally responsible for the conduct of the hospital. The CEO attends the weekly PI meetings where If a hospital does not have an organized nursing chart audit results; medication errors, governing body, the persons legally responsible and quality indicators are reported along with for the conduct of the hospital must carry out the plans of corrections as needed. Also reported functions specified in this part that pertain to the are all training/in-services offered and includes governing body ... methods of training as well as evaluation results and percentage of employees trained. A This CONDITION is not met as evidenced by: Governing Board member is on the PI committee Based on interview, record review, and review of as well as a physician who is the Chairperson. The committee reports are sent to the Governing Governing Body Meeting minutes, facility audits, Board and MEC. Daily Operating Budget, and the Plan of Correction the facility submitted for the Statement The budget was approved by the Governing 4/14/19 of Deficiencies dated 01/30/19, it was determined Board on 2/26/19. An addendum will be added the facility failed to have an effective governing to include repayment of outstanding debt which body that was responsible for the conduct of the includes all vendor debt and the repayment facility. During a complaint visit concluded on schedule for tax liabilities. The Board has approved agreements with taxing authorities to 01/30/19, Immediate Jeopardy was identified in ensure liabilities are met see board minutes. the areas of Governing Body, Patient Rights, Quality Assurance and Performance The Chart Audit tool was revised to include more 4/14/19 Improvement (QAPI), Nursing Services, detail and better capture medication errors. Pharmaceutical Services, Discharge Planning, Chart audits were being done dailybut were not Surgical Services, and Emergency Services. The capturing the full 24-hour. Audits will now be performed to include the full 24-hour period from facility submitted a Plan of Correction which alleged compliance/correction of the above the same time each day to the next day. Nursing Administration will maintain a nursing verbal noncompliance on 03/06/19. However, the facility counseling log to include all medication failed to implement the plan of correction related Counselling sessions. Medication errors will be to the Chief Executive Officer (CEO), Budget, reported though a paper report to the Risk QAPI, and Nursing Services. Management committee to monitor patterns or Irends. The CEO failed to ensure staff had completed the trainings included on the above plan and the CEO failed to ensure audits were completed per the hospital's plan of correction. The facility failed to ensure the annual operating budget was prepared according to generally accepted accounting principles. The budget did not include

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.

Event ID: NS5G12

Facility ID: 100020

TITLE

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4/2/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF	CORRECTION	IDENTIFICATIONNUMBER:	A. BUILDING	S	COMPLETED	
i		180021	B. WING		R	
	OVIDER OR SUPPLIER			STREETADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	03/12/2019	
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(A 043)	disclose the hospital facility failed to pay estate, and city) for the facility was still unable on 03/01/19. Staff we (a week after due). It still behind on repaydistributor and as of medications are fille. The facility failed to indicators and audit per the Quality Improplan of Correction for Deficiencies issued. Correction for the St dated 01/30/19 included and the per the plan and did orders. However, the per the plan and did omitted/missed dos Patient #16 and Patient #16 and Patient wo sampled patient related to medications Patient #14.	inding debt and failed to fully it's monetary situation. The employee taxes (federal, e 4th quarter of 2018 and the ole to meet payroll for all staff ere not all paid until 03/08/19 in addition, the hospital was ing their debt to the pharmacy 03/12/19, orders for don a case by case basis.  The sure that performance is were collected and reviewed over the Statement of on 01/30/19. The Plan of atement of Deficiencies added the completion of daily included monitoring medication completion of physician is audits were not completed and identify concerns with es of medications involving	(A 04:	3}		
(A 057)	and A0395.) CHIEF EXECUTIVE CFR(s): 482.12(b)		{A 05	The Governing Board appointed a CEC The CEO will provide monthly and as reports to the Governing Board which youtstanding debt including pharmacys	eeded vill list upplier	/19
FORM CHS, 256	(M),99) Presince Versions Cr	Radia Event ID 1156G	,	payments, taxes, and employee payro	nual on shael Page 2 o	131

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PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	LE CONSTRUCTION	(X3) DATE 5 COMPL	
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				PINEVILLE, KY 40977		
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{A 057}	executive officer who the hospital.  This STANDARD is a Based on interview, i	is responsible for managing not met as evidenced by: ecord review, and review of ting minutes, facility audits,	{A 057	The budget was approved by the Govern Board on 2/26/19. An addendum will be to include repayment of outstanding detincludes all vendor debt and the repaym schedule for tax liabilities. The Board has approved agreements with taxing authorns ure liabilities are met see board min	e added otwhich lent is rities to utes.	4/14/19
	Correction the facility of deficiencies is sue determined that the facility Chief Executive Official for managing the holimplementing the Plafailed to ensure the current revenues and failed to ensure staff	submitted for the statement d on 01/30/19, it was acility failed to ensure the er (CEO) was responsible spital budget and an of Correction. The CEO sperating budget included d debts. In addition, the CEO training and audits were		Staff training/in-services are being condineeded based on ongoing nursing auditraining is done in classroom, one on on small group meetings. Staff understand training is measured. A list of training/ir services as well as methods, attendance valuation of understanding is reported Committee of which the CEO, a Board Mand Medical Staff Member attend.	ts. This le or ding of le, and to the PI	4/14/19
	Correction.  The findings include Review of the Gover dated 02/22/19 rever to serve as the Interi  1. The Pharmacy Surposphospital with medica revisit and information received on 03/13/19 information received the facility's Pharma facility was behind a their payment plan a on 03/20/19. Addition 03/14/19 revealed the hospital had paid ap their past due amous shipments. Howeve	pring Body Meeting minutes aled the CEO was approved m CEO effective 02/27/19.  In the policy was contacted during the confrom the pharmacy was and 03/14/19. Review of twia email on 03/13/19 from cy Supplier revealed the pproximately \$115,000 on and another \$27,000 was due that information received on the company that owns the proximately \$89,000 toward		The Chart Audit tool was revised to include tail and better capture medication errorbart audits were being done daily but a capturing the full 24-hour. Audits will not performed to include the full 24-hour pethe same time each day to the next day. Administration will maintain a nursing vecouns eling log to include all medication. Counselling sessions. Medication error reported though a paper report to the Rimanagement committee to monitor patt trends.	ors. were not ow be riod from . Nursing erbal s will be isk	4/14/19

FORM CMS-2567(02-99) Previous Versions Obsidele

Event ID: NS6G12

Facility IQ 100029

If continuation sheet Page 3 of 31

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PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		180021	B. WING		03/12/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEAS	STERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE		
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(A 057)	information received supplying pharmacy, provide medications each time an order is Review of the daily or evenue and expens basis for the current June 2019. However include payments for debt owed to the Pha addition, the revenue Disproportionate Sh	on 03/14/19 from the the decision whether to to the facility is determined placed.  perating budget revealed the es were listed on a monthly fiscal year July 2018 through the daily budget did not routstanding debts (loans, armacy Supplier). In	{A 0	In the case of Patient #16 the patient had discharged and IV access was removed the 11:00 o'clock dose of IV Levaquin with the pharmacist was not notified timely the EHR that the patient had been disclime omission of patient #16's Levaquin identified because the pharmacy was to the discharge date and not the discharge The pharmacists have been verbally ed on the necessity of looking at the discharge well as the date in order to discover medication errors. The director of pharmacounseled the nursing staff to discharge from the EHR system as soon as the padischarged.	d before vas due. shrough harged. was not booking at ge time. ucated aarge time all nacyhas e patients	
	June 2019.  Interview with the Ch	nief Executive Officer (CEO) 7 AM, 2:20 PM, and 4:12 PM,		Licensed nursing staff will be counsele nurse administration to not remove any access until patient is ready to leave the	IV	
	PM revealed the Go on 02/22/19 and app CEO stated he and the budget; however, the of debt was not incluced, even though the contracted pharm payments of \$28,00	PM, and on 03/12/19 at 2:02 verning Body Board had met bointed him as CEO. The he owner developed the e CEO stated the repayment uded in the budget. Per the ne facility was still in debt to macy and was making 0 per month to repay the not included in the budget.		Patient # 13 was on a fluid restriction a documentation related how nursing statemplement the fluid restriction plan. In 2019, a policy and procedure were develored Restriction. Nursing staff will be inserviced by nursing administration on the Restriction Policy which includes place the fluid restriction plan on the Medact of the electronic Kardex for nursing orders.	ffwas to March eloped on n- he Fluid ment of which is	
	Further interview wit employee taxes (Fer fourth quarter (Octob not been paid. The (	th the CEO revealed deral, State, and City) for the der - December) of 2018 had DEO stated the taxes had		The Registered Dietician will provide fued ucation on fluid restriction diet to nur Evaluation of knowledge will be demorthrough a written test.	sing staff	
	but had not yet beer city governments. In paid employee state Continued interview hospital did not have	the employees' pay checks, n paid to the federal, state, or n addition, the facility had not e taxes for February 2019, with the CEO revealed the e the funds to pay employees I not know until late afternoon	3	RN #5 was identified as being the sam involved in the med errors on Patient # #16. This RN #5 received 1:1 counsel re-education on the Physician Orders p Medication Administration policy by AC Evaluation of the nurse's knowledge w demonstrated through a written test.	14 and ling and policy and NO.	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NS6G12

Facility ID: 100020

If continuation sheet Page 4 of 31

M.K.C.

CEO Y/N/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	LE CONSTRUCTION	(X3) DATE COMPI	
		530			F	≀
		180021	B. WING_		03/1	2/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RESC ID ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) CMPLETION DATE
(A 057)	on 03/01/19 that fund the CEO, direct care 03/07/19 and admini 2:00 PM on 03/08/19	e 4  ds were not available. Per staff were not paid until istrative staff were paid at 9. The CEO stated funds for were not available as of	(A 057	Licensed nursing staffwill be re-educa Medication Administration Policy and F Orders Policy by Nursing Leadership. of the nurse's knowledge will be demo through a written test.	hysician Evaluation	4/14/19
	Continued interview calculating the budg June 2019, he include month that was expective the expective received until Nothe same fiscal year.  2. Review of the Plasubmitted for the State (SOD) dated 01/30/responsible for ensutrained/in-serviced.  Interview with the As (ACNO) on 03/08/19 tried to do as much person with the nurse the policies were giver expected to rein-service roster. We completed the in-service on 03/08/19 at 2:30	n of Correction (POC) atement of Deficiencies 19 revealed the CEO was uring staffwere assistant Chief Nursing Officer eat 2:25 PM revealed, "We of the training/in-service in sing staff, however, some of wen to the staff and the staff ad the policy and sign the edid not ensure the staff had				
4'	on plan of correction left for staff to read a	n-service training (included n) consisted of a policy being and signing a training roster there was a book at the the policies.				150

FCRM CMS-2567(02-99) Provious Versions Obsoleto

Event ID: NS6G12

Facility ID: 100020

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M.K.C.

CEO Y/2/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION		MPLETED
		180021	B. WING			R 3/12/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C			STREET ADDRESS, CITY, STATE, ZIP 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		3112413
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TON SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
{A 057}	3. Review of the Plan submitted for the Sta (SOD) dated 01/30/1 be responsible to en were available, allow participate in Quality Improvement (QAPI) appropriate informal and analyzing data. CEO would report at governing body.  3. A. Review of Patier at governing body.  3. A. Review of Patier at governing body.  3. A. Review of Patier at governing body.  3. A. Review of Patient #1 03/03/19 with a diag Review of Patient #1 03/03/19, included a (antibiotics) 750 mill to be administered at Governmented the patier be planned the follow to continue the patier review of Patient #1 Record (MAR) reveaulement #16's IV antiprescribed.  Interview with Regis 03/07/19 at 10.45 Al administered Patient (Levaquin) as prescribed.  Interview with the Assertice with the Assertic Market with the Assertic Market with the Assertic Market with the Assertic Market with the Assertic Market with the Assertic Market with the Assertic Market With the Assertic Market Ma	n of Correction (POC) Interment of Deficiencies 19 revealed the CEO would It revealed the CEO would It revealed the CEO would It revealed the CEO would It revealed the CEO would It revealed the resources It replans to the It revealed the revealed the patient on It revealed It revealed the patient on It revealed the physician orders dated It revealed the physician intravenous (IV) It revealed the physician intravenous (IV) It revealed the physician intravenous intravenou	(A)	057)		

FORM CMS-2597(02-99) Prevous Versions Obsolete

Event ID: 1156G12

Facility ID: 100020

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M.K.C.

CCO Ylalia

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(22) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
					F	1	
		180021	B. WING		03/	12/2019	
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) CUPLET ION DATE	
(A 057)	had conducted a chamedical record on 03 the medication error. Interview with the Phat 9:30 AM revealed medications were on error. Per the Pharm that Patient #16 had Levaquin as prescrib 3. B. Review of Patierevealed the hospita 03/08/19 with a diag Failure (CHF). The p 03/08/19 included armilligrams (mg) IV tw 03/09/18, an order for restriction was receive thowever, further reviewealed no docume scheduled dose of Lino documentation replanned to impleme restriction.  Review of the Plant Statement of Deficie audits would be comaudit tool revealed the nsure physician or correctly; medication or correctly and correc	armacy Director on 03/08/19 she was monitoring daily for the facility, and when nitted, it was a medication acist, she had not identified not received the IV Antibiotic and on 03/06/19.  ent #13's medical record I admitted the patient on nosis of Congestive Heart hysician's orders dated norder for Lasix40 vice per day. In addition, on or a 2000-milliliter (ml) fluid	(A O	57)			
	03/11/19 revealed th that a dose of Lasix given on 03/09/19 o	e hospital had not identified was not documented as r that there was not plan for atient #13's fluid restriction					

FORM CMS-2567(02-99) Previous Versions Cosdete

Evient ID: NS6G12

Facility ID: 100020

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M.K.C.

CEO 4419

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DELAN OF CORRECTION IDENTIFICATIONNUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED		
			-			R
		180021	B WING			/12/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER	850 F	EET ADDRESS, GITY, STATE, ZIP COE RIVERVIEW AVENUE EVILLE, KY 40977	DE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	ID PRÉFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(XS) COMPLETED DATE
{A 057}	Continued From pag	je 7	{A 057}			
	Chart Audit Tool) dai revealed there four (medical-surgical uni 03/11/19. The tool in timely administration omissions, etc. On 0 to include a review of 03/10/19 and 03/11/19 and 03/11/19 and 03/11/19 and out identified an administration or the documented as administration or the documented as administration or the documented as administration or the documented as administration or the documented as administration or the documented as administration or the documented they did the Audit for 03/09/19. Toompleted the audit 10:00 AM. She state documentation that 12:00 AM, and state frame would be revisaw now she was dishould be looking a ADON stated they of	audit tool (Medical-Surgical ted 03/08/19 through 03/11/19 (4) to six (6) patients on the it between 03/08/19 and included a category to audit in of medication, medication 03/09/19, the audit tool failed of Patient #13. Review of 19 audit sheets revealed staff int #13's medical record, but my problems with medication at the ordered Lasix was not ministered on 03/09/19.  Itant Director of Nursing on 03/12/19 at 8:45 AM in Medical-Surgical Chart The ADON stated she at for 03/09/19 at approximately ed she reviewed thad been completed since and the next day the same time ewed. The ADON stated she toing the audit wrong and the 24-hour period. The did not identify that Patient to documented as given for the				
	PM revealed she had ay shift until the pa	e Aide #1 on 03/11/19 at 4:40 ad cared for Patient#13 on atient was discharged home. , she was not aware Patient				
	revealed she had ca	7 on 03/11/19 at 4:57 PM ared for Patient #13 on day				

FORM CMS-2587(02-99) Previous Vorsions Obsolete

Event ID: NS6G12

Facility ID: 100020

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M.K.CI

CEO 42/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED	
			N. BOICDI		R	
		180021	B. WING_		20	12/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
COLENIEAR	TTON 1/4 MEDICAL C	ENTER	26	850 RIVERVIEW AVENUE		
SOUTHEAS	STERN KY MEDICAL C	ENIEK		PINEVILLE, KY 40977		
(XA) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICENCY)	ND BE	(X5) EXPLETION CATE
{A 057}	Continued From pag	ee 8	{A0	57)		
		/19). The RN stated the	,	1		
		00 ml fluid restriction and				
	· ·	estriction was documented				
		ct (Kardex used for nursing	1.0			
		ere was no specific plan as to ion would be implemented.	1			
		r that morning showed the				
£3	patienthad consum	ed 960 ml by 8:00 AM.				
	Interview with the As	sistant Director of Nursing				1
	(ADON) and RN #8	on 03/12/19 at 8.45 AM				
		N #8 had completed the				
		09/18. The ADON reviewed				
		and could not find a plan for eld restriction. The ADON				
		anning for the fluid restriction				
:	had not being identi	fied on the chart audit.				0.
		EO on 03/08/19 at 10:00 AM				7
		d the weekly QAPI Meetings				
		nitoring stafftraining. The 'learned today'' (after				
		veyors) that some staffhad				
		The CEO stated he was				
		taff training consisted of staff				
		signing an in-service record.  ought the training would be				
		tting with some sort of testing				
		e CEO further stated he had				
	not been notified of	any concerns with the chart				
		aware of any medication	×	- G		
(6.072)	errors or omissions	*	10.0	3701	*	
(AU/3)	INSTITUTIONAL PL CFR(s): 482.12(d)	AN AND BUDGET	(AC	773)		
	The institution must	thave an overall institutional				
		following conditions:				
		oclude an annual operating				1
:						

FORM CMS-2567(02-99) Prozous Versions Obsidete

Evient ID: NS6G12

Facility ID 100020

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CGO 4/2/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLA (X2) MULTIPLE CONSTRUCTION (X3) DATE SI COMPLE  A. BUILDING					
					1	R
		180021	B. WING		03/	12/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1	850 RIVERVIEW AVENUE		
SOUTHEAS	STERN KY MEDICAL C	ENIER		PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES KCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
(A 073)	budgetthat is prepa accepted accounting (2) The budget mus income and expens require that the budget components of each expense. (3) The plan must properties of a section (4) The plan must in objective of, and the financing for, each a in excess of \$600,0 established, in accounting for, each a in excess of \$600,0 established, in accounting to a section (ii) Improvement equipment; or (iii) The replaced expansion of building This STANDARD is Based on interview review of accounting facility budget, it was falled to ensure the prepared according accounting principal budget revealed the budget included re and failed to fully di	grinciples. It include all anticipated es. This provision does not get identify item by item the h anticipated income or  rovide for capital expenditures period, including the year in budget specified in paragraph h is applicable. Include and identify in detail the e anticipated sources of anticipated capital expenditure (00 (or a lesser amount that is ordance with section 1122(g) e State in which the hospital is so to any of the following: Into fland, buildings, and ment, modernization, and ment, modernization, and mest, modernization, and mest, modernization, and grand equipment.  In not met as evidenced by: In record review, policy review, Ing websites, and review of the east determined that the facility eannual operating budget was go to generally accepted les. Review of the facility's east facility failed to ensure the payment of outstanding debt listose the hospital's monetary	{A 07	The budget was approved by the 0 Board on 2/26/19. An addendum to include repayment of outstandin includes all vendor debt and the reschedule for tax liabilities. The Boapproved agreements with taxing ensure liabilities are met see board.	will be added ng debt which epayment ard has authorities to	4/14/19
	taxes (federal, state of 2018; employee owed \$377,000 to	ty failed to pay employee e, and city) for the 4th quarter taxes for February 2019; and the Pharmacy Supplier. ty failed to include the debt in				

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Event ID: NS6G12

Facility ID: 100020

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CEO Yeliq

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	
		180021	B. WING			03/12/2019	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEAS	STERN KY MEDICAL C	ENTER		8	850 RIVERVIEW AVENUE		1
SOUTHLASTERN AT MEDICAL CERTER			ı	PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC (DENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRE PREFIX (EACH CORRECTIVE ACTION SH TAG CROSS-REFERENCED TO THE APP DEFICIENCY)		BE	(X5) CMPLETION DATE
{A 073}	Continued From pag	e 10	.{A	073			
	not available to mee addition, the budget per month from Janu	as of 03/12/19, funds were tpayroll due on 03/15/19. In included revenue (\$99,000 lary through June 2019) for se received until November year).					
	The findings include						<u>.</u>
	Budget, and Three (; Budget," dated Febru Hospital Administrat complete an annual budget, and three-ye that will be forwarde	"Strategic Plan, Operating 3) Year Capital Expense uary 2019, revealed the ion will initiate, develop, and strategic plan, operation ear capital expense budget d to the Medical Executive rd of Directors for approval.					
	Exchange Commiss Accounting Principle standards, conventic companies use to m These results includ companies record as US, the SEC has the	estor.gov (US Securities and identification), Generally Accepted is (GAAP) are accounting on an accepted in the easure their financial results. The length of the easter and liabilities. In the eathority to establish GAAP, as historically allowed the ablish the guidance.					
	Accepted Accounting "Principle of periodic divided by standard such as fiscal quarte Principle of material disclose the organiz Review of the daily of	ating.com, "Generally g Principles" (GAAP) include city. Reporting of revenues is accounting time periods, ers or fiscal years and ity: Financial reports fully ation's monetary situation." operating budget revealed the ess were listed on a monthly					6

FCRM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NS6G12 Facility ID: 100020

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CEO Yalig

PRINTED: 03/29/2019 FORM APPROVED OMB\_NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
						R	
		180021	B WING			03/1	12/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		- 1
SOUTHEAS	STERN KY MEDICAL C	FNIFR		8	50 RIVERVIEW AVENUE		
00011127		614 T6474		P	INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(25) COLETTOR DATE
{A 073}	Continued From pag	e 11	{A	)73)			
{A 073}	basis for the current June 2019. Further midd not include paym In addition, the reven Disproportionate Shirof \$99,000 per mont June 2019.  The Pharmacy Supp hospital with medica revisit and informatic received on 03/13/19 information received the facility's Pharma facility was behind a their payment plan a on 03/20/19. Addition 03/14/19 revealed the hospital had paid ap their past due amou shipments. However, owe the Pharmacy Ser information received supplying pharmacy provide medications each time an order is linterview with the Chan 03/07/19 at 11:27	fiscal year July 2018 through eview revealed the budget ents for outstanding debts. the section included a are Hospital (DSH) revenue the from January 2019 through dier, who supplied the attorn was contacted during the profession of the promote of the province of the proximately \$115,000 on and another \$27,000 was due the proximately \$15,000 on the proximately \$15,000 o	{A (	)73)			
	PM revealed the Go on 02/22/19 and app CEO stated he and I budget; however, the of debt was not incluCEO, even though the contracted pharm payments of \$28,00	verning Body Board had met pointed him as CEO. The the owner developed the ac CEO stated the repayment and in the budget. Per the he facility was still in debt to macy and was making 0 per month to repay the notincluded in budget.					

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Event ID: NS6G12

Facility ID 100029

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M. K. Cy

CEO Ydia

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION	(X3) DATE !	
			N. BUILDIN		R	
		180021	B. WING_		03/1	2/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEAS	STERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	CUPLET ON DATE
(A 073)	Further interview with employee taxes (Fed fourth quarter (Octobrot been paid. The Cobeen withheld from the buthad not yet been city governments. In paid employee state Continued interview hospital did not have on 03/01/19, but did on 03/01/19 that funthe CEO, direct care 03/07/19 and admin 2:00 PM on 03/08/1		{A 07	3}		
(A 263)	O3/12/19.  Continued interview calculating the budg June 2019, he inclumenth that was expensed by the expect be received until Not the same fiscal year QAPI CFR(s): 482.21  The hospital must distribute an effective data-driven quality a improvement program reflects hospital's organizations pital department.	with the CEO revealed when set for January 2019 through ded \$99,000 of revenue per sected from DSH Payments. ted DSH payment would not wember 2019 (which is not in r).  evelop, implement and e, ongoing, hospital-wide, assessment and performance	(A 26	The Chart Audit tool was revised to incede the detail and better capture medication e Chart audits were being done daily but capturing the full 24-hour. Audits will aperformed to include the full 24-hour the same time each day to the next day Medication errors will be reported thou paper report to the Risk Management to monitor patterns or trends.	rrors. t were not a now be eriod from y. gh a	

FORM CMS-2597(02-99) Prevous Versions Obsolete

Event ID: NS6G1Z

Facility ID: 100020

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M.K.C.

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PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPUER  SOUTHEASTERN KY MEDICAL CENTER  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFINITY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVA ACTION SHOULD BE CROSS-REPERCED TO THE APPROPRIATE OF THE APPROPRIA	(X3) DATE SURVEY COMPLETED			(X2) MULTIPLE A. BUILDING _	(X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:	DEFICIENCIES CORRECTION	
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER    SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCES) (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (CROSS-REFERENCE) TO THE APPROPRIATE OF DEFICIENCY MUST BE PRECEDED BY FULL TAG (CROSS-REFERENCE) TO THE APPROPRIATE OF DEFICIENCY MUST BE PRECEDED BY FULL TAG (CROSS-REFERENCE) TO THE APPROPRIATE OF DEFICIENCY)    (A 263)   Continued From page 13 arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.    The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.	R 03/12/2019			B. WING	180021		
(A 263)  (A 263)  Continued From page 13 arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.  The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.  This CONDITION Is not met as evidenced by: Based on interview, record review, audit review, review of the Quality Improvement Plan, and review of the Plan of Correction for the Statement of Deficiencies issued on 01/30/19, it was determined the hospital failed to develop and implement an ongoing, hospital-wide, date-driven quality as sessment and performance improvement Plan and per the Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies dated 01/30/19 included the completion of daily chart audits which included monitoring medication administration and completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders. The plan of correction completion of physician orders.			RIVERVIEW AVENUE	850 RIVERVIEW AVENUE			
arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.  The hospital must maintain and demonstrate evidence of its QAPI program for review by CMS.  This CONDITION Is not met as evidenced by: Based on interview, record review, audit review, review of the Quality Improvement Plan, and review of the Plan of Correction for the Statement of Deficiencies issued on 01/30/19, it was determined the hospital failed to develop and implement an ongoing, hospital-wide, date-driven quality assessment and performance improvement program. The hospital failed to ensure that performance indicators and audits were collected and reviewed per the Quality Improvement Plan and per the Plan of Correction for the Statement of Deficiencies issued on 01/30/19. The Plan of Correction for the Statement of Deficiencies dated 01/30/19 included the completion of daily chart audits which included monitoring medication administration and completion of physician orders. The plan of correction completion date or	(XS) CUPLET IDN DATE	DEE CHILLET	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PREFIX
the audits were not completed per the plan and did not identify concerns with omitted/missed doses of medications involving Patient#16 and Patient #13.				{A 263}	ocuses on indicators related outcomes and the prevention dicat errors.  naintain and demonstrate a program for review by CMS.  not met as evidenced by: record review, audit review, y Improvement Plan, and of Correction for the Statement and on 01/30/19, it was pital failed to develop and ing, hospital-wide, date-driven and performance am. The hospital failed to lance indicators and audits reviewed per the Quality and per the Plan of Correction of Deficiencies issued on of Correction for the encies dated 01/30/19 etion of daily chart audits nitoring medication completion of physician correction completion date or is listed as 03/06/19. However, a completed per the plan and cerns with omitted/missed	arrangement); and fito improved health of and reduction of me.  The hospital must mevidence of its QAPI.  This CONDITION Is Based on interview, review of the Quality review of the Plan of Deficiencies issued termined the host implement an ongoing quality as sessment improvement programmers of the Statement of 01/30/19. The Plan Statement of Deficiencies included the complewhich included more administration and orders. The plan of correction date was the audits were not did not identify condoses of medication.	(A 263)
Refer to tags A273, A385, and A395.  DATA COLLECTION & ANALYSIS  CFR(s): 482.21(a), (b)(1),(b)(2)(i), (b)(3)  (a) Program Scope	n?			{A 273}	0N & ANALYSIS .(b)(1),(b)(2)(i), (b)(3)	DATA COLLECTIO CFR(s): 482.21(a),	{A 273}

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: N56G12

Facility ID: 100020

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CEO Yelig

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1 1	IPLE CONSTRUCTION PG		LETED
		180021	B. WING_		03/:	R   2/2019
141	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		i
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY ORLSC IDENTIFYING INFORMATION)		EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE		HULD BE	CAS) CAFET SA
{A 273}	(1) The program muto, an ongoing program muto, an ongoing program mutoric evidence that it will in (2) The hospital mustrack quality indicato	st include, but not be limited am that shows measurable cators for which there is in more health outcomes st measure, and its and other aspects of sess processes of care,	(A 2	73) The Chart Audit tool was revised to detail and better capture medication Chart audits were being done daily capturing the full 24-hour. Audits we performed to include the full 24-houthe same time each day to the next Medication errors will be reported the paper report to the Risk Managemento monitor patterns or trends.	n errors. but were not ill now be r period from day. ough a	4/14/19
	(b)Program Data (1) The program must incorporate quality indicator data including patient care data, and other relevant data, for example, information submitted to, or received from, the hospital's Quality Improvement Organization. (2) The hospital must use the data collected to- (I) Monitor the effectiveness and safety of services and quality of care; and (3) The frequency and detail of data collection must be specified by the hospital's governing body.			An annual meeting calendar has be developed to ensure timely meeting medical staff committees. These coinclude: MEC, PI, Utilization Review Management, Blood Utilization/Infecontrol/Surgery and P&T/ Dietary. Also, those department members of the PI Committee vischeduled on a rotating basis to attraction their quality reports. All Medical Stareports will be given to the PI Command Governing Board.	of the ommittees v/Risk ction ent managers vill be end and give ff Committee	4/14/19
	Based on interview, and review of the Qu hospital failed to ensindicators and audit per the Quality Imported Plan of Correction for Deficiencies issued Correction for the St dated 01/30/19 revelbe completed which medication adminis	not met as evidenced by: record review, audit review, uality Improvement Plan, the sure that performance s were collected and reviewed ovement Plan and per the or the Statement of on 01/30/19. The Plan of atement of Deficiencies aled daily chart audits would included monitoring tration and completion of		The facility process frame work is the Study, Act (PDSA). The program herisk, high volume, problem prone pulso, Utilization Review/ Risk Mana Committees meet every two month Blood Utilization/ Infection Control, Dietary/ Health Information Managemeet quarterly. Data on Organ pro Mortality Review, Incident reports, I Seclusion use are collected concurreported at respective committees.	ooks at high roces ses. gement s. Surgery/ and P&T / ement will all curement, Restraint and rently and	4/14/19

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Event ID: NS6G12

Facility ID 100020

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M.K.C.

CEO Yaliq

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SUMMARY STATESIST FOR EXPORESS, CITY, STATE, ZP CODE 898 RIVERVIEW MERUE PINEVILLE, KY 40977  SUMMARY STATESIST OF EXPORENCES EACH DESCRIBANCES EACH DESCRIBANCE PROCEEDED BY PULL REQULATORY ORLS (IDBN 119 YMS) PROVIDER STAND CORRECTION ACTION SHOULD BE CROSS REPRESENTED TO THE APPROPRIATE OF THE AUDIS WERE OR OF THE AUDIS WERE AU		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILOING	E CONSTRUCTION	COMPLETED R	
SOUTHEASTERN KY MEDICAL CENTER    SUMMARY STATEMENT OF DEFICIENCES   PROVIDERS PLANOF CORRECTION   PRETIX		180021	B WING			· I	
(A 273)  (A				BSO RIVERVIEW AVENUE			
completion date or correction date was listed as 03.06/19. However, the audits were not completed per the plan and failed to identify concerns with omitted/missed doses of medications involving Patient #16 and Patient #13. The nursing audits also failed to identify a transcription error with Patient #14. The Plan of Correction also stated a review of all Performance Indicators would be conducted in the weekly Quality Assurance Performance Improvement (QAPI) meeting; however, only the performance indicators included in the Plan of Correction were reviewed in these meetings. In addition, the hospital's revised Quality Improvement Plan included scope of the program and areas to be reviewed in the program; however, the facility failed to obtain data for several of these areas to include. Mortality Review, Organ Procurement, Data Management, Measures related to Regulatory Requirements, Moderate/Deep Sedation, and Anesthesia Adverse Events, etc.  The findings include:  Review of the hospital's 2019 Quality Improvement Plan signed 03/05/19 revealed the areas included in the scope of the program were high risk, high volume or problem prone processes; infection control; restraint and sectusion use; mortality review; blood and blood product use; organ procurement, utilization review; data management; measures related to regulatory requirements, etc. The plan also listed the committee members, the process improvement framework, and reporting format.  Review of the Plan of Correction (POC) for the	PREFIX	(EACH DEFICE	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	DBE	COMPLETION
Citation to the Companies (Companies Companies	{A 273}	completion date of 03/06/19. However completed per the concerns with om medications involved in the medication also stoperformance Individual the weekly Quality Improvement (QA performance individual correction were readdition, the host Improvement Pla and areas to be rehowever, the facilla several of these are Review, Organ P. Measures related Moderate/Deep S. Adverse Events,  The findings included in high risk, high vo processes; infect seclusion use; more productuse; organ regulatory requires the committee mimprovement fra.	r correction date was listed as in, the audits were not plan and failed to identify litted/missed doses of wing Patient #16 and Patient audits also failed to identify a with Patient #14. The Plan of lated a review of all cators would be conducted in y Assurance Performance PI) meeting; however, only the cators included in the Plan of eviewed in these meetings. In bital's revised Quality in included scope of the program eviewed in the program; lity failed to obtain data for areas to include. Mortality rocurement, Data Management, it or Regulatory Requirements, it or Regulatory Requirements, it is deation, and Anesthesia etc.  Lide:  spital's 2019 Quality in signed 03/05/19 revealed the inthe scope of the program were lume or problem prone tion control; restraint and cortality review; blood and blood an procurement; utilization in agement; measures related to ements, etc. The plan also listed tembers, the process mework, and reporting format.	(A 273)			

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Event ID: NS6G12

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M. ICCI

CEO Ydig

PRINTED: 03/29/2019 FORM APPROVED OMB NO 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDERSUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			LETED
		180021	B. WING_		03/	12/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		3
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDEN TIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	CVFLETION DATE
{A 273}	revealed "Chart audi medication administ change in condition treatment, nutritional monitoring and follow be performed dailyn compliance. Chart at the ACNO who will reaudits will be reported immediate at the ACNO who will reaudits will be reported immediate at the ACNO who will reaudits will be reported immediate at the ACNO who will reaudits will be reported immediate at the ACNO who with the Medical Quality M	its, including timely ration, medication omissions, documentation, consent for lasocial services consults, wing up on medications, will sursing staff to ensure udit tools are collected by eport results of the charted to QAPI weekly so if actions are taken."  Edical Director on 03/08/19 at the was also appointed as the ical Director in late February edical Director stated she easily Quality Improvement 04/19, but had not discussed with the Chief Nursing Officer cting Quality Director.  Esistance Chief Nursing 3/07/19 at 3:25 PM and with 9 at 4:00 PM revealed the int staff, and direct care nurses for the chart audits as for the 01/30/19 Statement ACNO and CNO stated that e who cared for the patient	{A 2	73)		

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Facility ID 100020

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M.K.C.

CEO 4/19

FORM APPROVED OMB NO. 0938-0391

PRINTED: 03/29/2019

AND PLAN OF CORRECTION				MPLETED	
	180021	B, WING			R 03/12/2019
NAME OF PROVIDER OR SUPPLIE SOUTHEASTERN KY MEDICA			STREET ADDRESS, CITY, STATE, ZIP 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
PREFIX (EACH DEFK	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL LY OR LSCIDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) CCUPLET CH DATE
documented the be planned the foto continue the preview of Patient Record (MAR) re Patient #16's IV prescribed.  Interview with the (ACNO) on 03/0 had conducted a medical record of the medication ewhy the medication ewhy the medication error identified that the administered as Pharmacist state and was unsure been identified.  2. Review of Patrevealed the hos 03/08/19 with a Gailure (CHF). To 03/08/19 revealed (diuretic) 40 mill addition, on 03/02000-milliliter (medication of control of the contro	page 17 revealed the physician patient's discharge home would following morning (03/06/19) and atients IV antibiotics. However, #16's Medication Administration revealed staff failed to administer antibiotics on 03/06/19, as  e. Assistant Chief Nursing Officer 7/19 at 3:25 PM revealed she chart audit of Patient #16's n 03/06/19, but did not identify rror. She stated she was unsure ion error had not been identified.  e. Pharmacy Director on 03/08/19 alled she was monitoring daily for s in the facility, but had not be Levaquin had not been ordered to Patient #16. The ed 'we should have caught that," why the medication error had not find the patient on diagnosis of Congestive Heart the physician's orders dated and the patient required Lasix forams (mg) IV twice per day. In 19/18, the physician ordered a 19/18, the physician ordered a 19/19/19/19/19/19/19/19/19/19/19/19/19/1	{A:	273)		

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Facility ID: 100020

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		180021	B. WING		F	1		
		180021			03/1	12/2019		
NAME OF P	ROVIDER OR SUPPLIER		s	STREET ADDRESS, CITY, STATE, ZIP CODE				
SOUTHEAS	STERN KY MEDICAL C	ENTER		ISO RIVERVIEW AVENUE				
300INEA	SIEKIA KI MEDICAL C	CHIER	F	PINEVILLE, KY 40977				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) CCVFLETIC'S DATE
{A 273}		7/	(A 273)					
	2000 ml fluid restric	tion.	_					
	Statement of Deficie audits would be con audit tool revealed the ensure physician or correctly, medicatio etc. Review of the to 03/11/19 revealed that a dose of Lasix given on 03/09/19 or	of Correction for the 01/30/19 encies revealed daily chart inpleted. Review of the chart he hospital was monitoring to ders were completed inswere administered timely, pol for 03/08/19 through he hospital had not identified twas not documented as in that there was not a plan for atient #13's fluid restriction.						
	Review of the daily Chart Audit Tool) da revealed there were the medical-surgica 03/11/19. The tool in timely administratio omissions, etc. Furt dated 03/09/19 reve evidence the facility record. Review of 0 sheets revealed stamedical record, but problems with med	audit tool (Medical-Surgical sted 03/08/19 through 03/11/19 to four (4) to six (6) patients on all unit between 03/08/19 and included a category to monitor on of medication, medication her review of the audit tool saled no documented audited Patient #13's medical 3/10/19 and 03/11/19 audit of had reviewed Patient #13's had not identified any ication administration or that ed Lasixwas not documented				D.		
	(ACNO) and RN #8 revealed they cond- Chart Audit for 03/0 completed the 03/0 10:00 AM and revie 12:00 AM that morr next day, the same	stant Director of Nursing on 03/12/19 at 8:45 AM ucted the Medical-Surgical 19/19. The ACNO stated she 19/19 audit at approximately wed documentation since ning. The ACNO stated the time frame would be O stated she saw now she		ÿ				

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Facility ID 100020

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE A. BUILDING		E CONSTRUCTION	(23)	COMPLETED		
		180021	B WING	0		R 03/12/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, Z 150 RIVERVIEW AVENUE PINEVILLE, KY 40977	IP CODE	
				· · · · · · · · · · · · · · · · · · ·	25.0005.000	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN( (EACH CORRECTIVE/ CROSS-REFERENCED TO DEFICIE	ACTION SHOULD BE O THE APPROPRIATE	DATE CONFLETION (X5)
{A 273}			{A 273			
	looking at a 24-hour	ncorrectly and should be period. The ACNO stated that Patient #13's 6:00 PM				
4		09/19 was not documented				
	PM revealed she ha day shift until the pa	Aide #1 on 03/11/19 at 4:40 d cared for Patient#13 on tient was discharged home. she was not aware Patient trictions.		3 3		
	revealed she had ca shift until the patient (mid-morning, 03/11 aware the patient wa restriction and point facility Med Act (Kar however, there was Kardex as to how th implemented. Revie	ed out the restriction on the dex used for nursing orders); no specific plan on the effuid restriction would be twof Patient #13's intake revealed the patient had				
1.0	(ACNO) and RN #8 revealed she and RI charts audits for 03/ Patient #13's record implementing the flu stated the lack of pli had not being identi 3. Review of Patient revealed the patient	esistant Director of Nursing on 03/12/19 at 8:45 AM N #8 had completed the 09/18. The ACNO reviewed I and could not find a plan for aid restriction. The ACNO anning for the fluid restriction fied on the chart audit.  t #14's medical record twas admitted to the facility flagnoses which included		£3		
	Chronic Obstructive and Anemia.	Pulmonary Disease (COPD)				

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Facility ID: 100020

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Coo Yhlig

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING			(X3) DATE SURVEY COMPLETED		
		100004	0.100115		R
		180021	B WING_		03/12/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
SOUTHEAS	STERN KY MEDICAL C	ENTER	VI I	850 RIVERVIEW AVENUE	
				PINEVILLE, KY 40977	
(X4) 1D PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC I DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	TD SE COASTELON
{A 273}	Continued From pag	e 20	(A 27:	3)	
	Physician #4 ordered				
	congestion) one (1)	DM (treats cough and or two (2) leaspoons (tsp) to nouth four times daily, as		7,	
	dated 03/07/19 revea on 03/07/19 at 5:21 Tussionex (treats co allergies) into the fac	ation Error Tracking Form aled pharmacy staff identified PM that RN #5 had entered ughs and common cold and cility medication m, ins tead of entering the			98
	physician.	sin) that was ordered by the		FF (7)*	
	at 9:30 AM revealed transcription error or transcribed a medic Patient #14. She sta and the patient neve medication. The Pha	n 03/07/19, where RN #5 had ation ordered incorrectly for led the error was identified, or received the wrong armacist stated she notified ficer (CNO) of the error.			
	Director on 03/08/19 weekly QI meeting v stated not all Perford indicators were review indicators/audits in t 01/30/19 Statement reviewed in the wee CNO stated the aud	NO who was also the Quality at 8:55 AM revealed the last was on 03/04/19. The CNO mance Improvement ewed. Per the CNO, only the he Plan of Correction for the of Deficiencies were kly meeting. However, the it tool did not include change pressure sore monitoring as plan of correction.			

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Event ID: NS6G12

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , , .	LE CONSTRUCTION	COMPL	ETED DETE
		180021	B. WING			2/2019
	ROVIDER OR SUPPLIER  STERN KY MEDICAL O	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) CCMPLETICH DATE
(A273) (A385)	Refer to A385 and A NURSING SERVICE CFR(s): 482.23  The hospital must his service that provide The nursing service supervised by a region of the Side	ave an organized nursing services. services as must be furnished or stered nurse.  Inot met as evidenced by: record review, policy review, lits, and review of the Plan of atement of Deficiencies as determined that the facility sing services were furnished egistered nurse.  Interview with staff revealed administer Patient #16's requin (antibiotic medication as prescribed by the physician	(A 273	In the case of Patient #16 the patient had be discharged and M access was removed bef 11:00 o'clock dose of M Levaquin was due, pharmacist was not notified timely through that the patient had been discharged. The or patient #16's Levaquin was not discovered the pharmacy was looking at the discharge not the discharge time. The pharmacists haverbally educated on the necessity of looking discharge time as well as the date in order to all medication errors. The director of pharmacounseled the nursing staff to discharge patithe B-IR systemas soon as the patient is dischared nursing staff will be counseled by when ACNO not available by nurse administ not remove any M access until patient is real teave the facility.  Patient #14 and #16's med error was by the The RN received 1:1 counseling and reeduc the physician orders policy and Medication Administration policy by the ACNO evaluation nurse's knowledge was demonstrated throut written test. Also, all Icensed nursing staff receiving education on Medication Administration policy and Physician Orders policy with a with a well-asserted nursing staff receiving education on Medication Administration policy and Physician Orders policy with a well-asserted nursing staff receiving education on Medication Administration policy and Physician Orders policy with a well-asserted nursing staff receiving education on Medication Administration policy and Physician Orders policy with a well-asserted nursing staff received as the patient and the patient and the patient as the patient a	ore the T	4/14/19
	notified of the medic #5, as required on 0 Further, record revice nursing staff (RN#5 physician's ordered #14's Medication Ac Although, the incorreadministered, inter- administration had Patient #14 and #16 Review of Patient # the patient had phy- to received IV (intra	t#16's physician was not cation omission error by RN 13/06/19.  ew and interview revealed a cough medication to Patient Iministration Record (MAR), sect medication was not desired involved the error with 5 involved the same nurse.  13's medical record revealed sician's orders dated 03/08/19 evenous) Lasix (diuretic) twice here was no documentation		demonstrate knowledge. Medication errors reported to Fisk Management Committee to patterns or trends.  Patient #13 had order for a fluid restriction begin to carry out the order. Also, Patient #1 dose of Lasix. The nurse aides will be educ fluid restriction policy by Nurse Administration primary nurse of the patient will be responsively in the Medact the electronic Kardex orders and ensuring that the nurse aides an knowledgeable of the patient's diet order increstrictions from the patient's had for fuctarification for all dietary restrictions. Nursing staff and the Dietary Manager will be y Nursing Administration on the Fluid Rest Policy and how to implement a plan for fluid restrictions. The nursing staff will be given amount of fluid on each meal tray when traindelivered.	out had no 3 missed a sated on the ible for for nursing cluding fluid lift. A sign inther be educated riction	

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M. K.C.

CEO /2/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	COMPL	ETED
		180021	B. WING			03/1	2/2019
	ROVIDER OR SUPPLIER	ENTER	100	8	TREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE 'INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	XE	(X5) COMPLETION DATE
(A 385)	(A385) Continued From page 22 that the patient received the 6:00 PM dose of Lasixon 03/09/19. Patient #13 also had a physician order for 2000-milliliter fluid restriction;		{A3		Nursing staff and the Dietary Manager will be by Nursing Administration on the Fluid Restric Policy and how to implement a plan for fluid restrictions. The nursing staff will be given w amount of fluid on each meal tray when trays delivered.	ritten	4/14/19
	however, interviews to develop a plan to restriction.  Review of medical revealed the facility is	revealed nursing staff failed implement the fluid ecords and facility audits failed to implement the Plan			Also, all licensed nursing staff are received ucation on Medication Administration and Physician Orders policy with a writted demonstrate knowledge. Medication erreported to Risk Management Committed monitor patterns or trends.	policy en test to ors are	4/14/19
	dated 01/30/19 in what Nursing Services was Correction stated da included ensuring placempleted correctly	Statement of Deficiencies nich immediate jeopardy for us identified. The Plan of illy chart audits which hysician orders were and monitoring for tration were completed.			The CNO will ensure that pharmacy will repo- medication errors to the ACNO who is perfor audits and to the Risk Manager by way of pri reports. Risk Manager will report number of n errors to Pt. Medication errors will be review any action taken logged on a nursing verbal of log sheet to monitor patterns and trends.	ming chart inted nedication ved, and	4/14/19
	However, review of the facility failed to identify failed to identify the facility f	the chart audit revealed the lify any concern with Patient tration on 03/09/19, the ent #14's cough medication, id not receive IV Levaquin as			The Chart Audit tool was revised to include mand better capture medication errors. Chart were being done daily but were not capturing 24-hour. Audits will now be performed to incifull 24-hour period from the same time each cnext day. Nursing Administration will maintain nursing verbal counseling log to include all maches counseling sessions. Medication errors will reported though a paper report to the Risk	audits I the full I ude the I ay to the I a edication	4/14/19
{A 395}	Refer to A395, A263 RN SUPERVISION CFR(s): 482,23(b)(3	OF NURSING CARE	(A:	395	Management committee to monitor patterns	or trends.	
	A registered nurse r the nursing care for	nust supervise and evaluate each patient.					
	Based on interview, review of the facility submitted in respor Deficiencies dated t audits, it was detern	not met as evidenced by: record review, policy review, s Plan of Correction use to a Statement of 01/30/19, and review of facility nined that the facility failed to nurse supervised and					

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Facility ID 100020

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M.K.Cy

CEO Yalig

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	
180021 8-WING 02/12/2019	
Q3(12/2015	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ER OR SUPPLIER
SOUTHEASTERN KY MEDICAL CENTER 850 RIVERVIEW AVENUE	N KY MEDICAL CEN
PINEVILLE, KY 40977	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE DATE DEFICIENCY)  TAG REGULATORY ORLSC IDENTIFYING INFORMATION)  TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	(EACH DEFICIENCY
(A 395) Continued From page 23 evaluated the nursing care for three (3) of fifteen (15) sampled patients (Patients #13, #14, and #16). Wedical record review revealed the facility failed to administrate Patient #16's intravenous (IV) Levaquin (antibiotic medication to treatinfections) as prescribed by the physician, on 0.306/19. Patient #16's physician was notnotified of the medication omission error by RN #5, as required on 03/06/19. Review of Patient #14's medical record revealed nursing staff(RN #5) incorrectly transcribed a physician's ordered cough medication to Patient #14's Medication Administration Record (MAR). Although, the incorrectmedication by Patient #14's medical record revealed oxide the record with nursing administration staffeveled theydid not identify the errors with Patient #14'and #16' involved the same nurse.  Review of Patient #13's physician's orders dated 03/08/19, revealed an order for the patient to receive IV (Intravenous) Lasix(diuretic) twice per day, however, there was no documentation in the medical record hat the patient received the 6 00 PM dose of Lasix on 03/09/19, Patient #14's also had a physician order for 2000-milliliter faild restriction; however, record review and interviews with staff revealed nursing staffailed to develop a phan to implement the fluid restriction.  Review of the facilitys Plan of Correction for the Statement of Deficiencies dated 01/30/19 in which immediate lepopary for Nursing Sendees was identified, and review of the facilitys audits revealed daily chart audits were being conducted to ensure physician orders were followed and medication administration was accurately conducted, however, the facility's chart audits	luated the nursing of a sampled patients is ampled patients. It Medical record research (and in the prescribed by the pr

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4/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, 7, 1	TIPLE CONSTRUCTION  NG		(X3) DATE SURVEY COMPLETED	
			8		R	# 1	
ļ		180021	B. WING_		03/1	/12/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				850 RIVERVIEW AVENUE			
SOUTHEA	STERN KY MEDICAL C	ENTER		PINEVILLE, KY 40977			
(X4) ID	SHAWARYS	STATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRECTIO	N	(15)	
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG		) BEE	DATE	
				Patient #13 had order for a fluid restric	tion but	4/14/19	
(A 395)	Continued From pag	je 24	{A 3	95 had no plan to carry out the order. Als	o, Patient		
	failed to identify Pati	ent#13's Lasixmedication	,	#13 missed a dose or Lasix The nurs	e aides		
8.1		ed on 03/09/19, Patient #14's		will be educated on the fluid restriction Nurse Administration. The primary nu			
		ras incorrectly transcribed, or		patient will be responsible for reviewin			
		not receive IV Levaquin as		Medact the electronic Kardex for nursi			
	prescribed on 03/06			and ensuring that the nurse aides are	19 010010		
		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		knowledgeable of the patient's diet ord	er		
	The findings include	1		including fluid restrictions from the pati	ent's		
100				nurse each shift. A sign will be posted			
	Review of the "Medi	cation Administration" Policy	1	patient's bed for further clarification for	all dietary		
		aled Antibiotics were		restrictions.			
	time-critical schedu	led medications, which could		Nursing staff and the Dietary Manager	willhe	4/14/19	
	have a significant or	negative impact on the	l l	educated by Nursing Administration of			
	intended pharmaco	logical or therapeutic effect of		Restriction Policy and how to impleme	ntaplan		
	the medication. The	policy stated Antibiotics	İ	for fluid restrictions. The nursing staff	will be		
	should be administe	ered as ordered by the		given written amount of fluid on each r	neal tray		
	physician, and in the	e event the medication was		when trays are delivered.			
1	not administered as	ordered, the patient's		The CNO will ensure that pharmacy w	ill report ali	4/14/19	
1		notified related to the error,	Ţ	medication errors to the ACNO who is	iii iepoitaii	4/14/13	
1		sult of a missed dose of the	1	performing chart audits and to the Ris	k Manager		
	medication. The pol		32	by way of printed reports. Risk Manag			
- ×		trations will be performed		report number of medication errors to			
1		MAR in the computerF.		Medication errors will be reviewed, and			
		administer the medication is		action taken logged on a nursing verb			
	1 '	preparation of the medication		counseling log sheet to monitor trends	٠		
		tion on the MAR and on the		Nursing staff and the Dietary Manager	willhe	4/14/19	
		heet if indicated." Review of		educated by Nursing Administration o		4774770	
53	Delicudated 02/201	are/Techniques for Charting" 9 revealed "The nursing	1	Restriction Policy and how to impleme	enta plan		
		ument the patient stay in the		for fluid restrictions. The nursing staff			
	facility in such a ma			given written amount of fluid on each r	neal tray		
	1	lerstanding of the patient's		when trays are delivered.			
	well-beingProced			The CNO will ensure that pharmacy w	ill reportal l	4/14/19	
	_	cations with date, times and		medication errors to the ACNO who is		7/1-9/13	
	initials on the MAR.			performing chart audits and to the Ris	k Manager		
				by way of printed reports. Risk Manag			
	Review of the Plan	of Correction for the		report number of medication errors to			
		encies dated 01/30/19		Medication errors will be reviewed, an action taken logged on a nursing verb			
	revealed "Chart aud	lits, including timely		counseling log sheet to monitor trends			
1	medication adminis	tration, medication omissions,					

FCRM CMS-2587(02-99) Previous Versions Obsidete

Event ID: NS6G12

Facility ID: 100020

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M.KEU

CGO 4/2/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

AND BLANCE CORRECTION IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION (X3) I			
		180021	B. WING_		03/1	2/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATÈMENT OF DEFICIENCES CY MUST BE PRECEDED BY FULL R LSC I DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	Ø5) CHPLETION DATE
(A 395)	change in condition of treatment, nutritional monitoring and follow be performed daily collected by the ACN the chart audits to dimmediate actions a to the audit tool on 0 monitor to ensure ptreatments.	documentation, consent for I/social services consults, wing up on medications, will Charl audit tools are IO who will report results of QAPI weekly so if needed re taken."The facility added 3/08/19 that the facility would nysician orders were	26 A}	The Chart Audit tool was revised to include tail and better capture medication error chart audits were being done daily but to capturing the full 24-hour. Audits will not performed to include the full 24-hour pet the same time each day to the next day. Administration will maintain a nursing we counseling log to include all medication. Counselling sessions. Medication error reported though a paper report to the R. Management committee to monitor patt trends.	ors. were not ow be riod from . Nursing erbal t s will be isk	4/14/19
	revealed the patient on 03/02/19 with a d Pyelonephritis. Revi physicians orders d Levaquin (antibiotic)	_		The CEO is a member of the PI Comm Data on medication errors is reported a Committee, the PI Committee, and is for to the MEC and Governing Board.	tthe P&T	4/14/19
	dated 03/05/19, reve documented the pat be planned the follo to continue the patie review of Patient #1 Record (MAR) reves	l6's physician progress notes caled the physician ient's discharge home would wing morning (03/06/19) and ents IV antibiotics. However, 6's Medication Administration aled staff failed to administer biotic (Levaquin) on 03/06/19,				
	03/07/19 at 10:45 Al administer Patient # as prescribed by the stated medications directed by the phys medication error be omitted. She stated should be notified w	tered Nurse (RN) #5 on M revealed she did not 16's IV Antibiotic (Levaquin) physician on 03/06/19. She that were not administered as ician, were considered a cause the medication was the patient's physician then a medication was not lered. However, RN #5 did				//.

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Event ID: NS6G12

Facility ID: 100020

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M.ICCY

CEO

1/1/19

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES (X1) PROVIDERSUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMPI	
		180021	B. WING		<u> </u>	03/1	2/2019
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER			85	REET ADDRESS, CITY, STATE, ZIP CODE 10 RIVERVIEW AVENUE NEVILLE, KY 40977	33		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC (DENTIFYING INFORMATION)	ID PREFII TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COUFLETION DATE
(A 395)	not contact Patient # Antibiotic was not ac 03/06/19.  Interview with the As (ACNO) on 03/07/19 had conducted a char medical record on 03 identified the medical was unsure why the been identified.  Interview with the Pi at 9:30 AM revealed medication errors, a omitted it was a medication errors forty-eight (48) hour conducted, she had had not received the prescribed, on 03/06 stated, "We should unsure why the medicatified.	the sphysician when the IV sministered as ordered on sistant Chief Nursing Officer at 3:25 PM revealed she art audit of Patient #16's 3/06/19, and had not ation error. She stated she medication error had not she was monitoring daily for and when medications were dication error. Even though, and occurred approximately sprior to the interview being not identified that Patient #16 at IV Antibiotic Levaquin as 6/19. The Pharmacist also have caught that," and was dication error had not been	{A:	395)			
	revealed the hospits 03/08/19 with a diagram of the failure (CHF). The part of the failure (CHF) in the failure of the failure	t#13's medical record al admitted the patient on gnosis of Congestive Heart patient's physician orders uded daily weights, monitoring and administering Lasix ams (mg) IV twice per day. In 8, a physician's orderwas -milliliter (ml) fluid restriction. view of Patient #13's medical			**1		
	record revealed no PM scheduled dose	documentation that the 6:00 e of Lasixwas administered tion related to how nursing	į				

FORM CMS-2567(02-99) Previous Versions Clasoleta

Event ID: NS6G12

Facility ID: 100020

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FORM APPROVED OMB NO. 0938-0391

M.K.

CEO YN19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	NAME OF CORPECTION IDENTIFICATION NUMBER			PLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED
		180021	B. WING_		03/12/2019
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL RLSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE CHALTION
(A 395)			{A 39	95)	
	staff planned to implifluid restriction.	lement the patient's 2000 ml		•	
	revealed he was rescare on 03/09/19 du PM). RN #2 stated hadministration of Pathe RN, he administration of Pathe RN, he administration of Pathe RN, he administration was not up all night stated his routine with the Omnicell (machuse the paper Medic (MAR), give the methen document that administered in the The RN stated he kutilize the COW who document on the conot always follow proceeded there were the medical-surgica 03/11/19. The tool include a review record. Review of the state of the state of the state of the cordered Lasixwadministered on 03/11/19.	Computer on Wheels (COW).  new the procedure was to en giving medications and to emputerized MAR, but he did rocedure.  audit tool (Medical-Surgical ated 03/08/19 through 03/11/19 e four (4) to six (6) patients on al unit between 03/08/19 and included a category of timely edication, medication 03/09/19, the audit tool failed of Patient #13's medical 3/10/19 and 03/11/19 audit affhad reviewed Patient #13's thad not identified any lication administration or that was not documented as			

FORM CIAS-2567(02-99) Previous Versions Obsolete

Event ID; NS6G12

Facility ID: 100020

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PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDIN	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
				<u> </u>		
		180021	B. WING_		03/1:	2/2019
NAME OF P	ROVIDER OR SUPPLIER	<u></u>		STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL CI	ENTER		850 RIVERVIEW AVENUE		
				PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  OF MUST BE PRECEDED BY FULL  RLSC ID ENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ND BE	OX5) COVP.E1 CH CATE
{A 395}	3	e 28 nn 03/12/19 at 8:45 AM	{A 39	95)		
	revealed they did the Audit for 03/09/19. The	Medical-Surgical Chart ne ACNO stated she				
	10:00 AM. She state documentation since conducted the audit next day. The ACNO was doing the audits looking at a 24-hour they did not identify the not documented as con 03/09/19.  Interview with Nurse PM revealed she had day shift until the pat	for 03/09/19 at approximately dishe reviewed records for a 12:00 AM that morning, and for the same time frame the stated she saw now she incorrectly and should be period. The ACNO stated hat Patient #13's Lasixwas given for the 6:00 PM dose  Aide #1 on 03/11/19 at 4:40 dicared for Patient#13 on incorrectly and should be period.	82			
	breakfast and had al additional juice. The tray contained the fo and juice. Per the Nu	ed she had served the patient so given him/her an Nurse Aide stated the meal tlowing fluids; coffee, milk, urse Aide, she was not as on fluid restrictions.				¢
	revealed she had ca shift until the patient (mid-morning, 03/11 also given the patient stated the patient wa restriction and pointe facility Med Act (Karr However, there was Kardex as to how the implemented and the	ed out the restriction on the dex used for nursing orders). no specific plan on the e fluid restriction would be e intake record for that showed the patient had			.2.	
	Interview with the As	sistant Director of Nursing				

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Event ID: NS6G12

Facility ID 100020

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M.K.Cy

(EU 4/2/19

PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE COMP	SURVEY
16				_		1	₹
		180021	B. WING	_		03/	12/2019
	RN KY MEDICAL CE	ENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 350 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	(X5) COPTETION DATE
(Are revenue che che che che che che che che che ch	vealed she and RN narts audits for 03/05 attent #13's record, in plementing the fluid nould have had a plane ACNO said nursi roviding part of the fluid restriction has art audit.  Review of Patient #14 avealed the patient vin 03/06/19 with diaghronic Obstructive Find Anemia.  eview of Patient #14 avealed the patient win 03/06/19 with diaghronic Obstructive Find Anemia.  eview of Patient #14 avealed the patient with the patient with the fluid patient with the facility of the Medical attention (Robituss thysician) and (Robituss thysician).  Iterview with the Phase ans cription error on anscribed a medical and calculation of the medical and calculation are recorded and and calculation are recorded and and calculation are recorded and	#8 had completed the #8 had completed the #9/18. The ACNO reviewed could not find a plan for direstriction, and stated, "We an for the fluid restriction." Ing should have been uids and dietary the other id the lack of planning for direction in the fluid record was admitted to the facility noses, which included pulmonary Disease (COPD)  It's physician orders revealed Robituss in DM (treats cough and retwo (2) teaspoons (tsps.) Amouth four times daily, as tion Error Tracking Form led pharmacy staff identified with that RN #5 had entered uighs and common cold and lity medication in, instead of entering the sin) that was ordered by the	{A:	395			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event 1D: NS6G12 Facility ID: 100020

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PRINTED: 03/29/2019 FORM APPROVED OMB NO. 0938-0391

PREFIX		F CORRECTION	IDENTIFICATION NUMBER:	-	NG	COMPLETED
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  (A) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  (A) 395)  Continued From page 30 and the patient never received the wrong medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19.  Interview with the CNO on 03/08/19 at 9.50 AM revealed she was notified by the Pharmacist related to Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of fthe errors.  Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors;			180021	B WING		
REGULATORY ORLSCIDENTIFYING INFORMATION)  (A 395)  Continued From page 30 and the patient never received the wrong medication. The Pharmacists tated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19.  Interview with the CNO on 03/08/19 at 9.50 AM revealed she was notified of RN #5's medication omission error for Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of the errors.  Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors;				850 RIVERVIEW AVENUE	03/12/2019	
and the patient never received the wrong medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19.  Interview with the CNO on 03/08/19 at 9:50 AM revealed she was notified of RN #5's medication omission error for Patient #16 and the RN's transcription error identified by the Pharmacist related to Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of the errors.  Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors;	PREFIX	(EACH DEFICIEN	CY MUSTBE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE CHILETICS
	(A 395)	and the patient never medication. The Phathe Chief Nursing Offit was identified on the Interview with the Clarevealed she was not omission error for Patranscription error id related to Patient #1 she had not conduct RN after being notification 03/08/19 at 10:15 been notified of RN interview with the Clareview with t	received the wrong armacist stated she notified fficer (CNO) of the error when 3/07/19.  NO on 03/08/19 at 9:50 AM potified of RN #5's medication attent #16 and the RN's entified by the Pharmacist 4 on 03/07/19. She stated ted any re-education with the ed of the errors.  Inief Executive Officer (CEO) 5 AM revealed he had not #5's medication errors;	{A 35		

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Evient ID: NS6G12

Facility ID: 100020

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M.16

CEO

Office of Inspector General DATE SURVEY (X2) MULTIPLE C STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: R-C B. WING 03/12/2019 100020 Division of Health Care STREET ADDRESS, CITY, STATE. NAME OF PROVIDER OR SUPPLIER Southern Enforcement Branch 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) {E 000} (E 000 Initial Comments An on-site revisit was conducted on 03/07-12/19. Tags E3060, E3440, and E3660 were determined to be corrected as alleged. However, the facility remained out of compliance with tags E0041 and E2340. 4/14/19 The CEO will revise budgeted revenues and {E 041} {E 041 902 KAR 20:016 3(2)(a)2 Section 3: debts for FY19 and submit to board for approval Administration and Operation at the next board meeting scheduled for 4/11/19. The review budget will show amounts to repay (2) Administrator, loans and drug supplier. (a) The administrator shall: 4/14/19 The CEO will ensure the facility pays tax liabilities to the federal, state, and city taxing 2. Be responsible for the management of the authorities on an ongoing basis. This will be done by way of agreements made in March 2019 hospital; with the taxing authorities. This requirement is not met as evidenced by: Based on interview, record review, and review of Governing Body Meeting minutes, facility audits, Daily Operating Budget, and the Plan of Correction the facility submitted for the statement of deficiencies issued on 01/30/19, it was determined that the facility failed to ensure the Chief Executive Officer (CEO) was responsible for managing the hospital budget and implementing the Plan of Correction. The CEO failed to ensure the operating budget included current revenues and debts. In addition, the CEO failed to ensure staff training and audits were completed in accordance with the facility's Plan of Correction. The findings include: Review of the Governing Body Meeting minutes dated 02/22/19 revealed the CEO was approved to serve as the Interim CEO effective 02/27/19. 1. The Pharmacy Supplier who supplied the

LABORATORY DIRECTOR'S OR PROVIDER/SURPLIER REPRESENTATIVE'S SIGNATURE

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TITLE

29/19

STATE FORM

PRINTED: 03/25/2019 FORM APPROVED Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING: R-C B. WING 03/12/2019 100020 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** PROVIDER'S PLAN OF CORRECTION (X5)SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {E 041} (E 041) Continued From page 1 4/14/19 CEO is attending current weekly PI meetings hospital with medication was contacted during the where nursing chart audit results are reported revisit and information from the pharmacy was and medication errors from Risk Management received on 03/13/19 and 03/14/19. Review of are reported. Inservice's offered and evaluations information received via email on 03/13/19 from are reported in these weekly PI meetings. the facility's Pharmacy Supplier revealed the facility was behind approximately \$115,000 on their payment plan and another \$27,000 was due on 03/20/19. Additional information received on 03/14/19 revealed the company that owns the hospital had paid approximately \$89,000 toward their past due amount in order to receive shipments. However, continued to owe the Pharmacy Supplier a total of \$377,000. Per information received on 03/14/19 from the supplying pharmacy, the decision whether to provide medications to the facility is determined each time an order is placed. Review of the daily operating budget revealed the revenue and expenses were listed on a monthly basis for the current fiscal year July 2018 through June 2019. However, the daily budget did not include payments for outstanding debts (loans, debt owed to the Pharmacy Supplier). In addition, the revenue section included a Disproportionate Share Hospital (DSH) revenue of \$99,000 per month from January 2019 through June 2019. Interview with the Chief Executive Officer (CEO) on 03/07/19 at 11:27 AM, 2:20 PM, and 4:12 PM. on 03/08/19 at 2:10 PM, and on 03/12/19 at 2:02 PM revealed the Governing Body Board had met on 02/22/19 and appointed him as CEO. The CEO stated he and the owner developed the budget; however, the CEO stated the repayment of debt was not included in the budget. Per the CEO, even though the facility was still in debt to the contracted pharmacy and was making payments of \$28,000 per month to repay the

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Office of I	nspector General					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			- 1
					R-C	- 1
		100020	B WING		03/12/2019	9
NAME OF B	ROVIDER OR SUPPLIER	CTREET AD	DRESS, CITY, ST	ATE ZIP CODE		
NAME OF PI	KUVIDER OR SUPPLIER		VIEW AVENU			1
SOUTHEA	STERN KY MEDICAL C	ENTER		-		
		<del></del>	E, KY 40977		1 1 0	
(X4) IĐ		TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD)		(5) PLETE
PREFIX TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		ATE
!		27		DEFICIENCY)		
{E 041}	Continued From pag	e 2	{E 041}			1
	debt, the debt was no	ot included in the budget.				
	Further interview with	_		ii		
	employee taxes (Fed	ieral, State, and City) for the				1
	fourth quarter (Octob	per - December) of 2018 had				- 1
		CEO stated the taxes had				
		he employees' pay checks,				1
		paid to the federal, state, or				
1		addition, the facility had not				l
		taxes for February 2019. with the CEO revealed the			1	- 1
	l .	the funds to pay employees				1
	· '	not know until late afternoon				
		ds were not available. Per				ļ
	1	staff were not paid until				1
		istrative staff were paid at	Ì			
	2:00 PM on 03/08/19	9. The CEO stated funds for				
		were not available as of	ļ			- 1
	03/12/19.		į			
		with the OFO severaled when				
		with the CEO revealed when			1	
		et for January 2019 through ded \$99,000 of revenue per				
		ected from DSH Payments.	1			
		ted DSH payment would not				1
		vember 2019 (which is not in				
	the same fiscal year	•				
	I .	in of Correction (POC)		Licensed nursing staff will not be give	the policy 4/1	4/19
	1	atement of Deficiencies		to read and a sign-in roster. All in-serv		
1		19 revealed the CEO was		be conducted by nursing leadership us group sessions or one on one on Med		
	responsible for ensu	uring staff were		Administration Policy and Physician O	rders	
	trained/in-serviced.			Policy and this will be evaluated throu	gh written	
	Interview with the A	ssistant Chief Nursing Officer		test.		
		9 at 2:25 PM revealed, "We		CEO is notified through weekly PI rep		
		of the training/in-service in		training / in-services method of in-services method in-services method in-services me		
		sing staff; however, some of		evaluation results.	2 8110	
		ven to the staff and the staff		a condition i quanto.		
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Office of Inspector General STATEMENT OF DEFICIENCIES (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 03/12/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY {E 041} Continued From page 3 {E 041} completed the in-services." Interview with Licensed Practical Nurse (LPN) #1 on 03/08/19 at 2:30 PM and with Registered Nurse (RN) #2 on 03/12/19 at 1:40 PM confirmed some of the recent in-service training (included on plan of correction) consisted of a policy being left for staff to read and signing a training roster. LPN #1 also stated there was a book at the nurses' station with the policies. 3. Review of the Plan of Correction (POC) submitted for the Statement of Deficiencies (SOD) dated 01/30/19 revealed the CEO would be responsible to ensure adequate resources were available, allow staff sufficient time to participate in Quality Assurance Performance Improvement (QAPI) activities, and institute appropriate information systems for collection and analyzing data. The plan further stated the CEO would report any and all findings to the governing body. 3. A. Review of Patient #16's medical record revealed the facility admitted the patient on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physician orders dated 03/03/19, included an order for Levaguin (antibiotics) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patient's IV antibiotics. However, review of Patient #16's Medication Administration Record (MAR) revealed staff failed to administer Patient #16's IV antibiotics on 03/06/19, as

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER A. BUILDING: R-C B. WING 03/12/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (E 041) {E 041} Continued From page 4 prescribed. The Chart Audit tool was revised to include more 4/14/19 Interview with Registered Nurse (RN) #5 on detail and better capture medication errors. Chart audits were being done daily but were not 03/07/19 at 10:45 AM revealed she had not capturing the full 24-hour. Audits will now be administered Patient #16's IV Antibiotic performed to include the full 24-hour period from (Levaquin) as prescribed by the physician on the same time each day to the next day. Nursing 03/06/19. Administration will maintain a nursing verbal counseling tog to include all medication Interview with the Assistant Chief Nursing Officer Counselling sessions. Medication errors will be (ACNO) on 03/07/19 at 3:25 PM revealed she reported though a paper report to the Risk had conducted a chart audit of Patient #16's Management committee to monitor patterns or medical record on 03/06/19, but had not identified trends. the medication error. Interview with the Pharmacy Director on 03/08/19 at 9:30 AM revealed she was monitoring daily for medication errors in the facility, and when medications were omitted, it was a medication error. Per the Pharmacist, she had not identified In the case of Patient #16 the patient had been that Patient #16 had not received the IV Antibiotic discharged and IV access was removed before 4/14/14 Levaquin as prescribed on 03/06/19. he 11:00 o'clock dose of IV Levaquin was due. The pharmacist was not notified timely through 3. B. Review of Patient #13's medical record the EHR that the patient had been discharged. The omission of patient #16's Levaquin was not revealed the hospital admitted the patient on identified because the pharmacy was looking at 03/08/19 with a diagnosis of Congestive Heart the discharge date and not the discharge time. Failure (CHF). The physician's orders dated The pharmacists have been verbally educated 03/08/19 included an order for Lasix 40 on the necessity of looking at the discharge time milligrams (mg) IV twice per day. In addition, on as well as the date in order to discover all 03/09/18, an order for a 2000-milliliter (ml) fluid medication errors. The director of pharmacy has restriction was received. counseled the nursing staff to discharge patients from the EHR system as soon as the patient is However, further review of the medical record discharged. revealed no documentation that the 6:00 PM Licensed nursing staff will be counseled by nurse administration to not remove any IV scheduled dose of Lasix was administered and access until patient is ready to leave the facility. no documentation related to how nursing staff planned to implement the patient's 2000 ml fluid restriction. Review of the Plan of Correction for the 01/30/19 Statement of Deficiencies revealed daily chart

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER. A. BUILDING: \_ R-C B. WING 03/12/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH CORRECTIVE ACTION SHOULD BE COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {E 041} (E 041) Continued From page 5 audits would be completed. Review of the chart audit tool revealed the hospital was monitoring to ensure physician orders were completed correctly; medications were administered timely, etc. Review of the tool for 03/08/19 through 03/11/19 revealed the hospital had not identified that a dose of Lasix was not documented as given on 03/09/19 or that there was not plan for implementing the Patient #13's fluid restriction. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and 03/11/19. The tool included a category to audit timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ADON stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed documentation that had been completed since 12:00 AM, and stated the next day the same time frame would be reviewed. The ADON stated she saw now she was doing the audit wrong and should be looking at a 24-hour period. The ADON stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40

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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING; \_ R-C B. WING 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) (E 041) Continued From page 6 {E 041} PM revealed she had cared for Patient #13 on day shift until the patient was discharged home. Per the Nurse Aide, she was not aware Patient #13 was on fluid restrictions. Interview with RN #7 on 03/11/19 at 4:57 PM In March 2019, a policy and procedure were 4/14/19 revealed she had cared for Patient #13 on day developed on Fluid Restriction. Nursing staff will shift until the patient was discharged home be in-serviced by nursing administration on the (mid-morning, 03/11/19). The RN stated the Fluid Restriction Policy which includes placement of the fluid restriction plan on the patient was on a 2000 ml fluid restriction and Medact which is the electronic Kardex for pointed out that the restriction was documented nursing orders. on the facility Med Act (Kardex used for nursing The Registered Dietician will provide further orders); however, there was no specific plan as to education on fluid restriction diet to nursing staff. how the fluid restriction would be implemented. Evaluation of knowledge will be demonstrated The intake record for that morning showed the through a written test. patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing (ADON) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ADON reviewed Patient #13's record and could not find a plan for implementing the fluid restriction. The ADON stated the lack of planning for the fluid restriction had not being identified on the chart audit. Interview with the CEO on 03/08/19 at 10:00 AM revealed he attended the weekly QAPI Meetings. 4/14/19 The CEO will receive a weekly report through and that he was monitoring staff training. The the PI Committee of all nursing staff training/in-CEO stated he had "learned today" (after services, method of training/in-service, identified by the surveyors) that some staff had percentage of attendance, and evaluation not received training. The CEO stated he was results. not aware that the staff training consisted of staff reading a policy and signing an in-service record. The CEO said he thought the training would be 1:1 or in a group setting with some sort of testing after the training. The CEO further stated he had not been notified of any concerns with the chart audits and was not aware of any medication errors or omissions.

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NAME OF PROVIDER OR SUPPLIER STREET AD  SOUTHEASTERN KY MEDICAL CENTER 850 RIVER			DDRESS, CITY, STARVIEW AVENUE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
(E2340)	Services  (2) Nursing service.  (g) A registered nursevaluate the nursing accordance with the nursing staff availabent of the service of the	e)(g) Section 4 Provision of sees shall assign staff and grare of each patient in a patient's need and the le.  not met as evidenced by: record review,	{E2340}		
	review of the facility submitted in respon Deficiencies dated audits, it was detern ensure a registered evaluated the nursi (15) sampled patier #16). Medical recorfailed to administer Levaquin (antibiotic as prescribed by th Patient #16's physi	's Plan of Correction se to a Statement of D1/30/19, and review of facility nined that the facility failed to nurse supervised and ng care for three (3) of fifteen nts (Patients #13, #14, and d review revealed the facility Patient #16's intravenous (IV) medication to treat infections) e physician, on 03/06/19. cian was not notified of the n error by RN #5, as required			
	Review of Patient # nursing staff (RN # physician's ordered #14's Medication A Although, the incoradministered, interadministration staff the errors with Patsame nurse.  Review of Patient 03/08/19, revealed	#14's medical record revealed 5) incorrectly transcribed a 1 cough medication to Patient dministration Record (MAR). rect medication was not views with nursing frevealed they did not identify tent #14 and #16 involved the #13's physician's orders dated an order for the patient to nous) Lasix (diuretic) twice per		RN #5 was identified as being the same involved in the med errors on Patient #14 #16. This RN #5 received 1:1 counselling re-education on the Physician Orders polition Medication Administration policy by ACNO Evaluation of the nurse's knowledge will be demonstrated through a written test.  Licensed nursing staff will be re-educated Medication Administration Policy and Phy Orders Policy by Nursing Leadership. Evaluation Policy and Phy of the nurse's knowledge will be demonst through a written test.	and pand or and

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		100020	B. WING		R-C 03/12/2019
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Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: R-C B. WING 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE DATE TAG TAG DEFICIENCY) {E2340} Continued From page 9 (E2340) and the documentation on the MAR and on the Nursing Daily Flowsheet if indicated." Review of the "Continuum of Care/Techniques for Charting" Policy dated 02/2019 revealed "The nursing department will document the patient stay in the facility in such a manner to provide a comprehensive understanding of the patient's well-being...Procedure for Charling...8. Document all medications with date, times and initials on the MAR..." Review of the Plan of Correction for the The Chart Audit tool was revised to include more 4/14/19 Statement of Deficiencies dated 01/30/19 detail and better capture medication errors. revealed "Chart audits, including timely Chart audits were being done daily but were not medication administration, medication omissions, capturing the full 24-hour. Audits will now be change in condition documentation, consent for performed to include the full 24-hour period from treatment, nutritional/social services consults, the same time each day to the next day. Nursing monitoring and following up on medications, will Administration will maintain a nursing verbal counseling log to include all medication be performed daily...Chart audit tools are collected by the ACNO who will report results of Counselling sessions. Medication errors will be reported though a paper report to the Risk the chart audits...to QAPI weekly so if needed Management committee to monitor patterns or immediate actions are taken." The facility added trends. to the audit tool on 03/08/19 that the facility would monitor to ensure physician orders were completed correctly. 1. Review of Patient #16's medical record revealed the patient was admitted to the facility on 03/02/19 with a diagnosis of Acute Pyelonephritis. Review of Patient #16's physicians orders dated 03/03/19, included Levaquin (antibiotic) 750 milligrams (mg) intravenous (IV) to be administered daily. Review of Patient #16's physician progress notes dated 03/05/19, revealed the physician documented the patient's discharge home would be planned the following morning (03/06/19) and to continue the patients IV antibiotics. However, review of Patient #16's Medication Administration

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING: \_ R-C B. WING 03/12/2019 100020 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) COMPLETE (X4) ID PREFIX (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) (E2340) {E2340} Continued From page 10 Record (MAR) revealed staff failed to administer Patient #16's IV antibiotic (Levaquin) on 03/06/19, as prescribed. Interview with Registered Nurse (RN) #5 on 03/07/19 at 10:45 AM revealed she did not administer Patient #16's IV Antibiotic (Levaquin) as prescribed by the physician on 03/06/19. She stated medications that were not administered as directed by the physician, were considered a medication error because the medication was omitted. She stated the patient's physician should be notified when a medication was not administered as ordered. However, RN #5 did not contact Patient #16's physician when the IV Antibiotic was not administered as ordered on 03/06/19. Interview with the Assistant Chief Nursing Officer (ACNO) on 03/07/19 at 3:25 PM revealed she had conducted a chart audit of Patient #16's medical record on 03/06/19, and had not identified the medication error. She stated she was unsure why the medication error had not In the case of Patient #16 the patient had been 4/14/19 been identified. discharged and IV access was removed before the 11:00 o'clock dose of IV Levaquin was due. Interview with the Pharmacy Director on 03/08/19 The pharmacist was not notified timely through at 9:30 AM revealed she was monitoring daily for the EHR that the patient had been discharged. medication errors, and when medications were The omission of patient #16's Levaquin was not omitted it was a medication error. Even though, discovered because the pharmacy was looking the medication error had occurred approximately at the discharge date and not the discharge time The pharmacists have been verbally educated forty-eight (48) hours prior to the interview being on the necessity of looking at the discharge time conducted, she had not identified that Patient #16 as well as the date in order to discover all had not received the IV Antibiotic Levaquin as medication errors. The director of pharmacy has prescribed, on 03/06/19. The Pharmacist also counseled the nursing staff to discharge patients stated, "We should have caught that," and was from the EHR system as soon as the patient is unsure why the medication error had not been discharged. identified. Licensed nursing staff will be counseled by ACNO or when ACNO not available by nurse administration to not remove any IV access until Review of Patient #13's medical record patient is ready to leave the facility.

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 PROVIDER'S PLAN OF CORRECTION (X5) SUMMARY STATEMENT OF DEFICIENCIES (X4) ID EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY (E2340) (E2340) Continued From page 11 revealed the hospital admitted the patient on 03/08/19 with a diagnosis of Congestive Heart Failure (CHF). The patient's physician orders dated 03/08/19 included daily weights, monitoring intake and output, and administering Lasix (diuretic) 40 milligrams (mg) IV twice per day. In addition, on 03/09/18, a physician's order was received for a 2000-milliliter (ml) fluid restriction. 4/14/19 Some 1:1counselling is being done with RN staff However, further review of Patient #13's medical by nurse administration on Medication record revealed no documentation that the 6:00 Administration Policy and Physician Orders PM scheduled dose of Lasix was administered Policy. Evaluation of the knowledge will be and no documentation related to how nursing demonstrated through a written test. Due to continued medication errors, licensed staff planned to implement the patient's 2000 ml nursing staff will be re-educated on Medication fluid restriction. Administration Policy, Physician Orders Policy. Interview with RN #2 on 03/12/19 at 1:40 PM revealed he was responsible for Patient #13's care on 03/09/19 during the day shift (7 AM to 7 PM). RN #2 stated he failed to document the administration of Patient #13's medication. Per the RN, he administered the medication at approximately 5 00 PM because the patient wanted the medication early to ensure he/she was not up all night using the restroom. The RN stated his routine was to pull the medication from the Omnicell (machine slocked with medication), use the paper Medication Administration Record (MAR), give the medication to the patient, and 4/14/19 then document that the medication was RN #2 received 1:1 counseling and re-education administered in the Computer on Wheels (COW). on Medication Administration policy and The RN stated he knew the procedure was to Physician Order policy. Evaluation of RN #2's utilize the COW when giving medications and to knowledge of policies will be demonstrated through a written test and verbalization of proper document on the computerized MAR, but he did procedure of medication administration. not always follow procedure. RN #2 was counselled on importance of always following hospital policy and procedures. Review of the daily audit tool (Medical-Surgical Chart Audit Tool) dated 03/08/19 through 03/11/19 revealed there were four (4) to six (6) patients on the medical-surgical unit between 03/08/19 and

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FORM APPROVED Office of Inspector General STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_\_\_ R-C B. WING 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5)(EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) (E2340) Continued From page 12 {E2340} 03/11/19. The tool included a category of timely administration of medication, medication omissions, etc. On 03/09/19, the audit tool failed to include a review of Patient #13's medical record. Review of 03/10/19 and 03/11/19 audit sheets revealed staff had reviewed Patient #13's medical record, but had not identified any problems with medication administration or that the ordered Lasix was not documented as administered on 03/09/19. Interview with Assistant Chief Nursing Officer (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed they did the Medical-Surgical Chart Audit for 03/09/19. The ACNO stated she completed the audit for 03/09/19 at approximately 10:00 AM. She stated she reviewed records for documentation since 12:00 AM that morning, and conducted the audit for the same time frame the next day. The ACNO stated she saw now she was doing the audits incorrectly and should be looking at a 24-hour period. The ACNO stated they did not identify that Patient #13's Lasix was not documented as given for the 6:00 PM dose on 03/09/19. Interview with Nurse Aide #1 on 03/11/19 at 4:40 The nurse gides will be educated on the fluid restriction 4/14/19 PM revealed she had cared for Patient #13 on policy by Nurse Administration. The primary nurse of the patient will be responsible for reviewing the Medact the day shift until the patient was discharged home. electronic Kardex for nursing orders and ensuring that the The Nurse Aide stated she had served the patient nurse aides are knowledgeable of the patient's diet order breakfast and had also given him/her an including fluid restrictions from the patient's nurse each additional juice. The Nurse Aide stated the meal shift. A sign will be posted above the patient's bed for further clarification for all dietary restrictions. tray contained the following fluids; coffee, milk, Nursing staff and the Dietary Manager will be educated by and juice. Per the Nurse Aide, she was not Nursing Administration on the Fluid Restriction Policy and aware Patient #13 was on fluid restrictions. how to implement a plan for fluid restrictions. The nursing staff will be given written amount of fluid on each meal tray

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Interview with RN #7 on 03/11/19 at 4:57 PM revealed she had cared for Patient #13 on day shift until the patient was discharged home (mid-morning, 03/11/19). Per the RN, she had

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when trays are delivered.

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION COMPLETED IDENTIFICATION NUMBER: A. BUILDING: \_ R-C 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **850 RIVERVIEW AVENUE** SOUTHEASTERN KY MEDICAL CENTER **PINEVILLE, KY 40977** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE COMPLETE PREFIX PREFIX CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC | DENTIFYING INFORMATION) TAG TAG DEFICIENCY) (E2340) {E2340} Continued From page 13 also given the patient juice that morning. The RN stated the patient was on a 2000 ml fluid restriction and pointed out the restriction on the facility Med Act (Kardex used for nursing orders). However, there was no specific plan on the Kardex as to how the fluid restriction would be implemented and the intake record for that morning (03/11/19) showed the patient had consumed 960 ml by 8:00 AM. Interview with the Assistant Director of Nursing (ACNO) and RN #8 on 03/12/19 at 8:45 AM revealed she and RN #8 had completed the charts audits for 03/09/18. The ACNO reviewed Patient #13's record, could not find a plan for implementing the fluid restriction, and stated, "We should have had a plan for the fluid restriction." The ACNO said nursing should have been providing part of the fluids and dietary the other part. The ACNO stated the lack of planning for the fluid restriction had not being identified on the chart audit. 3. Review of Patient #14's medical record revealed the patient was admitted to the facility on 03/06/19 with diagnoses, which included Chronic Obstructive Pulmonary Disease (COPD) and Anemia. Review of Patient #14's physician orders revealed Physician #4 ordered Robitussin (Dextromethorphan) DM (treats cough and congestion) one (1) or two (2) teaspoons (tsps.) to be administered by mouth four times daily, as Review of the Medication Error Tracking Form dated 03/07/19 revealed pharmacy staff identified on 03/07/19 at 5:21 PM that RN #5 had entered Tussionex (treats coughs and common cold and

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Office of Inspector General (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED A. BUILDING: \_ R-C B. WING 100020 03/12/2019 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE SOUTHEASTERN KY MEDICAL CENTER PINEVILLE, KY 40977 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID COMPLETE (EACH CORRECTIVE ACTION SHOULD BE PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) {E2340} (E2340) Continued From page 14 allergies) into the facility medication administration system, instead of entering the medication (Robitussin) that was ordered by the physician. Interview with the Pharmacy Director on 03/08/19 4/14/19 The CNO will ensure that pharmacy will report all at 9:30 AM revealed she had identified a medication errors to the ACNO who is performing chart audits and to the Risk Manager by way of printed reports. transcription error on 03/07/19, where RN #5 had Risk Manager will report number of medication errors to Pl. transcribed a medication ordered incorrectly for Medication errors will be reviewed, and any action taken Patient #14. She stated the error was identified, logged on a nursing verbal counseling log sheet to monitor and the patient never received the wrong trends. medication. The Pharmacist stated she notified the Chief Nursing Officer (CNO) of the error when it was identified on 03/07/19. Interview with the CNO on 03/08/19 at 9:50 AM revealed she was notified of RN #5's medication omission error for Patient #16 and the RN's transcription error identified by the Pharmacist related to Patient #14 on 03/07/19. She stated she had not conducted any re-education with the RN after being notified of the errors. Interview with the Chief Executive Officer (CEO) on 03/08/19 at 10:15 AM revealed he had not been notified of RN #5's medication errors; however, he stated he should have been.

A.K.

CEO

NS6G12

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3/28/19

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.

CE12

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	TPLE CONS	TRUCTION		DATE SURVEY COMPLETED
	4,	180021	B. WING				C 01/30/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE		01/30/2019
SOUTHEASTERN KY MEDICAL CENTER				ERVIEWAVENUE ILLE, KY 40977			
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A 000	services that the med provide. Subsequently Patients #2, #8, and a diagnoses that the factorization of the facility failed to enorganized to provide facility failed to have a Registered Dietitian (feeding tubes, pressure Diabetes; failed to have ensure patients received failed to administer morders; failed to notify had a change in condications were not assess/provide treatments. The RD stated I one patient in the application of the facility failed to have the facility failed to have the facility failed to have the facility failed to have provided to supply medications.	lical surgical unit could y, the facility admitted #11 for treatment of cility could not provide.  Insure nursing services were twenty-four hour care. The a system for consulting the RD) when patients had are ulcers/wounds, or we an effective system to wed physician ordered diets; sedications per physician or physicians when patients a vailable; and failed to ment for a patient's pressure the had only consulted on proximately eight months tracted with the facility.  ave a Pharmacy Distributor	A	000			
	record review revealer medications that were formulary; including a and medications required including Verapamil (or pressure, chest pain, Epinephrine (used to reactions and cardiac Bicarbonate (used in arrest and metabolic facility only had one A clots in patients having	ad the facility failed to have a required by the facility's intibiotics, intravenous fluids, sired for emergencies used to treat high blood and heart arrhythmia), treat life-threatening allergic arrest), and Sodium emergencies for cardiac acidosis). In addition, the Activase (used to treat blood by heart attacks and evealed the facility was a going to obtain				ij	

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: NS6G11

Facility ID 100020

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Signature: MLQ	Date: 3/4/11

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION (X3) DATE STATEMENT OF CORRECTION (X3) DATE STATEMENT OF COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF COMPLEX (X3) DATE STATEMENT OF COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X4) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF COMPLEX (X4) PROVIDER/SUPPLIER/CLIA (X5) MULTIPLE CONSTRUCTION (X5) DATE STATEMENT OF COMPLEX (X6) PROVIDER/SUPPLIER/CLIA (X6) PROVIDER/SUPPLI							
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PREFIX (EACH DE	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	IX (EACH CORRECTIVE ACTION SHOULD BE			COMPLETION DATE
referred to appon 01/16/19 a was requested did not have rehave transport pharmacy. Ho a social service #9 home on 0  The facility fail achieved and medical practite Patient #1 was signed a consequence to exportion of the of the "Operatifacility investig attempted to performed a separt of the recepatient's consequence to examine the performed as part of the recepatient's consequence patient #12 responsed to the facility fail patient #12 responsed to the facility fail treat the paties supplied to the	ed to epropria to 5:30 If for Pauning ation to the maintage and it is admitted to the maintage and it is admitted to the maintage and to maint	ensure Patient #9 was te agencies for follow-up. PM, a social services consult atient #9 because the patient water at home and did not o/from appointments or the the facility failed to conduct sult and discharged Patient 0.  nave surgical services that ined a high maintenance of patient care. On 08/16/18, tted for abdominal pain and	A	000			

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: NS6G11

Facility ID: 100020

If continuation sheet Page 3 of 135

Signature Date: 3/4/19

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	OF DEFICIENCIES CORRECTION				
		180021	B. WING		C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER	85	FREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE INEVILLE, KY 40977	*
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A 000	transfer a patient to taking and symptoms. However, when EMS them that they were a were informed by RN to the ED because the Subsequently, EMS a helicopter and the patient #10 p "significantly elevated exhibiting signs and a facility failed to imple Practice Standard for Department," subsequenceive medical image head computed to more than the significant to the significan	18, EMS was attempting to the ED who was exhibiting of an acute stroke. contacted the ED to inform an route with the patient, they would "kill this guy." contacted a transport tient was flown to another resented to the ED with a diblood pressure" and symptoms of a stroke. The ment their Acute Stroke the Emergency wently, Patient #10 did not ling including a non-contrast ography (CT) scan until after medical/surgical floor and	A 000		
	the facility did not har monitor (shows the elecated at the nursing containers or function ED rooms, or adequate casting on fractured in In addition, the facility institutional plan that operating budget was	y failed to ensure an overall			
A 043	medications to adequal facility also failed to hassurance committee quality deficiencies was a second control of the control o	uately care for patients. The nave a functioning Quality a to identify and respond to within the facility.	A 043		

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Event ID: NS6G11

Facility ID 100020

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Signature: 1. Date: 3/4/15

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	FIPLE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
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	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
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A 043	There must be an legally responsible if a hospital does regoverning body, the for the conduct of functions specified governing body  This CONDITION Based on interview facility policies and facility failed to have that was responsible facility, and failed financial means to the health and safe and interviews corn on 01/22-24/19 and Chief Executive Off facility did not have medications, but from the facility did not have medications, but from the facility of the facility care institutional plan the operating budget to income, expenses for a three-year perinterviews with state have adequate su medications to add to budgetary constouched to budgetary constouched to budgetary constouched to facility also have deligible of approximation of approx	effective governing body that is for the conduct of the hospital, not have an organized be persons legally responsible the hospital must carry out the lin this part that pertain to the	A	The facility failed to have a functioning board and did not convene per policy left, new members were not appointed in effective governing board, which concelled board and CEO there was no oversign plan and its implementation. No one OAPI findings were presented to ME meetings were being held weekly. The resigned 7/2018, a physician sation attended meetings but had not been correct the lack of a governing board candidates was drafted by hospital to presented to the existing Governing consisted of one person, Americore governing board was established an The new governing board consist of general surgeon, a retired RN, and A MEC meeting was held on 2/20/19 following physician committee chairs appointed: QAPI committee, Utilizati Management: Blood Utilization / Infe Surgery; and, P & T / Dietary. Also is Medical Directors of Surgery and Ho QAPI plan was developed with new indicators for 2019. The QAPI plan approved by MEC on 2/20/19 and the board as reflected in attached minutiactivities will be reported through the weekly and then to MEC monthly, to bi-monthly and to the Governing Bo attached QAPI plan. The new Govelappointed a new CEO on 2/22/19 will oversight to ensure quality care is broad as reflected by board minutes. (Committee of the province of the pro	ed. This led to an ould not hold the ive governing ght of the QAPI was ensuring EC, and QAPI he QAPI director QAPI committee, appointed. To d. a list of potential eadership and Board which CEO. A new id met on 2/22/19, three members, a Americore CEO. If at which time the persons were ion review/ Risk ection Control / appointed were one Health. A performance was reviewed and the new governing es. All QAPI committee the Medical staff for will provide elng provided. This	

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Signature:

Date:

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1	) MULTIPLE CONSTRUCTION (X3) DATE SURV BUILDING	
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	<u> </u>			PINEVILLE, KY 40977	
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A 043	now refusing to provi without upfront paym Interviews with the fa (CNO), Chief Financ Executive Officer (Cl no plan to ensure the operate. (Refer to A0057, A00 A0273, A0385, A038	ide services and goods	A 04	The facility had no institutional plan or annual operating budget due to no effective Governing in place. The institutional plan, includin operating budget that included all anticipated expenses, and capital expenditures for a three period was made. This plan was presented to and approval. This is verified by attached board not an approval. This is verified by attached board induces. See Attached minutes. (Controller)  Because the governing board was not meeting monthly, it was not able to provide proper owe policy was in place for meetings of the govern but was not followed. The policy 200.103 Govern Board Responsibilities was revised for the govern but was not followed. The policy 200.103 Govern Board to meet monthly instead of twice annual ensure better oversite for the facility. This porevision was approved by MEC and the govern board. A calendar with meeting dates and timbeen created by the Administrative Assistant copy attached. This will be verified by committee and attendance log. Verified by minutes and attendance log. Verified by minutes and attendance log. Verified by minutes and attendance log. MEC, QAPI accommittees were not meeting often enough to proper implementation of the QAPI plan. The meeting calendar will be developed to ensure meetings by the necessary committees. This verified by committee attendance logs and minutes. The Administrative Assistant will rethe schedule and attendance compliance to committee. (Administrative Assistant)	ang Board g annual income, se-year of MEC or review and a series from and a series from and P&T or ensure a annual e timely is will be aport on the QAPI and a series from the QAPI facility 3/5/2019
				had the financial means to operate effectivel failing to have an institutional plan and annul operating budget, creating issues with adequate supplies, equipment, and medications. The operating budget that included all anticipated expenses, and capital expenditures for a throperiod to MEC, and it was sent and reviewed governing board. This is verified by attached minutes. See Attached minutes. The relation the material supply vendors is corrected. Misupply orders are being ordered weekly. This issues with placing orders and receiving order to a lack of communication the facility staff weekly.	y due to al late controller al dincome ee-year diby the board iship with aterial ere are no eers Due vas not
EORM CHS.251	57(02-99) Previous Versions Ob	solete Event ID NS6G	11	always calling the materials management de Facility ID: 100020 If continua	ept and i tion sheet Page 6 of 135
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asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ae replaced now through weekly orders to our materials supply vendor. The Cardinal Wholesaler debt which had been identified in the findings as being the cause of drug supply issues is being addressed. An initial payment was made on 2/7/2019 and additional payment will be made to release order. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory, which is attached. The CEO was found to not be in compliance with overseeing the facility by ensuring that necessary equipment was in proper working order. The ED Central Cardiac Monitor has been repaired by DTG, initial payment submitted 2/11/2019 and final payment was submitted on 2/19/2019. Central monitor back in operation 3/1/2019. The nursing staff in the ED have been making rounds every 5-10 minutes for patients who requiring on going cardiac monitoring. Any patient who requires closer cardiac monitoring than q 5-10 minutes has a nurse 1 on 1. The ED is staff with 2 RN's or 1 RN and Paramedic 24/7. Due to not having EMR support we were not able to edit the computer software and perform regular updates. The support was restored 2/19/19 and an electronic reflex process was established to trigger dietary consults and social services consults. (CEO)

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Signature:

3/1/2019

A 057

CHIEF EXECUTIVE OFFICER CFR(s): 482.12(b)

The governing body must appoint a chief executive officer who is responsible for managing the hospital.

This STANDARD is not met as evidenced by: Based on interview, record review, and review of facility policies and bylaws, it was determined the facility failed to have an effective governing body that was responsible for the conduct of the facility, and failed to ensure the facility had the financial means to operate effectively and protect the health and safety of patients. Observations and interviews conducted throughout the facility on 01/22-24/19 and 01/28-30/19 revealed the Chief Executive Officer (CEO) was aware the facility did not have adequate supplies and medications, and therefore was failing to provide goods and services necessary to care for patients.

The findings include:

A 057

The facility failed to have a functioning governing board and did not convene per policy. As members left, new members were not appointed. This led to an ineffective governing board, which could not hold the CEO accountable. Without an effective governing board and CEO there was no oversight of the QAPI plan and its implementation. No one was ensuring QAPI findings were presented to MEC, and QAPI meetings were being held weekly. The QAPI director resigned 7/2018, a physician sat on QAPI committee. attended meetings but had not been appointed. To correct the lack of a governing board, a new governing board was established and met on 2/22/19. The new governing board consisting of three members, a general surgeon, a retired RN, and Americare CEO A MEC meeting was held on 2/20/19 at which time the following physician committee chairpersons were appointed. QAPI committee, Utilization review/ Risk Management: Blood Utilization / Infection Control / Surgery, and, P & T / Dietary. Also appointed were Medical Directors of Surgery and Home Health. A QAPI plan was developed with new performance indicators for 2019. The QAPI plan was reviewed and approved by MEC on 2/20/19 and the new governing board as reflected in attached minutes. All QAPI activities will be reported through the QAPI committee weekly and then to MEC monthly, to the Medical staff bi-monthly and to the Governing Board monthly. See attached QAPI plan. The new Governing Board appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes, new board members were appointed by the existing board which consisted of one member. A new governing board was established and met 2/22/19. An interim QAPI director was appointed, and a QAPI meeting was held. A permanent QAPI physician director, Medical Director of Surgery, P&T physician director were appointed by MEC and approved by the new governing board, see attached minutes and attendance log. A QAPI plan was developed with new performance indicators for 2019. The plan for 2019 was reviewed and approved by MEC and the new governing board so oversite will be provided for quality care of the facility. MEC minutes were presented by Chief of Staff. Board minutes are attached. The new governing body appointed a new CEO on 2/22/19 who will provide oversight to ensure quality care is being provided. This may be verified by board minutes.

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Signature: 10. 10. Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A DUM DIVIS			(X3) DATE SURVEY COMPLETED		
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SOUTHE	ASTERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE		
	OTERN KT MEDIOAE O			PINEVILLE, KY 40977		
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A 057	Review of the facility Board Responsibilities revealed the governitwice annually and woonduct of the facility objectives of the facility objectives of the facility objectives of the facility objectives of the facility objectives of the facility established standard.  Review of Patient #1 the patient was admit abdominal pain on 08 consent on 08/16/18 the facility on 08/16/18 the facility admitted to the facility admitted to the facility admitted to the facility admitted to the facility admitted to the facility admitted to the facility admitted to the facility admitted to the facility did services available or monitor the patient. Frecord revealed the facility do patient to monitor the patient frecord revealed the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility and the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility and the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitter than the facility admitted tha	policy titled "Governing es," approved June 2017, and board would meet at least as responsible for the reconsistent with the lity and consistent with sof patient care.  's medical record revealed ted to the facility for 8/16/18 and signed a to have an denoscopy (EGD); however, ty performed a colonoscopy take.  's medical record revealed the patient on 10/10/18 with a out a heart attack even if not have cardiology an intensive care unit to further review of Patient #2's facility failed to conduct heart are monitoring, and laboratory expatient's cardiac status as int's physician. On 10/11/18 ent developed a heart acility failed to notify the mely and Patient #2 was not atte care facility for cardiac attment until 10/11/18 at 6:00 nirty-four hours after the	A.	The Cardinal Wholesaler debt which had been the findings as being the cause of drug supply is addressed. An initial payment was made on 2/2 another payment will be made to have Cardinal orders. The medications which were identified available were ordered on 2/21/19. The Directe Pharmacy will oversee the restocking of the Orwhich occurs twice a day via the restock report automatically print in the inpatient pharmacy. availability of medications will be verified by the from the wholesaler and Omni inventory - which The CEO was found to not be in compliance woverseeing the facility by ensuring that necessal was in proper working order, this was in part the funding needed to provide goods and services is care for patients's. The ED tour revenled the fabave a functioning telementry monitor located station and staff were unable to monitor a patient's add not have functional pulse oximeters, or have biohazard "sharps container", limited casting suput dated casting supplies. To correct this issuit relationship with the material supply vendors is Material supply orders are being ordered week no issues with placing orders and receiving ord lack of communication the facility staff was no calling the materials management dept and ask supplies to be restocked when supplies has been lown a materials clerk makes inventory supply week days for each unit. If supplies are needed replenished from the inventory in the stock row from supplies ae replaced now through weekly maternials supply vendor. The Cardinal Whole which had been identified in the findings as be of drug supply issues is being addressed. The E Cardiae Monitor has been repaired by DTG, in submitted 2/11/2019 and final payment was su 2/19/2019. Central monitor back in operation 3/1/2019. (CEO)	sues is being //2019 and release as not being or of micells that The ne receipts h is attached the receipts h is attached the receipts h is attached at the nursing nt's cardiac oom. The ED e functional pplies and the corrected yy. There are crs. Due to a talways ng for a depleated rounds on they are m. Stock orders to our saler debt ng the cause D Central tial payment	

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Event ID: NS6G11

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Signature Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SL AND PLAN OF CORRECTION IDENTIFICATION NUMBER A. BUILDING COMPLE					
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		180021	B WING		01/	30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
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A 057	the ED physician ord prevent and treat blo (antibiotic) to be adm however, staff falled	ered Lovenox (used to	A 0	The CEO was found to not be in complian overseeing the facility for stocking medication the formulary. The CEO will oversee a pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy to ensure that the pharmacy that the pharmacy to ensure that the pharmacy to ensure that the pharmacy that th	ations as indicated the director of all review the ations that were not a. The list of these amittee for the formulary or	2/22/2019 and ongoing
	Review of Patient #4 the patient was admi Congestive Heart Fa 01/22/19. However, the patient because it was not at the medical record recordered on 01/23/19 patient's blood gluco the record revealed the physician was not blood sugar was elected the patient presented 11/26/18; however, a until 11/27/18. The x hip was fractured. He transfer the patient the fracture until 11/28/19 provide tube feeding to the facility from 11/26/18 to administer the patient's fingers facility from 11/26/18 to administer the pamedications on 11/2 the medications were	's medical record revealed ted for treatment of illure and Diabetes on the facility failed to the facility failed to the facility failed to the facility failed to the facility failed to the facility failed to the physician to be notified when the se was above 200. However on 01/23/19 and 01/24/19, of notified when the patient's vated above 200.  It's medical record revealed to the ED with hip pain on the facility did not to obtain treatment for the facility also failed to the Fatient #5 while admitted 1/26/18 through 11/28/18. In the facility did not to patient #5 while admitted 1/26/18 through 11/28/18, and failed the fatient four (4) STAT 6/18 until (two) 2 hours after the ordered by the physician.		for a therapeutic substitution. (Newly applif he facility was found to not be in complif CEO did not ensure the conduct of the faccomphiance. As a result, the facility did nower following proper procedure in obtain informed consent for patient #1 on 8/16/1 lissue from reoccurring, the CEO will over will ensure the Surgery Charge Nurse, surphysicians are in-serviced on the Informed Correct Procedure and Correct Patient for Surgical Procedures. This will be verified attendance log. A new QAPI performance been added to the QAPI plan to monitor 1 will be verified by the in-service attendance log. A new QAPI performance been added to the QAPI plan to monitor 1 will be verified by the in-service attendance log. A new QAPI performance been added to the QAPI plan to monitor 1 will be verified by the in-service attendance log. A new QAPI performance been added to the QAPI plan to monitor 1 will be verified by the in-service attendance overseeing the CNO to ensure Policy and regarding medication administration were followed. Patient's #3, #4, #5 (for STAT not receive the medication as ordered on nursing documentation was present in sufficient for the medication of the CNO and verify that licensed nursing station policy 600.034, Medication Administration policy 200.421, Continum of Care to ensunderstanding of medication administration policy 200.421, Continum of Care to ensunderstanding of medication administration importance the patient's medical record. Chart audits medication administration, medication documentation, consent for treatment of the patient's medical services consults, monifollowing up on medications, will be performed at the patient's will be reported to QAPI weekly summediate actions are taken. (CEO)	ance because the fifty was in the current the staff and the proper 8. To prevent this see the CNO who received the control of Correct Site, Invasive or Invasive o	3/1/2019
		ew revealed the facility to the facility on 01/06/19 with				

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Event ID: NS6G11

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Signature | Date: 3/4/19

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

CENTER	S FUR MEDICARE &	MEDICAID SERVICES				
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
		180021	B. WING		01/3	; 30/2019
MAME OF B	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	KOVIDER OR SOFFLIER			ISO RIVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICAL C	ENTER		PINEVILLE, KY 40977		
			201			ME
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROPE  DEFICIENCY)	BE	(X5) COMPLETION DATE
A 057	Cellulitis to the right infection), early seps life-threatening cond response to an infection. However, the fipatient's Lovenox (modes) on 01/06/19 at the patient until 01/0 twenty-two (22) hour physician and failed pressure sore was a Review of Patient #8 the patient was directly symptoms of stroke,	ower extremity (skin is (a potentially ition caused by the body's tion), and a Stage 2 pressure acility failed to administer the edication to prevent blood and it was not administered to 7/19, approximately after it was ordered by the to ensure the patient's ssessed/treated.  I's medical record revealed atly admitted to the medical 1/19 with signs and even though the facility did	A 057	The CEO was found to not be in compliance with overseeing all departments to ensure a good work relationship throughout the facility. CEO will of department managers and verify all hospital stall serviced on 700.708, Interdepartmental Relation implement this policy, department by department will be discussed at weekly Managers meetings interdepartmental cohesiveness. The Administrative Assistant will report on the section and the model of the meeting o	king versee f will be in- ships. To at updates to promote ative allendar. The dule and veckly. The verseeing all hip timent serviced on inplement vill be note ative allendar. The dule and (CEO)	3/1/2019
	In addition, the phys patient to another fa assessment and car admission.  Review of Patient #*Patient #10 present a "significantly eleval exhibited signs and However, the patien imaging including a tomography (CT) so to the medical/surginafter arrival to the Estransferred to Facility for treatment of an attempt to Patient # the patient was administration of the patient was adm	l/physical therapy services. ician failed to transfer the cility for neurological e until 01/22/19 the day after  i 0's medical record revealed ed to the ED on 11/12/18 with ated blood pressure" and symptoms of a stroke. t did not receive medical non-contrast head computed an until after being admitted cal floor and five (5) hours D. Patient #10 was y #6 on 11/12/18 at 8:15 PM		The CEO failed to oversee the CNO to ensure that in place for the notification for dietary comperformed. HIM Director put in place a new electronic reflex process to trigger automatic addictary for a consult. The reflex is attached to a flowchart and when nursing staff selects answereflex is then sent electronically to dietary staff verify with nurse and then notify dietician of the CEO will oversee and verify that dietary and miservices will be in-serviced on the electronic real Registered Dietician was hired 2/22/19. Die was used to verify that the reflex process for Deconsultants would work. (HIM Director)  The CEO failed to oversee the CNO to ensure facility's nursing service would follow policy service failed to report and follow up on medic was identified in the survey findings. Nursing be in-serviced on the Medication Error Policy, to reinforce the need to report all incidents for the pharmacist, the Risk Management committee and MEC. This will be verified by attendance log. CEO will oversee and verify th nursing staff will be in-serviced on policy 600 Medication Error. (CEO)	antis be attification to a question on a question on a choice the who will be consult.  Irsing flex process. I orders were a test patient betary  list the The nursing attion errors Service will 600,085 and follow-up by ce, the QAPI the in-service at licensed	3/1/2019

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Event ID NS6G11

Facility ID 100020

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Signature Da

Date: 3/4/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	1 ' '	PLE CONSTRUCTION	(X3) DATE S COMPLE	
THE PERSON OF TH			A BUILDING	G	c	
		180021	B. WING _		01/3	0/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF {EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 057	available." The conservations were commendations were where they can do facility failed to transuntil 09/24/18, three Review of Patient # Patient #12 present Department (ED) in 12/04/18. On two direquired multiple do medication to stimu sustain the patient's failed to have enough attent, and Epinep the facility by the Ec (EMS) that had translated the ED who was expected the ED to the ED who was expected the ED to the ED would "kill this contacted a transpower was flown to anoth."  The facility failed to the Registered Die feeding tubes, presented the ED in the Registered Die feeding tubes, presented the Registered Die feeding tubes, and failed to the Registered Die feeding tubes.	uncertain if anesthesia was sulting Gastrointestinal ant #11 on 09/21/18 and his were to transfer the patient surgery." However, the ster Patient #11 for treatment a days later.  12's medical record revealed ed to the Emergency full cardiac arrest on afferent occasions the patient ases of Epinephrine (a late the heart) in an effort to a late the heart) in an effort to a life. However, the facility gh Epinepherine to treat the sherine had to be supplied to mergency Medical Services asported the patient to the ED.  Emergency Medical Director on M., revealed on 07/17/18, EMS ransfer an unknown patient to thibiting signs and symptoms. However, when EMS or inform them that they were latient, they were informed by the patient to the ED because a guy." Subsequently, EMS ort helicopter and the patient	A 0	The CEO failed to oversee the CNe facility's nursing service would foll service failed to monitor and notify change of status. Licensed nursing on policy 200.403, Assessment and patient. Chart audits, including tim administration, medication omissic documentation, consent for treatmeservices consults, monitoring and medications will be performed dail ensure compliance. Chart audit to ACNO who will report results of the reported to QAPI weekly so if neet taken. This will be verified by way attendance log. The facility's nurse consult the RD and notify the physical integrity was compromised, be in-serviced on policy 200.420, audits will be performed daily by compliance. This will be verified by intended to get the facility of the facility. This will be destroyed by the new board on the scope of services, and to better set of the facility. This will be destraff on the MedSurg-Scope of Care was revised of the facility. This will be destraff on the MedSurg-Scope of Care was revised to the facility. This will be destraff on the MedSurg-Scope of Care was revised to the facility. This will be destraff on the MedSurg-Scope of Care was revised to the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility of the facility. This will be destraff to the facility of the	low policy. The nursing patient's physician of staff will be in-serviced I Reassessment of the lely medication ons, change in condition ent, nutritional/social following up on ly by nursing staff to observe of said actions are collected by the chart audits will be ded immediate actions are of an in-service ing service failed to sician when a patient's Licensed nursing staff will Skin Integrity. Chart nursing staff to ensure by way of an in-service facility integrate the ED lity. Policy 700,709, led by MEC on 2/20/2019 to 2/22/19 to better define integrate the ED with the one by in-servicing clinical are policy. 700,709. The the staff is in-serviced, this indance log. (CEO) insure adequate resources number of staff allowing in QAPI activities and in systems for collecting III report any and all CEO).  Og Board, MEC, QAPI and schedule was not ar will be developed to cessary committees. This endance logs and	3/1/2019 3/1/2019 3/1/2019

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Event ID: NS6G11

Facility ID: 100020

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Signature: Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCE AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X3) DATE A. BUILDING COMP		SURVEY LETED	
		40004			1	2
		180021	B. WING _		01/	30/2019
NAME OF PROVIDER OR SOUTHEASTERN KY	1382	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
11190	CH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
o1/23/19 revealed telemetry the heart were una unless th Further o rooms in oximeter of oxyger also reve container revealed and devid biohazar addition, revealed necessar presentir The ED's expired a available  Observat o1/23/ at surgical currently surgical (VirexTB Interview Processi Sterile p a period no instru biologics Physicia	se Emerger 9:45 AM are the facility of monitor (sl.) located at ble to monice between the ED did (a device un in the blocaled none of a function of the ED staff had contained by to cast frough do contained by to cast frough to treat valuations of the ED staff had contained by to cast frough to the ED staff had contained by to cast frough to the ED staff had contained by to cast frought to the ED staff had contained by to cast frought to the ED staff had contained by to cast frought to the ED staff had contained by the ED staff had contained	de 10  and 1/30/19 at 5:15 PM  did not have a functioning hows the electrical activity of the nursing station, and staff for a patient's cardiac status esent in the patient's room. To revealed eight (8) of nine (9) The nine (9) ED rooms all biohazard "sharps" Tons on 1/30/19 at 5:15 PM and to transport used needles the hallway to get to a the dispose of the items. In the of the casting room did a limited number of supplies actured bones of patients of in need of casting services, ply of casting tape was rropriate sizes were not rious injuries.  Surgical Department on revealed the department's solutions that they were clean and disinfect the surgical instruments had expired in 2018.  July 10:55 AM with Sterile tian #1 and at 11:00 AM with Technician #2 revealed during er 2018 (exact date unknown) dibable. Interview with July 11:00 AM revealed and at the facility in October	AC	Due to not having EMR support we were	rdates. The support ex process has now rvices. The reflex and when nursing en sent rifly with nurse and lex was also ing to social vers to questions, it is department and and both dietary	

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	188		CONSTRUCTION	(X3) DATE COMPI	
						[ c	
		180021	B. WING			01/3	30/2019
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			İ	85	O RIVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICAL C	ENTER	i	PII	NEVILLE, KY 40977		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	I ID	-	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI. TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
A 057	2018 because continuous facility was endange. The physician stated equipment or supplie there had been time; be sterilized, and stamiddle of a surgical facility for needed surgical facility	ruing to provide care in the ring the lives of his patients. I there was not adequate as in the surgery department, as when instruments could not lift has had to leave in the procedure to search the applies.  Tector of Pharmacy on revealed the facility had only led to treat blood clots in the had informed the facility's luation. The Director of the reason for the lack of the cost. The Director of the facility owed around half a liding distributor for the facility any more medications and. Continued interview are some medications in the expired that the facility in due to the cost. Continued are cor of Pharmacy revealed to CEO and the medication and the vendor referred her to ant. The Director of Pharmacy go the crash carts with the last Verapamil, EPI, Nitroglycerin and Eicarbonate 8.4%50 ml in a bility to obtain anymore. The cor and the CEO's plan was ase on 02/01/19 in Missouri, rmacy was questioning the	A		The facility failed to have a functioning governing therefore the facility had no institutional plan or a perating budget in place. The facility was also for a policy or procedure related to the development of the procedure related to the development of the procedure related to the development of the procedure related to the development of the plan was presented to MEC and sent to newl governing board for review and approval. This is strached board minutes. See Attached minutes. Plandget Policy was developed. The Cardinal Wholebt which had been identified in the findings as cause of drug supply issues is being addressed. Anyment was made on 27/2019 and another paymende to have Cardinal release orders. The medical which were identified as not being available were on 2/21/9. The Director of Pharmacy will overs restocking of the Omnicells which occurs twice a restock reports that automatically print in the inpulsarmacy. The availability of medications will be anythe receipts from the wholesaler and Omni involvant is attached. Due to no institutional plan and being in place the facility failed to ensure that near equipment was in place and in proper working or also, includes, the cardiac monitor for the ED, monitor has being in place the facility failed to ensure that near equipment was restored on 2/19/19 so regular software now being performed. The relationship with a supply vendors is corrected. Material supply orders and receiving orders. Due to a lack of communication the facility staff was not always materials management dept and asking for suppling the support was restored on 2/19/19 so regular software now being performed. The relationship with the supply vendors is corrected. Material supply ordered and receiving orders. Due to a lack of communication the facility staff was not always materials management dept and asking for suppling the stock of when supplies has been depleated. No materials clerk makes inventory supply rounds of or each unit. If supplies are needed they are repfrom the inventory in the s	nnual ound to not nent of a perating , and een created yeared verified by olicy plesaler peing the an initial nent will be cations ordered ee the day via the item e verified eentory, d budget pessary der. This aterial , and en repaired 0.19. EMR are updates he material ers are placing calling the est to be with a week days enished in supplies	

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Signature:

Date:\_

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	B. WING_			01/3	30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	ZIP CODE		,
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC (DENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOU		E ACTION SHOULD BE TO THE APPROPRIA		(XS) COMPLETION DATE
A 057	"scheme."  Review of the last Go Minutes conducted b revealed the meeting three (3) members w Body made recomme temporary privileges approved the privileg administration's mediand adopted the form rules/regulations, and Further review of the no other discussions actions taken.  Interview with a Form on 01/30/19 at 2:07 Flonger employed by the no longer functioned member as of "last w stated that the Chief responsible for "nine provided to the facility communication with (CNO) and the Chief are at the facility. The that the Governing B and not consistently unable to state when meeting was held for besides herself had a The Former Member constant conversation finances, and that the always the topic of p stated that she was a conversation she had	everning Board Meeting by the facility dated 08/21/18, was a virtual meeting and ere present. The Governing endations to approve for eight (8) physicians, es of the former cal staff for six (6) months, her administration's bylaws, d policies/procedures. meeting minutes revealed took place or no further  The Governing Body Member of the facility's corporation and as a governing body heek." The Former Member executive Officer (CEO) was by percent" of oversight y, and had daily he Chief Nursing Officer Financial Officer (CFO) who he Former Member stated ody only met "sporadically ody only met "sporadically the facility or whatmembers hade up the governing body stated that there was n about the facility's he cash flow of the facility was riority. The Former Member hot aware of a meeting or d attended or participated in	AO	957		•	
	1 regarding the facility	that was not dominated by	1 1				

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STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			ONSTRUCTION		ATE SURVEY OMPLETED
		180021	B. WING				C 01/30/2019
	OVIDER OR SUPPLIER			850	REET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE DEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILD BE	(X5) COMPLETION DATE
A 057	never involved in or the facility.  Interview on 01/30/ and Owner of the facility, and are resoperations. The CE oversight by talking CFO several times he and two other moverning body of state who the other CEO was unable to body met or provid meetings. The CE oroutinely discussed meetings or when the CEO stated the been informed or of that had occurred as	r aware of care concerns at  19 at 2:38 PM with the CEO acility revealed the CNO and e onsite administration at the ponsible for the day to day co stated he provided via telephone to the CNO and a day. The CEO stated that members comprise the the facility, but was unable to r two members were. The o state how often the governing e any structural details of the D was unable to say what was I in the governing body the last meeting had occurred. e governing body had never discussed any adverse events	A	057			
A 073	A0273, A0385, A0: A0837, A0940, A0: and A1104.) INSTITUTIONAL F CFR(s): 482.12(d) The institution must plan that meets the (1) The plan must i budget that is prep accepted accounti (2) The budget mu income and expen	395, A0489, A0490, A0799, 951, A0955, A1100, A1103, PLAN AND BUDGET at have an overall institutional following conditions: include an annual operating larged according to generally	A	073			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B. WING			04/3	10/2019
		180021	D, WING			01/3	10/2019
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		İ
COUTUEA	STERN KY MEDICAL C	ENTER			850 RIVERVIEW AVENUE		
SOUTHER	STERM KT WEDICAL C	ERIER			PINEVILLE, KY 40977		
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	l ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFI		(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR		COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	j	DEFICIENCY)	-	1.0
					The facility failed to have a functioning governing	g board,	3/6/2019
4 070		4.4		07	therefore the facility had no institutional plan or	nnual	128
A 073			A	07.	Operating budget in place. The facility was also	ound to not	- 1
	components of each	anticipated income or			have a policy or procedure related to the develop budget. An institutional plan, including annual of	ment of a perating	
	expense.				budget including all anticipated income, expense	s, and	
		ovide for capital expenditures			capital expenditures for a three-year period has b	een created.	
		period, including the year in			This plan was presented to MEC and sent to new	ly seated	
		budget specified in paragraph			governing board for review and approval. This is attached board minutes. See Attached minutes. 1	olicy	
	(d)(2) of this section				Budget Policy was developed. The Cardinal Wh	olesaler	
		clude and identify in detail the			debt which had been identified in the findings as	heing the	
		anticipated sources of			cause of drug supply issues is being addressed, payment was made on 2/7/2019 and another pay	va musai	i
		nticipated capital expenditure			made to have Cardinal release orders. The med	cations	
		00 (or a lesser amount that is			awhich were identified as not being available wer	ordered	
		rdance with section 1122(g) State in which the hospital is			on 2/21/19. The Director of Pharmacy will over	see the	_
		to any of the following:			restocking of the Omnicells which occurs twice restock reports that automatically print in the inf	atient	
	(i) Acquisition of				pharmacy. The availability of medications will	ne verified	
		of land, buildings, and			by the receipts from the wholesaler and Omni in	ventory.	
	equipment; or	or land, buildings, and			which is attached. Due to no institutional plan a being in place the facility failed to ensure that no	nd budget	
		nent, modernization, and	ł		equipment was in place and in proper working o	rder. This	
ļ	expansion of building				also, includes, the cardiac monitor for the ED, of	naterial	
		30			supplies throughout the facility, the EMR system payroll. The ED Central Cardiac Manitor has be	i, and	
	This STANDARD is	not met as evidenced by:			by DTG, Central monitor back in operation 3/1/.	2019. EMR	<b>6</b> 1
ŀ		riew and interview it was			support was restored on 2/19/19 so regular softw	are updates:	
	determined the facili	ity failed to have an overall			are now being performed. The relationship with	the material	
	institutional plan with	h an annual operating budget			supply vendors is corrected. Material supply or heing ordered weekly. There are no issues with	nlacing	
	that included all anti				orders and receiving orders. Due to a lack of		
1		ained capital expenditures for			communication the facility staff was not always	calling the	
		Observations and interviews			materials management dept and asking for suppressocked when supplies has been depleated. No	ies to ne	
		he facility failed to have			materials clerk makes inventory supply rounds (	in week days	
1		equipment, or medications to			for each unit. If supplies are needed they are re-	lenished	
	1	patients due to budgetary			from the inventory in the stock room. Stock roo	m supplies	
		facility's inability to obtain			ae replaced now through weekly orders to our n supply vendor. (CEO/Controller)	micrimas	
		se needed items. The facility			sulfed sammer (seems seems)		
		g pharmacy approximately					Į
		ars, and their electronic ndor approximately six					1
		follars, and all vendors			B		1
		y are now refusing to provide					
		without prepayment					
	payments.						
	,				1 6		
	1		- 1				

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Signature Date:

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	B. WING			01/	30/2019
	ROVIDER OR SUPPLIER ASTERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
A 073	Interviews with the fac (CNO), Chief Financi Executive Officer (Clino plan to ensure the operate.  The findings include: Interview with the fac 6:00 PM, revealed the policy or procedure of a budget.  Review of the facility Period Ending June had projected total of for each month from December 2018. Furtifacility had projected 1,175,517 dollars for through December 2 had a projected net dollars for each month December 2018.  Further review of the for January 2019 the revenue of 1,012,46 operating expenses February 2019, the fac revenue of 1,082,40 operating expenses March 2019, the facility had 1,120,016 dollars, a expenses of 903,76	acility's Chief Nursing Officer ial Officer (CFO), and Chief EO) revealed the facility had a facility could continue to cility's CFO on 01/28/19 at the facility did not have a related to the development of 's "Operating Budget for the 30, 2019" revealed the facility et revenue of 927, 110 dollars	A	073			

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Date:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) M IDENTIFICATION NUMBER: A. BU		IPLE CONSTRUCTION		C C		
		180021	B WING_			01/30/2019		
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STA 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	ATE, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	COMPLETION DATE		
A 073	net revenue of 1,159 total operating exper for June 2019 the far revenue of 1,200,98 total operating exper Continued review of Budget revealed for through June 2019, 644,748 dollars.  The facility was unal plan for capital experiment of Continued Paper of Continued Paper of Continued the facility had a lact areas to ensure pating and Services.  Observations and in and 01/28-30/19 revunit, staff were limited could utilize for pating cut back to or not have ordered menot available from the Physician #5 on 01/2 was instructing pating to the could utilize for pating the could utilize for pating cut back to or not have ordered menot available from the Physician #5 on 01/2 was instructing pating to the could utilize for pating the could	2,512 dollars and projected asses of 903,760 dollars, and cility had a projected net 2 dollars and projected of asses of 903,760 dollars.  The facility's Operating the fiscal year of July 2018 the facility projected a loss of the facility projected a loss of the facility projected a loss of the facility projected a loss of the facility projected a loss of the facility projected a loss of the facility and facility on (28-30/19 revealed the facility and Medical/Surgical Floor, and, and Surgical floor, and surgical feet of the facility and facility	AC	073				

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NS6G11

Facility ID: 100020

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Signature: 1 1 Date: 34/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	98		CONSTRUCTION		TE SURVEY MPLETED
		180021	B. WING				C 01/30/2019
	ROVIDER OR SUPPLIER	ENTER		850	REET ADDRESS, CITY, STATE, ZIP CODE O RIVERVIEW AVENUE NEVILLE, KY 40977	,	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		JLD BE	(X5) COMPLETION DATE			
A 073	the heart) located at were unable to moniunless they were preeight (8) of nine (9) a functional pulse or measures the amounone of the nine (9) functional biohazard ED's entire supply o and the appropriate treat various injuries.  Observations of the 01/23/19 at 10:50 Al supply of surgical diand Envy)that the st clean and disinfect t surgical instruments Interviews on 01/23/Processing Technicistruments could be being available. Inte 01/30/19 at 11:00 Al practicing at the faci continuing to provide endangering the live physician stated the equipment or supplithere had been time be sterilized, and stamiddle of a surgical facility for needed signal and the sterilized of the surgical facility for needed signal and the sterilized of the surgical facility for needed signal and the sterilized of the surgical facility for needed signal and the sterilized of the surgical facility for needed signal and the surgical facility for needed signal a	the nursing station, and staff for a patient's cardiac status asent in the patient's room; sooms in the ED did not have simeter (a device used to not of oxygen in the blood); ED rooms contained a "sharps" container, and the focating tape was expired sizes were not available to surgical Department on Morevealed the department's sinfectant solutions (Virex TB aff was currently utilizing to the surgical rooms and had expired in 2018, 19 at 10:55 AM with Sterile an #1 and at 11:00 AM with sechnician #2 revealed during for 2018 (exact unknown) no esterilized due to no biologics rview with Physician #9 Morevealed he stopped lity in October 2018, because as of his patients. The re was not adequate the surgery Department, as when instruments could not aff has had to leave in the procedure to search the upplies.	A	073			
	PM, and the ACNO were aware that the	/19, with the CNO at 12:00 at 12:30 PM, revealed they facility had an overall lack of hable to obtain medications					

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Event ID: N56G11

Facility ID: 100020

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Date

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	EMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION   IDENTIFICATION NUMBER:   A. BUILDING			(X3) DATE SURVEY COMPLETED		
		180021	B. WING			C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION}	ID PREFIX TAG		HOULD BE	(X5) COMPLETION DATE
A 073	funds to pay for the sign ACNO stated any very with the facility would payment was received funds available, serving The CNO stated she and did not know of a current financial probing primary goal on a day patients received addition, the CNO sign and been unable to reconsistently since the over the facility in Mac CNO stated that emphealth insurance prepaychecks by the fact not been paying the instaff was without cover went on to say that do "walk out" of the facility receive a paycheck to finances at the fact current CEO had acc 2018. He stated he will be to finances at the fact current CEO had acc 2018. He stated he will be to finances at the fact current CEO had acc 2018. He stated he will be to finances at the fact current CEO had acc 2018 and the fact the numbers utilized came from the CEO, explain why the facility operating income had for July 2018 through addition, the CFO was	patients due to a lack of services. The CNO and not provide services unless and in advance, and with notices could not be paid for. Italked daily with the CFO any solutions to the facility's elems. The CNO stated her at to day basis was to ensure equate care in the facility. Itated that was becoming ult to do each day. In add ACNO stated the facility neet payroll for facility staff a current CEO had taken by of 2018. In addition the ployees had been having miums deducted from their illity; however, the facility had insurance premiums and the erage. The administrators irect care staff planned to lity the next time they did not imely.  Cility's CFO on 01/28/19 at was responsible for the day illity, and had been since the quired the facility in May of was in contact with the Chief EO) daily. The CFO stated for the Operating Budget and the CFO was unable to ty's total net revenue and net d remained exactly the same	A	073		

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Event ID: NS6G11

Facility ID 100020

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Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	0.00	IPLE CONSTRUCTION		X3) DATE COMP	SURVEY LETED
		180021	B. WING _			01/	30/2019
	STERN KY MEDICAL	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	EIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORE ( (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE		(×5) COMPLETION DATE
A.073	the facility was to mand attempt to obta and inventory needs it running. The CFO viable plan to make plans on paying over the facility's pharma approximately "one-approximately "six hacility owed the me Continued interview physical building courrently being "litig Court, and the CEO the building." Howe the acquisition"; the	stated that his main priority at anage day to day expenses in the most critical services ed to fund the facility and keep of stated that the facility had no up the facility losses nor erdue expenditures, such as acy supplier who was owed chalf million dollars" or the nundred thousand dollars" the edical records vendor.  If with the CFO revealed the imprising the facility was lated in Federal Bankruptcy was attempting to purchase over, "there was opposition to be physical building such as	A	073			
	Interview with a For on 01/30/19 at 2:07 longer employed by no longer functione member as of "last stated the Chief Exc Chief Financial Officto the facility's finant stated the facility has constraints. The Formost urgent probler was "cash flow com Former Member state facility was experiturn a high settler Former Member state facility had develop	rmer Governing Body Member PM, revealed she was no r the facility's corporation and d as a governing body week." The Former Member ecutive Officer (CEO) and the cer (CFO) spoke daily related ces. The Former Member as significant financial rmer Member stated that the m at the facility as of last week ning through the door." The ated that she was unsure of budget plans but knew that ecting the 2018 cost report to ment back to the hospital. The ated that she unaware if the ed a "formalized" budget since the facility had occurred					

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Event ID: NS5G11

Facility ID: 100020

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Signature:

Date:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	_	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180021	B. WING_		C 01/30/2019
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN KY MEDICAL			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	01130/2013
PREFIX (EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
Executive Officer revealed the facility and he was constitute hospital aroun important objective to stabilize the facility to stabilize the facility to stabilize the facility to stabilize the facility to stated he be financial point of vibad." The CEO stated compatible facility's collect of the CEO stated the facility's collect of the CEO stated that his pecific budget, so responsibility of the CEO stated that his specific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the CEO stated that his pecific budget, so responsibility of the cEO stated that his pecific budget, so responsibility of the cEO stated that his pecific budget, so responsibility of the cEO stated that his pecific budget, so responsibility of the facility of	(6) months ago.  2/19 at 2:38 PM with the Chief (CEO) and Owner of the facility by was in a "turnaround mode" antly looking for ways to "turn d." The CEO stated the most e at this point was to find a way sility's financial position. The lieved that as of now the iew of the hospital was "not that ated the facility had changed in October 2018, and the any had done a "terrible job" and stions "have fallen off a cliff." the facility was in the process of collection company, and was a and grow the hospital. The se was unaware of the facility's tating that would be the ne CFO.  A0057, A0115, A0145, A0263, 2395, A0489, A0490, A0799, 2951, A0955, A1100, A1103,	A 07	73	

FORM CMS-2557(02-99) Provious Versions Obsolete

Event ID: NS6G11

Facility ID 100020

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		180021	B. WING _		C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER	8	STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION DATE
A 115	Observations revealed Emergency Departm Surgical Services (so general surgery), and medical surgical inpartevealed the facility dintensive/critical care policy/procedure in particular services that the meteory procedure in particular services that the meteory procedure in particular services that the fact Patients #2, #8, and diagnoses that the fact Patient #2 was admit rule out a heart attact not have cardiology intensive care unit to facility failed to conduct pressure monitoring, monitor the patient's physicial developed a heart anotify the patient's physicial developed a heart anotify the patient's physicial developed a heart anotify the patient's physicial developed a heart anotify the patient's physicial developed a heart anotify the patient's physicial developed a heart anotify the patient paresented to pain.  Patient #8 was direct surgical unit with sign even though the faction speech/occupation.  Patient #8 was direct surgical unit with sign even though the faction patient for treatment pain, and chronic king revealed staff notifies the patient was having however, the physical physical surgical unit was having the patient was having however, the physical procedure in patient was having the	ed the facility provided lent (ED) services, and ervices were limited to d had a twelve (12) bed atient unit. Interviews did not provide e services and had no blace regarding the scope of dical surgical unit could ally, the facility admitted #11 for treatment of acility could not provide. Itted with chest pain and to ek even though the facility did services available or an emonitor the patient. The funct heart testing, blood and laboratory testing to cardiac status as ordered by an. When the patient frhythmia, the facility failed to hysician timely, and Patient and to an acute care facility for	A	The facility had no effective process in place to promote each patient's rights. Twelve patient che reviewed and the facility failed to protect the rigithe patients from neglect. No intensive/critical ewere available at the facility, no policy and procedure in place to define the services for the medical surgical unit. Patient's #11 were admitted for treatment of diagnoses the could not treat. The physician was not notified there was a change in status for the patient or when edications were not administered timely, and an place to ensure timely transfers of patients when required services not available at the facility. Por 1700.315 ER Scope of Care, and Policy 700.709 (Scope of Care were revised and approved by Mt 2/20/2019 and the approved by the new board or better define all scope of services. This was donntegrate the ED with the rest of the facility and the scope of services for the medical surgical unensure and verify that licensed nursing staff are policies and will be in-serviced on policy 200.20 (Rights, policy 600.034 Medication Administration, Patients), policy 200.421 Continuum of Care, p. 200.403 Assessment and Reassessment of patient Transfer of Patients and on policy 700.240 Phys Orders. Chart audits, including timely medication documentation, consent for treatment, nutritional services consults, monitoring and following up of medications will be performed daily by nursing ensure compliance. Chart audit tools are collect ACNO who will report results of the chart audit taken. The CEO will oversee and verify that the serviced on the revised polices that have been af MEC and the new Governing Board. A procede compliance with the policy has been put into plathe charge nurse/supervisor will evaluate each proposition to see if it meets acceptable admiss according to scope of services policy. (CEO, C	rts were tts of six of are services edure in I the facility e scope of I2, #8, and I facility imely when en o process in the patients officy MedSurg C on 2/2/19 to e to better better define t. CNO to following I Patients on condition Usocial on endity staff to ed by ewill be exactions are staff is in- proved by even that tient prior ion criteria

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Event ID: NS6G11

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Signature Date: 3 Mg

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING		COMP	(X3) DATE SURVEY COMPLETED		
		180021	B. WING _		1	30/2019
	ROVIDER OR SUPPLIER ASTERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEWAVENUE PINEVILLE, KY 40977	4	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 115	stated, "Don't call me it tonight and transfer. The facility admitted Services on 09/21/18 with pain, nausea, vo ED physician was "u available." The consumendations we "where they can do a facility failed to transuntil 09/24/18, three In addition, Patient # Emergency Department pain. The facility failed after the patient was x-ray revealed the patient regular diet; howeve tube due to swallowing consume a diet by me contact the physician to ensure the patient nourishment and the feeding while at the days. Further, the fat reat wounds to the burns to the patient's administer medication by the physician.  Patient #3 presented.	e until the day after g to the nurse, the physician e back anymore. We'll sit on r [him/her] out tomorrow."  Patient #11 to Surgical G for treatment of Gall Stones omiting, etc., even though the ncertain if anesthesia was ulting Gastrointestinal ht #11 on 09/21/18, and his ere to transfer the patient surgery." However, the fer Patient #11 for treatment	A	The facility had no effective process in promote each patient's rights. Twelve pareviewed and the facility failed to protect the patients from neglect. For patient #5 to contact the physician or RD to ensure appropriate nourishment, failed to assess failed to administer medications to the puthe physician, and failed to transfer patie electronic reflex process was put in place attached to questions on the flowchart at staff selects answer choice the reflex is the electronically to dietary staff who will withen notify dietician of the consult. A re (RD) was hired on 2/22/19. Diet orders verified by the RD. The reflex process werified during the 2/22/19 visit. Nursin in-serviced on 200.421 Continuum of Co. Assessment, 600-034 Medication Admin (Pharmacy), 700.707 Medication Admin and 200.603 Transfer of Patients. Chart timely medication administration, medic change in condition documentation, conhutritional/social services consults, mon following up on medications will be per nursing staff to ensure compliance. Chaellotted by ACNO who will report rest and will be reported to QAPI weekly immediate actions are taken. The CEO werify that the staff is in-serviced on the have been approved by MEC and the ne (CEO)	atient charts were at the rights of six of the rights of six of the rights of six of the patient received and treat wounds, atient as ordered by nt timely. An earlier of the reflex is ad when nursing hen sent crify with nurse and gistered diction were reviewed and was tested and g services will be are, 200, 420 Skin istration (Nursing) audits, including ation omissions, sent for treatment, itoring and formed daily by rt audit tools are alls of the charts of freeded will oversee and revised polices that	3/1/2019

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PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977  (X4) ID PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE COMB. TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE (X4) MULTIPLE		COMPL	COMPLETED			
SOUTHEASTERN KY MEDICAL CENTER  (X4) ID PREFIX TAG  A 115  Continued From page 23  the patient's left foot and little toe were blue in color and cold. At 3:30 PM, the ED physician ordered Lovenox (used to prevent and treat blood clots), Zosyn (antibiotic), and Demerol  B50 RIVERVIEW AVENUE PINEVILLE, KY 40977  ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTION SHOULD BE (			180021	B. WING_		1	
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG REGULATORY MUST BE PRECEDED BY FULL TAG REGULATION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  The facility had no effective process in place to protect and promote each patient's rights. Twelve patient churts were reviewed and the facility failed to protect the rights of six of the patients from neglect. For patient #3 the facility's staff failed to administer medication on time as ordered by physician, failed to contact the physician and failed to physician, failed to contact the physician and failed to transfer patient timely. CNO to ensure and verify that licensed nursing staff are following policies and will be in-			CENTER		850 RIVERVIEW AVENUE		n in
A 115  Continued From page 23  the patient's left foot and little toe were blue in color and cold. At 3:30 PM, the ED physician ordered Lovenox (used to prevent and treat blood clots), Zosyn (antibiotic), and Demerol  A 115  promote each patient's rights. Twelve patient churs were reviewed and the facility failed to protect the rights of six of the patients from neglect. For patient #3 the facility's staff failed to administer medication on time as ordered by physician, failed to contact the physician and failed to irransfer patient timely. CNO to ensure and verify that licensed nursing staff are following policies and will be in-	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFI	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPL	ULD BE	(X5) COMPLETION DATE
administer Lovenox and Zosyn until the next day, approximately twenty-four hours after the medication was ordered. In addition, at 4:13 PM, testing confirmed the patient had a blood clot in an artery in the teg that was blocking blood flow. However, the facility admitted the patient to the facility and did not transfer Patient #3 to a facility that could treat the blood clot until 01/01/19 at 12:00 PM.  Medication Administration (phannacy) and 700.787 Medication Administration (nursing), on policy 200.421 Continuum of Care, on policy 200.403 Assessment and Reassessment of patients, 200.603 Transfer of Patients and on policy 700.240 Physician Orders. Chart audits michulding timely medication administration, medication medication medication medication medication medication medication medication medication medication medication onissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)		the patient's left foo color and cold. At 3 ordered Lovenox (u clots), Zosyn (antibit (medication to treat administer Lovenox approximately twen medication was ord testing confirmed than artery in the leg However, the facility and did not that could treat the 12:00 PM.  The facility admitter Congestive Heart F to administer the patient's blood sug to notify the patient elevated blood sug	and little toe were blue in 1:30 PM, the ED physician used to prevent and treat blood liotic), and Demerol a pain); however, staff failed to a and Zosyn until the next day, alty-four hours after the dered. In addition, at 4:13 PM, the patient had a blood clot in that was blocking blood flow, by admitted the patient to the transfer Patient #3 to a facility blood clot until 01/01/19 at defailure and Diabetes but failed atient's Insulin because it was a facility. Then, when the ar was high, the facility failed it's physician as ordered of the ears.		promote each patient's rights. Twelve patient reviewed and the facility failed to protect the patients from neglect. For patient #3 the failed to administer medication on time as on physician, failed to contact the physician at transfer patient timely. CNO to ensure and licensed nursing staff are following policies serviced on policy 200.201 Patient Rights. J Medication Administration (pharmacy) and Medication Administration (nursing), on po Continuum of Care, on policy 200.403 Associates and patients, 200.603 Transfer on policy 700.240 Physician Orders. Chart timely medication administration, medicationage in condition documentation, consennutritional/social services consults, monitor following up on medications will be perfornursing staff to ensure compliance. Chart a collected by ACNO who will report results audits will be reported to QAPI weekly so i immediate actions are taken. The CEO will verify that the staff is in-serviced on the reviave been approved by MEC and the new C(CEO)  The facility had no effective process in plac promote each patient's rights. Twelve patier reviewed, and the facility failed to protect I the patients from neglect. For patient #4 the administer a medication due to unavailabilinotify the physician as ordered. CNO to enthat licensed nursing staff are following poin-serviced on policy 600.098 Drug Produc Formulary, policy 200.403 Assessment and patients, policy 600.034 Medication Admin (pharmacy), 700.707 Medication administration omissions, change in condition documental treatment, nutritional/social services consuland following up on medication will be per nursing staff to ensure compliance. Chart a collected by ACNO who will report results audits will be reported to QAPI weekly so immediate actions are taken. The CEO will verify that the staff is in-serviced on the rehave been approved by MEC and the new (CEO)	at charts were erights of six of facility's staff redered by defailed to verify that and will be impolicy 600,034 700,707 liey 200,421 syment and of Patients and audits, including on omissions, for treatment, ing and ned daily by udit tools are of the chart feeded oversee and iscel polices that foverning Board. The triples of six of efacility failed to sure and failed to sure and failed to sure and will be t Selection - Reassessment of istration (nursing) than audits, medication ion, consent for its, monitoring formed daily by udit tools are of the chart if needed oversee and vised polices that Governing Board.	

Signature: Date: Blue

OLIVILING	S FOR MEDICARE & MEDICAID SERVICES	J A 4 4 19	1	3/1/2010
OLIVI LIVE	TON WEDIONIE & WEDIONID DENVIOLE	A115	In-service education related to proper nursing documentation will be provided by Nurse Educator from Lincoln Memorial University. This will be verified by way of the in-service attendance log. (CNO)  The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600.085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and iMEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on policy 600.085. Medication Error. This will be verified by way of the in-service attendance log. (ACNO)  Licensed nursing staff will be in-serviced on policy 200.407.	3/1/2019 3/1/2019
			Licensed nursing staff will be in-serviced on policy 200-407 Identifying and Reporting Victims of Abuse and Neglect, This will be verified by way of the in-service attendance log. (ACNO)	
	7(02.99) Province Varsions Chemista	Event ID: NSSG11 F.	If continuation sheet P	1 2 -1 125

Signature:

3/1/2019

A 145 | PATIENT RIGHTS: FREE FROM ABUSE/HARASSMENT CFR(s): 482.13(c)(3)

> The patient has the right to be free from all forms of abuse or harassment.

This STANDARD is not met as evidenced by: Based on observation, interview, record review, review of the facility's Abuse/Neglect policy, and review of medical records from Facilities #2, #3, and #4 revealed the facility failed to protect six (6) of ten (10) patients from neglect.

Observations revealed the facility provided Emergency Department (ED) services, and A 145

The facility had no effective process in place to keep the patient free from all forms of abuse and harrassment. Ten patient charts were reviewed and the facility failed to protect the rights of six of the patients. For patient #2 the facility's staff failed to contact and document the physician when orders were not carried out, failed to notify the physcian regarding change in patient status and failed to transfer patient timely. No intensive/critical care services were available at the facility, no policy and procedure in place to integrate the ED with other departments of the facility and no policy and procedure in place to define the scope of services for the medical surgical unit. Policy 200.201 Patient Rights, policy 700.315 ER Scope of Care, and Policy 700,709 MedSurg Scope of Care were revised and approved by MEC on 2/20/2019 and the approved by the new board on 2/22/19 to better define all scope of services. This was done to better integrate the ED with the rest of the facility and better define the scope of services for the medical surgical unit. CNO to ensure and verify that licensed nursing staff are following policies and will be inserviced on policy 200 421 Continuum of Care, on policy 200,403 Assessment and Reassessment of patients, 200,603 Transfer of Patients and on policy 700 240 Physician Orders. Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, manitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to OAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is inserviced on the revised polices that have been approved by MEC and the new Governing Board. (CEO)

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Event ID: NS6G11

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Signature

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			(X3) DATE SURVEY COMPLETED		
		180021	B. WING		C 01/30/2019
NAME OF D	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	0.000.000
NAME OF P	YOVIDER OR SUPPLIER			850 RIVERVIEW AVENUE	
SOUTHEA	STERN KY MEDICAL C	ENTER		PINEVILLE, KY 40977	
(X4) ID		FATEMENT OF DEFICIENCIES	10	PROVIDER'S PLAN OF CORRECTION	
PREFIX		LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)			54.77
	Continued From pag surgical services (se surgery), and had a surgical inpatient unifacility did not provid services and had no regarding the scope surgical unit could provide surgical unit could provide surgical unit could provide surgical unit could provide surgical unit could provide surgical unit of the provide surgical unit of the provide surgical unit of the provide surgical unit of the provide surgical unit of the facility cardiac status as ordered physician. When the arrhythmia, the facility physician timely and transferred to an act assessment and treather the provide surgical unit with sign even though the fact or speech/occupation. The facility failed to and the patient did in Tomography (CT) so hour after arrival. In administer medicati treatment of high blochronic kidney disease.	rvices were limited to general twelve (12) bed medical it. Interviews revealed the le intensive/critical care policy/procedure in place of services that the medical rovide.  Incility admitted Patients #2, ment of diagnoses that the vide. Patient #2 was pain and to rule out a heart the facility did not have available or an intensive care attent. The facility failed to g, blood pressure monitoring, and to monitor the patient's expatient developed a heart try failed to notify the patient's I Patient #2 was not ute care facility for cardiac atment until approximately after the patient presented oped chest pain.  Incily admitted to the medical pass and symptoms of stroke, fility did not have a neurologist onal/physical therapy services. Infoliow their stroke protocol not receive a Computerized can for approximately one addition, the facility failed to ons to the patient for ood pressure/chest pain, and ase. Interviews revealed staff	A 14	[The facility had no effective process in place to patient free from all forms of abuse and harrassipatient charts were reviewed and the facility fail the rights of six of the patients. For patient #8 the directly admitted a patient to the Medical Surgious the facility was unable to care for. The facility is follow the Stroke Protocol on the MedSurg unit necessary test was not completed timely. A menot administered to the patient. The physician fransfer that patient timely. Policy 200,201 Pat policy 700,709 MedSurg Scope of Care was recaptroved by MEC on 2/20/2019 and the approvince board on 2/22/19 to better define all scope. A procedure has been put into place for the charge/supervisor nurse to screen the direct admitted based uscope of services. CNO to ensure and verify the nursing staff are following policies and will be on Policy 200, 201 Patient Rights policy 700, 70/Scope of Care, policy 700, 321 Stroke Protocol, 600, 034 Medication Administration (Nursing), 700, 240 Physician Orders, policy 200, 603 Tran Patients. Chart audits, including timely medica administration, medication omissions, change in documentation, consent for treatment, nutrition services consults, monitoring and following upmedications will be performed daily by nursing ensure compliance. Chart audit tools are colled ACNO who will report results of the chart audit reported to QAPI weekly so if needed immedia taken. The CEO will oversee and verify that the serviced on the revised polices that have been a MEC and the new Governing Board. (CEO)  The facility had no effective process in place to patient free from all forms of abuse and harassipatient charts were reviewed and the facility faithe rights of six of the patients. For patient #11 failed to transfer the patient timely. CNO to enverify that licensed nursing staff are following will be in-serviced on policy 200 603 Transfer. Chart audits, including timely medication admirmedication omissions, change in condition doconsent for treatment, nutritional/social service professed to the ch	nent. Ten ed to protect the facility al unit that this of failed to therefore a lication was alled to therefore a lication was alled to therefore a lication was alled to therefore a lication was alled to therefore a lication was alled to tent Rights, vised and ed by the of services  Lit patients to pon the at licensed n-serviced De MedSurg policy sand policy safer of tion t condition alt/social on staff to ted by s will be te actions are staff is in- pproved by  Leep the nent. Ten led to protect the facility sure and policies and of Patients, nistration, umentation, s consults, iill be piliance vill report API weekly
		s physician that the patient	4	so if needed immediate actions are taken. The	CEO will
	was having stroke s	symptoms and the patient's CT		oversee and verify that the staff is in-serviced to polices that have been approved by MEC and t	
FORM CMS-25	67(02-99) Previous Versions Of	bsolete Event ID; NS6	G11		lation sheet Page 29 of 135

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Event ID: NS6G11

Facility ID 100020

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PRINTED: 02/14/2019

Signature:

Date:

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	ITATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRU		СОМР	X3) DATE SURVEY COMPLETED		
		180021	B, WING _		01/3	; 30/2019
SOUTHEA	STERN KY MEDICAL (			STREET ADDRESS, CITY, STATE ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977  PROVIDER'S PLAN OF CORRECT	ON	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENT	TATEMENT OF DEFICIENCIES  CY MUST BE PRECEDED BY FULL  R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	LD BE PRIATE	COMPLETION DATE
A 145	artifacts;" however, the patient to another assessment and car admission. According stated, "Don't call mit tonight and transfer the facility admitted Services on 09/21/1 with pain, nausea, we ED physician was "available." The consequence of the physician saw Patient recommendations we "where they can do facility failed to transmit 09/24/18, three of the pain on 11/26/1 not obtained until 1 the patient's hip was facility did not transmit reatment for the fraddition, Patient #5 regular diet; however the due to swallow consume a diet by contact the physiciato ensure the patient and the feeding while the papproximately two failed to assess and leg and cigarette be admission.	imal study due to movement the physician failed to transfer er facility for neurological re until the day after ing to the nurse, the physician is back anymore. We'll sit on er [him/her] out tomorrow."  I Patient #11 to Surgical 8 for treatment of Gall Stones romiting, etc. even though the funcertain if anesthesia was sulting Gastrointestinal ent #11 on 09/21/18, and his were to transfer the patient surgery." However, the sfer Patient #11 for treatment e days later.  #5 presented to the ED with 8; however, a hip x-ray was 1/27/18. The x-ray revealed is fractured; however, the fer the patient to obtain acture until 11/28/18. In had physician orders for a er, the patient had a feeding ving issues and could not mouth. The facility failed to an or the Registered Dietitian int received appropriate is patient received no tube attent was at the facility for (2) days. Further, the facility did treat wounds to the patient's turns to his/her fingers and medications to the patient as	A 1	The facility had no effective process in place patient free from all forms of abuse and harra patient charts were reviewed and the facility is the rights of six of the patients. For patient # failed to contact the physician or RD to ensure received appropriate nourishment, failed to physician orders, failed to assess and treat work administer medications to the patient as order physician, failed to have a needed supply on to transfer patient timely. The reflex is attact on the flowchart and when nursing staff selecthoice the reflex is then sent electronically to who will verify with nurse and then notify disconsult. A registered diction (RD) was hired Diet orders were reviewed and verified by the electronic reflex process was put in place. The process was tested and verified during the 27. Nursing services will be in-serviced on Polic Patient Rights, policy 200-421 Continuum of Skin Assessment, 600-034 Medication Administration (Pharmacy), 700,707 Medication Administration apolicy 200-207 Chain of Command for Eclinical Issues. Chart audits, including time administration, medication omissions, change documentation, consent for treatment, nutritiservices consults, monitoring and following medications will be performed daily by nursiensure compliance. Chart audit tools are collacted to QAPI weekly so if needed immediation. The CEO will oversee and verify that serviced on the revised polices that have bee MEC and the new Governing Board. (CEO)	isment. Ten ailed to protect to, the facility is, the facility is the patient implete ands, failed to ed by the aand, and failed ed to questions is answer dictary staff tician of the on 2/22/19. RD. An e reflex 2/19 visit. 200.201 "Care, 200.420 instration ion (Nursing), to f patients, ian's Orders esolution of y medication in condition mal/social up on mg staff to ected by dits will be liate actions are the staff is in-	3/1/2019

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION ND PLAN OF CORRECTION DENTIFICATION NUMBER: A BUILDING		1'''	(X3) DATE SURVEY COMPLETED		
			X. 00.25.			
		180021	B. WING _		01/	30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD 8E	(X5) COMPLETION DATE
A 145	12/30/18 at 2:35 PM the patient's left foot color and cold. At 3:3 ordered Lovenox (us clots), Zosyn (antibio (medication to treat padminister Lovenox approximately twenty medication was orde testing confirmed the an artery in the leg the However, the facility facility and did not trathat could treat the boundary of the patient of Conges Diabetes. However, administer the patient available at the facility lood sugar was high the patient's physicial blood sugars.  The findings include:  Review of the facility policy, approved Jurabuse and neglect is physical, sexual or vor mistreatment." The facility were response is a term refeintentional, or negliging the patient, or negliging the patient, or negliging the patient, and the facility were response is a term refeintentional, or negliging the patient, or negliging the patient, or negliging the patient, and the facility were response to the facility and the facility and the fac	with severe left foot pain and and little toe were blue in 80 PM, the ED physician ed to prevent and treat blood titc), and Demerol pain); however, staff failed to and Zosyn until the next day, y-four hours after the red. In addition, at 4:13 PM, a patient had a blood clot in that was blocking blood flow, admitted the patient to the ansfer Patient #3 to a facility lood clot until 01/01/19 at different facility failed to the facility failed to the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an as ordered of the elevated in the facility failed to notify an action of the facility failed to notify an action of the facility failed to notify and failed to	A 1	The facility had no effective process in place patient free from all forms of abuse and harral patient charts were reviewed and the facility the rights of six of the patients. For patient # failed to document the adminstration of medito ensure and verify that licensed nursing stal policies and will be in-serviced on policy 200. Rights, policy 200-421 Continuum of Care, p. Medication Administration (Pharmacy), and Medication Administration (Nursing). Chart including timely medication administration, nomissions, change in condition documentation treatment, nutritional/social services consults and following up on medications will be perfoursing staff to ensure compliance. Chart au collected by ACNO who will report results of audits will be reported to QAPI weekly so if immediate actions are taken. The CEO will overify that the staff is in-serviced on the revis have been approved by MEC and the new GC (CEO)  The facility liad no effective process in place patient free from all forms of abuse and haral patient charts were reviewed, and the facility protect the rights of six of the patients. For placility failed to provide and administer an omedication, failed to notify physician of medomission and change in patient status. CNO verify that licensed nursing staff are following will be in-serviced on Policy 200-201 Patient 600-098 Drug Product Selection - Formulary including timely medication administration, omissions, change in condition documentatic treatment, nutritional/social services consults and following up on medications will be performed actions are taken. The CEO will overify that the staff is in-serviced on the review have been approved by MEC and the new Ge (CEO)	ssment. Ten ailed to protect 8 the facility cations. CNO 6 are following .201 Patient olicy 600 034 700.707 audits, aedication in, consent for monitoring ormed daily by lit tools are 6 the chartneeded versee and ed polices that werning Board. Ten failed to attent #4 the dered ication to ensure and g policies and Rights, policy Chart audits, medication in, consent for monitoring ormed daily by dit tools are 6 the chartneeded versee and sed polices that were fired airconnection of the chartneeded versee and sed polices that ded polices that the chartneeded versee and sed polices that	3/1/2019

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Event ID: NS6G11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION  A. BUILDING (X		(X3) DATE : COMPL		
					c	;
_	180021	B. WING	B. WING		01/3	30/2019
NAME OF PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
			85	O RIVERVIEW AVENUE		
SOUTHEASTERN KY MEDICAL CI	ENTER		PINEVILLE, KY 40977			
(X4) ID SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID.			1	(X5)
PREFIX (EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION DATE
PM, 01/24/19 at 5:30 AM, revealed the faci ranged from three (3) medical-surgical unit the ED.  Review of physician the facility had three Practice physicians a  Interview with the Ch 01/30/18 at 6:20 PM (COS) on 01/28/19 a facility did not provide services and had no regarding the scope surgical unit could pr revealed the Genera the facility and only o outpatient surgeries addition, the facility of services available on Department was not 7:00 AM, but was on  1. Review of the Emerecord for Patient #5 presented via Emerg (EMS) on 11/26/18 a for left leg swelling, p leg that had been pro According to the ED sustained a "direct b	cility on 01/23/19 at 4:30 PM, and 01/29/19 at 9:00 ility's inpatient census to six (6) on the and three (3) to eight (8) in  credentialing files revealed Internal Medicine/General and one General Surgeon.  sief Nursing Officer (CNO) on and with the Chief of Staff at 5:00 PM revealed the eintensive/critical care policy/procedure in place of services that the medical rovide. Further interview I Surgeon was not on call at conducted scheduled one day per week. In did not have anesthesian call and the Radiology in house from 12:00 AM to call.  ergency Department (ED) revealed the patient gency Medical Services and was triaged at 3:35 PM poain, and a wound to the left esent for one week.  physician's note, Patient #5 show" to the left leg "several increased, pain, redness, and	A	145	The facility had no institutional plan or annual op- pudget due to no effective Governing Board being The institutional plan, including annual operating that included all anticipated income, expenses, an expenditures for a three-year period was made. The was presented to MEC on 2/19/19 and sent to nev governing board on 2/22/19 for review and appro- verified by attached board minutes. See Attached (CEO)  The facility did not have an effective system for e- social services was consulted. An electronic refle- was infitiated. A reflex was attached to questions flowchart pertaining to social services. When nu- choose answers to questions, it sends an electroni- social services department and staff, Licensed nu- will be in-serviced on policy 200,606, Nursing D. This will be verified by way of an in-service atter Chart audits, including timely medication admini- medication omissions, change in condition docun- consent for treatment, nutritional/social services of monitoring and following up on medications will performed daily by nursing staff to ensure compli- Chart audit tools are collected by ACNO who will results of the chart audits will be reported to QAI so if needed immediate actions are taken. (ACNO In-service education related to proper nursing documentation will be provided by Nurse Educat Lincoln Memorial University. This will be verifi- of the in-service attendance log. (CNO)  The reporting and follow up on medication errors identified in the survey findings. The Medication Policy 600,085 has been in-serviced to reinforce report all incidents for follow-up by the pharmac Management committee, the QAPI committee an MEC. This will be verified by the in-service attendance log. Licensed nursing staff will be in-serviced on poli- Medication Error. This will be verified by way of service attendance log. Licensed nursing staff will be in-serviced on poli- Medication Error. This will be verified by way of serviced on policy 600,085, Medication Error. To verified by way of the in-service attendance log.	in place, budget d capital his plan dy sented val. This is minutes, as process in sing staff e trigger to sing staff e trigger to sing staff estration, consults, be ance d report of weekly or from ed by way i was a firror the need to ist, the Risk d mdance log cy 600.085, of the infill be infinis will be	

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Date:

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S					
			200	_		c				
		180021	B WING			01/3	30/2019			
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE					
			850 RIVERVIEW AVENUE		350 RIVERVIEW AVENUE		ľ			
SOUTHEA	STERN KY MEDICAL (	CENTER		ļ	PINEVILLE, KY 40977					
(X4) 1D	SUMMARY S	TATEMENT OF DEFICIENCIES	ID PROVIDER'S PLAN OF CORR		PROVIDER'S PLAN OF CORRECTION	Ž.	(X5)			
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			ATE	COMPLETION			
A 145	A 145 Continued From page 28 Review of a Venous Doppler Study of the left leg		А	y, policy eporting ed by way	3/1/2019					
	Patient #5 was "Pos compressibility of su	/18 at 4:13 PM revealed that iltive for DVT" with no uperficial femoral vein of the in Thrombosis or blood clot).			All Medical and Nursing staff will be in-service of 200 201 Patient Rights, Policy 200 401, Scope of (Facility). This will be verified by the in-service alog. (ACNO)	Care	3/1/2019			
	revealed the facility 11/26/18 with diagn Leg (skin infection),	cal record for Patient #5 admitted the patient on oses of Cellulitis of Left Lower Deep Vein Thrombus of Left			Due to not adhering to the AHA Standards and NI Protocol the facility requested that the ED contrac in-service their own physicians on the stroke proto Inservice logs and verification from in-service will and placed in the employee files by 3/7/19. (CNO	that the ED contract company s on the stroke protocol, from in-service will be sent				
	(H&P) dated 11/27/18 at 11:23 AM revealed Physician #5 documented that "[Patient #5] complains of significant pain in the left hip area." Continued review of the H&P revealed upon			1.a. Review of Patient #5's History and Physical  (H&P) dated 11/27/18 at 11:23 AM revealed Physician #5 documented that "[Patient #5] complains of significant pain in the left hip area."  Continued review of the H&P revealed upon  Interpretation in the left hip area."  Interpretation in the left hip area."  EMR. All QAPI activities will be reported through a weekly QAPI committee meetical interpretation.				Re-inservice the Emergency Department regardin stroke policy 700.321 and the requirement to provisuadard of care. The Emergency Department Micollect data on "Door to MD" and "Door to Through apart of the QAPI process through chart audits, specific departments, and running reports from w EMR. All QAPI activities will be reported by mathrough a weekly QAPI committee meeting so imaction can be taken. (ACNO)	ide the inager will inbolytics" logs from ithin the inagers	3/1/2019
	in distress due to particular Review of a Physica at 4:00 PM revealed pain. According to the second	at was "arebrile to touch and ain in the left hip area."  at Assessment dated 11/27/18 at Assessment dated to have the assessment, the patient are are alized pain with signs of pain	action of Re-inst policy Manage to CT of QAPI p		Re-inservice the Radiology Department regarding policy 700.321 Stroke Protocol The Radiology I Manager keeps a daily log to monitor stroke proto CT completed" and "Door to CT report" as par QAPI process that meets weekly. This will be ve the QAPI meeting minutes. (Director of Radiological Process of Radiological Proc	Department scots "Door t of the rified by	3/1/2019			
	that included diaphorestlessness. The a medication was adrassessment was do	oresis (sweating) and ssessment revealed pain ninistered and a follow-up ocumented at 5:30 PM;			The Emergency Department staff will be re-educed ED Manager on the Mission Statement, the emple descriptions and the Policies and Procedures for the Emergency Department. (ACNO/Human Resout Director)	iyee job he	3/1/2019			
	the patient's pain le There was no document of Patient #5's left h	sment was not completed and vel was not documented.  mented evidence that an x-ray hip was completed until the to the facility. Review of			The Radiological Policy 300.421 was edited to cleall technologist response time for a stroke protocythin 15 minutes. This policy will be taken to CMEC and to the Governing Board for approval. Radiology staff will be in-service on this policy of Chirector of Radiology.	ol to be API to The	3/1/2019			
	Patient #5's physici #5 ordered a left hi AM. Review of the on 11/27/18 at 11:3	an orders revealed Physician p x-ray on 11/27/18 at 11:00 left hip x-ray report completed 8 AM revealed the clinical ray was "Left Hip Pain; Patient			The Radiological Policy 300.441 was edited to el call technologist response time to be within 15 m policy will be taken to QAPI to MEC and to the Board for approval. The Radiology staff will be on this policy changes. (Director of Radiology)	inutes. The lioverning	3/1/2019			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
			B			0	
		180021	B, WING			01/3	30/2019
NAME OF P	ROVIDER OR SUPPLIER			"	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL C	ENTER			ISO RIVERVIEW AVENUE		
				F	PINEVILLE, KY 40977	y.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		BE	(XS) COMPLETION DATE	
A 145	conclusion was, "Acu fracture proximal sha	e 29 inued review revealed the ute relatively undisplaced aft of femur" (upper thigh	A	145	The CEO was found to not be in compliance woversceing the facility by ensuring that necessal was in proper working order. The ED Central of Monitor has been repaired by DTG, initial pays submitted 2/11/2019 and final payment was sul 2/19/2019. Central monitor back in operation3/1/2019. (ACNO/CEO)	ry equipment Cardiae nent	3/1/2019
	11/28/18 at 9:30 AM patient continued to and pain medication of physician credentiphysician was crede repair of a hip fracture documented evident transfer Patient #5 for fracture until 11/28/1 According to the Nuracute care hospital vuntil 11/28/18, Registered	i's progress note dated and 2:00 PM revealed the have moderate left hip pain was administered. Review ialing files revealed no ntialed to conduct surgical re. However, there was no ce the facility attempted to or treatment of the hip is, the next day.  rsing Progress Notes, another was not contacted for transfer 30 AM. At 12:00 PM on d Nurse (RN) #2 documented pted the patient's transfer and			The Cardinal Wholesaler debt which had been the findings as being the cause of drug supply in addressed. An initial payment was made on 2/ another payment will be made to have Cardinal orders. The medications which were identified available were ordered on 2/21/19. The Direct Pharmacy will oversee the restocking of the Or which occurs twice a day via the restock report automatically print in the inpatient pharmacy. Availability of medications will be verified by a from the wholesaler and Omni inventory - white (CEO)	ssues is being 7/2019 and release I as not being or of naicells s that The the receipts	3/6/2019
	the patient was trans PM by Emergency N Review of the Disch 11/28/18 at 11:32 Al "Positive for a DVT of	sferred on 11/28/18 at 3:53					
	PM revealed that he when he examined admission, he found Physician #5 stated communicate with Fradiological studies Physician #5 stated	cian #5 on 01/29/19 at 4:35 c knew Patient #5 well and the patient the day after if the patient to be in pain. that because it was difficult to Patient #5, he often ordered to rule out any broken bones, when Patient #5's x-ray was re of the femur, he contacted					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		180021	B. WING		and the format of the first of	0	C 1/30/2019
	ROVIDER OR SUPPLIER	CENTER		850 RI\	T ADDRESS, CITY, STATE, ZIP CODE VERVIEW AVENUE VILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFII TAG	C	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDS OF THE APPROVINCE)  CROSS-REFERENCED TO THE APPROPRIEMENCY)	ULD BE	(X5) COMPLETION DATE
A 145	a General Surgeon the facility. Physicia knowledge, surgeo repairs. Continued he was notified the could not do the re #5 to be transferred. Interview with the I at 4:24 PM reveale #5 because the pathospital. She state regarding the timef patient. According Physician #5 attem 11/27/18 to a phys however, the physician #5 arran and he could not a Physician #5 arran another acute care orthopedic surgery stated she was sur attempt to transfer Hospital" and was not an "Orthopedic 1.b. Review of the 11/26/18 at 5:23 P patient's abdomen Further review of the #5 was admitted fo DVT, abrasion, and hypokalemia. Progress Notes de Patient #5 weighte admission, and reviews of the admission, and reviews of the patient #5 weighte admission, and reviews of the patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte admission, and reviews progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weighte progress Notes de Patient #5 weight	who used to work with him at an #5 stated that to his an #5 stated that to his ans conducted orthopedic interview revealed that when next day that the physician pair, he arranged for Patient if to another acute care facility.  Discharge Planner on 01/24/19 d she was familiar with Patient was discharged from the dishe spoke with Physician #5 rame for transferring the to the Discharge Planner, pted to transfer Patient #5 on ician that he used to work with; cian did not get back to him told him he did not have the the facility he worked at now occept the patient." At that time, ged to transfer the patient to facility that provided  The Discharge Planner prised that Physician #5's first was to a "Critical Access to just a "General Surgeon,"	A	145			

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Event ID: NS6G11

Facility ID 100020

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Signature. Date: 3/1/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION  G	COMPLETED	
		180021	B. WING_		01/30/2019	
	STERN KY MEDICAL	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID FREFIX TAG	(EACH DEFICIEN	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORR.  (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHORE ACTION				
A 145	Continued From pa	ge 31	A 1	45		
Ш	Assessment dated Patient #5 was at ridifficulty swallowing a feeding tube. Furt patient had facial woutrition (feeding tureferred to a "nutriti information. Howeven utritional information evidence that staff patient could not coobtained orders to patient's feeding tube.					
er.	staff documented the or tube feeding) on PM, 5:49 PM, 10:19 AM. On 11/28/18 at that good nutrition encouraged, even	15's Progress Notes revealed the patient had no intake (food 11/27/18 at 8:07 AM, 12:31 PM, and 11/28/18 at 6:32 tt 8:00 AM, an RN documented and adequate fluid intake was though staff documented on patient had a feeding tube with				
	01/29/19 at 1:30 Pi all patients who ha ensure they were r meet the patient's stated staff did not a feeding tube and patient. According requested a consu the approximately contracted with the	Registered Dietitian (RD) on M reveated he should assess d a feeding tube or wounds to eceiving adequate nutrition to needs. However, the RD notify him that Patient #5 had he had not assessed the to the RD, the facility had only litation for one patient during eight months that he had been a facility. The RD stated he e facility did not consult him for n.	**			

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Event ID: NS6G11

Facility ID: 100020

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Signature Date: 34/9

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		180021	B. WING_			C 01/30/2019	
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STA 850 RIVERVIEW AVENUE PINEVILLE, KY 40977			
(X4) (D PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREF		ID PREFIX TAG	PROVIDER'S I (EACH CORREC' CROSS-REFERENT DE	
A 145	Interview with the Di- 11:10 AM revealed s related to inpatients' contraints. Interview with Regis 01/24/19 at 2:30 PM why Patient #5's phy tube feeding orders. Interview with the As	e 32  etary Manager on 01/24/19 at the did not consult the RD needs due to facility budget  dered Nurse (RN) #2 on revealed he was not sure sician was not contacted for esistant Chief Nursing Officer O on 01/30/19 at 6:00 PM	A 1	45			
C	revealed all patients have a physician's o nutritional needs. The expectation of the fabe fed, unless there (nothing by mouth).  1.c. Review of the faddinistration," date staff should provide using the most curre policy stated the definith medication order should be administed of the order.	with a feeding tube should rder to address the patient's ey stated it was the cility that each patient would was an order to be NPO acility policy titled "Medication ed August 2017, revealed care, treatment, and services ent physician orders. The inition of "STAT" when used ers meant the medication red within fifteen (15) minutes			*		
	11/26/18 at 4:20 PM was low at 2.7 (norm physician orders data revealed potassium According to Patient (H&P) the patient happokalemia [low posupplemented." How	I revealed the patient's level nal is 3.5 to 5.3). Review of ted 11/26/18 at 5:09 PM, was ordered "STAT." t #5's History and Physical			<i>1</i> 0		

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Event ID: NS6G11

Facility ID: 100020

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Signature. Date: 34/9

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE C	ONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER	A BUILDING		COWNETER
		180021	9. WING		01/30/2019
	ROVIDER OR SUPPLIER	FAITER	-	REET ADDRESS, CITY, STATE, ZIP CODE PRIVERVIEW AVENUE	
SOUTHEA	STERN KY MEDICAL C	ENIEK	PIN	VEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIENC	'ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
A 145	11/26/18 at 6:56 PM minutes after it was o STAT).  Further review of Parevealed the followin to be given "STAT" (i	e 33 was not administered until (one hour and forty-seven ordered to be administered  tient #5's physician orders g medications were ordered immediately): Lovenox 90 and prevents blood clots) was	A 145	· · · · · · · · · · · · · · · · · · ·	
	ordered at 11/26/18 (used to treat nausea (IV); and Morphine 4 11/26/18 at 5:02 PM However, review of Administration Recorevealed the facility patient's medications	at 4:44 PM; Zofran 4 mg a and vomiting) intravenously mg IV was ordered on  Patient #5's Medication rd (MAR) dated 11/26/18 did not administer the s STAT as required by the			
	until 11/26/18 at 5:30 medication was order for the first series of the first series o	venox was not administered D PM (45 minutes after the ered); and Zofran and administered until 11/26/18 at and fifty-four minutes after it tered Nurse (RN) #8 on M revealed that she recalled g to the ED with a swollen leg with a DVT. RN #8 stated			
	because she did not needed to access the catheter that is insert heart). RN #8 stated needles for "some till attempted to start at times, but was unsuranother nurse to start."	itions were administered late It have a needle that was the patient's port-a-cath (a red in a large vein above the if the ED had been out of the ime." RN #8 stated she in IV on the patient two (2) accessful and waited for art an IV for the patient. RN could not recall whether she			

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Facility ID 100020

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Signature Date: 3/4/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFI	_	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				SURVEY PLETED
	3					1	С
		180021	B. WING_			01,	/30/2019
NAME OF PROVIDE	R OR SUPPLIER  N KY MEDICAL C	ENTER	:	85	REET ADDRESS, CITY, STATE, ZIP CODE O RIVERVIEW AVENUE NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(XS) COMPLETION DATE
notific receiminum.  1.d. Integ 2018 ensurance	Review of the fagrity/Pressure Ulia, revealed the pure all patients are assed for skin intiew of the Plan for sessment of Paruary 2017, reversibilities and readily, the follow-up frequent evalual us and needs in the patient of the Emergency Medit (26/18 and was the patient of the ED philade of the E	cility's Skin cer policy, approved August urpose of the policy was to dmitted to the facility were egrity.  or Assessment and dients policy, approved aled patient assessments dmission and continued nt's stay. The goal of patient assessment was to determine care the patient required and response to that care, ions for changes in patient order to change the plan of gency Department (ED) 5 revealed he/she presented cal Services (EMS) on aged at 3:35 PM for left leg wound to the left leg that or one week.  oysician's note dated 11/26/18 Patient #5 was paralyzed on ult of a prior stroke. The note ont had hit his/her leg against and days ago and had an	A	145			

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Signature/L/L/L Date: 34/4

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		180021	B. WING			C 1/30/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 3 850 RIVERVIEW AVENUE PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	IX (EACH CORRECTIVE	TO THE APPROPRIATE	(X5) COMPLÉTION DATE	
A 145	extremity. The nursing bed was red with are the wound edges we drainage or odor was admitted for DVT, abrasion, celluly hypokalemia.  Review of Patient #4 dated 11/26/18 at 83 documented that the yellow granulation to redness and edema to the patient progres 10:37 PM, a dressing completed in the EDR Review of Patient #4 (H&P) dated 11/27/ patient had cigaretty middle finger and the abrasion and cellulish was no documented been identified during assessment. In additional was to do well to dry Silvadene cream to treatment was never was at the facility.  Further review of Prevealed no documentessessed the world gor the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patient's treatment was proving the patien	open wound to the left lowering note stated the wound eas of yellow granulation and ere black. The note stated no	A	145			

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Event ID: NS6G11

Facility ID 100020

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Signature. Date: 34/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		180021	B. WING		C 01/30/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP C 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ION SHOULD BE COMPLETION DATE
A 145	and 8:00 PM, reve dressings to the sk patient's skin was	age 36 aled Patient #5 had no kin, had no edema, and the within normal limits. istered Nurse (RN) #8 on	A	145	
	01/28/19 at 10:30 recall if Patient #5 however, she state pictures of wounds	AM revealed she could not had an open wound or not; ed that she had never taken s or pressure sores; or ailed description of the			
	on 01/30/19 at 6:0 expectation of the follow facility polic it was the policy of	Assistant Chief Nursing Officer OPM revealed that it was the facility for all nursing staff to ies. The Assistant CNO stated it the facility for all wounds to be sted on a wound care sheet, trent ordered.			
	revealed that he c RN #2 stated that happened with Pa remained in the fa patient's hip was b know why there w #5's leg or finger w	#2 on 01/24/19 at 2:30 PM ould "kind of" recall Patient #5. he did not know what tient #5 or why he/she cility after they were aware the proken. Further, RN #2 did not as no assessment of Patient wounds and did not recall ring any type of treatments to wounds.			
	4:00 PM revealed facility failures reg medications in a ti wound care; not reorder regarding fe her attention at the	Assistant CNO on 01/28/19 at that she was unware of the parding Patient #5 not receiving simely manner; not receiving eceiving g-tube feeding; and no reding until they were brought to e time of this survey. Continued Assistant CNO revealed that			

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Event ID: NS6G11

Facility ID 100020

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Signature: Date: Bull9

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
		180021	B. WING	72		C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER	850 F	ET ADDRESS, CITY, STA RIVERVIEWAVENUE EVILLE, KY 40977	ITE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECT CROSS-REFERENCE	PLAN OF CORRECTION TIVE ACTION SHOULD E CED TO THE APPROPRI EFICIENCY)	E COMPLETION
A 145	currently Quality Rev Documentation and were being complete Review of the medic Facility #2 revealed #5 on 11/28/18 with following a fall." Rev for Patient #5 reveal following: Acute Unc Left Shaft of Femur, DVT, Cellulitis, and Extremity, CVA with Status Post PEG Tu and Probable Physichospital plan was to feeding, orthopedic care consult, and capossible Adult Prote Further review of the revealed the facility 12/03/18 to a long-ticknarge diagnose malnutrition." Accorpatient's weight was 2. Review of Patier revealed the patient		A 145			
	10/10/18 at 7:58 AM loss of consciousne insufficient blood fic injury. A review of the 10/10/18 revealed the two syncopal episostanding. The note	If with Syncope (temporary ess usually related to low to the brain) and a left arm the ED physician's note dated the physician examined Patient documented the patient had des that morning after stated the patient lost collapsed. The note further				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		STRUCTION		TE SURVEY MPLETED
		180021	8, WING		N. A.	0	C 1/30/2019
	ROVIDER OR SUPPLIER			850 RI	T ADDRESS, CITY, STATE, ZIP CODE VERVIEW AVENUE VILLE, KY 40977	7.5	
(X4) ID PREFIX TAG	(EACH DEFICE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	•	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 145	stated the patient the night before a A review of the E 10/10/18 at 8:28 developed chest of the heart's electheart conditions) note, the patient's compared to a pr 2018. In addition, elevated troponin of damage to the Further review of 10/10/18 at 9:36 stable and the chnitroglycerin.  Review of physicant to Physician #7's chest pain with s myocardial infarcant Review of Physician #7's chest pain with s myocardial infarcant Review of Physician #7's chest pain with s myocardial infarcant Review of Physicant 10/10/18 at 11:33 a test of the patie another EKG at 10/10/18 due to no documented e EKG or Troponin The facility compute patient's Tro	had sustained a wrist fracture offer sustaining a fall.  D physician's note dated AM, revealed Patient #2 discomfort and an EKG (a test strical activity used to detect was obtained. According to the se EKG was unchanged when evious EKG completed in July the patient's Troponin (an level may indicate some degree heart) was within normal limits.  the physician's notes for AM revealed Patient #2 was est discomfort was relieved by dian orders dated 10/10/18 at ed Patient #2 was being admitted care for observation due to syncope and to rule out a stion (MI or heart attack).  Scian Orders for Patient #2 dated 5 AM revealed an order to repeat ent's Troponin level and conduct 1:00 PM and 5:00 PM on chest pain. However, there was evidence the facility obtained an a level at 1:00 PM on 10/10/18. Oleted the tests at 5:00 PM and ponin level was within normal KG showed a normal rhythm with	A	145			
		f physician orders dated 10/10/18 aled an order to conduct					

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Signature. Date: 34/17

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A, BUILDING		(X	(3) DATE SURVEY COMPLETED
		180021	B. WING				C 01/30/2019
	ROVIDER OR SUPPLIER	ENTER		850 F	ET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	COMPLETION DATE
A 145	orthostatic blood pre (10/11/18) (process of pressure while lying, abnormal decrease if person stands up cathere was no docume conducted orthostation of the person stands up cathere was no docume conducted orthostation.  Further review of phy at 9:55 AM, revealed "STAT" for Patient #2 dated 10/11/18 at 10 heart rate was 80, at a trial fibrillation (an if rate that can increas failure, and other heart continued to show a repeat EKG dated 1 minutes later, reveal was 92, and the patifibrillation and acute was no documentati was no documentati was notified that the fibrillation.  Review of a nursing AM revealed Regist documented that wholed after having an syncopal episode at (sweaty) and hypote The nursing note stands and the patient was notified and an Review of a physicial 11:15 AM revealed EKG. According to 10/11/18 at 11:19 Apatient was in atrial	ssures the next morning of taking a patient's blood sitting, and standing. An in blood pressure when a in cause syncope). However, ented evidence the facility coblood pressures.  Assician orders dated 10/11/18 of an order to obtain an EKG of the EKG report of the EKG report of the EKG report of the patient had developed the patient had developed the your risk of stroke, heart fart-related complications) and cute ischemia. Further, a color of the patient's heart rate tent continued to have atrial ischemia. However, there on that Patient #2's physician patient had developed atrial	A	145			

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Signature: Date: 24/15

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	92	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
						С
		180021	B. WING			01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL (	CENTER		STREET ADDRESS, CITY, STATE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTION CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD B D TO THE APPROPRI ICIENCY)	E COMPLETION
A 145	documented evidented obtained.	ge 40 ce that another EKG was atlent #2's nursing notes	A	145		
5	revealed at 1:43 PM documented that the fibrillation, "went inteconverted to sinus redocumented that the with no distress. Ac #2's physician was	on 10/11/18, staff e patient was having atrial c asystole (no heart beat), and hythm." The nurse e patient was sitting up in bed cording to the note, Patient notified and the physician ht be transferred to another				
	revealed on 10/11/1 documented that the and the patient was Contractions (PVC) however, there was an assessment of the According to a nurs 4:30 PM, Emergent was notified of the rand the patient left.	atient #2's medical record 18 at 4:10 PM, staff e patient heart rate was 69 having Premature Ventricular (irregular heartbeat); no further documentation of ne patient's condition. ing note dated 10/11/18 at by Medical Services (EMS) need to transport Patient #2 the facility with EMS at 6:00 transport to Facility #4.				
	revealed Physician patient "evolved" to	#2's Discharge Summary #7 documented that the atrial fibrillation with "pause" d "in case need pacer		VI		
	revealed that she re about Patient #2; h was the RN that to from Physician #7.	e7 on 01/28/19 at 2:35 PM eally could not recall specifics owever, she did state that she ok verbal orders for the patient RN #7 stated that Physician e back and "add" orders and				

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- 1.

AND PLAN OF CORRECTION IDENTIFICATION NUMBER				(X2) MULTIPLE CONSTRUCTION  A BUILDING			
		180021	B WING			C 1/30/2019	
	ROVIDER OR SUPPLIER	27.5	B50 F	ET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		173012013	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
A 145	could see how some #2 were missed. RN nursing staff had just for an EKG and tropo Interview with RN #2 revealed he did not r #2 on 10/11/18. RN why the EKG or the at 1:00 PM or why or had not been taken. #2 revealed that he f spoken with Physicia recall what he was to	of those orders for Patient #7 stated that evidently missed the 1:00 PM orders onin level.  on 01/29/19 at 5:20 PM ecall taking care of Patient #2 stated he did not know Froponin level was not done thostatic blood pressures Continued interview with RN felt certain that he had an #7; however, he could not	A 145				
2	Interview with the As (CNO) on 01/28/19 a did not know why the were not completed. that RN #2 failed to a policy and failed to a followed. Continued CNO revealed that a Nursing Documental orders were being a conducted.  An interview was reconducted.  An interview was reconducted.  Review of Patlent #2 Facility #4 revealed #2 on 10/11/18 with Syncope, Atrial Fibri Disease, Hyperlipide	esistant Chief Nursing Officer at 4:00 PM revealed that she at EKG and troponin level. The Assistant CNO stated document according to facility insure physician orders were interview with the Assistant currently Quality Review of iton and ensuring Physician completed was not being quested with Physician #7; d.  2's medical record from Facility #4 admitted Patient diagnoses that included llation, Coronary Artery emia, Dementia, Essential Closed Fracture of the Left					

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Signature: Date: 3/4/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO: 0938-0391

STATEMENT C AND PLAN OF	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER.	A. BUILDIN	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		180021	B. WING_		01/30/2019
	STERN KY MEDICAL	CENTER		STREET ADDRESS, CITY, STATE ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE COMPLETION
A 145	the vessels of the han Echocardiogram electrodes to check ultrasound technology through your hearty recommendations of Atrial Fibrillation for patient on a low do used to assist with hearty. Facility #4 d 10/13/18 with Homappointments.  3.a. Interview with officer (ACNO) on the facility did not have the facility could admitted to the menulogy for the facility swallowing ACNO stated the facility swallowing ACNO stated the facility is the facility's Acute Strofacility's Acute Strofacility's Emergency implemented wher signs/symptoms of Review of the facility of the facility of the facility is the facility of the facility is Emergency implemented wher signs/symptoms of Review of the facility of th	catheter is inserted to check eart) on 10/12/18 along with (a procedure that uses your heart rhythm and gy to see how blood moves. Facility #4 made or medical management of Patient #4 and started the se of Sotalol (a medication rhythm disturbances of the ischarged Patient #2 home on the Health and follow-up  the Assistant Chief Nursing 01/28/19 at 4:00 PM revealed have a rotocol regarding the scope of all provide for patients dical surgical unit of the facility. O acknowledged the facility did to care for patients with a Cerebrovascular Accident attents who were having g or signs of Aspiration. The acility did not have a all/occupational/speech for a patient with a diagnosis of Accident (CVA/stroke) on an other, the ACNO stated the lock Practice Standard for the cap Department should also be an inpatient had	A -	145	
	(ED), undated, rev	realed patients exhibiting signs a stroke should receive imaging			

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Event ID NS5G11

Facility ID: 100020

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Signature Date: 34/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	100	TPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED C
		180021	B. WING		- 17	01/30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, ST 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	TATE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH CORRECTED CROSS-REFEREN	PLAN OF CORRECTION CTIVE ACTION SHOULD BE NCED TO THE APPROPRIA DEFICIENCY)	
A 145	Continued From pag	e 43	А	145		
	including a non-control tomography (CT) scale of arrival.	rast head computed an within twenty (20) minutes			g.	
	Physician #7 evaluar 01/21/19, and the pa the medical surgical included Acute CVA accident/stroke), Old Concussion, even the	I's medical record revealed led the patient in his office on attent was admitted directly to unit with diagnoses that (cerebrovascular I CVA, and a recent fall with abough the facility did not have the patient who was having a				
	patient was not orier the patient was conf had diagnoses that i (presence of phosph Kidney Disease Sta	tient #8's record revealed the need to person or place, and ined to bed. The patient also included Phosphatemia nate in the blood), Chronic ge 4, and a surgical history of removal of a kidney).				
	01/21/19 revealed the medical surgical united in a disoriented x 3," at the Kleenex to [his/her] was having trouble a spouse also informed unable to walk or control to the patient was unable to during neurological.	ing assessment dated ne patient arrived at the t at 5:25 PM. The patient was tempting to eat, "but holding a mouth and stated [he/she] swallowing." The patient's ad staff the patient "has been tommunicate with him today." able to do "pushes or grips" assessments, and was "very de, mouth drooping noticed e."				
	01/24/19 at 3:10 PN Patient #8 to the fac	stered Nurse (RN) #7 on If revealed she admitted cility on 01/21/19 and stated, "I what I was dealing with." She				

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Event ID: NS5G11

Facility ID: 100020

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PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		180021	B WING		01/30/2019	
	ROVIDER OR SUPPLIER	ENTER	8	TREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE VINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION	
A 145	stated the patient wa	ge 44 as drooling, hand grips were atient had visible deficits that	A 145		22.	
	were signs of a strol not feel like the patie the facility. RN #7 st	ce. She also stated she did ent's needs could be met at ated at times she felt patients that did not receive		E #		
	01/21/19 revealed a (CT) scan was orde not completed until hour after the patier Review of the CT so was a "suboptimal sartifacts, no obvious noted and if the pati	d's physician orders dated computerized tomography red; however, the scan was 6:36 PM, approximately one at arrived at the hospital. can results revealed the scan study due to movement is bleeding or midline shift is sent has persistent symptoms, but movement artifacts would				
	01/22/19 at 8:20 PM Patient #8 during the 01/21/19, the night stated the patient "sadmitted here and to jeopardy." She state neurological deficits a "stroke" which incomoling. The RN stated the facility no let the facility no	stered Nurse (RN) #3 on If revealed she cared for the night shift (6 PM-6 AM) on the patient was admitted. She should never have been the doctor put [his/her] life i				

FORM CMS-2567 (02-99) Previous Versions Obsolete

Event ID: NS6G11

Facility ID: 100020

If continuation sheet Page 50 of 135

Signature 1 Date: 3h /19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	DELANCE CORRECTION DENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	B. WING			01/30/2019		
	ROVIDER OR SUPPLIER	ENTER		850	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIECTION OF THE APP	) BE	(X5) COMPLETION OATE	
A 145	stated she contacted shift" regarding the p difficulty swallowing, patient to another far unit. However, Physicall me back anymor transfer [him/her] out she also contacted the during the shift regar however, the physicito another facility unit to another facility unit to another facility unit to another facility unit to another facility unit two (2) separate occinvestigation; however received.  3.b. Review of Patier revealed the facility 01/22/19 with diagnor Cerebrovascular Accar ecent fall with Corporation (presence of phosph Kidney Disease States a left nephrectomy (Further review of Papatient was not orient the patient was confident was not orient the patient was confident was confident was abnormal heart rhythundred eighty (180 Renvela (phosphate)	Physician #7 "early in the atient's neurological deficits, and the need to transfer the cility with an intensive care cian #7 told the RN "Don't re. We'll sit on it tonight and it tomorrow." The RN stated ne physician one other time riding the patient's condition; an did not transfer Patlent #8 if the next morning, 01/22/19.  Pysician #7 was requested on asions during the rer, no return call was  Int #8's medical record admitted the patient on oses of Acute cident (CVA/stroke), Old CVA, neussion, Phosphatemia rate in the blood), Chronic ge 4, and a surgical history of removal of a kidney).  Itient #8's record revealed the need to person or place and	A	145				

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Event ID: NS6G11

Facility ID: 100020

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Signature Date: 34/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION PLAN OF CORRECTION IDENTIFICATION NUMBER: A BUILDING		(	(X3) DATE SURVEY COMPLETED			
		180021	B. WING		9	C 01/30/2019	
	PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977			V110312010			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECT CROSS-REFERENCE)	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIAT EFICIENCY)	(X5) CCMPLETION DATE	
A 145	Record (MAR) revadministered on 0 01/22/19 at 9:00 / revealed Renvela administered on 0 Staff documented "omitted" because the unit." The MA the formulary pati There was no dot facility notified the medications were interview with Re 01/22/19 at 8:20 Patient #8 during 01/22/19, the night stated Cardizem not been availably she recalled anot medication the winot notified the pamedications were administered as a "not having the mappens so often occurrence, and wilke we should."  4. Review of Pati revealed the patilizemergency Department had comparadiating to the coguarding present region (pain was even patient was even region (pain was even region).	at #8's Medication Administration wealed Cardizem was not phi/21/19 at 9:00 PM or on AM as ordered. Further review and Biotin were not phi/22/19 at 9:00 AM as ordered. I that the medications were a medication was "absent from R also stated Biotin was "not on ent will need to bring own."	A	145			

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Event ID: NS6G11

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Signature Le M Q Date: 54/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  (XA) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 145 Continued From page 47  Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 09/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholangitis (infection of the liver bile duct), gallstones, and pancreatilis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed encountered to the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
STREET ADDRESS, CITY, STATE, 2IP CODE  SOUTHEASTERN KY MEDICAL CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 145  Continued From page 47  Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholengitis (infaction of the liver bile duct), gallstones, and pancreatilis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted.  Review of Physician #1's notes revealed he evaluated Platient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The					-			
SOUTHEASTERN KY MEDICAL CENTER  (XA) ID PREFIX TAG  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  A 145  Continued From page 47  Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholengistic (infection of the liver bile duct), gallstones, and pancreatitis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted.  Review of Physician #1's notes revealed he evaluated Patient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The			180021	B. WING	···-	······································	01/	30/2019
CX4) ID   SUMMARY STATEMENT OF DEFICIENCIES   ID   PREFIX   TAG   REGULATORY OR LSC IDENTIFYING INFORMATION   TAG   CROSS-REFERENCE TO THE APPROPRIATE   DATE	NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		i
Interpretation   Province   Pro	COUTUEA	CTEDN KY MEDICAL C	ENTED		85	O RIVERVIEW AVENUE		- 1
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A 145  Continued From page 47  Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholangitis (infection of the liver bile duct), gallstones, and pancreatitis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted.  Review of Physician #1's notes revealed he evaluated Patient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The	SOUTHER	ASTERN RY WEDICAL C	ENIER		PI	NEVILLE, KY 40977		
Further review of Patient #11's record revealed he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholangitis (infection of the liver bile duct), gallstones, and pancreatitis (inflarmation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted.  Review of Physician #1's notes revealed he evaluated Patient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	8E	(X5) COMPLETION DATE
he/she previously had been evaluated by Physician #1 on 08/30/18 and was diagnosed with choledocholithiasis (stone in the common bile duct), with cholangitis (infection of the liver bile duct), gallstones, and pancreatitis (inflammation of the pancreas). Patient #11 had a scheduled appointment with Physician #1 on 10/05/18 for further evaluation and treatment.  Further review of Patient #11's medical record revealed even though the facility was "uncertain if anesthesia was available," Patient #11 was admitted to the facility for surgical services on 09/21/18 under Physician #5's care and Physician #1 was consulted.  Review of Physician #1's notes revealed he evaluated Patient #11 on 09/21/18, and his recommendations were, "I think the patient needs to transferred where they can do surgery." The	A 145	Continued From pag	e 47	A	145			5 5 7 9 9 1 1 1 1
physician also stated, "I do not have access to any instrument here, nor do I have access to anesthesia, this patient needs to have ERCP [endoscopic retrograde cholangiopancreatography], stone removed and needs to be transferred." However, there was no documented evidence that the facility arranged for transfer of Patient #11 to another facility for further care and treatment until 09/24/18 (3 days after Physician #1 documented the need for transfer).  Further review of Patient #11's medical record revealed from 09/21/18 through 09/24/18, the facility treated the patient with Intravenous (IV)	1186	he/she previously ha Physician #1 on 08/3 with choledocholithia bile duct), with chola bile duct), gallstones (inflammation of the a scheduled appoint 10/05/18 for further extended even though an esthesia was availadmitted to the facili 09/21/18 under Physician evaluated Patient #1 recommendations who transferred where physician also state any instrument here anesthesia, this patification for transfer of Patier further care and trea after Physician #1 depended from 09/21.  Further review of Parevealed from 09/21.	and been evaluated by 80/18 and was diagnosed usis (stone in the common ingitis (infection of the liver is, and pancreatitis pancreas). Patient #11 had ment with Physician #1 on evaluation and treatment.  Itient #11's medical record in the facility was "uncertain if illable," Patient #11 was try for surgical services on sician #5's care and Physician #1's notes revealed he in on 09/21/18, and his ere, "I think the patient needs they can do surgery." The ind, "I do not have access to ent needs to have ERCP adde graphy], stone removed and red." However, there was no ce that the facility arranged in #11 to another facility for atment until 09/24/18 (3 days occumented the need for eatient #11's medical record in its through 09/24/18, the					

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Event ID: NS6G11

Facility ID: 100020

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Signature.

Date:\_

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED C		
		180021	B WING	01/30/20	
	ROVIDER OR SUPPLIER		850 R	ET ADDRESS, CITY, STATE, ZIP CODE IVERVIEW AVENUE VILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPLETION
A 145	patient could also for pain and Zofn Review of Patient Record (MAR) re Dilaudid on 09/2 at 11:44 AM for opatient rated at a Follow up docum was effective.  Review of Patient dated 09/24/18 retransferred to Fa Physician #1 for summary stated been transferred had been no been transferred to Fa at Facility #3 on evaluation reveallevated liver furth pancreatitis. Physician we because there we the physician we been transferred to be transferred to be the physician we had some recovering from recovering from the patient had some	or receive Dilaudid IV as needed an IV as needed for nausea.  It #11's Medication Administration evealed staff administered 1/18 at 8:30 PM and on 09/22/18 complaints of pain which the in eight (8) on a scale of 0-10. Inentation revealed the medication in t #11's discharge summary evealed the patient was incility #3 to the services of "immediate ERCP." The the patient had not previously as recommended because there is available.  It is documentation revealed tient #11 when the patient arrived 09/24/18. The physician's alled the patient had a history of inction tests and acute ysician #1 stated Patient # 11 insferred "over the weekend to [a stal] as the patient had requested, were no beds available, however as not aware the patient had not d." The physician stated the ine pain, as the patient was a pancreatitis.	A 145		
		s attempted with Patient #11 on ver, the attempt was			
	Interview with F	Physician #5 on 01/29/19 at 4:30 awas Patient #11's primary			

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Signature/

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(XZ) MULTIPLE CO	NSTRUCTION		TE SURVEY MPLETED
		180021	B. WING		01/30/2019	
	ROVIDER OR SUPPLIER	CENTER	850 R	ET ADDRESS, CITY, STATE, ZIP CO IIVERVIEW AVENUE EVILLE, KY 40977	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 145	physician during to until he transferre receive the needed #5 stated he had any other facility and needed surgical packnowledged the needs of the paties should not have to because staff we were available withe facility.  5. Review of Paties revealed the patie Department (ED) severe left foot pale/she believed to According to the	he hospital stay from 09/21/18 do the patient on 09/24/18 to ad surgical procedure. Physician not attempted to obtain a bed at so Patient #11 could receive the procedure. Physician #5 de facility was unable to meet the ent. He also stated the patient peen admitted to the facility, re unsure if surgical services then the patient was admitted to the patient on 12/30/18 at 2:35 PM with ain. The patient reported that his/her foot was broken.  ED record, the side of the and little toe were blue in color	A 145			
	3:30 PM, revealed Patient #3 to recommend treat blood of every eight (8) has medication to transport to the facility admit 12/30/18 at 4:40. There was no do	ian orders dated 12/30/18 at and the physician ordered for eive Lovenox (used to prevent clots), Zosyn (antibiotic) 3.375mg ours IV, and Demerol eat pain) 25 mg every four (4) l.  f Patient #3's ED record revealed ted the patient to the facility on PM due to cellulitis and swelling coumented evidence the facility expalient's medications while in				
		nt #3's Medication Administration evealed no documented evidence				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED				
rate i enti Gr	THE THE PER PER PER PER PER PER PER PER PER PE	189021	B. WING		0.	C 01/30/2019	
	ROVIDER OR SUPPLIER		STRE 850 R	ET ADDRESS, CITY, STATE, ZIP ( RIVERVIEW AVENUE EVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 145	that the facility add 12/30/18 at 11:19 after the medication Further, there was the facility administ when the medicate the MAR, Patient Lovenox until 12/3 twenty-four hours ordered. Further revealed the facili 12/31/18 at 1:55 f (23) hours and this medication was o Zosyn was only one ight hours, staff was administered minutes after the In addition, a revious administered medication was a Further review re 12/30/18, Patient was no document administered medication was no document administered medication PM.  Review of a CT from and ankle reveal swelling of the autissue ulceration Review of a Con (CTA) report data an approximated occlusion (block purpless the facility of the control of the	ministered Vancomycin until PM, approximately eight hours on was initially ordered. Is no documented evidence that stered Lovenox on 12/30/18 ion was ordered. According to #3 did not get the first dose of 13/18 at 5:08 PM, more than after the medication was initially eview of Patient #3's MAR ty did not administer Zosyn until PM, approximately twenty-three lity (30) minutes after the redered. Further, even though redered to be administered every documented that a second dose if at 2:21 PM, approximately 25 first dose was administered.  ew of the Emergency umentation dated 12/30/18 at if Patient #1's pain on a scale of if ten, the worst possible pain. vealed that at 5:15 PM on if #3's pain level was eight. There ited evidence that the facility dication to treat the patient's pain  Report dated 12/30/18 of the foot ed Patient #3 had soft tissue inkle and a 9.2 millimeter soft	A 145				

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Facility ID: 100020

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Signature: Date: 36/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	8. WING_			C 01/30/2019	
	ROVIDER OR SUPPLIER			850 (	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LDBE	(X5) COMPLETION DATE
A 145	another facility for canext day, 01/01/19. It dated 01/01/19 at 12 was transferred to F  A review of Patient # Facility #4 revealed 01/01/19 with no pul redness to the left loand surrounding are touch, and there waside of the left foot. Summary dated 01/Catheterization note femoral artery was partery had a six-centreated. The patient under the care of hot treat cellulitis and gather than the patient #3. The patient #3. The patient #3. The patient #3. The patient #3. The patient #3 was possible to the day Patient #44. The patient #45 was foot and someone had the medication. Continue RNs could not recall was not administered at one time the facility.	pted to transfer the patient to the of the blockage until the Review of progress notes 1:00 PM revealed Patient #3 acility #4 by private vehicle.  #3's medical record from the patient was admitted on ses in the foot, swelling and wer extremity, the fifth toe a were purple and cool to s an ulceration of the right According to the Discharge 10/19, and a Cardiac dated 01/08/19, the patient's patient; however, the popliteal timeter occlusion that was was discharged on 01/10/19, one health for wound care to angrene of the fifth toe.  Itered Nurse (RN) #2 on and RN #4 on 01/24/19 at they remembered providing RN #2 stated after reviewing all record, that he could not 3 did not receive his/her recall was that it was "pretty int #3 was admitted. RN #4 not have Zosyn on the floor,	A	145			

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Event ID: NSSG11

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Date:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CO	(X3) DATE SURVEY COMPLETED					
71107 (2111 0)			A. BUILDING		C 01/30/2019		
	DF PROVIDER OR SUPPLIER HEASTERN KY MEDICAL CENTER		STREET ADDRESS, CITY, STATE, ZIP COD  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977				
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NOY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(XS) COMPLETION DATE	
A 145	Interview with the A (CNO) on 01/28/19 was unaware that his/her medication with the Assistant Review of Nursing conducted.  6. Review of Patie patient was admitt with diagnoses of (CHF), Generalize Further review of I revealed the patie Victoza 1.2 mg, to AM. Further review physician orders on otify the physician readings were bel above two hundre ordered that staff output over the net Review of Patient record revealed the Victoza for 01/23/19 the patie 2:05 PM on 01/24 was 219; and at 3 #4's blood sugar and redication.	Assistant Chief Nursing Officer 2 at 4:00 PM revealed that she Patient #3 had not received 3 timely. Continued interview CNO revealed that Quality Documentation was not being  Int #4's record revealed the ed to the facility on 01/22/19 Acute Congestive Heart Failure d Weakness, and Diabetes.  Patient #4's medical record Int's physician had ordered be administered daily at 9:00 by revealed Patient #4 had lated 01/23/19 at 8:15 AM to In if the patient's blood sugar ow one hundred thirty (130) or d (200). The physician also Inotify him of Patient #4's urine ext two (2) hours.  #4's medication administration file patient's 9 AM dose of 19 was "omitted" and had not d. Review of Patient #4's blood revealed at 10:57 AM on ent's blood sugar was 344; at I/19 the patient's blood sugar E:30 PM on 01/24/19, Patient Was 237. However, there was	A 145				
A	no documented e the patient's phys insulin was not av	vidence that the facility notified ician that the patient's Victoza railable or that the physician was lent's elevated blood sugar					

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Event ID: N56G11

Facility ID: 100020

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Signature: Date: 34/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
THE FLAT OF	wern had treet	180021	A. BUILDING		C 01/30/2019
	ROVIDER OR SUPPLIER		8:	TREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE INEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD! CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
A 145	Interview with Regis 01/29/19 at 5:00 PM administered Patien 01/23/19 because it facility. However, Rinotified the patient's was not available arphysician of the patilevel.  Interview with Patien 5:00 PM revealed the admitted to the faciliadmissions "last mospouse stated, "The medications here the to receive. I try to remedications, but so #4 "just has to go with QAPI CFR(s): 482.21  The hospital must of maintain an effective data-driven quality improvement program reflect hospital's organizationspital department those services furnarrangement); and to improved health and reduction of mospital must of the program reflect hospital department those services furnarrangement); and to improved health and reduction of mospital must	tered Nurse (RN) #2 on a revealed he had not at #4's Victoza insulin on was not available at the N #2 stated he had not physician that the medication and had not notified the ent's elevated blood sugar at #4's spouse on 01/23/19 at the patient was frequently ity, including two (2) anth" (December 2018). The ey don't have a lot of at [the patients] are ordered emember to bring the needed metimes I forget," and Patient ithout them while we're here."  Idevelop, implement and re, ongoing, hospital-wide, assessment and performance arm.  It is and services; involves all this and services (including ished under contract or focuses on indicators related outcomes and the prevention	A 263	The facility had no institutional plan or annual obudget due to no effective Governing Board bet The institutional plan, including annual operatir that included all anticipated income, expenses, expenditures for a three-year period was made, was presented to MEC on 2/20/19 and sent to n governing board on 2/22/19 for review and appiverified by attached board minutes. See Attache (Controller)  The Governing Board is ultimately responsible and implementation of the QAPI plan/process. Governing Board did not take responsibility for CEO or overseeing the QAPI process. The Gol Board has now appointed a new CEO who will responsibility of overseeing the implementation process. The CEO is delegated responsibility by a allocate adequate resources for quality impresectivities. (Newly appointed CEO)	ing in place ag budget and capital. This plan ewly seated roval. This is ed minutes.  for QAPI 3/1/2019. The rappointing a verning have the n of the QAPI by the Board.

FORM Chts-2567(02-99) Previous Versions Obsolete

Event ID, NS6G11

Facility ID: 100020

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Signature Date: 34/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

		F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE S		
ANU	PLAN OF	CORRECTION	IDENTIFICATION NOMBER.	A. BUILDI	A. BUILDING		С	С	
			180021	B. WING				0/2019	
NA	ME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE			
87	NITHEA	STERN KY MEDICAL (	CENTER			O RIVERVIEW AVENUE		1	
	JUI NEM	SIERR KI WEDIORE	JEHI CK		PI	NEVILLE, KY 40977		26	
	(X4) ID PREFIX TAG	(EACH DEFICIENT	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DBE	COMPLETION DATE	
	A 263	Based on observation and review of the factor Manual and Perform determined the factor maintain an effective data-driven Quality Improvement (QAP) the Chief Nursing Officer revice conducted QAPI and QAPI resigned in John Minutes revealed the facility activities during the Subsequently, revicinterviews with static identify patient card and failed to developments.  (Refer to A0043, AA0273, A0385, A0A0837, A0940, A0	ge 54  s not met as evidenced by: on, interview, record review, ecility's Quality Management mance Indicators, it was lity failed to implement and re ongoing, hospital-wide, Assurance and Performance I) Program. Interviews with Officer and Assistant Chief ealed the facility had not ctivity since the Director of uly 2018. Review of QAPI ne last meeting was in October I Performance Indicators I failed to conduct QAPI Is last quarter of 2018. I ew of patient records and If revealed the facility failed to the and patient safety concerns op action plans to address the  10057, A0073, A0115, A0145, 1395, A0489, A0490, A0799, 1951, A0955, A1100, A1103,	A	263	The facility failed to have a functioning governand did not convene per policy. The CEO did oversight of the QAPI plan and its implementa governing board was established and met on 2 MEC meeting was held on 2/20/19 at which it following physician committee chairpersons wappointed: QAPI committee, Utilization review Management: Blood Utilization / Infection Co Surgery; and, P & T / Dietary. Also appointed plan is in place with new performance indicate the monitoring related to the JTags. The data collected through chart audits, logs from specific departments, and running reports from within QAPI activities will be reported by managers weekly QAPI committee meeting so immedia be taken, then to the MEC monthly and to the Board monthly. See attached QAPI plan. The was reviewed and approved by MEC on 2/20/new governing board as reflected in attached new Governing Board appointed a new CEO who will provide oversight to ensure quality of provided. This may be verified by board minutes. (CEO/CNO)  The facility failed to implement and maintain ongoing hospital-wide, data-driven QAPI profailed to meet on a regular set schedule. The calendar will be developed to ensure timely in necessary committees. The QAPI committee weekly, this will be verified by committee attand minutes. The Administrative Assistant withe schedule and attendance compliance to the committee. (Administrative Assistant)	not provide tion. A new //22/19. A me the ere s/ Risk ntrol / rd were h. A QAPI ors to reflect is being fie the EMR. All through a te action can Governing c QAPI plan 19 and the minutes. The on 2/22/19 are is being an effective, gram which annual meeting teetings by the will meet endance togs ill report on	3/1/2019 2/22/2019	
	A 273	(a) Program Scope (1) The program m to, an ongoing pro improvement in ine evidence that it wit (2) The hospital m	, (b)(1),(b)(2)(i), (b)(3)		A 273	The facility had no institutional plan or annu- budget due to no effective Governing Board. The institutional plan, including annual open that included all anticipated income, expense expenditures for a three-year period was mad- was presented to MEC on 2/20/19 and sent to governing board on 2/22/19 for review and a verified by attached board minutes. See Atta (Controller)	being in place uting budget s, and capital le. This plan rowly scated pproval, This 15	2/22/2019	

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Event ID: NS6G11

Facility ID: 100020

If continuation sheet Page 60 of 135

Signature: Date: 3h/19

Signature:

Page 61 of 135	laarie noitei	Facility ID: 100020 If continu		115	Event ID NSE	oteload	2 and anobias 9 (00 costas	
6107/77/7	iffective.  In The Application of the community of the community oved manues, oved manues, or the community of the community	the governing board and this will be verified by it (Newly appointed CEO)  The facility fuiled to implement and maintain and ongoing hospital-wide, data-driven QAPI program ongoing hospital-wide, data-driven QAPI program committee, attended meetings but had not been appointed on 2/14/19. A permanent QAPI physician appointed on 2/14/19. A permanent QAPI physician appointed by AILC and approved by the appointed on 2/14/19. A permanent QAPI physician appointed by AILC and approved by the appointed by AILC and approved by the population of Surgery, and a deceloral by AILC and approved by the board. A QAPI plan was developed with new permanent of Surgery, and a different of Surgery and a different of the Governing Board. See anached by the configuration of the Coverning Board. See anached and attendance to that immediate action can be talkent or facility failed to intered to the anached to ensure implying the surgery of data collected told fail to offer and interesting the spiral immediate action can be talkent and the collected told failed to meet on a regular set foot in the selection of the anached account of the anached to an are approved by the anached to an are approved to casure timply meeting the profit of the anached to an are approved to casure timply meeting the profit of the anached to an are approved to an are approved to the anached to an area and maintain an anached to the anached to the anached to an area and the talkent and antendance to any profit of the anached to the accordance (Administrative Assistant).  Apply The Administrative and an area december compared to the account of the schedule. The anached to an area and an area december of the anached to a server the anached to a server of the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server the anached to a server th			ation and saids as a single as	ng patient care data for example, informs ived from, the hosp to Coganization.  Torganization.   ervices and quality (3) The frequency body.  This STANDARD is Based on observating and review of the facily and review of the facily and review of the facily and review of the facily and review of the facily and review of the facily and revealed hospital operations indicators revealed interviews revealed interviews revealed interviews revealed interviews revealed interviews revealed interviews revealed interviews with activities during since the Director of Subsequently, reviews the patently patiently patient safetidently patiently patient safetidently patiently		
	a Buinninga boiningan boiningan boiningan binana bina bi	The Governing Board is ultimately responsible for and implementation of the QAPI plantprocess. "If GOVerning Board did not take responsibility for all CEO or overseeing the QAPI process." The newly the QAPI plan, The CEO will report any and all the QAPI plan.	E7S	A	,916	sess brocesses of c	Continued From pag performance that ass hospital service and	£72 A
6107/1/8	i myo.							
(XS) COMPLETION DATE	3 3TA	NOITJARDO 70 NAJA 2 RADIVORA B OLUGHE NOITJA SVITJERROD HJAS) IRAORAYA EHT OT GESPERERERENCED TO TORONO (YONGICHERERERENCY)		OI 1389 DAT	SY FULL	ATEMENT OF DEFICIENC 9 MUST 36 TRECEDED 1 LSC IDENTIFYING INFOR	CACH DEFICIENC	OI (AX) XITERY DAT
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OBTB	S STAD (EX) JAMOD	CONSTRUCTION		א פחורם (xs) שחר.	באיכרוא	и иоптариятия (гх)	F DEFICIENCIES	STATEMENT O
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7000 0000					62	DERVICE OF A PERVICE	RAH LAABH 40 LMBN	DEPARTN

Date:

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED C								
		180021	B WING			1/30/2019							
	ROVIDER OR SUPPLIER	CENTER	8	TREET ADDRESS, CITY, STATE, ZIP CO SO RIVERVIEW AVENUE INEVILLE, KY 40977	DE								
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES INCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	COMPLETION DATE							
A 273	Continued From p	age 56	A 273	7		-th-sp-symmetry, th-sh-symmetry,		The findings inclu	de:				
	Manual dated Jurimplemented a Q documents the fa processes to ach continually improte the facility's qualiproviding world cin the most compmanner. According Quality Offer was Representative a included ensuring management we and reporting the manual further si Management plaimprovement foothe Key Perform however, intervision 01/30/19 at 6 Chief Nursing Or revealed the fact quality reviews reperformance in 1. Review of Parevealed the parev	lity's Quality Management the 2015 revealed the facility wality Management System that cility's basic policies and seve customer satisfaction while wing quality. The manual stated by policy was dedicated to ass, comprehensive healthcare assionate and cost effective ag to the manual, the Chief of the Management and had responsibilities that ag that the processes for quality are established and implemented, facility's performance. The ated the facility's Quality an addressed key performance are areas. The facility provided ance Indicators for 2018; we with the Chief Nursing Officer 20 PM and with the Assistant and ficer on 01/30/19 at 6:20 PM lity had not been conducting for had a Quality Meeting approvement) since October 2018.  Ident #3's medical record ient presented to the facility artment (ED) on 12/30/18 at 2:35 left foot pain and the patient's left were blue in color and cold. At 0 physician ordered Lovenox ased to prevent and treat blood antibiotic), and Demerol (narcotic pat pain); however, staff failed to anox and Zosyn until 12/31/18,											

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Event ID: NS6G11

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Signature: Date: 34/15

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		180021	B, WING		01	C /30/2019
	ROVIDER OR SUPPLIER	2		STREET ADDRESS, CITY, STATE, ZIP ( 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(XS) COMPLETION DATE
A 273	medication was ord was not administer approximately three in addition, review revealed the patient with Cellulitis to the infection), early seplife-threatening con response to an infesore. Patient #1's p (anticoagulant) me patient to prevent to no documented evictovenox until 01/0' (22) hours later.  Patient #8 was directly and biotin (water-solution of strok administer physicial included Cardizem pressure/chest paid drug for patients we biotin (water-solution of 01/22/19 as physician.  Review of the facil Cardizem was listed Registered Nurse PM revealed the in Further review of the and Biotin were not there was no docupatient's physician.	ty-four hours after the lered. In addition, Demerol ed until 6:00 PM, on 12/30/18, e hours after it was ordered.  of Patient #7's medical record t was admitted on 01/06/19 e right lower extremity (skin basis (a potentially edition caused by the body's ection), and a Stage 2 pressure ohysician ordered Lovenox dication on 01/06/19 for the blood clots; however, there was idence the facility administered approximately twenty-two ectly admitted to the medical (21/19, with signs and e. The facility failed to an ordered medications that	A 2	273		

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Event ID: NS6G11

Facility ID: 100020

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Signature:	Date: 34	15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL A. BUILD		NSTRUCTION		SURVEY
			7,80,60			1	С
		180021	B. WING			01.	/30/2019
NAME OF P	ROVIDER OR SUPPLIER		· ·	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
				850 R	IVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICA	L CENTER		PINE	VILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 273	Review of Patient the facility admitted treatment of Cong Diabetes with phy insulin. However, the patient's Insul not available at the documented eviding patient's physicial available and insufficial record rewas elevated on there was no documented the patient's blood Further review of revealed on 01/2: physician ordered "now", discontinus medication. Howe medication. Howe medication admir revealed the facil potassium supple after the "now" or administered Lasthough the medicaddition, there we facility contacted patient's urinary by the patient's properties of the facil potassium supple after the "now" or administered Lasthough the medicaddition, there we facility contacted patient's urinary by the patient's properties of the facil potassium variant that did not react quarter 2018), are own medication of control of the facility contacted patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's urinary by the patient's properties of the facility contacted patient's urinary by the patient's urinary	#4's medical record revealed at the patient on 01/22/19 for pestive Heart Failure and resician orders to administer the facility failed to administer in on 01/22/19 because it was be facility. There was no ence that the facility notified the in that the medication was not alin was not administered. There eview of Patient #4's evealed Patient #4's blood sugar 01/22/19 and 01/23/19; however, the patient was above two-hundred. The patient's medical record 3/19 at 8:15 AM, Patient #4's dia potassium supplement ed the patient's Lasix ever, review of the patient's histration record dated 01/23/19 ity failed to administer the ement until 5:17 PM, nine hours der. In addition, the facility failed to administer the example of the patient's physician was discontinued. In as no documented evidence the the patient's physician with the output on 01/22/19, as ordered	A	273			

FORM CMS-2557(92-99) Previous Versions Obsolete

Event ID NS8G11

Facility ID: 100020

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Signature: Date: 3/4/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	(X2) MULTIPLE CONSTRUCTION A BUILDING			
		180021	180021 B WING				
1	ROVIDER OR SUPPLIER		850 R	ET ADDRESS, CITY, STATE, ZIP CODE IVERVIEW AVENUE VILLE, KY 40977			
(X4) ID PREFIX TAG	IEACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION		
A 273	services: percenta administered with the fourth quarter medications were one-hour window and percentage of administered with in the fourth quart 100%. There was facility had impler medications were administered per Interviews with R RN #4 on 01/24/101/22/19 at 8:20 PM, and with RN revealed they ne physician orderer RNs stated where had to "hunt" in the RNs stated where had to "hunt" in the RNs stated where had to "hunt" in the RNs stated often, it's just be interview with Phym revealed she Administration Removement processed and anticoagula administered in stated however, a medication with the reducation with the reduc	ing situations for Pharmacy age of times antibiotics were in the one-hour window (85% in percentage of time diabetic administered within the (65.1% in the fourth quarter); If times anticoagulants were in the one-hour window (81.2% er). The facility's threshold was no documented evidence the nented an action plan to ensure available for patients and were	A 273				

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Signature:	Date: 34/	15
7-6-7		

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER		TIPLE CONSTI			re survey APLETED
		180021	B. WING			01/30/2019	
	ROVIDER OR SUPPLIER			850 RIVE	DDRESS, CITY, STATE, ZIP CODE RVIEWAVENUE LE, KY 40977.		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
A 273	track those medic currently counted pharmacist stated patients were not ordered or that madministered late medications. Furt facility had trouble of a past due deb The pharmacist stock, but could budget allowed; he documented evide educated about in shortages/unaval monitoring to ensimedications, or addition, the Direpharmacy service during Pharmacy Committee quart been a P&T Conwhen the physicic Committee resignormal resignations. Committee resignations of the far Therapeutics Corevealed the conformation of the far Therapeutics Corevealed the conformations were drug shortatook to obtain the Review of the Original Review of the Origina	navailable), then she did not ations and they were not as medication errors. The lashe had not identified that receiving medications as edications were being due to the unavailability of the interview revealed the elobatining medications because at with the Pharmacy Distributor, tated she monitored medication only order medications as the nowever, there was no ence that staff had been nedication lability or that the facility was sure patients received ordered at least equivalent substitutes. In ctor of Pharmacy stated as were routinely discussed and Therapeutics (P&T) erly; however, there had not neating since July 2018, an that led the Quality ned.  cility's Pharmacy and mmittee meeting Minutes mittee had not met since by of the 04/10/18 minutes eight medications/Intravenous are listed as "drug shortages." incumentation regarding why there ages or what actions the facility are medications/substitutes.  7/18/18 minutes revealed drug "unable to determine due to lack"	A	273			

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Event ID: NS6G11

Facility ID 100020

If continuation sheet Page 66 of 135

Signature: Date: 3/4/19

PRINTED 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  180021		(X2) MULTIP A, BUILDING B, WING		co	TE SURVEY MPLETED  C 01/30/2019		
	OVIDER OR SUPPLIER STERN KY MEDICA		STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977				
(X4) ID PREFIX TAG	(EACH DEFIC	RY STATEMENT OF DEFICIENCIES IENCY MUST BE PRECEDED BY FULL Y OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETION DATE	
A 273	Review of emails facility did not has supply medication the email, the rethe handling of team and will no account." Observeview revealed medications that formulary, include and medications addition, observer facility's Verapa in emergencies; facility only had blood clots in pastrokes). Interviunsure how the	page 61 s revealed effective 01/24/19, the live a Retail Pharmacy Vendor to live a Retail Pharmacy Vendor to live a Retail Pharmacy Vendor to live a Retail Pharmacy Vendor to live a Retail Pharmacy was "turning over live a Retail pharmacy was "turning over live and live a retail pharmacy was "turning over live and live a live and record the facility failed to have a were required by the facility's sing antibiotics, intravenous fluids, a required for emergencies. In live attended to a live and live and live and live and the live and the live attended to 01/31/18, and the live attended to 1/31/18, and the live attended the facility was y were going to obtain use at the facility.	A 2	73			
	for 2018 reveal Services quarte ensuring proce forms. According percent of the process of the pr	e facility's Performance Indicators ed the facility monitored Surgical erly. The monitoring included dures matched patient consenting to the 2018 data, one hundred procedures matched the patient's However, review of a "Variance pation" dated 08/16/18 revealed the pare that Patient #1 received a procedure to examine the colon m) "in error." Patient #1 had an EGD troduodenoscopy is a procedure to tomach and upper portion of the patient's medical and staff documented that a "time and the patient's procedure was cording to the investigation, the RN initiated the time out procedure for			10		

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Event ID NS6G11

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	•	Date: 4/4/16	•_
Signature:	1	Date: 19/10	1
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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY COMPLETED	
		180021	B. WING		C 01/30/2019	
	ROVIDER OR SUPPLIER		850 R	ET ADDRESS, CITY, STATE, ZIP COD IVERVIEWAVENUE VILLE, KY 40977	Ē	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A 273	equipment for a coobjections from an attempted colonos investigation revealed conducted; however supposed to have initially stated the RN stated the procolonoscopy, and said it was supposed to have initially stated the procolonoscopy, and said it was supposed it was supposed.  3. Further review Indicators for 201 the following inpasurgical unit: nutring management asses However, there we fourth quarter and monitoring the quain 2019.  Record review rethe facility's Eme 11/26/18 with hip physician order for review of the Initial 11/26/18 at 8:29 risk for aspiration chewing and was review revealed and received entassessment therefor nutrition information information information information informatic in the physician that the ph	the room had been set up with blonoscopy and "with no by team members, an acopy was performed." The aled the Operating Room that the time out was eer, staff stated the patient was a colonoscopy. The CRNA time out was conducted and the cedure was supposed to be a then changed her mind and sed to be an EGD.  of the facility's Performance 8 revealed the facility monitored tient care on the medical stional assessments, pain essment, and pain intervention, as no data documented for the in o evidence the facility was ality of care provided to patients wealed Patient #5 presented to regency Department (ED) on pain and was admitted with a corresponding to the patient #5 was at a due to difficulty swallowing and a fed by a feeding tube. Further the patient had facial weakness eral nutrition (tube feeding). The interior assessment information, as no evidence that staff notified at the patient could not consume obtained orders to feed the	A 273			

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Event ID: NS6G11

Facility ID 100020

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Signature: Date: Sky /4

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILD	ING			
		180021	B. WING			01/3	30/2019
	ROVIDER OR SUPPLIER	ENTER	•	85	REET ADDRESS, CITY, STATE, ZIP CODE 0 RIVERVIEW AVENUE NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
A 273	the patient presented Department (ED) on severe left foot pain, he/she believed his/side of the patient's blue in color and colordered Demerol (mevery four hours as PM. Review of the EDocumentation date revealed Patient #1' ten was a ten, the wreview revealed that Patient #3's pain level documented eviden administered medicuntil 6:00 PM.  Further review of the 2018 for the Medical evidence the facility ensure care was prophysician orders or of changes in patient there was no documentation was reconsultation was reconsultation was reconsultation was reconsultation that no recess to care and facility discharged fresources.	It's feeding tube.  It's medical record revealed to the Emergency 12/30/18 at 2:35 PM with The patient reported that ther foot was broken and the left foot and little toe were d. The patient's physician redication to treat pain) 25 mg reeded on 12/30/18 at 3:30 regrency Department at 12/30/18 at 3:45 PM regrency Department r	A	273			
	revealed the patien	of Patlent #2's medical record at was admitted with chest pain eart attack on 10/10/18;					1

FORM CMS-2567(02-99) Pravious Versions Obsolete

Event ID: NS6G11

Facility ID: 100020

If continuation sheet Page 69 of 135

Signature: Date: Sluly

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT (	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			ONSTRUCTION		SURVEY PLETED
AND LOW OF	CORRECTION	IDEIAHI ICKHON NOMBER	A: BUILO	NG	the state of the s		c I
		180021	B. WING				/30/2019
NAME OF P	ROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE ZIP CODE		
SOUTHEA	STERN KY MEDICAL O	ENTER		***	RIVERVIEW AVENUE		
SOUTHER	STERN AT MEDICAL			PIN	IEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D 8E	COMPLETION DATE
A 273	however, the facility testing, blood pressitesting to monitor the ordered by the paties and/or 10/11/18. Will heart arrhythmia on notify the patient's pwas not transferred cardiac assessment approximately thirty presented to the EE 4. Observations on 01/30/19 at 5:15 PN Emergency Departs Surgical Services (general surgery), a medical surgical in Officer (CNO) on 0 the Chief of Staff (Crevealed the facility intensive/critical capolicy/procedure in services that the machine provide. Subseque revealed the facility #11 (Patients #2 ar the fourth quarter 2 during the first quadiagnoses that the transfer to another #2 was admitted on chest pain, to rule the facility had no intensive care unit	failed to conduct heart ure monitoring, and laboratory e patient's cardiac status as ent's physician on 10/10/18 hen the patient developed a 10/11/18, the facility failed to obysician timely and Patient #2 to an acute care facility for t and treatment until -four hours after the patient 0 and developed chest pain.  01/23/19 at 9:45 AM and on d revealed the facility provided ment (ED) services, and services were limited to and had a twelve (12) bed obtainent unit. Chief Nursing 1/30/18 at 6:20 PM and with COS) on 01/28/19 at 5:00 PM of did not provide re services and had-no place regarding the scope of edical surgical unit could antly, review of medical records of admitted Patients #2, #8, and and #11 were admitted during 1/2018; Patient #8 was admitted afacility was delayed. Patient and 10/10/18 with a diagnosis of out a heart attack, even though cardiologist on staff and no  #11's medical record revealed	A	273			
	the patient was ad 09/20/18 with a co	mitted to the facility on nsult for surgical services, even		<u>-</u>			

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Event ID NS6G11

Facility ID: 100020

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Signature:	Date:	4/1	<u> </u>	

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER    STREET ADDRESS, CITY, STATE, JP CODE	STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  PREVIATORY SYNEADIST OF DEPOIDINGES PINEVILL REVAILED FOR SYNEAR SYNEADIST OF DEPOIDINGES PINEVILL REVAILED FOR SYNEAR SYNEADIST OF DEPOIDINGES PROCESSOR BY FOLL RECOLD FOR SYNEAD SYNEA									
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  A 273  Continued From page 65 though the ED physician documented he was unsure if anesthesia services were available. On 09/21/18, the surgeon documented Patient # 11 should be transferred to another facility because he did not have the instruments or anesthesia available to treat the patient. However, the facility failed to transfer the patient uniti 09/24/18, three days later.  In addition, review of Patient #8's medical record revealed the facility directly admitted the patient from a physician's office on 01/21/18 with a diagnosis of Cerebrovascular Accident (CVA or stroke), even though the abea intensive care unit. In addition, interview with the Director of Pharmacy on 01/23/19 at 2:45 PM revealed the facility only had one vial of Activase. The pharmacist stated she had not had enough of the medication for several weeks, but was unable to order the medication due to the high cost and not enough money in the budget.  In addition, review of Patient #5's hip x-ray report completed on 11/27/18, revealed the patient for treatment of the hip fracture until 11/28/18.  Further, review of Patient #3's medical record revealed CT scans/anglograms on 12/31/18 revealed the patient had a blood clot in the femoral artery of the leg. The facility failed to transfer the patient had a blood clot in the femoral artery of the leg. The facility failed to transfer the patient to receive treatment for the blood clot until 01/01/19, and allowed the patient.				STREET ADDRESS, CITY, STATE, ZIP CODE  850 RIVERVIEW AVENUE					
though the ED physician documented he was unsure if anesthesia services were available. On 09/21/18, the surgeon documented Patient # 11 should be transferred to another facility because he did not have the instruments or anesthesia available to treat the patient. However, the facility failed to transfer the patient until 09/24/18, three days later.  In addition, review of Patient #8's medical record revealed the facility idirectly admitted the patient from a physiciant's office on 01/21/18 with a diagnosis of Cerebrovascular Accident (CVA or stroke), even though the facility did not have a neurologist on staff, did not have an intensive care unit. In addition, interview with the Director of Pharmacy on 01/23/19 at 2:45 PM revealed the facility only had one vial of Activase. The pharmacist stated she had not had enough of the medication for several weeks, but was unable to order the medication due to the high cost and not enough money in the budget.  In addition, review of Patient #5's hip x-ray report completed on 11/27/18, revealed the patient had a fractured hip. However, there was no evidence the facility transported the patient for treatment of the hip fracture until 11/28/18.  Further, review of Patient #3's medical record revealed CT scans/angiograms on 12/31/18 revealed the patient had a blood clot in the femoral artery of the leg. The facility failed to transfer the patient to receive treatment for the blood clot until 01/01/19, and allowed the patient	PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREF	1.7	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	IOULD BE	(X5) COMPLETION DATE	
to go by private vehicle.  Review of the facility's Performance Indicators for 2018 revealed the facility monitored Case	A 273	though the ED phy unsure if anesthesi 09/21/18, the surge should be transferr he did not have the available to treat the failed to transfer the days later.  In addition, review revealed the facility from a physician's diagnosis of Cereb stroke), even thou neurologist on state care unit. In addition of Pharmacy on 0° facility only had or pharmacist stated medication for sever order the medication for sever the medicati	sician documented he was a services were available. On ean documented Patient # 11 ed to another facility because instruments or anesthesia e patient. However, the facility e patient until 09/24/18, three  of Patient #8's medical record y directly admitted the patient office on 01/21/18 with a provascular Accident (CVA or go the facility did not have a f, did not have an intensive on, interview with the Director 1/23/19 at 2:45 PM revealed the evial of Activase. The she had not had enough of the eral weeks, but was unable to on due to the high cost and not the budget.  of Patient #5's hip x-ray report 27/18, revealed the patient had owever, there was no evidence orted the patient for treatment of atil 11/28/18.  Patient #3's medical record s/angiograms on 12/31/18 ent had a blood clot in the the leg. The facility failed to not to receive treatment for the 1/01/19, and allowed the patient ehicle.	A	273				

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Facility (D: 100020

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Signature:

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

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OR MEDICARE	& MEDICAID SERVICES			OMB NO. 0938-039
DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '		(X3) DATE SURVEY COMPLETED
				С
	180021	B. WING		01/30/2019
VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	CENTER	1	850 RIVERVIEW AVENUE	
EKN KY MEDICAI	LCENTER		PINEVILLE, KY 40977	
(EACH DEFICIE	ENCY MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	IOULD BE COMPLETIO
Management indictor transfers to a fagreater level of careview of the factor and ferent and the four days. There is that the facility ideransfers and tool were transferred.  5. Review of the for 2018 revealed monitor Radiolog backs for radio	cators that included the number actility that provided equal or a are and average length of stay. Sility data for the fourth quarter of air (4) patients had been be average length of stay was awas no documented evidence antified any concerns with a cany action to ensure patients timely.  Facility's Performance Indicators of the facility was required to be y delays in service and call gry services; however, there was noted for the fourth quarter of the fourth quarter of the fourth quarter of the fourth quarter of the fourth quarter of the formance in 2019.  It #12's medical record revealed do at the facility's ED on 12/04/18 apponsive and in full cardiac arrest the no heart function or breathing) to onary resuscitation (CPR) in the facility's ED on 12/04/18 at 9:10 PM, physician ordered Patient #12 to any obtained "STAT" owever, review of Patient #12's evealed no evidence the chest are deas ordered.	A 27	3	
	VIDER OR SUPPLIER  SUMMARY (EACH DEFICIE REGULATORY)  Continued From progression of the factory	DRRECTION IDENTIFICATION NUMBER:	DEFICIENCIES DERRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER  180021  VIDER OR SUPPLIER  TERN KY MEDICAL CENTER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 66  Management indicators that included the number of transfers to a facility that provided equal or a greater level of care and average length of stay. Review of the facility data for the fourth quarter of 2018 revealed four (4) patients had been ransferred and the average length of stay was four days. There was no documented evidence that the facility identified any concerns with transfers and took any action to ensure patients were transferred timely.  5. Review of the facility's Performance Indicators for 2018 revealed the facility was required to monitor Radiology delays in service and call backs for radiology services; however, there was no data documented for the fourth quarter of 2018 and no documented evidence that the facility was monitoring performance in 2019.  Review of Patient #12's medical record revealed the patient arrived at the facility's ED on 12/04/18 at 8:02 PM unresponsive and in full cardiac arrest (unconscious with no heart function or breathing) with cardio pulmonary resuscitation (CPR) in progress upon arrival. Review of physician orders for Patient #12 dated 12/04/18 at 9:10 PM, revealed the ED physician ordered Patient #12 to have a chest x-ray obtained "STAT" (immedically). However, review of Patient #12 to have a chest x-ray obtained "STAT" (immedically). However, review of Patient #12's medical record revealed no evidence the chest x-ray was obtained as ordered.  Interview with Registered Nurse #13 on 01/30/19 at 2:30 PM revealed she could not state emphalically why Patient #12 did not get the	DEFICIENCIES  (X1) PROVIDERISUPPLIER  180021  180021  STREET ADDRESS, CITY, STATE, ZIP CODE ESO RIVERVIEW AVENUE PINEVILLE, KY 40977  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PRECEDED BY PULL REGULATORY OR LSC DENTIFYING INFORMATION)  Continued From page 66  A 273  Continued From page 66  A 273  Continued From page 66  A 273  Continued From page 66  Continued From page 66  Continued From page 67  Continued From page 68  Continued From page 68  Continued From page 69  Continued From page

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one from the Radiology Department present in the facility white Patient #12 was receiving treatment. Review of the Radiology Department's

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Facility ID: 100020

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Signature: Date: 7/Mg

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	A. BUILDIN	TIPLE CONSTRUCTION  NG	COA	TE SURVEY  APLETED  C  1/30/2019
	ROVIDER OR SUPPLIER	L CENTER	B, WING_	STREET ADDRESS, CITY, STATE, ZIP 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		1/30/2019
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	and a second block To 1	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 273	but were on call f however, there we monitoring to ensisterions.  6. Review of Patirecords and inter on 01/24/19 at 1 failed to have a segistered Dietit Dietary Manager to budget constructional pounds. However revealed the patireceived no nutradmission from documented eving D for Patient # nutritional needs was recomment were met.  In addition, reviewer evealed the faction of the patient # nutritional needs was recomment were met.  In addition, reviewere met.	ed that staff were not scheduled, from 12:00 AM until 7:00 AM; as no evidence the facility was ure staff were providing timely  ent #4, #5, and #7's medical view with the Dietary Manager I:10 AM revealed the facility system for consulting the ian (RD). According to the , staff did not consult the RD due eints.  at #5's medical record revealed admitted on 11/26/18, with an er diet, and a weight of ninety-five er, further review of the record ient had a feeding tube and intonal intake during the patient's 11/26-28/18. There was no dence the facility consulted the 5 to ensure the patient's swere assessed and tube feeding ied to ensure the patient's needs ew of Patient #7's medical record cility failed to ensure the RD attent #7 who was admitted on diagnosis of Cellulitis and a Stage	A	273		

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Event ID NS6G11

Facility ID: 100020

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Signature: Date: 3/u/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED C
		180021	B. WING_		01/30/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 850 RIVERVIEWAVENUE PINEVILLE, KY 40977	CODE
(X4) 1D PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG		TION SHOULD BE COMPLETION THE APPROPRIATE DATE
A 273	administered the observation on 01 resident was recended the RD to assess Interview with the revealed he had a the approximately contracted with the Review of the factorizated with the ensure Register occurred within for however, there with the second quitable occurred within for however, there with the second quitable occurred within for however, there with the second quitable occurred within for the s	nsulin on 01/22/19. In addition, /23/19 at 4:30 PM revealed the iving a regular diet. There was vidence the facility consulted Patient #4.  RD on 01/29/19 at 1:30 PM only consulted on one patient in y eight months that he had been	A	273	

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Signature: Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: A BUILDING			(X3) DATE SURVEY COMPLETED			
		180021	B. WING			55	C 01/30/2019
	NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN KY MEDICAL CENTER		<u> </u>	850 R	ET ADDRESS, CITY, STATE ZIP CODE IVERVIEW AVENUE VILLE, KY 40977	:	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREF TAC	9.	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE
A 273	Epinephrine to repland could not purch their Pharmacy Dismedication to the facility of an audio revealed EMS was patient to the ED was ymptoms of an action of an action of a subsequently for the Eplace with specific the medical staff to patient was flown to the facility failed to care on 11/12/18 a presented to the Eplace with specific the Eplace with specific the medical staff to patient presented to the Eplace on 11/12/18 a presented to the Eplace on the Epl	ace the expired Epinephrine hase any medication because tributor stopped releasing acility due to unpaid debt.  recording dated 07/17/18, attempting to transfer a tho was exhibiting signs and tute stroke. However, when ED to inform them that they the patient, they were informed tring the patient to the ED d "kill this guy." Subsequently, transport helicopter and the to another facility.  Thad an "Acute Stroke Practice mergency Department" in criteria and interventions for to follow and implement when a to the Emergency Department mptoms of a stroke. However, to implement the standard of at 10:35 AM, when Patient #10 ED with a "significantly elevated and exhibiting signs and to ocute Stroke Practice Standard	A	273			

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Signature: Date: 34/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1''	(X2) MULTIPLE CONSTRUCTION A BUILDING		ATE SURVEY DMPLETED
		180021	B, WING_			C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP 850 RIVERVIEWAVENUE PINEVILLE, KY 40977	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
A 273	experiencing an appright parietal area. The Facility #6 on 11/12/of an acute stroke.  Observation and interpharmacy on 01/23/facility only had one Activator (IPA) (namitreat patients who will interview with the phinad been unable to the past because of medication and the However, as of 01/2 a Pharmacy Distribution and the However, as of 01/2 a Pharmacy Distribution.  Tours of the Emerge 01/23/19 and 01/30/have a functioning telectrical activity of the function and a patient's cardiac spresent in the patier observations revealed in the ED did not have (a device used to moxygen in the blood also revealed none contained a functior container. Observations revealed in the ED were located in the physician's children in the phy	arent evolving infarct in the he patient was transferred to 18 at 8:15 PM for treatment arview with the Director of 19 at 2:45 PM, revealed the vial of Tissue Plasminogen e brand Activase), used to be having a stroke. For a stroke, the stransfer is the high cost of the facility burchase the medication in the high cost of the facility's budget constraints. All 9, the facility did not have for from which to purchase the medication of 19 revealed the facility did not be elemetry monitor (shows the he heart) located at the staff were unable to monitor tatus unless they were	A:	273		
	needles and device a biohazard contain	s through the hallway to get to er to dispose of the items. In n of the casting room on				

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Signature: M. M. Date: 2/u/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		DISTRUCTION		TE SURVEY MPLETED
		180021	B. WING				C 01/30/2019
NAME OF D	ROVIDER OR SUPPLIER	= 100021	0,11.10	STRE	ET ADDRESS, CITY, STATE, ZIP CODE		11/30/2013
	STERN KY MEDICAL (	CENTER		8501	RIVERVIEW AVENUE EVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 273	O1/23/19 at 9:45 AM limited number of statured bones of pin need of casting supply of casting tar appropriate sizes warious injuries.  Further review of the Indicators for 2018 required to monitor entering the ED untar a doctor, the percentage of participation of the percentage of the perc	In revealed it contained a supplies necessary to cast patients presenting to the ED pervices. The ED's entire pe was expired and the ere not available to treat  e facility's Key Performance revealed the facility was the elapsed time from if the patient was first seen by stage of patients admitted, and patients receiving a Medical the Emergency Department re was no documented acility had been monitoring the provided in the ED, even	A	273			

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Facility ID 100020

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Signature:	mo	Date:	3luly_	

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A BUILDING			TE SURVEY MPLETED
		180021	B. WING _		l c	1/30/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	···	
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	COMPLETION DATE
A 273	remembered a comphysician #1 per procedure on a pasked to review the with Physician #1 revealed that she only had one (1) felt that as the Company should have further stated that pharmacy had a unavailable and been notified.  Interview with the only30/19 at 6:20 Nursing Officer (revealed the factor (Performance In The staff stated Assurance/Performance In The cNO and A reviewing nursing physician orders timeliness of mediality review on ACNO stated the trying to keep the linterview with a on only30/19 at 2 longer employed no longer function member as of "stated that ther the facility's final final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that ther the facility's final stated that there are the stated that there the facility's final stated that there are the stated that there are the stated that there are the stated that there are the stated that there are the stated that there the facility's final stated that there are the stated that there are the stated that there the facility's final stated that there are the stated that there the facility is final stated.	propage 72 conversation surrounding forming the incorrect surgical attent. However, she was never the medical record or to speak I. Further interview with the COS a was unaware that the facility Activase vial. She stated she OS, and an admitting physician, been informed. The COS at she was not aware the list of medications that were again felt like she should have  The COS on O1/30/19 at 6:20 PM litty had not had a Quality Meeting approvement) since October 2018. The Director of Quality formance Improvement (QAPI) 2018 and since that time the freen conducting QAPI activities. CNO stated they had not been ag documentation for accuracy, at to ensure they were followed, addication administration, or other of medical records. The CNO and the facility running.  Former Governing Body Member COT PM, revealed that she was no d by the facility's corporation and oned as a governing body last week." The Former Member the was constant conversation about ances, and that the cash flow of always the topic of priority. She	A 2	273		

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Event ID #86G11

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Signature: Date: 3/4/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT O AND PLAN OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED			
		180021	B. WING _		01/30/2019			
	NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN KY MEDICAL CENTER			STREET ADDRESS, CITY, STATE. ZIP CODE  850 RIVERVIEW AVENUE  PINEVILLE, KY 40977				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF ( EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION			
A 273	Continued From pag	e 73	A2	273				
	conversation she ha regarding the facility finances. The Forme	not aware of a meeting or d attended or participated in that was not dominated by the Member stated she was aware of care concerns at						
	Executive Officer (C revealed that the Ch and Chief Financial the onsite administrates ponsible for the CCEO stated that he quality assurance (C was not aware that met since October 2 identifying quality of CEO stated that he events that had occ never been informe Emergency Medical had to provide the fi	Services had on occasion acility with supplies and assist re of patients due to a						
A 385	A0263, A0385, A03 A0837, A0940, A09 and A1104.)	0057, A0073, A0115, A0145, 95, A0489, A0490, A0799, 951, A0955, A1100, A1103, ES	A	385				
	service that provide	nave an organized nursing es 24-hour nursing services es must be furnished or gistered nurse.						

FORM CMS-2557(02-99) Previous Versions Obsolete

Event ID: HS6G11

Facility D 100020

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Signature: Date: Sluyling

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
MIND FUNN OF	CONTROLIGIN	Benth temperatures.	A BUILDING		С	
		180021	B, WING		01/3	0/2019
	ROVIDER OR SUPPLIER ASTERN KY MEDICAL	. CENTER	850	REET ADDRESS, CITY, STATE ZIP CODE DRIVERVIEW AVENUE NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 385	Based on observa and review of facility failed to provided or supen. The facility failed to the Registered Die feeding tubes, predicted by the Registered Die feeding tubes, predicted by the Registered Die feeding tubes, predicted by the Registered Die feeding tubes, predicted by the Patient in the application of the Dietary Mark Down of the Dietary Mark Down of the Dietary Mark Down of the Dietary Mark Down of the Dietary Mark Down of the Dietary Mark Down of the Dietary Mark Down of the Patient #7 who had a diagnor received diets as Further, the facility failed to erreceived diets as Further, the facility system for ensuring consulted. A consulted A consult	age 74 is not met as evidenced by: tion, interview, record review, ity policies, it was determined be ensure nursing services were vised by a registered nurse. To have a system for consulting dititian (RD) when patients had ressure ulcers/wounds, or did to have an effective system to received physician ordered diets. That only consulted on one roximately eight months that he red with the facility. According reger, staff did not consult the charges \$140.00 an hour and rechard to operate on, we can't recility failed to consult the RD rechard a diagnosis of cellulitis ressure sore or for Patient #4 resis of Diabetes and was not the ordered diet. In addition, the resure Patients #4 and #7 rordered by their physicians. Ty did not have an effective reg Social Services was sultation was recommended for and no running water at home and resis to care and medications; It services consultation was and Patient #7 was discharged  recility failed to administer atients #4 and #7 as ordered by Patient #7's medical record lent was admitted on 01/06/19 the right lower extremity (skin response).	A 385	The facility had no institutional plan or annuludget due to no effective Governing Board I he institutional plan, including annual operation and included all anticipated income, expense expenditures for a three-year period was mad was presented to MEC on 2/20/19 and sent to Governing Board on 2/22/19 for review and is verified by attached board minutes. See At Controller)  The facility failed to ensure nursing services or supervised by a registered nurse. The nursommand has been established as: RN Chief Officer to RN Assistant Chief Nursing Office Tharge Nurse and RN Charge Nurse as Supervisors to do the daily chart audits. The consure an RN would supervise and evaluacere for each patient. Nursing staff will be in Policy 200-241 on Continuum of Care Policy This will be verified by way of an in-service Chart audits, including timely medication as medication omissions, change in condition deconsent for treatment, nutritional/social servinonitoring and following up on medications performed daily by nursing staff to ensure of Chart audit tools are collected by ACNO whresults of the chart audits will be reported to so if needed immediate actions are taken. (Consent for treatment audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken. (Consent for the chart audits will be reported to so if needed immediate actions are taken.	neing in place ting budget s, and capital e. This plan o newly scated approval. This tached minutes were provided sing chain of Nursing cr. to RN sor. Indicators and Shift facility failed te the nursing serviced on per ACNO, attendance log ministration, ocumentation, ices consults, i, will be ampliance, o will report QAPI weekly	3/1/2019

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A BUILDING	CONSTRUCTION	COMPL	ETED
		180021	B. WING		i	0/2019
NAME OF PR	ROVIDER OR SUPPLIER		1 -	REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL C	ENTER	- 1	RIVERVIEWAVENUE NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  LY MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	LDBE	(XS) COMPLETION DATE
A 385	life-threatening cond response to an infect sore. The facility fails medication to prever ordered by the physic pressure sore was a The facility also faile diuretic medication awere administered aphysician, and failed	ition caused by the body's tion), and a Stage 2 pressure ed to administer Lovenox at blood clots for patients as ician and failed to ensure the	A 385	or patient #4, the facility failed ensure the part ordered diet. The facility failed to administed medications and failed to complete a ruder. An electronic reflex process was put it effex is attached to questions on the flowchausing staff selects answer choice the reflex flectronically to dietary staff who will verify then notify dietician of the consult. A registe RD) was hired on 2/22/19. Diet orders were rerified by the RD. The reflex process was the rerified during the 2/22/19 visit. CNO to enhat licensed nursing staff are following polion-serviced on policy 700.240 Physician's Or 500.034 Medication Administration (Pharma 200.707 Medication Administration (Nursing meluding timely medication administration, omissions, change in condition documentation and following up on medications, will be penarsing staff to ensure compliance. Chart as collected by ACNO who will report results of audits will be reported to QAPI weekly so if immediate nections are taken. The CEO will everify that the staff is in-serviced on the revibave been approved by MEC and the new G (CNO/IIR Director/RD)  For patient #7, the facility failed to consult the administer physician ordered medications are ensure proper assessment and treatment presented in place. The reflex is attached to questify with nurse and then notify dietician or reflex is then sent electronically to dietary sylverify with nurse and then notify dietician or registered dietian (RD) was hired on 2/22/19 were reviewed and verified by the RD. The was tested and verified during the 2/22/19 were reviewed and verified by the RD. The was tested and verified during the 2/22/19 were reviewed and verified during the 2/22/19 were reviewed and verified by the RD. The was tested and verified during the 2/22/19 were reviewed and verified during the 2/22/19 were reviewed and verified during the 2/22/19 were reviewed and verified during the 2/22/19 were reviewed and verified during the 2/22/19 were reviewed and verified by the RD. The was tested and verified during the 2/22/19 were r	ister physician physician in place. The rt and when is then sent with nurse and red dietician reviewed and seried and sure and verify ites and will be ders, policy cy), and g). Chart audits, medication on, consent for s, monitoring formed darly by dit tools are of the chart needed oversee and sed polices that overning Board.  The RD and the facility failed to darled to sure sore. The hich social approcess was one the week of the chart needed oversee and sed polices that overning Board.  The consult AD Diet orders reflex process was one the week of the consult. AD Diet orders reflex process isit. CNO to are following 20.420 Skin seassessment of ge, policy 4 Medication edication has been ment of a lication ge in condition	2/22/2019
	567/07-99) Provinces Versions O	hadere Event ID: N	18631 Fn	services consults, monitoring and following cataly ID 100020 If co	tip on Hinuation sheet F	age 81 of 135

Signature: Date: Theliq

> medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. The CEO will oversee and verify that the staff is inserviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD)

3/1/2019

The reporting and follow up on medication errors was identified in the survey findings. The Medication Error Policy 600 085 has been in-serviced to reinforce the need to report all incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and MEC. This will be verified by the in-service attendance log Licensed nursing staff will be in-serviced on policy 600 085 Medication Error. This will be verified by way of the inservice attendance log. Licensed nursing staff will be inserviced on policy 600 085, Medication Error. This will be verified by way of an in-service attendance log. (ACNO)

3/1/2019

The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility. CEO will oversee department managers and verify all hospital staff will be inserviced on 700.708, Interdepartmental Relationships. Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO)

RN SUPERVISION OF NURSING CARE A 395 CFR(s): 482.23(b)(3)

> A registered nurse must supervise and evaluate the nursing care for each patient.

This STANDARD is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure nursing services were provided to supervise and evaluate the care of three (3) of twelve (12) sampled patients (Patients #4, #7 and #8). The facility failed to administer Lovenox (medication to prevent blood clots) for Patient #7 who was admitted on 01/06/19 with Cellulitis to the right lower extremity (skin infection), early sepsis (a potentially life-threatening condition caused by the body's response to an infection), and a Stage 2 pressure sore. The facility also failed to ensure staff assessed the pressure sore and failed to consult the facility dietitian as ordered by the physician.

In addition, Patient #4 was admitted with

A 395

3/1/2019

The facility failed to ensure nursing services were provided or supervised by a registered nurse. The nursing chain of command has been established as: RN Chief Nursing Officer to RN Assistant Chief Nursing Officer, to RN Charge Nurse and RN Charge Nurse/Supervisor. Indicators have been developed for the Charge Nurse and Shift Supervisors to do the daily chart audits. The facility failed to ensure an RN would supervise and evaluate the mursing care for each patient. Nursing staff will be in-serviced on Policy 200 241 on Continuum of Care Policy per ACNO. Chart audits, including timely medication administration. medication omissions, change in condition documentation. consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by norsing staff to ensure compliance Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken. This will be verified by way of an in-service attendance log. (CNO)

3/1/2019

Nursing service should be able to identify patients who potentially need a referral. The CEO was found to not be in compliance with overseeing all departments to ensure a good working relationship throughout the facility CLO will oversee department managers and verify all hospital staff will be in-serviced on 700,708. Interdepartmental Relationships. Department by department updates will be discussed at weekly Managers meeting to promote interdepartmental cohesiveness. The Administrative

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Date:

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A 395	diagnoses of Acute Congestive Heart Failure	Assistant will add this meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO) Indicators were added to QAPI program related to the II tags to monitor the procedures or processes that we have put in place to ensure that the plan is effective. This will be verified by the QAPI meeting minutes. (CNO)  For patient #4, the facility failed ensure the patient received the ordered diet. The facility failed to administer physician ordered medications and failed to complete a physician order. An electronic reflex process was put in place. The reflex is attached to questions on the flowchart and when nursing stuff selects answer choice the reflex is then sent electronically to dietary staff who will verify with nurse and then notify dictician of the consult. A registered dictician (RD) was hired on 2/22/19. Diet orders were reviewed and verified by the RD. The reflex process was tested and verified during the 2/22/19 visit. CNO to ensure and verify that licensed nursing staff are following policies and will be in-serviced on policy 700.240 Physician's Orders, policy 600.034 Medication Administration (Pharmacy), and 700.707 Medication Administration (Rursing). Chart audits, including timely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications, will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed mmediate actions are taken. The CEO will oversee and verify that the staff is in-serviced on the revised polices that have been approved by MEC and the new Governing Board. (CNO/HR Director/RD)	3/1/2019 2/22/2019	
				_

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Facility ID 100020

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A BUILDING			(X3) DATE SURVEY COMPLETED			
			A. BUILDING		С	
		180021	B. WING		01/30/2	2019
NAME OF P	ROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
CONTINE	OZEDNIKY MEDICAL O	ger at 4 min fee fee	85	0 RIVERVIEW AVENUE		
SOUTHER	ASTERN KY MEDICAL C	ENTER	PI	NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES LY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
A 395	(CHF) and Diabetes; provide a no-concen by the physician, fail diuretic medication a ordered by the patient monitor the patient's  Further, the facility fa Services regarding Frunning water or acc the patient the physito consult the dielitia wounds and diet.  The findings include  Review of the facility Administration," date staff should provide using the most curre policy stated the dei with medication ordes should be administed time the medication stated early or late a medications could himpact on the intending the most curre time the medication stated early or late a medications could himpact on the intending the most curre time the medication stated early or late a medications could himpact on the intendication could himpact on the intendication of the facility. Review of the facility capprove of the policy approve of the policy, approve the facility. Review of Reassessment of February 2017, reviewere initiated upon	thowever, the facility failed to strated-sweet diet as ordered ed to administer the patient's and potassium supplement as nt's physician, and failed to urinary output.  Called to consult Social Patient #7 who did not having sess to care, failed to provide ician ordered diet, and failed an to assess the patient's	A 395	For patient #7, the facility failed to consult the RD anatient did not receive the ordered diet. The facility administer physician ordered medications and failed proper assessment and treatment pressure sore. The also lacked an effective system in which social services consulted. An electronic reflex process was put into notify the dictary department of a consult. The refleattached to questions on the flowchart and when not electrost answer choice the reflex is then sent electror dictary staff who will verify with nurse and then no dictician of the consult. A registered dictian (RD) on 2/22/19. Diet orders were reviewed and verified RD. The reflex process was tested and verified dur 2/22/19 visit. CNO to ensure and verify that licensistaff are following policies and will be in-serviced c2/00.420 Skin Integrity, policy 2/00.403, Assessment Reassessment of the patient, policy 2/00.606 Nursin Discharge, policy 7/00.701 Discharge Planning, pol Medication Administration (Pharmacy), and 7/00.70 Medication Administration (Pharmacy), and 7/00.70 Medication Administration (Pharmacy), and 7/00.70 Medication Administration, medication omis change in condition documentation, consent for trenutritional/social services consults, monitoring and up on medications, will be performed daily by nursensure compliance. Chart audit tools are collected who will report results of the chart audits will be reCEO will oversee and verify that the staff is in-service attendance log. (CNO/HR Director/RD)  The reporting and follow up on medication errors videntified in the survey findings. The Medication 600.085 has been in-serviced to reinforce the need incidents for follow-up by the pharmacist, the Risk Management committee, the QAPI committee and will be verified by the in-service attendance log. Laursing staff will be in-service attendance log. (Anatom process of the pharmacist of the reflex is the reservice attendance log. (Anatom process and process attendance log. (Anatom process and process attendance log. (Anatom process).	y failed to d to ensure e facility vices was o place to ex is arsing staff nically to otify was hired d by the ring the ed nursing on policy it and by fice of the ed nursing on policy it and by fice of the ed nursing on policy it and by fice of the ed nursing on policy it and by fice of the ed nursing sing staff to by ACNO eported to aken. The viced on the and the new was Error Policy to report all k it MEC. This licensed is the in-	3/1/2019

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Event ID NS5G11

Signature: // / Date:

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		The state of the s		(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		180021	B. WING		0	C 1/30/2019
	OVIDER OR SUPPLIER STERN KY MEDICAL	CENTER	8501	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
A 395	assessment and rethe type and kind of initially; also to detresponse to that of for changes in patto change the plan.  Review of the "Interpolicy, approved Foursing Services potentially needed agency or nursing complete docume referral, and notify were identified. For revealed nursing sithe need to consultations.	eassessment was to determine of care the patient required termine the follow-up and are, and frequent evaluations tent status and needs in order to of care.  The departmental Relationships of the february 2017, revealed should identify patients who have a referral to some other facility after discharge, intation as necessary for each of Social Services when needs wither review of the policy staff should notify the dietitian of all ton patients, and were mate the interdisciplinary plan of	A 395			
	approved August the policy was to provision of food and The policy did not Dietitian would be Registered Dietitian revealed he had a provide services assess any patter tube feeding, or a 1. Patient #7's me facility admitted the diagnoses of Cell and early sepsis.	ility's policy, "Diets/Meals," 2018, revealed the purpose of ensure timely and efficient and nourishment to patients. address when a Registered consulted. Interview with the an (RD) on 01/29/19 at 1:30 PM a contract with the facility to and should be consulted to at with a pressure ulcer/wound, a diagnosis of Diabetes.  edical record revealed the ane patient on 01/06/19 with ulitis to the right lower extremity The patient was also admitted essure sore to his/her right				

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Date:

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
		180021	B, WING	_		C 01/30/2019	
	NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN KY MEDICAL CENTER		<u> </u>	85	TREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAC		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	9€	(X5) COMPLETION DATE
A 395	Review of Patient #7 01/06/19 at 1:26 PM vein thrombosis (DV which consisted of a injection forty (40) m orders dated 01/06/1 required to documer patient's Stage 2 presize, stage, depth, w amount of drainage, surrounding tissue. A also ordered when the 01/06/19.  Further review of Parevealed staff did not patient until 01/07/19 twenty-two (22) hou ordered. In addition, evidence that staff a pressure ulcer or colby the patient's physical line facility "at one tithe timeframe or if factor in Patient #4 Interview with the R 01/29/19 at 1:30 PM contacted to assess should consult him a wound/pressure sonly requested a collection of the staff and the staff a	"s admission orders dated, revealed the patient's deep T/blood clot) prophylaxis, Lovenox (blood thinner) g twice daily. Physician 19 also revealed staff were at the following regarding the essure sore: the location, round edges, any necrosis, and condition of the A dietary consultation was the patient was admitted on the effect of the	A	395			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION NG	_	(X3) DATE SURVEY COMPLETED
		180021	B, WING		************	C 01/30/2019
NAME OF PR	ROVIDER OR SUPPLIER	· I	1.	STREET ADDRESS, CITY,	STATE, ZIP CODE	
				850 RIVERVIEW AVENUE	5	70
SOUTHEA	STERN KY MEDICA	LCENTER		PINEVILLE, KY 4097		
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORI	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD BI RENCED TO THE APPROPRIA DEFICIENCY)	DATE
A 395	Continued From p	page 79	А	395		
	patient was admit with diagnoses of (CHF), Generalized 2.a. Observation revealed Patient dinner with family eating vanilla ice stated the patient though the patient The daughter shough that accompany in the patient shough that accompany is that accompany is that accompany in the patient though the patient though the patient that accompany is that accom	ent #4's record revealed the ted to the facility on 01/22/19 Acute Congestive Heart Failure ed Weakness, and Diabetes.  on 01/23/19 at 4:30 PM #4 was sitting in a chair eating . Patient #4 was observed cream. Patient #4's daughter was on a "regular" diet, even thad a diagnosis of Diabetes, ewed the surveyor the printed mied the patient's meal from with the patient's name that read				
	Interview with Re 01/23/19 at 4:40 supposed to rece no-concentrated-however, that "it ordered; every pa food every meal." any specialized of Continued intervi#2 on 01/27/19 a PM revealed, "No a regular diet, no	gistered Nurse (RN) #2 on PM revealed that Patient #4 was ive a no-added-salt and sweets diet. RN #2 stated, doesn't matter what diet is attient up here gets the same PRN #2 stated he had not seen iets on the trays ever. ew with Registered Nurse (RN) at 5:00 PM and 01/29/19 at 5:00 of one here gets a diet other than matter what's ordered, or what ave, even diabetics."				
	#4's diet order in entered into the of Manager stated in added salt diet; h concentrated swith dietary staff did r	Dietary Manager on 01/24/19 at ed she doubled checked Patient the computer and the order was computer "wrong." The Dietary nursing staff had entered no cowever, they had put "no eets" in the wrong section and not see the order. Continued		1¢	×	

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	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	DNSTRUCTION		SURVEY LETED
		180021	B. WING			30/2019
	STERN KY MEDICAL	CENTER	8501	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI  EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	entered in the wron should have seen to the order.  2.b. Further review revealed the patien 01/22/19 for staff to urine output over the signed off the physical was no documente monitored the patien after admission or a patient's urine output.  2.c. Continued revorders dated 01/23 physician prescribe milliequivalents (milliequivalents (milliequivalents (milliequivalents) (milligram #4's Medication Acrevealed Potassiur patient until 5:17 Pafter the "now" ord Lasix to the patien though the medical	ncentrated sweets" was g place, dietary staff still he order or at least questioned of of Patient #4's medical record t's physician wrote an order on a notify him of the patient's he next two (2) hours. RN #2 ician's order; however, there d evidence that the RN ent's urine output two hours notified the physician of the	A 395			
	5:00 PM revealed administered the p the facility policy, of the patient's IV La acknowledged he physician of the pa RN #2 stated, "I ju	he was unsure why he had not patient's potassium "now" per or why he had not discontinued six. The RN also had not notified the patient's atient's urine output as ordered.				

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	B. WING				C /30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		850	REET ADDRESS, CITY, STATE, ZIP CODE DRIVERVIEW AVENUE NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
A 395	o1/16/19 with diagnostasis disease (slow legs) with cellulitis (in extremities. Review assessment reveale malodorous drainagand the legs were "not ocalf area bilaterall."  According to the meinformed staff his/hebecause he/she had and had no transporscheduled physician pharmacy to get need to get need to get need to make the provides was ever of patient's inability to the provide at two gram continued to receive remainder of the hornest the subsequently, the Control of the provide at two gram continued to receive remainder of the hornest the subsequently in the Control of the hornes	admitted the patient on oses that included venous blood flow in the veins to the affection) to both lower of Patient #9's admission of the patient had weeping a from both lower extremities ed with yellow crusty buildup y."  dical record, Patient #9 or condition had worsened a no running water at home, tation to get to/from appointments or to the eded medications.  Attent #9's medical record 9 at 5:30 PM a social in was requested. However, led the facility discharged the 23/19, and there was no oce that Adult Protective contacted regarding the obtain medical care.  Anysician orders dated Physician #5 ordered a "2 gm is prior to the patient's not #9. However, record special diet order was not illity's computer system; bletary Department did not sodium diet and the patient as a regular diet during the espital stay.	A	395			
		was consulted for Patient #9,					4

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Event ID: NS6G11

Facility ID 100020

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Signature: Date: 34/17

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD		ONSTRUCTION		ATE SURVEY OMPLETED
		180021	B, WING		•		C 01/30/2019
	ROVIDER OR SUPPLIER			850 F	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETION DATE
A 395	and staff had not newly ordered die home on 01/23/19 Interview with the 01/29/19 at 1:30 if been asked to corpatient was received the patient's wour Interview with the 11:10 AM revealed though the facility did not consult him. The Dietary Manadiet changes, presimpairments, she "because he charthe budget we had him." Interview with Re 01/27/19 at 5:00 Patient #9 home not reviewed the discharge and was unaware that water at home, of transportation to to obtain physicial further stated he an order for a twithospital stay. Ac gets a diet other what's ordered, even diabetics."	educated Patient #9 on the at. The patient was discharged a on a regular diet.  Registered Dietitian (RD) on a revealed he should have a nsult on Patient #9 to ensure the a repropriate nutrition to heal	A	395			

FORM CMS-2567(02-99) Pravious Versions Obsolute

Event ID: NS6G11

Facility ID 100020

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PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER  (X2) MULTIPLE CONSTRUCTION A, BUILDING		(X3) DATE SURVEY COMPLETED C			
		180021	B, WING			30/2019
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE B50 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	ILO BE	(X5) COMPLETION DATE
A 395	(CNO) on 01/29/11 medications shoul and if physicians of consultations or di should be followed should be educate ordered in the faci Registered Dietitia also stated patient with diet instruction physician. Condition of Partic CFR(s): 482.25  §482.25 Condition Pharmaceutical S  The hospital must that meet the nee The institution must a registered pharm storage area under medical staff is redeveloping policie drug errors. This be delegated to the pharmaceutical so This CONDITION Based on observation and review of faci the facility failed the services were propatients. Interview revealed that efferent have a Pharm medications to the	at 11:00 AM revealed do be administered as ordered ordered social service et changes, those orders if. She also stated patients of when special diets were lity, and when applicable, the en should be consulted. She is should be discharged home insight that had been ordered by the cipation: Pharmaceutical Se if of Participation: ervices.  Thave pharmaceutical services do of the patients, is thave a pharmacy directed by macist or a drug er competent supervision. The sponsible for is and procedures that minimize function may the hospital's organized	A 48	The lack of consistent pharmaceutical supplication of the controller and adequate supplies a pharmacy budget of \$50 sent to the Controller. This will be verified by the Controller (Controller)  The supply of pharmaceutical supplies will be the QAPI plan which has been expanded to in Percentage of medications requested on Objector resupply to send versus the total number requested. The Director of Pharmacy will make the compliance, and this will be verificated by QAPI meeting minutes. (Director of the reporting and follow up on medication of identified in the survey findings. The Medical Policy 600.085 has been in-serviced to reinforce and incidents for follow-up by the pharmaceutic formal incidents for follow-up by the pharmaceutic formal the committee, the QAPI committed (ACNO)	ter to ensure 0,000 has been by email sent to be monitored by include ani restock with a of medications and the f Pharmacy) errors was ention Error orce the need to macist, the Risk ce and	2/22/2019
A 489	Condition of Partic CFR(s): 482.25 §482.25 Condition Pharmaceutical S The hospital must that meet the nee The institution must a registered pharmateristorage area under medical staff is redeveloping policied drug errors. This be delegated to the pharmaceutical staff is CONDITION Based on observand review of facility failed the facility failed t	have pharmaceutical services ds of the patients. st have a pharmacy directed by macist or a drug er competent supervision. The sponsible for and procedures that minimize function may be hospital's organized ervice. Is not met as evidenced by: ation, interview, record review, lity policies, it was determined to ensure pharmaceutical evided to meet the needs of evision of the stributor to supply the facility. According to the	A 48	received was identified in the survey. In ord adequate supplies a pharmacy budget of \$500 sent to the Controller. This will be verified I the Controller. (Controller)  The supply of pharmaceutical supplies will be the QAPI plan which has been expanded to import the compliance, and the will be verified to the compliance, and this will be verified to the compliance, and the will be verified to the reporting and follow up on medication of identified in the survey findings. The Medic Policy 600.085 has been in-serviced to reinforce and the compliance of the plan Management committee, the QAPI committed MEC. This will be verified by the in-service.	ter to ensure 0,000 has been by email sent to be monitored by include ani restock with a of medications and the f Pharmacy) errors was ention Error orce the need to macist, the Risk ce and	2/2

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: NS6G11

Facility ID: 100020

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Signature: Date: 3/4

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	47/	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
			7.000.000			;	
		180021	B. WING_		01/3	30/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
COUTUE	STEDNIKY MEDICAL C	enteb	İ	850 RIVERVIEW AVENUE			
SOUTHER	STERN KY MEDICAL C	ENIER	1	PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFII TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
A 489	A 489 Continued From page 84  team and will no longer be able to service the account." Observation, interview, and record review revealed the facility failed to have medications that were required by the facility's formulary; including antibiotics, intravenous fluids, and medications required for emergencies including Verapamil (used to treat high blood pressure, chest pain, and heart arrhythmia).		A	The Cardinal Wholesaler debt which had be the findings as being the cause of drug supp addressed. An initial payment was made on another payment will be made to have Card orders. The medications which were identify available were ordered on 2/21/49. The Dir Pharmacy will oversee the restocking of the which occurs twice a day via the restock regautomatically print in the inpatient pharmac availability of medications will be verified a from the wholesaler and Omni inventory - v. (CEO)		3/6/2019	
	Epinephrine (used to reactions and cardia Bicarbonate (used in arrest and metabolic facility only had one treat blood clots in p	treat life threatening allergic c arrest), and Sodium emergencies for cardiac acidosis). In addition, the (1) dose of Activase (used to atients having heart attacks aws revealed the facility was re going to obtain		The facility had no institutional plan of budget due to no effective Governing The institutional plan, including annuithat included all anticipated income, a expenditures for a three-year period was presented to MEC on 2/20/19 and governing board on 2/22/19 for reviewerified by attached board minutes. S (Controller)	Board being in place, al operating budget expenses, and capital vas made. This plan d sent to newly scated w and approval. This is	2/22/2019	
A 490		or Pharmaceutical Service	A	490 The lack of consistent pharmaceutica received was identified in the survey, adequate supplies a pharmacy budget sent to the Controller. This will be ve the Controller. (Controller)	of \$500,000 has been	2/15/2019	
	§482.25 Condition of Pharmaceutical Sent The hospital must have that meets the needs patients	vices. ave pharmaceutical services		The supply of pharmaceutical supplic the QAPI plan which has been expan "Percentage of medications requested zero resupply to send versus the total requested. The Director of Pharmacy report the compliance, and this will be weekly QAPI meeting minutes. (Director)	ded to include I on Omni restock with number of incdications r will monitor and the verified by the	3/1/2019	
	This STANDARD is Based on observation and review of facility the facility failed to provide t	not met as evidenced by: on, interview, record review, or policies, it was determined provide pharmaceutical eneeds of patients consistent clients the facility serves. ow of emails revealed that the facility did not have a or to supply medications to the othe email, the distributor		The reporting and follow up on medi- identified in the survey findings. The Policy 600 085 has been in-serviced report all incidents for follow-up by to Management committee, the QAPI of MEC. This will be verified by the in (ACNO)	e Medication Error to reinforce the need to the pharmacist, the Risk ommittee and	2/22/2019	

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Event ID: NS6G11

Facility ID: 100020

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Signature: Date: 34/9

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATE COMPI	
						:
		180021	B, WING		01/3	30/2019
NAME OF P	ROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE		
00011127				PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFI TAG	3)	85	(X5) COMPLETION DATE
A 490	amounts to our legal able to service the arinterview, and record failed to have medicathe facility's formular intravenous fluids, at emergencies. In addinterview revealed the Epinephrine (drugs to on 01/31/18, and the Activase (used to tre having heart attacks revealed the facility going to obtain medication, Cardizent treat high blood prescripthms, and chest pformulary; however, the medication was corder for Cardizem Eto administer the medication was corder for Cardizem Eto administer the medication Renvela (phosphate chronic kidney diseated by vitamin); however, the formulary and the substitute, were not Patient #4 had phys Victoza (an injectable milligrams (mg)/1 midose of 1.2 mg to be Interview with staff in not available; however ecognize that the ptype of insulin. Substitute, Subst	e handling of outstanding team and will no longer be count." Observation, direview revealed the facility ations that were required by y, including antibiotics, and medications required for ition, observation and the facility's Verapamil and used in emergencies) expired the facility only had one that blood clots in patients and strokes). Interviews was unsure how they were cations for use at the facility.  The ER (medication used to soure, abnormal heart pain) was on the facility's the facility failed to ensure available. Patient #8 had an ER; however, the facility failed edication because it was not an emedication were not on the medications, or a administered to the patient.  It ician orders to receive the diabetic medication) 6 tilliliter (ml) with the ordered	A	The Cardinal Wholesaler debt which had been id the findings as being the cause of drug supply ise addressed. An initial payment was made on 2/7/another payment will be made to have Cardinal rorders. The medications which were identified a available were ordered on 2/21/19. The Director Pharmacy will oversee the restocking of the Omi which occurs twice a day via the restock reports automatically print in the inputient pharmacy. The automatically print in the inputient pharmacy. The automatically print in the inputient pharmacy. The automatically print in the inputient pharmacy. The cause of the ca	sues is being 2019 and release is not being of inicells that he e receipts is attached.  The director eview the hat were not list of these e for rmulary or I CEO) tiffied in the compile the rwarded to of the will be tion lists will on and offied by the	2/20/2019 and ongoing 2/15/2019

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Event ID: NS6G11

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Signature: Date: Hulg

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STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION	(X3) DATE COMPI	SURVEY LETED
						_ (	1
		180021	B. WING			01/3	30/2019
NAME OF PR	OVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
COUTUEA	STEDNIKY MEDICAL O	Patron		85	0 RIVERVIEW AVENUE		
SUUTHEA	STERN KY MEDICAL C	ENTER		PI	NEVILLE, KY 40977		1
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION	- 1	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
A 490	Continued From pag	e 86	A	490			v
	made to ensure the p coverage for high blo	patient received insulin and sugar levels.					
	The findings include:				4		
	System" dated July 2 Department would pr approved drugs asset	essed on the basis of need,					
	medications were rea the hospital. The poli could also order med	nd cost to assure that adily available for use within icy stated that physicians dications that did not appear			25		
	pharmacist or pharm to obtain the item an	cording to the policy, the acy technician would attempt d would consult with the					
	its procurement woulevents occurred, the	cation was unobtainable or if ld be delayed. If these pharmacist would contact					
	order. The policy fun "must communicate	discontinue" or "substitute" ther revealed the Pharmacist medication shortages, if they					
	Then the medical sta	dical and nursing staff." aff, through the Pharmacy &T) Committee, were					
	required to establish for use within the ho	a formulary of medications spital based on the					
		g to the policy, the formulary at least quarterly within the					
	patient was admitted with Acute Congesti Generalized Weakn	nt #4's record revealed the d to the facility on 01/22/19 ve Heart Fallure (CHF) and ess. Review of the record					
	Victoza 1.2 mg, to b	ntient's physician had ordered e administered daily at 9AM.					
7	However, review of	Patient #4's medication					10

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Event ID: NS6G11

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Signature: Date: 4/4/19

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		180021	B. WING				C 1/30/2019
	ROVIDER OR SUPPLIER			850	REET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE IEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
A 490	AM dose of Victoza administered.  Review of the facility was not listed on the brands of insulin we Interview with Regis 01/23/19 at 4:40 PM administered Patien because it was not a stated, "We've battle need for a long time provide to the patien They won't buy then guess."  Interview with Patien 5:00 PM revealed the admitted to the facility admissions "last mostated, "They don't that [the patients] at remember to bring it sometimes I forget." medications, the patien while we're her them while we're her them while we're her victoza for the patien physician for a subsaccordance with the 1.b. Review of Patien 1	d revealed the patient's 9:00 for 01/23/19 was not  o's formulary revealed Victoza a formulary; however, other re available.  Itered Nurse (RN) #2 on a revealed he had not the second that we have a lot of medications that we have second in the second reverse of the second that we have a lot of medications here recordered to receive. I try to the needed medications, but the stated if she forgot the stend of the stated if she forgot the stend of the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated if she forgot the stated obtain and the patient of the medication in the facility's policy.	A	490			

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Event ID: MS6G11

Facility ID 100020

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Signature: Date: 44/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION NG	(X3) DATÉ SURVEY COMPLETED
		180021	a WNG		С
		180021	5, 171113_		01/30/2019
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E
SOUTHEA	STERN KY MEDICAL C	ENTER	- 2	850 RIVERVIEW AVENUE	
000111127	OTENTI MEDIONE O	h-111 by 11		PINEVILLE, KY 40977	1
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG		SHOULD BE COMPLETION
A 490	and a recent fall with (presence of phosph Kidney Disease Stag a left nephrectomy (r Further review of Patpatient was not orienthe patient was confil Review of Patient #8 01/21/19 revealed or ER one hundred eightwice daily, Renvela three (3) times a day (1000) mg daily.  Review of the facility Cardizem 60 mg, 90 were listed as being facility. Further review Biotin were not listed thowever, a review of Administration Recowas not administered on 01/22/19 at 9:00 review revealed Renadministered on 01/2	Concussion, Phosphatemia ate in the blood), Chronic se 4, and a surgical history of semoval of a kidney).  Itient #8's record revealed the sted to person or place, and ned to bed.  's physician orders dated sters to administer Cardizem only (180) milligrams (mg) sixteen hundred (1600) mg or, and Biotin one thousand  's formulary revealed or, and 120 mg tablets available to administer at the workealed Renvela and service workealed Renvela and service on 01/21/19 at 9:00 PM or AM as ordered. Further total and Biotin were not 22/19 at 9:00 AM as ordered.	A -	490	
	"omitted because the from the unit." The M "not on the formular, own." There was no attempted to obtain medications or notific the medications wer Patient #8 was trans	Renvela and Biotin ed the patient's physician that			

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Facility ID: 100020

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Signature: 1 | Date: 24/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		180021	B. WING		C 01/30/2019	
200000	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		01/30/2018	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION	
A 490	Interview with Regis	ge 89 stered Nurse (RN) #3 on 1 revealed she cared for	A 49	00		
=	Patient #8 during the 01/22/19, the night of stated the patient has cardizem; however, available to be adm #3, medication availand she stated, "If thome medications or remain on them, or	e night shift (6 PM-6 AM) on the patient was admitted. She ad physician orders for the medication was not instered. According to RN lability was a concern at times the patients don't bring their with them, they're not able to we have to substitute ey're not used to taking."				
	8:20 PM revealed n the facility was unal Cardizem ER, sixty She stated "that wo information."	with RN #3 on 01/22/19 at ursing staff were not aware ole to provide patients with (60) mg or ninety (90) mg. uld have been useful				
938	PM revealed he add and had not been nunable to provide C to patients in the fa #3, the facility shou	ician #3 on 01/24/19 at 1:50 mitted patients to the facility otified that the facility was ardizem ER 60 mg or 90 mg cility. According to Physician ld have notified him of the he medication so he could ans accordingly.		e: 8		
	PM revealed "in the removed all 60 mg tablets from the fac outdated. She state shortage of the me obtain replacement notified physicians	macist #1 on 01/23/19 at 2:45 beginning of December" she and 90 mg Cardizem ER ility because they were at there was a nationwide dication and she was unable to medication, but had not or licensed staff that the t available at the facility.		3.5		

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Signature: Date: 3/4/15

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			
		180021	B. WING		C 01/30/2019
	ROVIDER OR SUPPLIER	CENTER	850 R	ET ADDRESS, CITY, STATE, ZIP CODE SVERVIEW AVENUE EVILLE, KY 40977	0113012013
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC (DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
A 490	medications were responsible for co for a substitute. The conducted record facility and had not receiving med unavailability of mistated nursing stated nursing stated been made to received their ordeshe had difficulty with the current place because the facility make required particle totaled app Pharmacist #1 als Therapeutics Conquarterly, to discute facility, however, to	age 90  Ited if physician ordered not available, nursing staff was ntacting the patient's physician ne pharmacist stated she had reviews of inpatients at the it identified that patients were ications as ordered, due to the edications. However, she then iff were not documenting why been omitted, but no attempts identify why patients had not ered medications. She stated placing orders for medication narmacy vendor at times by had consistently failed to syments on outstanding debt, roximately half a million dollars. To stated the Pharmacy and mittee was required to meet as medication concerns in the the Committee had not met a period of six (6) months.	A 490		
	Therapeutics Conrevealed the Com 07/18/18. Review revealed twenty-e (IV) Solutions were There was no doo were drug shortage took to obtain the Review of the 07/ shortages were "to of drug orders be 2. Observation of Surgery Departm	ility's Pharmacy and militee Meeting Minutes imittee had not met since of the 04/10/18 minutes ight medications/Intravenous re listed as "drug shortages." sumentation regarding why there ges or what actions the facility medications/substitutes. 18/18 minutes revealed drug unable to determine due to lack ing placed."  medications available in the ent on 01/23/19 at 11:00 AM wing medications were not			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 1	TIPLE CONSTRUCTION		ATE SURVEY
	100	A. BUILDI	NG		
	180021	B. WING	A STATE OF THE STA		С
WALL OF SECURE OF SUPERIOR	180021	D, WING.			01/30/2019
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI		
SOUTHEASTERN KY MEDICAL CI	ENTER		850 RIVERVIEW AVENUE		
			PINEVILLE, KY 40977		
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	COMPLETION DATE
A 490 Continued From page	e 91	A	490		
available: Lidocaine (milliliter (ml) vials (pa (short-acting sedative procedures; also use mechanically ventilate was 35 vials); Dipriva was 20 vials); Ampici is 2); Atropine Sulfate low heart rate) 1 mg/r Bupivacaine/Epi .25% (par is 10); Ancef (an Gentamicin (antibiotic (intravenous) (par is in CT scans) 300 (50 addition, the facility seight vials of Lidocair 28 vials).  Interview with Certifier Anesthetist (CRNA) # revealed the facility dishe preferred to use vials of the company of the facility pharmacy 3:30 PM. The Director a new patient was adwas ordered after hosobtain the medication (specialized medication (specialized medications before so the company of the Pharmight not have every required, but the Om Department had mos	local anesthetic) 1%, 30 r was for 8 vials); Diprivan a used during surgical d to sedate patients ed) 10 mg/ml, 50 ml vial (par in 10 mg/ml, 100 ml vial (par illin (antibiotic) 2 gm vial (par a (emergency drug for no or ml, 1 ml vial (par is 4); 6 (local anesthetic) 30 ml vial tibiotic) 1 gm (par is 6); b) 80 mg/50 ml IV 4); or Isovue (contrast used ml vial) (par is 6). In urgery department only had he 1% 10 mg/ml vial (par is ed Registered Nurse ef1 on 01/30/19 at 3:00 PM lid not have the medications when anesthetizing patients.  Director of Pharmacy 1/23/19 at 2:45 PM revealed hours were from 7:00 AM to or of Pharmacy stated that if limited or a new medication urs, staff were required to on from the Omnicell on dispensing cabinet). The e stocked the Omnicells with the left for the day. rmacist, every Omnicell				

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Facility ID 100020

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Signature: Date: 44/19

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION DPLAN OF CORRECTION DENTIFICATION NUMBER:  A BUILDING			(X3) DATE SURVEY COMPLETED .		
		180021	B WING_			C 1/30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
A 490	Continued From pag	e 92	Α.	490		
		not recall the last time she k into the facility for that				
	medication supply ca Surgical Unit) on 01/ forty (40) medication administration after to PM. Some of the me available included: A (brand name Tylenol 50 mg (antidepressa Diltiazem 100 mg inj mg tablets (brand na blood pressure/ches Levemir Insulin 100 R 100 units/1ML 10h Disintegrating tablets nausea) (par level of mg/1 ml 4 ml susper and prevent seizures Bicarb 8.4% 50 ML stor cardiac arrest an level of 4 syringes); Flush 10 ML (used to (par level of 100 syring Health Unit dated 01 eight medications wow West (Medical Surgivere not available. Interviews with RN # RN #4 on 01/24/19 01/22/19 at 8:20 PM PM, and with RN #1	y medications in the Omnicell abinet on 3 South (Medical 25/19 at 12:30 PM revealed is were not available for the pharmacy closed at 3:30 dications that were not acetaminophen 325 mg.) (par level of 5); Amitriptyline int) (par level of 5 tablets); ectable, 60 mg, 90mg or 120 time Cardizem treats high the pain, heart arrhythmias); units/1ML 10ML vial; Novolin ML; Ondansetron Oral is (Zofran used to treat if 10 tablets); Phenytoin 25 insion (Dilantin used to treat is) (par level of 5); Sodium is syringe (used in emergencies if metabolic acidosis) (par or Sodium Chloride 0.9% of flush intravenous (IV) times) inges).  Supply on the Behavioral if 125/19 at 12:30 PM revealed ere not available and on 3 ical Unit) three medications  47 on 01/24/19 at 3:10 PM, at 5:20 PM, RN #3 on 1, RN #2 on 01/24/19 at 1:50 in on 01/29/19 at 6:45 PM is knew if the facility had				

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Signature:_	NO	Date: 24/19
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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		180021	B. WING_	LANGUAGE PROPERTY OF THE PROPE		C 01/30/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP ( 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	DODE		
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
A 490	physician ordered RNs stated when a had to "hunt" in evitocate the medical medication at all. I medications often  Interview with Phy PM revealed he proposed in the proposed in the instructed his predications due to the instructed his predications from acknowledged this practice for an actinterview with Phynot aware that the (a medication use and chest pain). Pexpected a phone him that certain m so he could make how best to procemedication.  4. Review of an er Chief Financial Of 2:03 PM revealed pharmacy order the stated "that still is last more than a west to procemedication."	medications available. The a medication was ordered, they ery Omnicell in the facility to ion, if they could find the The RNs stated "hunting" for caused a delay in treatment.  sician #5 on 01/29/19 at 4:30 racticed Internal Medicine at the his entire medical career. In the this entire medical career. In the their financial circumstances, ratients to bring their home. Physician #5 was not the standard of the care facility. Continued sician #5 revealed that he was facility did not have Cardizem at to treat high blood pressure thysician #5 stated that he call from the pharmacist telling edications were not available an informed decision about ed with care/prescribing  mail from Pharmacist #1 to the ficer (CFO) dated 01/18/19 at the pharmacist requested a nat totaled \$22,145.09 and in't enough of some things to week. When an order hasn't	A	490			
	result-we have to shelves." At 2:08 responded to Pha	4 and 5 weeks this is the have product to put back on the PM, on 01/18/19, the CFO armacist #1 that he had given by Officer (CEO)/owner\$46,000 rmacy Distributor.					

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Signature | Date: 3/4/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILD			c	
		180021	B. WING				30/2019
NAME OF P	ROVIDER OR SUPPLIER	1		ST	REET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	00,2010
COUTUE	DYFON KY MEDIOAL A			85	0 RIVERVIEW AVENUE		
SOUTHER	STERN KY MEDICAL O	SENTER		PI	INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E	COMPLETION DATE
A 490	Continued From pag	ge 94	А	490			
	to the Pharmacy Dis dated 01/24/19 at 1: needed a narcotic of	an email from Pharmacist #1 stributor's Advisor/Creditor 06 PM, revealed the she order reinstated and released hil orders to be released.				101	
	response dated 01/2 Pharmacist #1 and to the pharmacist, the and the CFO reveals release the orders if cover an overdraft (to fithe new orders. A Pharmacy Distribution more medications to stated, "Please be a last orders we will be we will be turning over outstanding amounts longer be able to sereview revealed the to the CEO and copic CNO and stated, "O order with (the pharmacy the state survey the country of the country o	o facility staff that included Chief Nursing Officer (CNO), ed the vendor would only the facility wired \$8,378.83 to counced check), plus the cost according to the email, the er would no longer release any the facility. The email dvised that these will be the e able to release. After today, er the handling of s to our legal team and will no rvice the account." Further CFO forwarded the response ied the CNO and Assistant ne of the drugs we have on macy distributor] is one of the eyor has asked if we have in t this, we are likely to get a					
	CEO, CFO, and CN revealed the facility' cardiac arrest, shock crash carts on 01/31 pharmacy to replace this and the Activase 12/10/18. We need	from Pharmacist #1 to the O dated 01/25/19 at 8:38 AM s Vasopressin (used in k, etc.) "expires in a couple of 1/19. We have none in the e this with. I have asked for e to be ordered since the 2nd Activase to be in the any possible ER diversions					

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Event ID: NS5G11

Facility | D 100020

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Signature. Date: 3/u/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
		180021	8. WING		C 01/30/2019
	ROVIDER OR SUPPLIER		850	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
A 490	due to lack of drug. S Activase)." The email order (from 1/18/19) payment issues we h 25mg/ml in the phare hospital. I have less 7.5/325mg in the phare email, "Verapamil an replaced on the cras have none in the phare lifetail pharmacy ven and all holds off the Tuesday of next wee these outdating drug [Pharmacy Distribute indicated that he is n communicate with us over to legal. I don't getting these and fut  Further review revea stated, "So when we I thought we ordered order how long will t responded with an e that stated the narco because the money debt. The email furth contain the Activase needed (The \$13K), the last order due to sending an order thi that are outdated an understand that this procedure for any pl Pharmacy drug orde else but at this facili operated up until fin	If January 13 (Vasopressin + I further stated, "My narcotic was deleted due to the lave. I have no Demerol macy and only 13 vials in the latenation of Norco armacy." According to the latenation of Epinephrine need to be high carts before 1/31/19. I armacy to replace withThe dor] note must be addressed accounts no later than lake to give me time to get in and replaced.	A 490		

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Signature: Date: 3/4/19

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-	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;	1 ' '	(X2) MULTIPLE CONSTRUCTION A BUILDING		()	(X3) DATE SURVEY COMPLETED	
		180021	B. WING	B_WING			C 01/30/2019	
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	PREF TAC		PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	E.	(X5) COMPLETION DATE
A 490	only source of sever from anywhere else again cut us off and Review of the list of #1 requested to be of PM revealed the foll available at the faciliointment (par is two with other meds to the swelling due to heal liver) HCL 5 mg tab. Amitriptyline (treats tablets (par is 100 to 250 mg/5 ml (par is (antibiotic)/Potclavuml); Azithromycin (a 30 ml); Epoetin Alfacells) 40,000 U/ml (Levoftoxacin (antibiotic) HCL/0.8 is 12 bags). Accord could not obtain Lefrom anywhere but stated, "have to have the pharmacist is medications that we Sodium Chloride 0 ml bags); Meperiding pain medication) H Cyanocobalamin (vis 25 doses); or Me (steroid) 40 mg/1 in to the email, the fa	al drugs. I can't get them and [the distributor] has frozen the accounts."  medications that Pharmacist ordered on 01/25/19 at 12:30 owing medications were not dity: Acyclovir (antiviral) 5% 5 gm tubes; Amiloride (used reat high blood pressure, t failure or cirrhosis of the dets (par is 100 tablets); depression) HCL 50 mg deblets); Amoxicillin (antibiotic) 100 ml); Amoxicillin (antibiotic) 100 ml); Amoxicillin (par is 75 antibiotic) 200 mg/5 ml (par is -Epbx (treats low red blood par is four 1 ml doses); otic) 250 mg/50 ml (par is 24 ml bags (par is 24 bags), or is 24 bags); or Moxifloxacin % NACL 400 mg/250 ml (par ing to the email, the facility vofloxacin or Moxifloxacin the Pharmacy Distributor and	A	490				

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Event ID: NS6G11

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Signature: Date: Zuly

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		180021	B WING			C 01/30/2019	
NAME OF PE	ROVIDER OR SUPPLIER			_	STREET ADDRESS, CITY, STATE, ZIP CODE	01/3	30/2013
					ISO RIVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICAL C	ENTER			PINEVILLE, KY 40977		
(X4) ID PREFIX	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREF		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	i 	CROSS-REFERENCED TO THE APPROPRIA	ATE.	, , , , , , , , , , , , , , , , , , ,
A 490	Continued From page	e 97	A	490			
		acidosis) 1 milliequivalent					
		oses). The email stated the					
	medication was "used out."	d on crash carts can't run					
	An interview was atte						
		le Pharmacy Distributor on  1. A message was left to					
		cy's call. However, as of the					
		ne vendor had not returned					
	the state agency's ca	lli.	-		-		
	Interview with the Dir	ector of Pharmacy on	ļ				
		revealed that she had sent					
۰	an email to the CEO	and the Pharmacy ded medications, and the	ĺ				
		er to their legal department.					
	According to the Dire	ctor of Pharmacy, the facility					
		in any more medications for				į	
	the facility. She state	o that to sign up with stributor would take eight (8)					
		pharmacist stated the				1	
	CEO's plan to obtain					1	
	distributor will no long "borrow" medication	ger supply the facility, was to			1		
		se on 02/01/19 in Missouri;					1
		cist questioned the legalities					
	of this "scheme."				-		
		ner Governing Body Member					
		PM revealed she was no the facility's corporation and					
	no longer functioned	• •					
	member as of "last w	eek." The Former Member					
		been aware while functioning				1	
		member that the facility was					
		eting financial obligations nedications. The Former					
		she knew the facility was on					
	*						

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Date:

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		SURVEY
		*11	1.300,30			С	
		180021	B. WING			01	/30/2019
NAME OF P	ROVIDER OR SUPPLIER			STE	REET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHER	STERN KY MEDICAL C	ENTER		850	RIVERVIEWAVENUE		
SUUTHER	STERN AT MEDICAL C	ENIER		PI	NEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
A 490	a payment plan with was unaware that the were going to stop si medication. The Forceommunication about concerning finances, she had been aware not be obtained becathe CEO would contivork out a deal. The when she was functionember, she was new was unable to obtain patients.  Interview on 01/31/1 Executive Officer (Corevealed he was aware medications at the facility did have to the Pharmacy Dishad paid down the distributor to pay while continuing to reflect the facility was unable to pharmacy distributo medications to the facility was unable to pharmacy distributo not the first time the refused to supply mas soon as a payme supplying medication on to state that the facilities, and if a page of the continuing to the facilities, and if a page of the payment of the facilities, and if a page of the continuing to the facilities, and if a page of the payment of the facilities, and if a page of the continuing to the facilities, and if a page of the payment of the facilities, and if a page of the continuing to the facilities, and if a page of the continuing to the facilities, and if a page of the payment of t	the Pharmacy Distributor, but a pharmacy had stated they upplying the facility with mer Member stated that at the facility was always. The Former Member stated that if needed supplies could ause of financial constraints, act the supplier and try to Former Member stated oning as a governing body ever informed that the facility in medications needed for 9 at 2:38 PM with the Chief EO) and Owner of the facility are of concerns with obtaining acility. The CEO stated that an outstanding balance owed stributor, but stated the facility lebt considerably. The CEO d a financial agreement with y on the outstanding debt	A	490			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,,	PLE CONSTRUCTION  G	(X3) DATE SURVEY COMPLETED
		180021	B. WING_	N	C 01/30/2019
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
	STERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE PINEVILLE, KY 40977	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETION
A 490	stock, the facility coumedication from a sisstate (one located apthe facility and the ot 500 miles from the facility and the ot 500 miles from the facility and "trailines" was permitted. DISCHARGE PLANN CFR(s): 482.43  The hospital must haplanning process the hospital's policies an specified in writing. This CONDITION is Based on interview, if facility policy, it was failed to have an efferocess for one (1) of (Patient #9). On 01/1 services consultation #9 because the patie water at home and distolfrom appointments the facility failed to c	ld "hopefully" borrow the ster facility located in another oproximately 300 miles from her located approximately scility). The CEO stated that cking to see if "borrowing" insporting them over state	A4		eing in place ting budget , and capital . This plan newly seated proval. This is hed minutes.  2/18/2019
FORM CMS-25	57(02-99) Previous Vorsions Ob	zoleta Event ID NS60		department managers and verify all hospital serviced on 700-708, Interdepartmental Relat Department by department updates will be di weekly Managers meeting to promote interdecohesiveness. The Administrative Assistant	taff will be in- ionships scussed at partmental

Signature: Date: 3/4/19

A799 A799 meeting to the meeting calendar. The Administrative Assistant will report on the schedule and attendance compliance to the QAPI committee. (CEO) Monthly New indicators were added to QAPI program related to the social services consultations and discharge consultations to monitor the procedures or processes that we have put in place to ensure that the plan is effective. This will be verified by the QAPI meeting minutes. (Discharge Planner) TRANSFER OR REFERRAL A 837 A837 3/1/2019 The facility had no institutional plan or annual operating CFR(s): 482.43(d) budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget The hospital must transfer or refer patients, along that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan with necessary medical information, to was presented to MEC on 2/20/19 and sent to newly sented appropriate facilities, agencies, or outpatient governing board on 2/22/19 for review and approval. This is services, as needed, for follow-up or ancillary verified by attached board minutes. See Attached minutes. (Controller) This STANDARD is not met as evidenced by: 3/1/2019 The facility did not have an effective system for ensuring Based on interview, record review, and review of social services was consulted. A reflex was attached to questions in flowchart pertaining to social services. When nursing staff choose answers to questions, it sends an electronic trigger to social services department and staff. Licensed nursing staff will be in-serviced on policy 200,206 Nursing Discharge Planning, and policy 700.701, Discharge Planning by Case Management. This will be verified by the in-service attendance log. Med/Surg and the ED will continue to keep a paper log of the referrals. The staff will be in-serviced on this process. This will be verified by way of an in-service attendance log. Chart audits, including limely medication administration, medication omissions, change in condition documentation, consent for treatment, nutritional/social services consults, monitoring and following up on medications will be performed daily by nursing staff to ensure compliance. Chart audit tools are collected by ACNO who will report results of the chart audits will be reported to QAPI weekly so if needed immediate actions are taken (Case Management Director)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF CORRECTION IDENTIFICATION NUMBER:  A BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE STATEMENT OF DEFICIENCIES (X3) DATE STATEMENT OF DATE STA							
			A BUILD	ING_			
		180021	B. WING			1 -	30/2019
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
				8	50 RIVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICAL C	ENTER		P	PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		PROVIDER'S PLAN OF CORRECTIO  (EACH CORRECTIVE ACTION SHOULD  CROSS-REFERENCED TO THE APPROP  DEFICIENCY)	BE	(X5) COMPLETION DATE
A 837	facility policy, it was a failed to ensure one (Patient #9) was refer for follow-up. On 01/services consultation #9 because the paties water at home and doffrom appointments the facility failed to consultation and disconsultation and anticipate reason for hospitaliz.  Review of the "Interconsultation of	determined that the facility (1) of twelve (12) patients (1) of twelve (12) patients (1) of twelve (12) patients (1) of twelve (12) patients (1) of twelve (13) PM, a social (1) was requested for Patient (1) on the twe running (1) on thave transportation (2) or the pharmacy. However, (3) on the pharmacy. However, (4) onduct a social services (5) charged Patient #9 home on (6) arge Planning policy dated (7) discharge planning as well (8) should focus on current (8) discharge on the	A	837	The CEO was found to not be in compliance with overseeing all departments to ensure a good worklationship throughout the facility. CEO will department managers and verify all hospital stal serviced on 700-708, Interdepartmental Relation Department by department updates will be discovered by Managers meeting to promote interdepartmenting to the meeting calendar. The Administrative Assistant will meeting to the meeting calendar. The Administ Assistant will report on the schedule and attend compliance to the QAPI committee. (CEO)  For patient #9, the facility lacked an effective symbolic social services was consulted. CNO to everify that licensed nursing staff are following will be in-serviced on policy 200.606 Nursing I policy 700.701 Discharge Planning. A reflex with questions in flowchart pertaining to social services in flowchart pertaining to social services department. Chart audits, including timely medication adminedication omissions, change in condition docconsent for treatment, nutritional/social service monitoring and following up on medications with performed daily by nursing staff to ensure committened daily by nursing staff to ensure committened tools are collected by ACNO who wresults of the chart audits will be reported to Quiso if needed immediate actions are taken. The Goversee and verify that the staff is in-serviced opolices that have been approved by MEC and it Governing Board. (CNO/HR Director/RD)  New indicators were added to QAPI program a social services consultations and discharge commonitor the procedures or processes that we haplace to ensure that the plan is effective. This everified by the weekly QAPI meeting minutes. Planner)	rking oversee If will be in- iships assed at intmental il add this intive ance  ystem in insure and policies and Discharge, as attached to ces. When inds an and staff, instration, amentation, s consults, ill be pliance, vill report API weekly CFO will on the revised the new  elated to the sultations to we put in will be (Discharge	3/1/2019 2/22/2019 Monthly

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		180021	8. WING			01/30/2019	
	OVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		8	TREET ADDRESS, CITY, STATE, ZIP CODE SORIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 837	According to the medinformed staff his/hei because he/she had and had no transport scheduled physician pharmacy to get nee Further review of Parevealed on 01/16/19 services consultation discharged the patie there was no docum Protective Services the patient's inability Interview with Regist 01/27/19 at 5:00 PM Patient #9 home on not reviewed the patient and not been contact was unaware that the water at home, or the	condition had worsened no running water at home, ation to get to/from appointments or to/from the ded medications.  Itient #9's medical record of at 5:30 PM a social news requested. The facility in thome on 01/23/19, and ented evidence that Adult was ever contacted regarding to obtain medical care.  Itered Nurse (RN) #2 on revealed he discharged 01/23/19. He stated he had lent's record at the time of maware that Social Services sted. RN #2 also stated he e patient did not have running at he/she had no to physician appointments or	A	837			
A 940	Interview with the As (CNO) on 01/29/19 services consultation consultation should SURGICAL SERVIC CFR(s): 482.51  If the hospital provides services must be we accordance with	ssistant Chief Nursing Officer at 11:00 AM revealed if social ns were recommended, the be completed.		∖94	0		

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Event ID: NS6G11 Facility ID: 100020

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Signature:	Date:
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		180021	B WING		C 01/30/2019				
NAME OF PE	ROVIDER OR SUPPLIER	150021			TREET ADDRESS, CITY, STATE, ZIP CODE	01/3	30/2019		
COLUMN	077711 (4) 447710 41 407			ı	50 RIVERVIEW AVENUE				
SOUTHEA	STERN KY MEDICAL C	ENTER		F	PINEVILLE, KY 40977				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B: CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE		
A 940	Continued From page 102 offered the services must be consistent in quality with inpatient care in accordance with the complexity of services offered.  This CONDITION is not met as evidenced by: Based on interviews, record reviews, review of a			[The facility had no institutional plan or annual of hudget due to no effective Governing Board bein The institutional plan, including annual operating that included all anticipated income, expenses, at expenditures for a three-year period was made. It was presented to MEC on 2/20/19 and sent to not governing board on 2/22/19 for review and approverified by attached board minutes. See Attached (Controller)			2/22/2019		
	facility policy, and re- it was determined the	view of a facility investigation, a facility failed to ensure cal services were provided in					The facility had failed to maintain surgical equipment in working order. A maintenance contract, with DC Services 2/2019) is in place to service Steris equipment/autoclaves Backup equipment is readily available. This will be verified by a daily maintenance log of Steris and autoclave equipment. All equipment has been verified by either by DC Services, Med Fech, or PMD services and is up to date		2/28/2019
Observations and interviews we the facility failed to maintain surportions available for sedate emergencies, and failed to ensure cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to cleaner/disinfectant used to ensure the surgical instruments and operation abdominal pain and signed an Esophagogastroduodenose procedure to examine the storn portion of the small intestine). If of the "Operating Room Nurse facility investigation revealed the attempted to perform a colonose."		naintain surgical equipmentin to have formulary e for sedation and illed to ensure used to clean/sanitize and operating rooms was  /18, Patient #1 was admitted nd signed a consent to have fuodenoscopy (EGD) (a e the stomach and upper ntestine). However, review om Nurses Note" and a revealed the facility			as of 2/2019. (Surgery Charge Nurse)  The facility was found to not be in compliance bec CEO did not ensure the conduct of the facility was compliance. As a result, the facility did not ensure were following proper procedure in obtaining the informed consent for patient #1 on 8/16/18. To prissue from reoccurring, the CEO will oversee the will ensure the Surgery Charge Nurse, surgical staphysicians are in-serviced on the Informed Consent 700.223, and policy 700.003 on Verification of CoCorrect Procedure and Correct Patient for Invasive Surgical Procedures. This will be verified by the intendance log. A new QAPI performance indicate been added to the weekly QAPI process to monitor measure. The OR circulator uses the surgery chectoverify the informed consent has been completed the procedure. The OR Charge Nurse will also rechecklist that was completed by the circulator priciprocedure, and if any problems identified, they will corrected prior to procedure being completed, log-gresults to report to QAPI weekly. This will be verified in-service attendance log. (CEO)	in the the staff proper event this CNO who off and on the policy, orrect Site, e or on-service toor has or this sklist tool. I prior to view the or to lil be ging officed by	3/1/2019		
		nd lower colon) without the			The lack of consistent pharmaceutical supplies be received was identified in the survey. In order to adequate supplies a pharmacy budget of \$500,000 sent to the Controller. This will be verified by entitle Controller. (Controller)	ensure has been	2/15/2019		
200 045 250	7(02-99) Provious Versions Ob	solate Event ID: NS6G1			The Cardinal Wholesaler debt which had been ide the findings as being the cause of drug supply isst addressed. An initial payment was made on 2/7/2 another payment will be made to have Cardinal reforders. The medications which were identified a leasty ID 100020 If continual	ics is being 019 and dense s not being	3/6/2019 ge 111 of 135		

OF141 P1/0	S FOR MEDICARE & MEDICAID SERVICES	OWB NO.	0938-0391
	<u>.</u>	available were ordered on 2/21/19. The Director of Pharmacy will oversee the restocking of the Omnicells which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the receipts from the wholesaler and Omni inventory - which is attached (CEO)	ngayor was
	*	Material supply issues were identified in the survey findings. The relationship with the material supply vendors is corrected. Material supply orders are being ordered weekly. There are no issues with placing orders and receiving orders. Due to a lack of communication the facility striff was not always calling the materials management dept and asking for supplies to be restocked when supplies has been depleated. Now a materials clerk makes inventory supply rounds on week days for each unit. If supplies are needed they are replenished from the inventory in the stock room. Stock room supplies ac replaced now through weekly orders to our materials supply vendor. (CEO)	2/22/2019
A 951	ODERATING BOOM BOLIGIES	Diversey was contacted on 1/24/2019 regarding manufacturer date and expiration date of Virex Tb by the Housekeeping Supervisor via phone. Diversey responded with an email stating that "the date on the product was the manufactured date, not the expiration date and if Diversey puts an expiration date on their products, the number is proceeded with EXP." The products in question were manufactured 5/1-1/2018 and have a shelf life of 3 years. The Surgery staff has been in-serviced on policy 900.001 Expired materials. This can be verified by the in-service lattendance log. (Housekeeping Director/Surgery Charge Nurse)	1/2-4/2019
	OPERATING ROOM POLICIES CFR(s): 482.51(b)  Surgical services must be consistent with needs and resources. Policies governing surgical care	The facility had no institutional plan or annual operating budget due to no effective Governing Board being in place. The institutional plan, including annual operating budget that included all anticipated income, expenses, and capital expenditures for a three-year period was made. This plan was presented to MEC on 2/20/19 and sent to newly scated governing board on 2/22/19 for review and approval. This is verified by attached board minutes. See Attached minutes (Controller)	2/22/2019
		The facility had failed to maintain surgical equipment in working order. A maintenance contract with DC Services (2/2019) is in place to service Steris equipment/autoclaves. Backup equipment is readily available. This will be verified by a daily maintenance log of Steris and autoclave equipment. All equipment has been verified by either by DC Services, MedTech, or PMD services and is up to date as of 2/2019. (Surgery Charge Nurse)	2/28/2019

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Event ID: NS6G11

Facility ID 100020

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Signature: Date: 3/u/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			7 20,20,110			;
		180021	B. WING			30/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1	
SOUTHER	STERN KY MEDICAL C	ENTED		850 RIVERVIEW AVENUE		
50011167	COTERN KT MEDICAL C.	ENTER	İ	PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFIGIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 951	A 951 Continued From page 103 must be designed to assure the achievement and maintenance of high standards of medical		A 95	The luck of consistent pharmaceutical supplies being received was identified in the survey. In order to ensudequate supplies a pharmacy budget of \$500,000 hasent to the Controller. This will be verified by email the Controller. (Controller)		2/15/2019
	Based on observation and review of facility the facility failed to proconsistent with needs designed to ensure the maintenance of high practice and patient of	not met as evidenced by:  n, interview, record review, policies it was determined rovide surgical services s and resources and ne achievement and	A Property and the first that the second sec	The Cardinal Wholesaler debt which had been ide the findings as being the cause of drug supply issuaddressed. An initial payment was made on 2/7/2 another payment will be made to have Cardinal reorders. The medications which were identified as available were ordered on 2/21/19. The Director a Pharmacy will oversee the restocking of the Omni which occurs twice a day via the restock reports that automatically print in the inpatient pharmacy. The availability of medications will be verified by the from the wholesaler and Omni inventory - which is (CEO)	es is being 019 and lease is not being of cells nat e	3/6/2019
	maintain surgical equifailed to have formula sedation and emerge cleaner/disinfectant usurgical instruments not expired.  The findings include:  Review of the facility	dipment in working order, ary medications available for encies, and failed to ensure used to clean/sanitize and operating rooms was		Material supply issues were identified in the surveilladings. The relationship with the material supply is corrected. Material supply orders are being ord weekly. There are no issues with placing orders a receiving orders. Due to a lack of communication facility staff was not always calling the materials management dept and asking for supplies to be reswhen supplies has been depleated. Now a materia makes inventory supply rounds on week days for if supplies are needed they are replenished from thinventory in the stock room. Stock room supplies replaced now through weekly orders to our materisupply yendor. (CEO)	v vendors ered nd the stocked als clerk ench unit.	2/22/2019
	January 2018, reveal equipment failures or reported to the Facilii Department. Continu revealed if the equipment and to find an alter borrow equipment from a rerithe equipment suppli policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the procedure, the physical policy revealed if the physical policy revealed if the physical policy revealed if the physical policy revealed if the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical policy revealed in the physical physical policy revealed in the physical physica	led all known or suspected and functions would be try's Management ed review of the policy ment was needed for the patient, attempts would be nate type of equipment, or another facility, or obtain that company or loaner from er. Further review of the patient was undergoing a cian would make the		All employees and providers will be in-serviced of Command Policy 200.107. In-service will be in 2/22/2019 This will be verified by the in-service log. (ACNO)	nitiated	3/1/2019

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Event ID: NS6G11

Facility ID: 100020

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Signature:

Date

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- ·	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		180021	B. WING_			C 30/2019	
NAME OF P	ROVIDER OR SUPPLIER		1 1 1	STREET ADDRESS, CITY, STATE, ZIP COD		44,2010	
SOUTHER	STERN KY MEDICAL O	PENTER		850 RIVERVIEW AVENUE		1.	
30011124	GIERIO KI NIEDICAL C	ZENTER		PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 951	Facility #1 dated 01/ was scheduled for a #3.  Interview with the Pe on 01/22/19 at 4:30 surgeries and procedue to equipment no working order. The 0 Physician #3 had to colonoscopy becaus broken and the facilithe scope used for a Nurse stated that du outstanding debt with would not repair the pre-paid for their ser Interview with Physic PM revealed he was Services at the facility was scheduled to pe colonoscopy the day "down." Physician # that had the facility it could have been rep perform the colonos Physician #3 stated have the patient go had privileges and of Continued interview of the facility's finan- impeded the ability it times. Physician #3 Steris Machine. He	erating Room Schedule for 17/19 revealed Patient #6 Colonoscopy with Physician Physici	AS	Diversey was contacted on 1/24/2019 in manufacturer date and expiration date of Housekeeping Supervisor via phone. Dividi an email stating that "the date on the manufactured date, not the expiration diputs an expiration date on their product proceeded with ENP." The products in manufactured 5/14/2018 and have a she [The Surgery staff has been in-serviced Expired materials. This can be verified attendance log. (Housekeeping Directo Nurse)	of Virex Th by the iversey responded the product was the ate and if Diversey s, the number is question were alf life of 3 years on policy 900.001 by the in-service	1/24/2019	
	times. Physician #3 Steris Machine. He have it repaired prio affected. However, a	used the example of the stated most facilities would					

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Event ID: NS6G11

Facility ID 100020

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Signature: Date: 3/4/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		180021	B WING _		1	C /30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
A 951	Interview with Mainte 01/23/19 at 2:00 PM was "out" last week a because the facility of money." He stated the refused to come with The Maintenance Tequalified to repair the Review of the medic Facility #3 revealed #6 on 01/17/19 with bleeding. Physician on Patient #6 without discharged home the Surgery Department revealed the following available: Lidocaine milliliter (ml) vials (p. (short acting sedative procedures; also use mechanically ventila (mg/ml), 50 ml vial (mg/ml), 100 ml vial (mg/ml), 100 ml vial (mg/ml), 1 ml vial (partibiotic) 2 gm vial (local anesthetic) 30 (antibiotic) 1 gm, (p. (antibiotic) 80 mg/s0 4); or Isovue (contra ml vial) (par is 6). In	enance Technician #2 on revealed the Steris Machine and could not be repaired owed the vendor "a lot of the vendor was contacted but nout payment in advance, echnician stated he was not a machine.  Tall record for Patient #6 from Facility #3 admitted Patient a complaint of rectal #3 performed a Colonoscopy at issue and the patient was a same day.  Tedications available in the ton 01/23/19 at 10:15 AM and medications were not (local anesthetic) 1%, 30 ar was for 8 vials); Diprivan are used during surgical ted to sedate patients atted) 10 milligrams/milliliter par was 35 vials); Diprivan 10 par was 20 vials); Ampicillin I (par is 2); Atropine Sulfate or no or low heart rate) 1 or is 4); Bupivacaine/Epi .25% of mil vial (par is 10); Ancefar is 6): Gentamicin of IV (intravenous) (par is ast used in CT scans) 300 (50 or addition, the facility surgery deight vials of Lidocaine 1%	A 9	51		

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Facility (D: 100020

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Signature: Date: 44/19

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE	SURVEY PLETED
		180021	B. WING			C
	ROVIDER OR SUPPLIER		STRE 850 F	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977	01/	30/2019
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH CROSS-REFERENCED TO THE APPROPRICIENCY)	ULD BE	(X5) COMPLETION DATE
A 951	on 1/30/19 at 1:50 PN the Operating Room supplies to continue interview with RN # had to cancel surge equipment or not had on hand.  Interview with Certif Anesthetist (CRNA) revealed the facility she preferred to use She stated the last approximately one of big vial" of Diprivan most of the medical because it was not  Interview with the Co on 01/28/19 at 6:00 facility's finances at Chief Executive Off financial situation of the Pharmacy Distrimedications to the debt of \$500,000 at facility through the According to the Co paying the Pharma approximately eight Pharmacy Vendor. plan was to attemp "sister" facility that purchase in Misson	stered Nurse (RN) #13 on at times to obtain needed a surgeries. Continued 13 revealed the facility also bries due to malfunctioning aving the appropriate supplies are Registered Nurse at 10 no 1/30/19 at 3 00 PM did not have the medications when anesthetizing patients. The she was at the facility month ago, the facility had "a, which was "wasteful" as tion had to be thrown away used on the patient.  Chief Financial Officer (CFO) PM revealed he managed the had was in contact with the ficer frequently regarding the financial to longer provide facility due to an outstanding had would only speak to the distributor's attorney.  FO, the facility had no plans on cy Distributor and it would take to (8) weeks to obtain another. The CFO stated the CEO's to to borrow medication from a the CEO was attempting to art.	A 951			
	AM of the sterile pr	ing tour on 01/23/19 at 10:50 rocessing area revealed three rex TB (an all-purpose,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
180021 B. WING				C 30/2019			
NAME OF P	ROVIDER OR SUPPLIER			-	STREET ADDRESS, CITY, STATE, ZIP CODE	017	30/2019
					850 RIVERVIEW AVENUE		
SOUTHEA	STERN KY MEDICAL CI	ENTER					
					PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(XS) COMPLETION DATE
A 951	Continued From page	≘ 107	A	951	1		
	hospital-grade cleane	r, sanitizer, and disinfectant)					
		leaning surgical instruments					141
		ed. Two (2) bottles expired					
		bottle expired on 08/10/18.					
		of three (3) Virex TB bottles					
	in storage revealed th 05/14/18.	iey also expired on					
	00/14/10,						
	Observation in centra	ıl supply on 01/23/19 at					
	10:55 PM revealed for	ourteen (14) bottles of Envy					
	Disinfectant Cleaner	with an expiration date of					
	06/14/18.		i .		93		
	Envy on 01/23/19 at that was stamped on expiration date of the stated it was not reco	product. The manufacturer immended to be used in a					
		est the expiration date.  Processing Technician #1					
	on 01/23/19 at 10:55	AM and with Sterile					
		n #2 on 01/23/19 at 11:00					
		re unaware the Virex TB					] 
	bottles were expired.	"hide" cleaner from the rest					
		to keep from running out.					
	The technicians state	ed they thought the Virex TB					
	solution came from a	facility in another state that					
		nterviews revealed the					
		f biological Indicators (an					
	indicator is placed in	each item to be sterilized					
	conditions were met	ation on whether necessary					
	confidence in the are	cess) in December 2018					
	and were not able to	sterilize any instruments for					
	approximately a week	k. The technicians stated					
	they were fearful it w						
	,		ļ				

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Event ID: NS6G1:

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Signature:	Date: Tyles

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		K2) MULTIPLE CONSTRUCTION  . BUILDING		(X3) DATE SURVEY COMPLETED	
		180021	B WING_			C 1/30/2019	
	ROVIDER OR SUPPLIER	CENTER		STREET ADDRESS, CITY, STATE, ZIP COD 850 RIVERVIEW AVENUE PINEVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
A 951	Interview with the DO1/23/19 at 11:10 A cleaners were also Operating Room, Epatient care areas, the cleaner was explient care areas, the cleaner was explient care areas, the cleaner was explient care areas. The cleaner was explient with the OO1/23/19 at 2:30 Plorders supplies but another state, to ar CEO (Chief Execut interview revealed staff to obtain supplied that facility and that facility and that facility and that facility and that facility and that facility and the continuing to provid "endangering the lifthere was not adect the facility. He state patients for laparos (removal of the gall was notified that the instruments. He state patients and tell the their surgery as so Physician #9 reveals a concern at that been times du staff had to leave the facility rooms adequately	irector of Housekeeping on M revealed Virex TB and Envy used to disinfect the mergency Department, and all The Director was unaware	A 95	51			

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Event ID: NS6G11

Facility ID: 100020

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Signature: Date: 34/19

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (DENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		180021	B. WING _		C 01/30/2019	
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER				STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(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 & CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION	
A 955	stated he was constantibiotic orders becawhich caused a delatreatment. Physician who presented to the blocked colon," which surgery, and a critica (WBC) of 0.8. He staknowledge, the hosp medication the paties bone marrow" to prostated "they had to guntil they were able to medication, which wountil late in the night he was "unsure how functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication was functioning without puthe medication must be surgery, except in error this STANDARD is Based on interviews facility policy, and reit was determined the informed consent for sampled patients (Print the surgery departion of the surgery departion of the surgery departion and Esophagogastroduo	antly forced to change a use they were not available, y in patient's antibiotic #9 stated he had a patient ED with a "completely in required emergency ally low white blood count ted that without his ital had stopped stocking the int needed to "stimulate the duce more blood cells. He is searching to area hospitals to obtain the needed asn't provided to the patient "According to Physician #9, a surgical department was repofol [Diprivan]" because requently used in the NT  Informed consent form for the in the patient's chart before in the patient's chart before in the patient's chart before in the patient, record reviews, review of a view of a facility investigation, the facility failed to execute an errore (1) of twelve (12) attent #1) prior to a procedure tement.  It #1 was admitted for signed a consent to have an	A 9	The facility failed to execute an informed consent welve sample patients (patient #1) in the surgery department. To prevent this issue from re-occurr CEO will oversee the CNO who will ensure the SC Charge Nurse, surgical staff and physicians are in on the Informed Consent policy, 700.223, and por 700.003 on Verification of Correct Site, Correct and Correct Patient for Invasive or Surgical Proc Surgical Checklist and Site Verification Checklis will be verified by the in-service attendance log review was conducted by the chief of surgery and staff on 2/21/19 and now the checklist is complet the procedure and surgical site verification criter completed prior to the procedure, checklist attach performance indicator has been added to the QAI dashboard. Through chart reviews, data will be a verify informed consents. The surgery charge management of the total consents. The surgery charge management in the total consents. The surgery charge management is QAPI weekly. This will be verified service attendance log, (CEO)	ing, the surgery inserviced licy Procedure edures, and t. This A peer defined for ed prior to in is also inced. A new Pl. offected to use will	

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Event ID: NSEG11

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Signature:	Date:	34/19
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		180021	B WING			C 01/30/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	E, ZIP CODE	
SOUTHEA	STERN KY MEDICAL O	PENTED	1.7	850 RIVERVIEW AVENUE		
30011124	STERM AT MEDICAL C	ZENTER		PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG	X (EACH CORRECTI CROSS-REFERENCE	LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIAT TICIENCY)	(X5) COVPLETION DATE
A 955	Continued From page 110		А	955		
	of the "Operating Ro facility investigation attempted to perform to examine the color performed a sigmoid	Intestine). However, review from Nurses Note" and a revealed the facility in a colonoscopy (a procedure in from the rectum) and doscopy (examined the inner and lower colon) without the				
	The findings include	1				
	Correct Site, Correct Patient for Invasive approved June 2017 complete the followinvasive or surgical the correct procedure/pre-potent whenever poot out for all cases. Corevealed time outs was surgical or invasive of the policy revealed out as the pause in conducted by the subefore starting the positioning, and proall relevant docume necessary equipme the policy, time outs to be suspended; was Registered Nurse of members of the sur the correct patient, consent form prese	y policy titled, "Verification of the Procedure and Correct or Surgical Procedures,"  7, revealed the facility must no steps before every procedure: confirmation of the and patient shall occur in operative area, involving the possible and completing a "time continued review of the policy would be performed before all procedures. Further review and the facility defined a "time or patient care activity procedure to conduct a final are available. According to swill cause all other activities ill be initiated by a designated irculator; will involve all gical leam; and will address correct side/site marked, int and accurate; agreement in be done; correct patient.				

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Event ID: NS6G11

Facility ID 100020

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Signature:

Date

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
180021			B. WING _				C 01/30/2019	
NAME OF PROVIDER OR SUPPLIER SOUTHEASTERN KY MEDICAL CENTER				850 RIVERV	DRESS, CITY, STATE ZIP CODE IEWAVENUE E, KY 40977		Ā	
(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 CORRI (EACH CORRECTIVE ACTION SH ROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE	
A 955	among team member Review of Patient #1 the facility admitted Review of Patient #1 (H&P) dated 08/15/1 at 12:00 PM, revealed complaint was "[Sho C, Vomiting and Abdocumented Impres Review of the "pre-a 08/16/18 revealed PAbdominal Pain and Pre-op medications surgeon's office and colonoscopy. However Consent form revea an EGD on 08/16/18 colonoscopy. In addinformed consent for 12:00 PM.  Review of Patient # Assessment," dated revealed the "propo Review of the "Anes 08/16/18, also revealed the "propo Review of the "Anes 08/16/18 at 12:56 POut" was conducted revealed anesthesia was initi 08/16/18 at 12:56 POut" was conducted revealed anesthesia the patient was take Care Unit (PACU).	l's medical record revealed the patient on 08/16/18. I's History and Physical 8 and updated on 08/16/18 ed Patient #1's chief ortness of Breath], Hepatitis dominal Pain," There was no sion/Diagnosis or plan.  Idmission order sheet" dated attent #1 was diagnosed with the pre-surgical orders were: as instructed by the prep as indicated for yer, review of an Informed led Patient #1 consented for 8 at 11:55 AM, not a ition, Physician #1 signed the rm for an EGD on 08/16/18 at	AS	955				
	dated 08/16/18 for I	orenensive Surgical Checklist Patient #1 revealed staff e RN confirmed with the						

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Signature: Date: 2/1/19

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER.		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
	*	180021 B. WING		С			
NAME OF D	ROVIDER OR SUPPLIER	100021	91, 1110			01/	30/2019
maine of the	TOVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL C	ENTER			50 RIVERVIEW AVENUE		
				P	INEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	- 1	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	-	(X5) COMPLETION DATE
A 955	Continued From page	e 112	A	955		er	
		dentity, the procedure, and				70	
		o documented a time out					
		confirmation of the patient's					
	identity, procedure, a	nd consent was conducted.					
	Poviou of the Open	dias Danie Norma Matell					
		ating Room Nurses Note" stated Patient #1 was					
		irthdate, chart, and operative					
	consent. However, co	onlinued review of the note					
		vas taken in the OR room at					
	12:56 PM and an "Ac						
		M and the procedure					
		opy" was verified, not an					
		dure to which the patient					
	consented.				7		
	Review of a facility "\	/ariance Report	l				
		08/16/18 revealed Patient #1					
	was taken into the O						000
		empled. Due to "poor prep,"					
		was done and Patient #1					
		ACU. The Investigation					
		#1 spoke with Patient #1's					
		nformed them the patient					
		ne family informed Physician as scheduled for an EGD,					
	not a colonoscopy. A						2
		ian #1 brought the patient's					
		eviewed the patient's medical					
	record and upon revi	ew of the surgical consent.					
	history and physical,	and physician orders, it was					1
	determined the atten	npted colonoscopy was					
	"performed in error,"						
		"believes" he initiated the nd stated the procedure was			A.		
		GD; however, the room had					
		ipment for a colonoscopy					
		ins from any team members					
		scopy was performed." The					

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Signature:_	Date:

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED			
		180021	B. WING			1	30/2019
	ROVIDER OR SUPPLIER	ENTER	J	85	TREET ADDRESS, CITY, STATE, ZIP CODE 50 RIVERVIEW AVENUE INEVILLE, KY 40977	017	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A 955	that the time out was stated the patient was colonoscopy. The CR conducted the time of was supposed to be at CRNA changed her insupposed to be an Edinvestigation revealed "time out" was conducted. Further incommodificiting statements announced. Further incommodificiting statements announced. Further incommodificiting statements announced. Further incommodificiting stated investigation stated Floack to the OR suite without incident.  Interview with Peri-Omegation of the incident with Patients and the the or colonoscopy, not for that she interviewed that the OR and the Center and the Ce	d the OR technician stated conducted; however, staff is supposed to have a kina initially stated the RN ut and stated the procedure a colonoscopy, then the nind and said it was GD. Further review of the diall staff involved stated a cted, but they made is about which procedure was review revealed the OR is colonoscopy. The Patient #1 was then taken and an EGD was performed in the circulation and began and in the Charge Nurse on mass prepped for a san EGD. She further stated the circulating nurse, the two CST) that were present in ified Registered Nurse who stated a "time out" was ulating Nurse and CRNA et an EGD; however, neither	A	955			

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Event ID: NS6G11

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Signature:	ME	Date: 34/19

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			c					
		180021	B. WING			01/:	30/2019	
NAME OF PE	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				8:	50 RIVERVIEW AVENUE		<u> </u>	
SOUTHER	STERN KY MEDICAL C	ENIER		P	INEVILLE, KY 40977			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	OI I	-	PROVIDER'S PLAN OF CORRECTION	1	(3:5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
A 955	Continued From pag	e 114	A	955				
	the Director of Surgion were unable to be re	npted with Physician #1 and cal Services; however, both ached and no longer worked				82		
A1100	CFR(s): 482.55  The hospital must me patients in accordance of practice.  This CONDITION is Based on observation review of facility police of the American Heal Stroke Association of the facility failed to me patients in accordance of practice. The facility facility facility may be partitive of the facility facility facility of the facility fac	eet the emergency needs of ce with acceptable standards not met as evidenced by:  n, interview, record review, cies/procedures, and review of Association/American duidelines, it was determined neet the emergency needs of ce with acceptable standards ity failed to ensure the lent was integrated with other accility to ensure the facility to ensure the facility to ensure the full extent sources to assess and render emergency patients, and policies and procedures are provided in the nent were a continuing medical staff.	A1		The facility failed to meet the emergency needs of with acceptable standards of practice. The CEO f provide oversight for the facility. The facility fail integrate the ED with other departments of the facility failed to ensure policy procedures governing and the ED where a responsibility of the medic The facility failed to have a functioning governing and did not convene per policy. The hospital staff providers will be in-serviced on policy 700,709, M Scope of Care, policy 700,315 ER Scope of Care, 200,401 Scope of Care (Facility). This will be verified in-service intendance log. MEC has requested attendance of the ED Medical Director at their medic reviewed and approved these policies, the ED irector was present for the MEC meeting on 2/2 review of two ED charts was requested by MEC contract company and the results were presented discussed in the 2/20/19 MEC meeting. The new Board appointed a new CEO on 2/22/19 who will oversight to ensure quality care is being provided be verified by board minutes. (CEO/Controller)  The facility had no institutional plan or annual ophudget due to no effective Governing Board being The institutional plan, including annual operating that included all anticipated income, expenses, an expenditures for a three-year period was made. Thus presented to MEC on 2/20/19 and sent to new governing board on 2/22/19 for review and approverified by attached board minutes. See Attached (Controller)	alled to ed to ed to idity. The ing medical al staff. g board f and dedSurg- pohey rified by I the retings. D Medical 0/19. Peer of ED and Governing provide . This may erating g in place budget d capital his plan vly scated val. This is	2/22/2019	
	medication to stimul sustain the patient's failed to have enoug	ses of Epinephrine (a ate the heart) in an effort to life. However, the facility in medication to treat the tion had to be supplied to the						

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			(X3) DATE COMPL	
			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			;
		180021	B. WING		01/3	30/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		1
SOUTHE	ASTERN KY MEDICAL C	ENTER		ISO RIVERVIEW AVENUE		
		. <u></u>		PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
A1100	that had transported Observation of the fa 5:00 PM revealed for Epinephrine were averand four (4) ampules pediatric patient. How Epinephrine had exponent day, and the face Epinephrine to replace not purchase any me vendor stopped release facility due to unpaid On 07/17/18, EMS we patient to the ED who symptoms of an acute EMS contacted the Ewere en route with the informed by RN #11 ED because they wo Subsequently, EMS helicopter and the patient presented to (ED) with signs/sympthe facility failed to in care on 11/12/18 at presented to the ED blood pressure" and symptoms of a strok implement their Acute for the Emergency E	ency Medical Services (EMS) the patient to the ED. cility's ED on 01/30/19 at ur (4) ampules of ailable for an adult patient of Epinephrine for a vever, all eight ampules of iration dates of 01/31/19, the ility had no available the medication and could dication because their retail using medication to the debt.  as attempting to transfer a to was exhibiting signs and the stroke. However, when ED to inform them that they the patient, they were not to bring the patient to the uld "kill this guy." contacted a transport attent was flown to another  ad an "Acute Stroke Practice tergency Department" in iteria and interventions for collow and implement when a the Emergency Department cotoms of a stroke. However, implement the standard of 10:35 AM, when Patient #10 with a "significantly elevated	A1100	The facility failed to have a functioning telementry located at the nursing station and staff were unable monitor a patient's cardiac status unless they were the patient's from. The ED did not have functional oximeters, or have functional biohazard "sharps colimited casting supplies and out dated casting supported this issue. The relationship with the material vendors is corrected. Material supply orders are bordered weekly. There are no issues with placing receiving orders. Due to a lack of communication facility staff was not always calling the materials management dept and asking for supplies to be rewhen supplies has been depleated. Now a material makes inventory supply rounds on week days for If supplies are needed they are repleaished from the stock room. Stock room supplies replaced now through weekly orders to our material vendors is corrected. Material supply orders are to ordered weekly. There are no issues with placing receiving orders. Due to a lack of communication facility staff was not always calling the materials management dept and asking for supplies to be rewhen supplies has been depleated. Now a material material weekly orders are not supply to the materials management dept and asking for supplies to be rewhen supplies has been depleated. Now a material material weekly orders to our mater supply vendor. (CEO)  The facility failed to ensure that the ED was integother departments of the facility. The hospital staproviders will be in-serviced on policy 700.709. Scope of Care, policy 700.315 ER Scope of Care, 200.401 Scope of Care (Facility). This will be very the in-service attendance log. MIEC has requested attendance of the ED Medical Director at their materials and providers will be in-serviced and approved these policies on 2/Peer review of two ED charts was requested of Ecompany and the results were presented and discustrated and office of the ED Medical Director at their materials were presented and discustrated and single provides and proved these policies on 2/Peer review of two ED char	e to present in I pulse present in I pulse portainer plies. To al supply peing orders and the stocked distilier each unit he stocked als clerk each unit he stocked distilier stocked distilier in grated with ff and MedSurg- policy riffed by d the eetings. 20/19 D contract	2/22/2019

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STATEMENT OF DEFICIE! AND PLAN OF CORRECT!		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			X3) DATE SURVEY COMPLETED	
					С		
		180021	B WING			01/3	30/2019
NAME OF PROVIDER OF		ENTER	· •	,	STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
	ACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
including to mogration to the mafter arm failed to assessor deficits 11/12/1 the head experies patient at 8:15  The fact Plasmir administ Activasia a stroke been un past be However a retail any me  Tours of 01/23/1 have a electric nursing a paties present observation the E (a devicoxygent also recontain contain contain the experies to the experies of the experies	aphy (CT) scaledical surgicial to the EU administer Finent screening experies at 4:20 PM defor Patient incing an appwas transferr PM for treatmility failed to larger Activation, and the Emerge 9 and 01/30/functioning the attain, and attivity of a station, and in the patier at in the patier at in the patier at in the place used to make a function and in the blood wealed none and a function are. There we are a station and a function are. There we are a surgicial as a function are. There we are a surgicial as a function are. There we are a surgicial as a function are. There we are a surgicial as a function are. There we are a surgicial as a function are. There we are a surgicial as a function are. There we are a surgicial as a surgici	e 116 rast head computed an until after being admitted all floor and five (5) hours D. In addition, the facility Patient #10 the stroke scale ag to determine the extent of enced by the patient. On the results of a CT scan of #10 revealed the patient was arent evolving stroke. The red to Facility #6 on 11/12/18 rent of an acute stroke.  The results of a CT scan of red to Facility #6 on 11/12/18 rent of an acute stroke.  The red to Facility #6 on 11/12/18 rent of an acute stroke.  The revealed the facility had revealed the facility had revealed the facility had revealed the facility did not have redication cost \$10,000.  Red To Pepartment (ED) on The revealed the facility did not relemetry monitor (shows the red heart) located at the staff were unable to monitor retatus unless they were red eight (8) of nine (9) rooms red eight (8) of nine (9) rooms red eight (8) of nine (9) rooms red eight (8) of nine (9) rooms red eight (8) of nine (9) rooms red biohazard "sharps" red only two (2) biohazard located in the ED; one	A1	1100	The facility failed to implement acute stroke stand therefore the stroke scale assessment screening will performed on patient #10. The facility also failed implement the standard of care in the ED on patient Due to not adhering to the AHA Standards and N Protocol the facility requested that the ED contraction-service their own physicians on the stroke profinservice logs and verification from in-service will and placed in the employee files by 3/7/19. Air-I Educators re-educated the clinical staff in the ED on the acute stroke practice standards. The ED dwill be in-service on policy 700.321 Stroke Policy Manager will monitor "Door to MD" and "Door to Thrombolyties" as part of QAPI process that mee This will be verified by the QAPI meeting minute. The facility was aware of previous employee stat which reflected poorly on the ED department and facility. The ED staff were re-educated by the Elon the Mission Statement, the employee job descible Policies and Procedures for the Emergency Diffis will be verified by the in-service attendance (ACNO/Humun Resources Director).  The facility failed to have a functioning telement located at the nursing station and staff were unabmonitor a patient's cardiac status unless they we the patient's room. The ED Central Cardiac Monbeen repaired by DTG, initial payment submitted and final payment was submitted on 2/19/2019, monitor back in operation3/1/2019. Nursing stational infinal payment was submitted on 2/19/2019, monitoring. If putient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring. If patient requires more frequent monitoring.	as not to nt #10. HI Stoke it company ocol. Il be sent evac on 2/25/19 cpartment y. The ED o its weekly. is (CNO) cments the D Manager riptions and epartment log.  ry monitor le to e present in itor has 12/11/2019 Central Thas been sualize in ardiac mitoring.	3/1/2019

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	DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRU DENTIFICATION NUMBER: A. BUILDING			(X3) DATE: COMPL	ETED	
		180021	180021 B WING		C 01/30/2019	
NAME OF P	ROVIDER OR SUPPLIER	100021		STREET ADDRESS, CITY, STATE, ZIP CODE	017.	3072013
SOUTHER	ASTERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	'ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(AS) COMPLETION DATE
A1103	container was locate in the physician's cha 01/30/19 revealed El needles and devices a biohazard containe addition, observation 01/23/19 at 9:45 AM limited number of su fractured bones of prin need of casting se supply of casting tap appropriate sizes we various injuries.  INTEGRATION OF ECFR(s): 482.55(a)(2)  [If emergency service hospital]  (2) The services must departments of the Four the Emerger integrated with other ensure the Emerger integrated with other ensure the facility of available the full extresources to assess for emergency patient #12 present Department (ED) or arrest. On two differ required multiple do medication to stimute of the properties of the properties of the properties of the facility of a partient #12 present the partment (ED) or arrest. On two differ required multiple do medication to stimute the stimute of the properties of the prope	d in the hallway and another arting room. Observations on D staff had to transport used through the hailway to get to er to dispose of the items. In of the casting room on revealed it contained a pplies necessary to cast atients presenting to the ED ervices. The ED's entire he was expired and the ere not available to treat EMERGENCY SERVICES  The entire the integrated with other hospital.  The integrated with other hospital.  The integrated with other hospital.  The integrated to record mined the facility failed to hold immediately make ent of its patient care and render appropriate care	A111	facility which were not accessed, and also in the pharmacy. Neither Administration nor the Phar notified that medication had been obtained from therefore their supply was not replenished. The failed to have more than one Activase on hand. Cardinal Wholesaler debt which had been identifindings as being the cause of drug supply issue addressed. An initial payment was made on 2/7 another payment will be made to have Cardinal orders. The medications which were identified available were ordered on 2/21/19. The Director Pharmacy will oversee the restocking of the Om which occurs twice a day via the restock reports automatically print in the inpatient pharmacy availability of medications will be verified by the from the wholesaler and Omni inventory - which (CEO)	in five ingh-out the inpatient impatient 6/2019	

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Signature:	Date: 36/19
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AND DIAM OF CORRECTION IDENTIFICATION NUMBER			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
					1	С	
180021 B			B WING_		01	30/2019	
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
SOUTHEA	STERN KY MEDICAL C	ENTER		850 RIVERVIEW AVENUE		1	
30011127	STERRENT MEDICAL C	ENTER		PINEVILLE, KY 40977			
(X4) ID		ATEMENT OF DEFICIENCIES	ID.	PROVIDER'S PLAN OF CORRE		(×5)	
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP		COMPLETION DATE	
TAG	REGULATORTOR	escibentifying information)	IAG	DEFICIENCY)	NOPNIATE		
			1	The facility failed to have enough medication	n to treat a	3/6/2019	
A1103	Continued From page	a 119	A4.	mations in the ED. The madiention was aver	lable in five	10	
,,,,,,,	· -		A1	103 additional crish carts (25 syringes) located	through-out the	·	
		n medication to treat the		facility which were not accessed, and also in pharmacy. Neither Administration nor the			
		on had to be supplied to the		notified that medication had been obtained			
		ency Medical Services (EMS)		therefore their supply was not replenished.		1	
	mat nau transported	the patient to the ED.		failed to have more than one Activase on he Cardinal Wholesaler debt which had been i			
	On 07/17/18 EMS	as attempting to transfer a		findings as being the cause of drug supply i			
		o was exhibiting signs and		addressed. An initial payment was made or	2/7/2019 and	i	
		e stroke. However, when		another payment will be made to have Card orders. The medications which were ident			
		ED to inform them that they		available were ordered on 2/21/19. The Di			
	were en route with th	-		Pharmacy will oversee the restocking of the	Omnicells		
		not to bring the patient to the		which occurs twice a day via the restock re			
	ED because they wo			automatically print in the inpatient pharma availability of medications will be verified	y. The by the receints		
		contacted a transport		from the wholesaler and Omni inventory -			
	helicopter and the pa	itient was flown to another		(CEO)			
	facility, Interviews wi	th staff revealed the facility		The facility failed to have a functioning tel	ments: monitor	2/22/2019	
	1.090	ation available used to treat		located at the nursing station and staff were			
	patients who were ha	aving a stroke.		monitor a patient's cardiac status unless the	y were present in		
	_			the patient's room. The ED did not have fur oximeters, or have functional biobazard "sl	ettonal pulse		
		ncy Department (ED) on		limited casting supplies and out dated easti	ng supplies To		
		19 revealed the facility did not		correct this issue the relationship with the	naterial The		
		lemetry monitor (shows the		relationship with the material supply vendo			
		he heart) located at the		Material supply orders are being ordered w no issues with placing orders and receiving			
		staff were unable to monitor		lack of communication the facility staff wa	not always		
	present in the patien	atus unless they were		calling the materials management dept and	asking for		
		ed eight (8) of nine (9) rooms		supplies to be restocked when supplies has Now a materials clerk makes inventory sup	ncen depteated ply rounds on		
		e a functional pulse oximeter		week days for each unit. If supplies are ne	eded they are		
		easures the amount of		replenished from the inventory in the stock	room Stock		
		. Observations in the ED		room supplies are replaced now through wo our materials supply vendor, (CEO)	ekty orders to		
		of the nine (9) ED rooms		The materials supply vendor ventor		55-35	
	1	al biohazard "sharps"		The facility failed to have a functioning tel	emetry monitor	3/1/2019	
		re only two (2) biohazard		located at the nursing station and staff were monitor a patient's cardiac status unless the	unable to		
		located in the ED, one		the patient's room. The ED Central Cardiau		15	
		d in the hallway and another		been repaired by DTG, initial payment sub	mitted 2/11/2019		
		arting room. Observations on		and final payment was submitted on 2/19/2	019 Central		
		D staff had to transport used		monitor back in operation3/1/2019. Nursi making patients rounds every 5-10 minutes	ng starr nas ocen to visualize in	1	
		through the hallway to get to		room monitor on patients who require ong	ing cardiac		
		er to dispose of the items. In		monitoring. If patient requires more frequ			
	addition, observation	of the casting room on		1:1 care is provided as ED is staffed with a RN and 1 Paramedic 24/7. (ACNO/CEO)			
FORM CMS-250	17(02-99) Previous Versions Ob	solete Event ID. NS60	Ité		ntinuation sheet f	Page 128 of 135	

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Event ID NS6G11

Facility ID 100020

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PRINTED 02/14/2019

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER			E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		0	1				:
		180021	B. WING	_		01/	30/2019
NAME OF PR	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEA	STERN KY MEDICAL CI	ENTER		8	850 RIVERVIEW AVENUE		
		11 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		F	PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
A1103	limited number of sup fractured bones of pa	e 119 revealed it contained a uplies necessary to cast tients presenting to the ED rvices. The ED's entire	A1	103	The facility was aware of previous employee state which reflected poorly on the ED department and facility. The ED staff were re-educated by the EI on the Mission Statement, the employee job describe Policies and Procedures for the Emergency De This will be verified by the in-service attendance (ACNO/Human Resources Director)	the Manager iptions and partment.	3/1/2019
	supply of casting tape appropriate sizes were various injuries.  The findings include:  Review of the facility for ED," revised Janu facility would provide for cardiac and/or res	policy titled, "Procedure List ary 2019, revealed the services including treatment spiratory arrest; cardiac			The facility failed to have a functioning telementr located at the nursing station and staff were unable monitor a patient's cardiac status unless they were the patient's room. The ED Central Cardiac Monibeen repaired by DTG, initial payment submitted and final payment was submitted on 2/19/2019, monitor back in operation3/1/2019. Nursing staff making patients rounds every 5-10 minutes to vis room monitor on patients who require ongoing camonitoring. If patient requires more frequent mo 1:1 care is provided as ED is staffed with either 2 RN and 1 Paramedic 24/7. (ACNO/CEO)	e to present in or has 2/11/2019 Central T has been unlize in rdiae	3/1/2019
	treatment for acute si administration of thro dissolve blood clots); fractures; treatment of hypertensive crisis; a	in respiratory distress; troke, including the mbolytics (medications to treatment of various of trauma patients; naphylactic shock; disaster			The Radiological Policy 300,441 Scope of Service dited to change on call technologist response time within 15 minutes. The policy will be taken to Qualificate and to the Governing Board for approval. Radiology staff will be in-serviced on this policy This will be verified by the QAPI meeting minute (Director of Radiology)	e to be API to The changes.	2/22/2019
	(heart attack) includir thrombolytics; and per Review of the facility of Service," approved the Radiology Depart specialty that employ imaging technologies conditions. The policibusiness hours, a technologies and responsible for a facility.  The policy stated "affiliation of the policy stated and per policy stated affiliation."	s policy, "Radiology Scope If February 2017, revealed Iment was a medical red the use of an array of It to diagnose or treat patient y stated that after normal chnologist would be "on call" If services provided in the			iEMS reported that during a code which began at a ended at 2155 a chest x-ray was not completed. It Radiology department was onsite during the time code and the x-ray was in fact ordered at 2119 code 2127. This can be verified by the eMAR time state (CEO)	he s of the upleted at	3/1/2019
	nursing staff for any	e contacted by the hospital and all emergencies that s. The policy also stated					

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Event ID NS6G11

Facility ID 100020

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Signature: Date: Hy/19

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,		NSTRUCTION		DATE SURVEY COMPLETED
		180021	B. WING				C 01/30/2019
	ROVIDER OR SUPPLIER	CENTER		850 F	ET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEWAVENUE EVILLE, KY 40977	: :	8
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
A1103	the facility within for contacted by facility  1. Review of Patient revealed the patient 12/04/18 at 8:02 PM report received from the patient to the fact attempted suicide, was cardiac arrest (uncoor breathing) with cardiac arrest (uncoor breathing) with cardiac arrest (uncoor breathing) with cardiac arrest (uncoor breathing) with cardiac arrest (uncoor breathing) with cardiac arrest (uncoor breathing) with cardiac been intubated windpipe so oxygen lungs) by EMS en reconstructed that upon a fact and lifesaving measures administered to the patient was determined to the patient was determined to the patient was determined to patient to orders for Patient #	thnologist would respond to ty-five (45) minutes of being staff.  It #12's medical record arrived at the facility's ED on the facility's ED on the facility, who had transported cities, revealed the patient had was unresponsive, and in full inscious with no heart function ardio pulmonary resuscitation upon arrival. Patient #12 had (a tube placed in the could be delivered to the	A1	103			
	have a chest x-ray (immediately). How medical record revex-ray was obtained  On 12/04/18 at 9:38 into cardiac arrest, eight (8) additional administered to the	obtained "STAT" ever, review of Patient #12's ealed no evidence the chest		t-full-printer			

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Event ID NS6G11

Facility ID: 100020

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			. 33		c
		180021	B. WING _		01/30/2019
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	DE
			1	850 RIVERVIEW AVENUE	
SOUTHEA	STERN KY MEDICAL	CENTER		PINEVILLE, KY 40977	Į.
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CO ( (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE COMPLETION
	Continued From pay pronounced decease Interview with RN # revealed she was we treated in the ED. The state emphatica the chest x-ray as one one from the Rad the facility while Pattreatment. The RN is out of epinephrine in #12. RN #13 stated a problem for "some EMS had to provide while Patient #12 wound to say exact "borrowed" from EN Interview with Paramedic #1 PM and with Emerg (EMT) #2 on 01/29/were the EMS pers #12 to the ED on 12 ED assisting facility was pronounced de EMT #2 stated that a chest x-ray on Pawith Paramedic #1 Patient #12 into the medication box into stated that they rou box into this facility routine for the ED rineeded, and they of Further interview of	ge 121 ed. 13 on 01/30/19 at 2:30 PM orking when Patient #12 was he RN stated that she could lly why Patient #12 did not get ordered, but stated there was diology Department present in lient #12 was receiving also stated that the facility ran in the ED while treating Patient supplies in the ED had been a time." The RN stated that a epinephrine to the facility as being treated, but was ly how many ampules were 15.  medic #1 on 01/29/19 at 2:45 pency Medical Technician 19 at 3:00 PM revealed they connel who transported Patient 2/04/18 and remained in the a personnel until Patient #12 eceased. Paramedic #1 and the ED staff never performed attent #12. Continued interview revealed that when they took a ED, they also took their of the facility. Paramedic #1 tinely take their medication with them, because it is not to have the medication often supply it to the facility. Confirmed that the facility ran		103	
	Patient #12 and the	medication while treating by used several ampules from			100
		pply. Although Paramedic #1			
	and EMT #2 were	unable to recall exactlyhow			

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			 		 _
signature:		1	Date:_	3/4/69	
	/				J
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PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1, ,	TIPLE CONSTRUCTION NG	11. /	E SURVEY IPLETED
		180021	B. WING		0.	C 1/30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP COD 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
A1103	many ampules of Epithe facility, they state majority" of Epinephr #12. EMT #1 stated to one he had ever had or equipment during.  Interview with the Dir 01/29/19 at 11:00 AM 01/29/19, she was fil (carts utilized for the dispensing of emergilifesaving situation) were gency medicat and she did not have more due to the facil.  Observation of the factory of the factor	inephrine were supplied to the they had supplied "the ine administered to Patient the facility's ED was the only to supply with medications his entire career.  The ector of Pharmacy on A revealed that as of ling the facility's crash carts transportation and ency medication used in a with the last of the facility's ions" including Epinephrine, at the ability to obtain any ity's financial situation.  The ectivity ED on 01/30/19 at the ED had four (4) ampules of and the administered to an or (4) ampules of Epinephrine stered to a pediatric patient.  The pules of Epinephrine had 1/31/19.	A1	103		

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Event ID: NS6G11 Facility ID: 100020

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Signature:	Date:	3/1/19

PRINTED; 02/14/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ` '	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		180021	B, WING			C 01/30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		STREET ADDRESS, CITY, STATE, ZIP CO 850 RIVERVIEW AVENUE PINEVILLE, KY 40977	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE HE APPROPRIATE	COMPLETION DATE
A1103	going to kill this guy, Just tell them it is crit immediately." The dis communicating with transporting the patie #11, "Okay, I'll call th then replies, "thank y Interview with the EN 2:45 PM revealed he call when RN #11 ins stroke patient to the stated that at that tim transporting the patie sixteen (16) minutes Director went on to s the helicopter to land patient was the helip was located directly facility. The Director arrived at the helipad another sixteen minuarrive to transport the according to the EM facility's helipad to th seventy-three (73) m thirty (30) minutes to the EMS Director rev since been informed that the facility did no Plasminogen Activat administered to dissi subsequently, the EI patient believed to b would be transporter facility, despite the lo alternative facility.	you know what I'm saying. ical that he gets treatment spatcher is then heard the EMS crew who was ent, and then stating to RN e helicopter." The nurse ou, dear," and the call ends.  IS Director on 01/29/19 at was the paramedic on the structed EMS not to bring the ED. The EMS Director the the ambulance ent was approximately from the facility. The tate that the helipad used for and pick up the stroke ad utilized by the facility and across the street from the stated that after EMS I with the patient they waited thes for the helicopter to e patient. In addition, S Director the flight from the the receiving hospital located tiles away was approximately ing. Further interview with realed that EMS staff had by the facility nursing staff of have any Tissue or (tPA) (a medication	A1	103		
ļ	1	Martina .				

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Event ID NS6G11

Facility ID: 100020

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRU		(X3) DATE : COMPL	
						c	;
		180021	B. WING	<del></del>		01/3	30/2019
	ROVIDER OR SUPPLIER STERN KY MEDICAL C	ENTER		850 RIVERV	DRESS, CITY STATE, ZIP CODE /IEW AVENUE E, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD & CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
A1103	revealed that she wa Dispatch called the faincoming stroke paties physician working the member who initiated instruct EMS to "fly the treating the patient in ED physician and she facility did not have refacility from midnight Computerized Tomoghave to be "called in, hour for the results to time, the patient "wor interview with RN #1 facility's ED was like doctor's office." RN # basic of laboratory st processed and nursing over the building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for or may not be found not have even the "building for one (1) dose of tPA reacility. The DOP stated that pharmacy supplier for million dollars, and the medications without She further indicated approximately ten the facility did not have the medication.	s working in the ED when acility informing them of the ent. RN #11 stated the ED at night was the staff if the conversation with her to be patient out" instead of the ED. The RN stated the ediscussed the fact that the adiology services in the until 7:00 AM, and a graphy (CT) technician would " and then it would take an abe available, and by that all be dead." Continued 1 revealed working in the working in a "low rent left stated that the most undies were sent out to be any staff had to search all medication, and then it may The RN stated the ED did	A1	103			
		and on 01/30/19 at 5:15 PM,		Facility ID: 10	Anna lé satissa	han short Or	age 135 of 135

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	1 ' '	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		180021	B. WING_	<u> </u>		C 01/30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ( (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE	(X5) COMPLETION DATE
A1103	revealed the facility h (2) of the rooms were services and one (1) for casting services. 01/30/19 at 5:15 PM was located at the numonitor was not oper utilized to monitor pa the ED with suspecte patients who were ex myocardial infarction  Interviews on 01/30/ Registered Nurse (RI #10, and at 2:30 PM telemetry monitor at worked for "months." been occasions where present in the ED wh monitoring; however, monitor the patient's the room with the patient's the room with the patient's the room with the patient in the ED, and situations that placed critical changes in the recognized timely an Further review of the of the nine (9) rooms pulse oximeter.  Further interviews or Registered Nurse (R #10, and at 2:30 PM one room in the ED occupations oximeter.	ad nine (9) ED rooms, two dedicated for trauma of the rooms was dedicated Continued observations on revealed a telemetry monitor trising station; however, the rational and could not be tients who had presented to ad cardiac problems or operiencing an acute (heart attack).  19, at 5:20 PM with RN with RN #13 revealed the the nursing station had not RN #13 stated there had not two or three patients were o required cardiac the only way to continuously cardiac status was to stay in	A1	103		

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	- 1		CONSTRUCTION	(X3) DATE	SURVEY PLETED
		180021	B. WING				C
	ROVIDER OR SUPPLIER	ENTER		850	REET ADDRESS, CITY, STATE, ZIP CODE I RIVERVIEW AVENUE NEVILLE, KY 40977	011	30/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC (DENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
A1103	disposable pulse oxir be used on one patie However, the nurses supplies in the ED and disposable pulse oxir staff utilized the same patient in the ED. The		At	103			
-14	of the nine (9) ED roo biohazard "sharps" or "sharps" containers to hallway and in the ph Observations on 01/3 to transport used nee the hallway to get to a dispose of the items,	ns of the ED revealed none ims contained a functional ontainer. The only biohazard ocated in the ED were in the sysician's charting room.  0/19 revealed ED staff had dles and devices through a biohazard container to creating a substantial risk of orne illness or injury to sitors in the ED.			*		
	with Registered Nursi RN #10, and at 2:30 the "sharps container been functional for "a they had to utilize the the hallway or the one The staff interviewed	on 01/30/19, at 5:20 PM e (RN) #9, at 5:45 PM with PM with RN #13 revealed s" in the rooms had not while." The staff stated large sharps container in e in the physician's room. stated they recognized this ous" problem related to					
	at 9:45 AM revealed in 1-inch casting tape ex	casting room on 01/23/19 t contained three (3) rolls of each of which had an ober 2015; nine (9) rolls of					

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED
		180021	B. WING		С
	ROVIDER OR SUPPLIER		STRI 850 i	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977	01/30/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLETION
A1103	2-inch casting tape e expiration date of De 2.5-inch casting tape October 2015; and or with no expiration dat the casting supplies r sponges were preser date of March 2017, the of October 2015, and date of December 20 Interview with the Ca at 10:00 AM revealed casting supplies had the only supplies ava Technician stated tha casting tape, which we such as legs, is an ite because a fractured lin the ED. Continued technician revealed the supplies "being so old difficult at times to main and to "make do" utilitape to try and make	ach of which had an cember 2018; one (1) roll of with an expiration date of the 6-inch roll of casting tape to present. Further review of evealed sixteen (16) casting but, one (1) with an expiration seven (7) with an expiration date six (6) with an expir	A1103		
ÿ.	Nursing Officer (CNO Nursing Officer (ACN having any knowledge "borrow" medications operate the ED. Howe with the CNO and AC Director had requeste "sometime in the surr	9 at 6:15 PM with the Chief ) and the Assistant Chief O) revealed they denied e of the facility having to and supplies from EMS to ever, continued interview NO revealed that the EMS ed to meet with them amer" of 2018, because of the facility's ED. The CNO			

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Event ID: NS6G11

Facility ID: 100020

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V	Signature: Date: 34/19
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		578					С
		180021	B. WING			01/	30/2019
NAME OF PI	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		01
SOUTUEA	CTERN VV MERICAL OF			8501	RIVERVIEWAVENUE		
SOUTHEASTERN KY MEDICAL CENTER				PIN	EVILLE, KY 40977		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	di		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI) TAG	(	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION
A1103	thintage is reint bogs		A1	103			
	and ACNO stated du	ring the meeting they were					
	informed by the Direct	ctor of the phone call that					
	had transpired betwe	en the ED and EMS					
	Dispatch, The CNO a	and ACNO stated an		77			
	mivestigation was initi	ated and they spoke with					
	ED According to the	cian who was working in the NCO and ANCO it was					
		1 and the ED physician that					
		providing neurological					
		better for the patient to be					
		ly, and no changes were					
	made in the ED as a	result of theinvestigation.					
į		with the CNO and ACNO					
		ware that the telemetry					
	monitor was not work	ing in the ED and they had					
	made the Chief Execu	utive Officer (CEO) and the	}				
	Chief Financial Office	er (CFO) aware, however, no n and the ED continued to					
		g cardiac monitor at the					
		nued interviews revealed					
		NO were not aware of the					
		sensors not being available					
	in the ED. The CNO a	and ACNO also stated the					
	facility had been out of	of biohazard sharps					
	containers for the ED	rooms for "months." The					
		ed that decisions on which	1				
	supplies were obtained						
		they try to obtain the most					
		but due to the financial					
		y, not all needed supplies					İ
A1104	could be made availa						
A1104	EMERGENCY SERV CFR(s): 482.55(a)(3)		A11	104			
	(If emergency service	es are provided at the					
	hospital}				54		
	(3) The policies and p	procedures governing					

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	DER/SUPPLIER/CLIA FICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
=	490004	B. WING		C		
NAME OF PROPERTY OF A STREET	180021	D. WIFIG			01/	30/2019
NAME OF PROVIDER OR SUPPLIER			ŀ	TREET ADDRESS, CITY, STATE, ZIP CODE		
SOUTHEASTERN KY MEDICAL CENTER				50 RIVERVIEW AVENUE		
			Р	INEVILLE, KY 40977		
(X4) ID SUMMARY STATEMENT OF PREFIX (EACH DEFICIENCY MUST BE PI TAG REGULATORY OR LSC IDENTIFY	RECEDED BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
medical care provided in the emor department are established be continuing responsibility of the number of department are established be continuing responsibility of the number of department are established be continuing responsibility of the number of acility policies/procedures, and American Heart Association/Am Association Guidelines, it was of facility failed to ensure the policiprocedures governing medical of the Emergency Department were evaluated on an ongoing basis, an "Acute Stroke Practice Stand Emergency Department" in placifieria and interventions for the follow and implement when a pathe Emergency Department (EL signs/symptoms of a stroke. Hoth failed to implement the standard 11/12/18 at 10:35 AM, when Papresented to the ED with a "sign blood pressure" and exhibiting a symptoms of a stroke. The facilimplement their Acute Stroke Profor the Emergency Department; Patient #10 did not receive medincluding a non-contrast head of tomography (CT) scan until after to the medical surgical floor and after arrival to the ED. In additional failed to administer Patient #10 assessment screening to determ deficits being experienced by the 11/12/18 at 4:20 PM the results the head for Patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient #10 reveals experiencing an apparent evolving the parietal area. The patient we recitive the patient we recitive the patient we recitive the patient we recitive the patient we recommend the recommendation of the patient we recommend the recommendation of the recommendation of the recommendation of the recommendation of the recommen	evidenced by: ew, review of review of the nerican Stroke letermined the nes and care provided in re established and The facility had dard for the se with specific medical staff to attent presented to b) with wever, the facility d of care on rationally elevated signs and ity failed to ractice Standard subsequently, lical imaging omputed re being admitted d five (5) hours on, the facility the stroke scale mine the extent of ne patient. On of a CT scan of ed the patient was ing infarct in the was transferred to	A1	104	The facility failed to ensure that the ED was integrother departments of the facility. The hospital staff providers will be in-serviced on policy 700,709, M Scope of Care, policy 700,315 ER Scope of Care, 200,401 Scope of Care (Facility). This will be ver the in-service attendance log. MEC has requested attendance of the ED Medical Director at their med MEC reviewed and approved these policies on 2/2 Peer review of two ED charts was requested of ED company and the results were presented and discust 2/20/19 MEC meeting. (CNO/Chief of Staff)  The facility failed to implement acute stroke stand therefore the stroke scale assessment screening was performed on patient #10. Due to not adhearing to Standards and NIH Stoke Protocol the facility require ED contract company inservice their own physithe ED contract company inservice their own physithe ED contract company inservice their own physithe ED on 2/25/19 on the acute stroke practice star (ED department will be in-service on policy 70 Stroke Policy. The ED Manager will monitor "Do and "Door to Thrombolytics" as part of QAPI procemeets weekly. This will be verified by the QAPI minitutes. (CNO)  Re-inservice the Radiology Department regarding policy 700,321 Stroke Protocol. The Radiology D Manager keeps a daily log to monitor stroke protoco CT completed" and "Door to CT report" as part QAPI process that meets weekly. This will be verified by the QAPI meeting minutes. (Director of Radiologist to change on call technologist response time for a protocol to be within 15 minutes. This policy will to QAPI and to MEC and to the Governing Board approval. The Radiology staff will be in-service of policy changes. This will be verified by the QAPI minutes and in-service log. (Director of Radiolog	and ledSurg-policy iffed by the strings. 0/19, 0 contract iscd in the seed in the seed in the AHA lested that icians on from ideads, 0/321 or to MD" ess that neeting the stroke cpartment cols "Door of the field by y). Callback was edited stroke be taken for n this meeting.	3/1/2019 3/1/2019 2/22/2019

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
	53	180021	B. WING			100	20/0040
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	017	30/2019
00117117	***				50 RIVERVIEW AVENUE		
SOUTHEASTERN KY MEDICAL CENTER				INEVILLE, KY 40977		,	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID.		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE
A1104	04 Continued From page 130		A1		The Radiological policy 300.441 Scope of Service edited to change on call technologist response time within 15 minutes. The policy will be taken to Q/	4 1	2/22/2019
	of an acute stroke,				Radiology staff will be in-serviced on this policy	ne	
	The findings include:				changes. This will be verified by the QAPI meeting and in-service log. (Director of Radiology)	ig minutes	
	(ED), undated, reveal to the Emergency De acute stroke, the use was recommended. I exhibiting signs and sereceive imaging include computed tomograph further stated that imate twenty (20) minutes of policy further stated the within twenty (20) minutes of prevealed a National Instroke Scale was to be presented with signs/state.	the Emergency Department ed when a patient presented partment with a suspected of a stroke severity scale In addition patients symptoms of a stroke should ding a non-contrast head y (CT) scan. The policy aging should occur within of arrival in the ED. The that imaging should occur nutes of arrival in the ED. facility's Acute Stroke the Emergency Department institute of Health (NIH) be utilized when a patient symptoms of a stroke for the objectively quantify any					
	could minimize the lor and/or even prevent of numbness and weakn side of the body, slurr as classic warning sig the guidelines classific severe increase in blo	In Stroke Association ime was critical when and immediate treatment ing-term effects of a stroke death. The guidelines listed less especially affecting one and speech, and confusion lying of a stroke. In addition led a hypertensive crisis as a lood pressure that could lead elines also stated that a					*

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Signature: Date: 34

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING			(X3) DATE SURVEY COMPLETED					
		180021	B. WING				01/:	30/2019
	ROVIDER OR SUPPLIER	ENTER	<u> </u>	850	EET ADDRESS, CITY, STATE, ZIP CODE RIVERVIEW AVENUE EVILLE, KY 40977		011.	30/2013
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) COMPLETION DATE
A1104	mercury (mm Hg) or number) of 120 mm h blood vessels.  Review of Patient #16 medical record reveathe ED on 11/12/18 a hypertension (an increided facial and arm the left side of the tor History and Physical 11/12/18, revealed Pexhibiting slurred spe by familiar health carnormally. The patient a family history signiff Further review of the Patient #10 was adminedication to lower be 11:01 AM and the patrecorded as 240/140 AM. The patient was However, there was rethe facility initiated the conducted imaging on non-contrast head (Cominutes of arriving to stroke scale assessment medical blood pressure was read and at 11:34 AM Metoprolol 5 mg (am pressure) via Intravel AM Patient #10's bloce 238/142 and at 11:45	higher or a diastolic (bottom ldg or higher can damage  D's Emergency Department led the patient presented to st 10:35 AM, with severe eased blood pressure), left heaviness and swelling of ague. In addition review of a for Patient #10 dated atient #10 also was each and was characterized a providers as not acting was also assessed to have icant for stroke.  medical record revealed inistered Clonidine 0.2 mg (a slood pressure) by mouth at tient's blood pressure was (normal 120/80) at 11:08 triaged as "urgent." no evidence found to indicate eir own Stroke protocol by f Resident #10 including a T) scan within twenty (20) the ED or administered the	A1				The state of the s	
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Event ID NS5G11 Signature Date:

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	227		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A BUILD	B. WING		C 55	
NAME OF B	TOWNS OF SUST	180021	B. WING			01/	30/2019
NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  (XALID. SUMMARY STATEMENT OF DESICIENCIES			85	REET ADDRESS, CITY, STATE, ZIP CODE ORIVERVIEW AVENUE NEVILLE, KY 40977			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG	1X	PROVIDER'S PLAN OF CORRECTION {EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	3E	(X5) COMPLETION DATE
A1104	(IV) access. At 12:20 pressure was recorded patient at that time w (a medication to lowe IV. At 12:35 PM Patie was recorded as 183 patient's blood pressize 201/134 and at 2:56 administered Labetat blood pressure) 5 mg the patient's medical the decision was madical surgical floor hypertensive crisis, direceiving medical immon-contrast head (Carriving to the ED or stroke scale assessmacility's policies and Further review of Patrevealed the patient as surgical unit on 11/12 PM the patient's blood as 180/108. At 3:47 Edocumented that a Cobtained "just to be of Review of a Radiolog Report for Patient #16 CT of the head was 3:42 PM and the documented that a Cobtained "in right parietal area."	PM the patient's blood ed as 230/142 and the as administered Hydralazine or blood pressure) 20 mg via ent #10's blood pressure /120. At 2:22 PM the ure was recorded as PM the patient was of (a medication to lower of via IV. Further review of record revealed at 3:15 PM de to admit the patient to the for management of espite Patient #10 not eaging including a including including including including including including including including including including including including including infarct including in	A1	1104			
		Patient #10's medical record					

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Signature:	Date: 34/	19
		/

PRINTED: 02/14/2019 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  AND PLAN OF CORRECTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		180021	B. WING_		01	C //30/2019
	ROVIDER OR SUPPLIER	ENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 850 RIVERVIEW AVENUE PINEVILLE, KY 40977		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT  (EACH CORRECTIVE ACTION SHOU  CROSS-REFERENCED TO THE APPRI  DEFICIENCY)	.D 8E	(X5) COMPLETION DATE
A1104	physician. Subseque was transferred to Fa acute stroke.  Interview with RN #8 reveled she was wor when Patient #10 prostated that the she wo of the head was not eED. The RN stated that the patient's block RN #4 stated she did scale assessment or best of her recollection exhibiting slurred speneurological deficits contrary documentative record.  Interview with Regist 01/29/19 at 12:45 PN to Patient #10 after be surgical floor. RN #4 the patient because I facility. She stated the tongued" and the patient #10 after be altered even a large amount of med after she evaluated F that a CT scan had n which was routine prostated this was conceived.	called to the admitting ntly, at 6:15 PM, Patient #10 acility #6 for treatment of an on 01/28/19 at 6:00 PM, king in the ED on 11/12/18, esented to the facility. RN #4 as unaware why a CT scan ordered for Patient #10 in the nat the physician was aware od pressure was elevated. I not perform the NIH stroke a Patient #10 because to the on the patient was not each or having any that she could recall, despite ion in Patient #10's medical ered Nurse (RN) #4 on I revealed she provided care eing admitted to the medical stated she was familiar with ne/she was employed at the	A1-	04		
	right." She stated she and orders were obtain	e contacted the physician ained for a CT scan. RN #4 onfirmed the patientwas				

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Signature:

Date:

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NAME OF PROVIDER OR SUPPLIER  SOUTHEASTERN KY MEDICAL CENTER  SUMMARY STATEMENT OF DEPICIENCIES  (EACH DEPICIENCY MAY BE PRECEDED BY FULL PREPAY TAG  (EACH DEPICIENCY MAY BE PRECEDED BY FULL PREPAY TAG  (EACH DEPICIENCY MAY BE PRECEDED BY FULL PREPAY TAG  (EACH DEPICIENCY MAY BE PRECEDED BY FULL PREPAY TAG  (EACH DEPICIENCY MAY BE PRECEDED BY FULL PREPAY TAG  (EACH DEPICIENCY OR LS. (DEHTHPHIC BY BORNATION))  A1104  Continued From page 134  having a stroke so an "immediate transfer" was arranged.  Interview with Physician #5 on 01/29/19 at 4:30  PM revealed Patient #10 presented to the ED with swelling of the longue, slurred speech, and high blood pressure. Physician #5 stated he fell that Patient #10 blood pressure. Physician #5 stated he was informed by nursing staff that the patient had already been admitted to the floor, after being "stabilized" in the ED. Physician #5 stated he was informed by nursing staff that the patient did not appear "normal," and a CT scan was ordered. Continued interview with Physician #5 revealed that as soon as the CT scan indicated Patient #10 was having a stroke, he immediately transferred Patient #10 to Facility #6.  Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the NIH stroke scale assessment screening should have been administered to Patient #10 and a CT scan of the head obtained immediately upon the patient presenting to the ED. The COS also stated that Patient #10 should have never been admitted to the medical surgical floor in a hypertensive crisis due to the lack of staff to care for a critically ill patient, the facility not having adequate supplies, nor the capability to provide the level of care that	AND PLAN OF CORRECTION   IDENTIFICATION NUMBER		1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
SOUTHEASTERN KY MEDICAL CENTER  SOUTHEASTERN KY MEDICAL CENTER  (A) ID  SUMMARY STATEMENT OF DEPICIENCIES  INC.  (A) ID  SUMMARY STATEMENT OF DEPICIENCY  REGULATORY OR LSC IDENTIFYING INFORMATION)  A1104  Continued From page 134  having a stroke so an "immediate transfer" was arranged.  Interview with Physician #5 on 01/29/19 at 4:30  PM revealed Patient #10 presented to the ED  with swelling of the tongue, slurred speech, and high blood pressure. Physician #5 stated he felt that Patient #10 was "clinically stable" other than the patient #10 was "clinically stable" other than the patient #10 was leaving a Stroke, he immediately transferred Patient #10 to Facility #6.  Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed that as soon as the CT scan indicated Patient #10 to Facility #6.  Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the NIH stroke scale assessment screening should have been administered to Patient #10 and a CT scan of the head obtained immediately upon the patient presenting to the ED. The COS also stated that Patient #10 should have never been admitted to the medical surgical floor in a hypertensive crisis due to the lack of staff to care for a critically ill patient, the facility not having adequate supplies,			180021	B. WING			_	
TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  A1104  Continued From page 134 having a stroke so an "immediate transfer" was arranged.  Interview with Physician #5 on 01/29/19 at 4:30 PM revealed Patient #10 presented to the ED with swelling of the tongue, sturred speech, and high blood pressure. Physician #5 stated he felt that Patient #10 was "clinically stable" other than the patient's high blood pressure. Physician #5 stated he was informed by nursing staff that the patient had already been admitted to the floor, after being "stablized" in the ED. Physician #5 stated he was informed by nursing staff that the patient did not appear "normal," and a CT scan was ordered. Continued interview with Physician #5 revealed that as soon as the CT scan indicated Patient #10 was having a stroke, he immediately transferred Patient #10 to Facility #6.  Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed the NIH stroke scale assessment screening should have been administered to Patient #10 and a CT scan of the head obtained immediately upon the patient presenting to the ED. The COS also stated that Patient #10 should have never been admitted to the medical surgical floor in a hypertensive crisis due to the lack of staff to care for a critically ill patient, the facility not having adequate supplies,			ENTER		8	50 RIVERVIEW AVENUE		
having a stroke so an "immediate transfer" was arranged.  Interview with Physician #5 on 01/29/19 at 4:30 PM revealed Patient #10 presented to the ED with swelling of the tongue, slurred speech, and high blood pressure. Physician #5 stated he felt that Patient #10 was "clinically stable" other than the patient's high blood pressure. Physician #5 stated when he examined Patient #10 the patient had already been admitted to the floor, after being "stabilized" in the ED. Physician #5 stated he was informed by nursing staff that the patient did not appear "normal," and a CT scan was ordered. Continued interview with Physician #5 revealed that as soon as the CT scan indicated Patient #10 was having a stroke, he immediately transferred Patient #10 to Facility #6.  Interview with the Chief of Staff (COS) on 01/28/19 at 5:00 PM revealed that Patient #10 and a CT scan of the head obtained immediately upon the patient presenting to the ED. The COS also stated that Patient #10 should have never been admitted to the medical surgical floor in a hypertensive crisis due to the lack of staff to care for a critically ill patient, the facility not having adequate supplies,	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREF		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
Patient #10 required. Continued interview revealed the facility did not have a Cardiologist or Neurologist on staff to consult regarding these types of patients.	A1104	having a stroke so an arranged.  Interview with Physici PM revealed Patient with swelling of the tohigh blood pressure. That Patient #10 was the patient's high blood stated when he exame had already been adribeing "stabilized" in the was informed by notice that as soon Patient #10 was having transferred Patient #1 Interview with the Chi 01/28/19 at 5:00 PM is scale assessment so administered to Patient #10 should have the medical surgical for the lack of state patient, the facility no nor the capability to patient #10 required. revealed the facility of Neurologist on staff to	ian #5 on 01/29/19 at 4:30 #10 presented to the ED ingue, slurred speech, and Physician #5 stated he felt "clinically stable" other than od pressure. Physician #5 ined Patient #10 the patient mitted to the floor, after the ED. Physician #5 stated fursing staff that the patient al," and a CT scan was therview with Physician #5 the as the CT scan indicated fing a stroke, he immediately to to Facility #6.  In a for Staff (COS) on the revealed the NIH stroke the reening should have been the #10 and a CT scan of the diately upon the patient The COS also stated that the rever been admitted to loor in a hypertensive crisis fif to care for a critically ill the thaving adequate supplies, the revoide the level of care that Continued interview id not have a Cardiologist or	A1	104			

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