

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

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FORM APPROVED
OMB NO. 0938-0391

RECEIVED

SEP 12 2012

Division of Health Care
Southern Enforcement Branch

DATE SURVEY COMPLETED
07/19/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423
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F 000	INITIAL COMMENTS	F 000	This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.	
F 221 SS=D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policies, it was determined the facility failed to ensure two of eighteen sampled residents (Residents #5 and #7) were free from physical restraints. Resident #5 was assessed and had a care plan for the use of a lap belt, lap buddy, or Posey vest support while up in a wheelchair. The facility failed to assess and develop a plan of care for Resident #5 for the least restrictive device. Resident #7 utilized a foam lap belt. The facility failed to obtain a physician's order that included the medical symptom that required the use of the device, for the use of the foam lap belt for Resident #7.</p> <p>The findings include:</p> <p>1. A review of the Restraint Policy (dated 03/18/04) revealed "physician's orders must state the specific reason, type and period of time for the use of restraints." Further review of the</p>	F 221	<p>F221</p> <p>The facility immediately implemented corrective action consisting of:</p> <ul style="list-style-type: none"> * Only using 1 positioning devise and/or restraint *having a new signed orders with each change of positioning devise and/or restraint *a pre-assessment completed with each restraint and/or positioning devise *physician order that includes medical symptoms and use for each restraint and/or positioning devise <p>The facility used these corrective actions and implicated a new policy effective 8/7/12.</p> <p>The facility did an audit on all residents to identify other residents having same potential deficient practice. The audit included restraints, care plans, nurse aid information sheets, physician orders and consent documentation forms. The audit was completed on 8-8-12. The audit checked each restraint and/or positioning devise and made sure corrective action listed above was in place. The audit also</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Admin	(X6) DATE 9-11-12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	<p>Continued From page 1</p> <p>Restraint Policy revealed the use of restraints must be documented in the resident's medical record and ongoing assessments and care plans were required to be conducted.</p> <p>A review of Resident #5's medical record revealed Resident #5 was admitted on 09/30/10, with diagnoses that included Severe Parkinson's Disease, Dementia with Lewy Bodies, Diabetes, Paralysis, Raynaud's Syndrome, and Hypertension.</p> <p>Review of the pre-restraining assessment dated 09/30/10, revealed a Lap Buddy, Posey Torso Support or Foam Lap Belt would be used for a history "of sudden onset of forward thrusting, approved by the POA [Power of Attorney]." The pre-restraining assessment was updated on 09/15/11, for continued usage of the lap buddy, Posey torso support, or foam lap belt. Further review of the pre-restraining assessment revealed an update on 07/13/12, which stated the resident's spouse "requests either lap belt or Posey vest support due to resident removed lap buddy cushion himself this AM and fell into floor."</p> <p>A review of physician's orders dated 07/02/12, revealed an order for Resident #5 to utilize a cushion lap belt for personal safety and positioning while in the wheelchair. The order stated a lap buddy may be used if the lap belt was not effective. Further review of physician's orders for Resident #5 dated 07/13/12, revealed the resident may use a Posey vest support or foam lap belt per the Power of Attorney's (POA's) request.</p> <p>Review of the Comprehensive Care plan dated</p>	F 221	<p>confirmed all restraint care plans were up to date. As well as the nurse aid information sheets had appropriate device/restraint listed if acceptable. All physician orders including consent forms and documentation were audited and updated if needed during this time.</p> <p>Systemic changes have been continually made to ensure that the efficient practice will not recur. Weekly Quality Assurance documentation for has been developed to ensure solutions are sustained.</p> <p>A mandatory in-service will be held for additional education and training purposes on August 17th. The facility intends to be compliant by August 17, 2012.</p> <p><i>please see attachments</i></p> <p>F241</p> <p>Employees were in serviced on 7-31-12 at approximately 7 am, 10 am, and 2 pm. During the in-service education and training, corrective and systemic changes were discussed to prevent and ensure the deficient practice would not recur. Key employec Carrie Byrd DM discussed and taught several areas including but not limited to:</p> <ul style="list-style-type: none"> *serving of tray's *appropriate tray pass * Not standing while feeding * Dignity and respect of individuality * timed trays 	8/7/12

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F 221	<p>Continued From page 2</p> <p>07/13/12, revealed the facility identified that Resident #5 utilized a Lap Belt, Posey Vest Support, and a Lap Buddy as a positioning device. According to the care plan, Resident #5 was required to utilize a lap buddy in the wheelchair. The Comprehensive Care plan further stated on 07/13/12, the resident's spouse "requested either lap belt or Posey vest support due to the resident removed lap buddy cushion this AM and was found on floor." The care plan stated a quarterly restraint review would be conducted for possible reduction of the restraint or a reduction in the amount of time the restraint was used and the results of the reduction periods would be documented.</p> <p>A review of Resident #5's Nurse Aide Information Sheet (care plan) revealed no information related to restraint usage for the resident.</p> <p>A review of the physical restraint elimination assessments dated 04/03/12 and 07/02/12, revealed the facility assessed Resident #5 not to be a candidate for restraint reduction or restraint elimination.</p> <p>Observation of Resident #5 on 07/18/12, at 7:30 AM, 8:30 AM, 10:30 AM, 1:30 PM, 2:30 PM, 3:30 PM, and 4:30 PM, and on 07/19/12, at 8:45 AM, 10:00 AM, and 11:30 AM, revealed the resident was up in the wheelchair with a soft belt that crossed over the chest, around the waist, and fastened behind the wheelchair. Resident #5 was calm while up in the wheelchair and no attempts were observed to remove the restraint or lunge forward from the wheelchair.</p> <p>Observation of Resident #5's room revealed a</p>	F 221	<p>* Equipment in dining room</p> <p>* following seating charts</p> <p>* New revised policy</p> <p>During the training each participant received a copy on the new policy, seating chart and dining room lists to keep for reference.</p> <p>On Tuesday July 24, 2012, the dining room was divided into more appropriate and even numbered groups.</p> <p>On Tuesday July 24, 2012 meal times were adjusted including tray times to allow more time for meals to become hotter on steam table. See attached schedule</p> <p>A hall corridor were divided into separate smaller carts to allow faster distribution and less time on halls untimely resulting in appropriate desired temperature when reaching residents.</p> <p>The facility meet in an emergency session of QA on 7/25/12, 7/26/12, 7/27/12, and again on 7/30/12 to identify and monitor other residents having the potential deficient practice.</p> <p>Systemic changes were put into place to ensure that the deficient practice would not recur. Daily monitoring of administrative staff as well as charge nurses, and dietitian</p>	

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F 221	<p>Continued From page 3</p> <p>Lap Buddy, a Posey Vest, and a Lap Belt available for use in Resident #5's recliner chair.</p> <p>Interviews with SRNA #1 on 07/19/12, at 8:45 AM, with SRNA #2 on 07/19/12, at 9:00 AM, with SRNA #3 on 07/19/12, at 9:15 AM, with SRNA #4 on 07/19/12, at 9:50 AM, and with SRNA #5 on 07/19/12, at 10:00 AM, revealed the SRNA nurse aide sheet should have the type of restraint the facility had assessed for Resident #5 to utilize. The SRNAs stated they could ask the Charge Nurse for the correct restraint to utilize for any resident. According to the SRNAs, Resident #5 was required to utilize a soft Posey vest belt while the resident was up in the wheelchair. The SRNAs stated the charge nurse had informed them what restraint should be used and they were aware the type of restraint the resident required was not on the nurse aide information sheet.</p> <p>Interviews were conducted with LPN #1 on 07/19/12, at 10:15 AM, and with LPN #2 on 07/19/12, at 11:10 AM. LPN #1 stated the correct restraint for any resident should be in the physician's orders. However, when asked what Resident #5's correct restraint should be, LPN #1 was unable to determine the correct restraint for Resident #5 as there were three restraints to choose from. LPN #1 stated the DON or charge nurse could be consulted to find the correct restraint for Resident #5. According to LPN #2, Resident #5's POA/family and the DON chose the restraint that was used for the resident. The LPNs stated they did not conduct the restraint assessments and were not aware what the care plan for Resident #5 stated.</p> <p>Interview with the DON on 07/19/12, at 1:45 PM,</p>	F 221	<p>will be necessary during meals to help monitor with quality assurance and compliance. Weekly audits will be completed on ensure compliance and reported to quality assurance committee. A new policy was adopted and effective 7/25/12.</p> <p>Lastly to monitor all dietary performance a weekly quality assurance form has been adopted and effective 7-31-12.</p> <p>All corrective actions were completed by July 31, 2012. <i>7/31/12</i> <i>please see attachments</i></p> <p><u>F253</u></p> <p>During a walk through on 7/19/12 areas of floor were pointed out as having old wax build up. On the afternoon of the 19th the HSK Supervisor and HSK supervisor assistant examined tile. Maintenance replaced tile on 7/23/12 then resealed with wax. The other area examined on 7/19/12 would not come up with stripper scraper and did not appear to have anything left on tile. A representative from the distributor where facility purchases cleaning and maintenance products was consulted. This representative was in facility on 7/20/12 and agreed that there was nothing on the tile to</p>

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F 221	<p>Continued From page 4</p> <p>revealed the Nurse Consultant and the DON assessed restraints for residents. The DON stated the nurse consultant made the decision to change the restraints at the request of Resident #5's family/POA. The DON stated the physician's order, the nurse aide information sheet, and the comprehensive care plan should specify the correct restraint to be utilized for Resident #5, and that only one restraint should be ordered and care planned at a time.</p> <p>2. A review of the Restraint Policy (dated 03/18/04) revealed "physician's orders must state the specific reason, type, and period of time for the use of restraints." According to the policy, before a resident was restrained the facility would determine the presence of a specific medical symptom that would require the use of a restraint and how the use of a restraint would treat the medical symptom.</p> <p>Hourly observations conducted for Resident #7 on 07/17/12, from 2:30 PM to 5:30 PM, and on 07/18/12, from 7:15 AM to 12:55 PM, revealed the resident had a foam lap belt in place tied to the back of the wheelchair.</p> <p>A review of a significant change assessment completed for Resident #7 with a reference date of 06/18/12, revealed the resident was assessed for the use of a trunk restraint daily when in the chair. A review of the Care Area Assessment (CAA) Summary for the restraint dated 06/20/12, revealed Resident #7 had poor safety awareness with a history of falls and used a foam lap belt when up in the wheelchair for safety. In addition, the use of the restraint allowed the resident to be out of his/her room for socialization with no</p>	F 221	<p>come out. The representative</p> <p>identified discoloration of the tile due to factors including but not limited to age, a previously used product or stain. This section of tile was replaced on 7/23/12.</p> <p>A walk through of entire facility was completed on July 24, 2012 in identify other potential areas that might have wax build-up. The facility met in an emergency session of QA on 7/25/12, 7/26/12, 7/27/12, and again on 7/30/12 to identify and monitor other residents having the potential deficient practice.</p> <p>New quality assurance logs were adapted for systemic changes and made to ensure that the deficient practice would not recur and effective 8/7/12. Log and results will be communicated to the quality assurance committee on a weekly basis.</p> <p>The facility plans to monitor its performance to ensure deficient practice is sustained by; HSK Supervisor or their designee will perform a check after stripping, and waxing and log the findings. In addition a monthly walk through will be conducted by HSK or Maintenance Supervisor or their</p>	

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F 221	Continued From page 5 negative outcomes according to the CAA. A review of the medical record for Resident #7 revealed the resident's responsible party (R/P) had approved the use of the foam lap belt on 05/12/12, however, there was no evidence of a physician's order that included the medical symptom that required the use of a foam lap belt. An interview conducted with State Registered Nurse Aide (SRNA) #3 on 07/18/12, at 10:50 PM, revealed the foam lap belt was primarily used for Resident #7. The resident could not remove the foam lap belt, and the lap belt was utilized to prevent the resident from getting up from the wheelchair unassisted. An interview conducted with Licensed Practical Nurse (LPN) #3 on 07/18/12, at 4:15 PM, revealed the physician's order was not written on 05/12/12, for the use of the lap belt and had been missed by the LPN. An interview conducted with the DON on 07/19/12, at 4:25 PM, revealed prior to a device being utilized a physician's order should be obtained for the device. The DON was not aware that a physician's order had not been obtained for Resident #7's foam lap belt until 07/18/12.	F 221	designee to check and log the condition of the floor tiles throughout the facility. All findings will be reported to the quality assurance committee. Facility corrected actions pertaining to F253 by 8/7/12. <i>please see attachments</i> F364 Employees were in serviced on 7-31-12 at approximately 7 am, 10 am, and 2 pm. During the in-service education and training, corrective and systemic changes were discussed to prevent and ensure the deficient practice would not recur. Key employee Carrie Byrd DM discussed and taught several areas including but not limited to: *serving of tray's *appropriate tray pass * Not standing while feeding * Dignity and respect of individuality * timed trays * Equipment in dining room * following seating charts * New revised policy During the training each participant received a copy on the new policy, seating chart and dining room lists to keep for reference.	8/7/12
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241		

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F 241	Continued From page 6 This REQUIREMENT Is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide care that promoted dignity and respect for one of eighteen sampled residents (Resident #5) and two unsampled residents (Residents D and E). During the evening meal on 07/17/12, Resident #5 and Resident D were observed to be lying in their beds and State Registered Nurse Aide (SRNA) #6 and SRNA #7 were observed to stand when they provided assistance with the residents' meals. The staff was observed to be talking with each other and not attentive to the residents. The residents had to look up to receive their food. In addition, Resident E waited thirty minutes for the meal after other residents at the same table had received their meals. The findings include: A review of the Facility's Resident Rights policy (not dated) revealed the facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. 1. The Director of Nursing (DON) revealed in an interview conducted on 07/19/12, at 9:00 AM, that even though the facility's policy did not specifically address staff standing to assist residents with meals it was facility practice to sit at the resident's eye level when assisting the residents. Resident #5 and Resident D were observed to be	F 241	In addition Dietary only employees were in serviced in addition on 7/31/12 at 1:30 p.m. by key employee Carrie Byrd on: <ul style="list-style-type: none"> • Dining room seating • Organization of cards and trays • Organization of numeric order pertaining by rooms • Tables in dining room • Appropriate temperatures • Temps recorded before serving and in 30 min. intervals on tray line • Sanitation Logs were put into place for systemic changes to be recorded daily. Results of log will be given to quality assurance committee. On Tuesday July 24, 2012 the dining room was divided into more apocopate and even numbered groups. On Tuesday July 24, 2012 meal times were adjusted including tray times to allow more time for meals to become hotter on steam table. A hall corridor were divided into separate smaller carts to allow faster distribution and less time on halls untimely resulting in	

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F 241	<p>Continued From page 7</p> <p>lying in their beds during the evening meal on 07/17/12, at 5:50 PM. Continued observation revealed SRNA #6 and SRNA #7 stood at the bedside of each resident when they assisted the residents with their meals. The SRNAs were engaged in a conversation with each other, not with the residents, and both residents had to look upward to receive their food.</p> <p>Interview with SRNA #6 and SRNA #7 on 07/17/12, at 5:50 PM, revealed the SRNAs could sit or stand, whichever was more comfortable for the SRNAs, when they provided residents with assistance with their meals. Both SRNAs stated it was more comfortable for them to stand.</p> <p>Interview with the LPN #2 (Charge Nurse) on 07/19/12, at 11:10 AM, revealed SRNAs were to sit at eye level with the resident when feeding residents so the resident would not feel rushed to eat.</p> <p>Interview with the DON on 07/19/12, at 9:00 AM, revealed the facility provided in-service training on 06/08/12, related to proper feeding techniques. According to the DON, staff was instructed they were not to stand when assisting residents with their meals and was to sit at eye level of the resident so the resident would not feel rushed during the meal service.</p> <p>2. A review of the facility policy, Delivery and Return of Trays, (undated) revealed meal trays would be placed in the meal cart in sequence for the most efficient service to the residents, e.g., "by dining area and table or room."</p> <p>Observation of the evening meal on 05/17/12,</p>	F 241	<p>appropriate desired temperature when reaching residents.</p> <p>The facility meet in an emergency session of QA on 7/25/12, 7/26/12, 7/27/12, and again on 7/30/12 to identify and monitor other residents having the potential deficient practice.</p> <p>Systemic changes were put into place to ensure that the deficient practice would not recur. Daily monitoring of administrative staff as well as charge nurses, and dietitian will be necessary during meals to help monitor with quality assurance and compliance. Weekly audits will be completed on ensure compliance and reported to quality assurance committee. A new policy was adopted and effective 7/25/12.</p> <p>In addition the dietitian was here on 7/30/12 and completed monthly quality assurance audit. Temperatures were noted acceptable, Food was palatable.</p> <p>A new cart for food distribution was ordered as well as cart covers to help with insulation on 7/26/12/ those were put into use on 7/31/12. To ensure sanitary compliance the covers will be cleaned three times a day, once after each meal. A log has been put in</p>	

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F 241	Continued From page 8 from 5:15 PM to 5:45 PM, revealed residents sitting at the same table were not served meal trays at the same time. Continued observation revealed facility staff failed to serve Resident E a meal tray for approximately 30 minutes after the other residents at the same table were served their meal tray. Resident E was observed to watch the other residents at his/her table and the other residents in the dining room eating their meals before facility staff served his/her meal tray. During the 30 minutes Resident E waited for the meal, he/she was observed to ask staff several times where his/her meal tray was because he/she was hungry. Interview with the DON, the Administrator, and the Dietary Manager on 07/17/12, at 9:00 AM, 3:35 PM, and 3:45 PM, revealed staff had been trained to feed all residents/deliver trays to all residents at the same table/room at the same time so residents didn't have to watch other residents eat.	F 241	place to ensure compliance. The results will be given to the quality assurance committee. Lastly to monitor all dietary performance a weekly quality assurance form has been adopted and effective 7-31-12. This tool will be used to monitor tray completion, appropriate temperature and palatability, tray order on carts in residents room and dining room, residents being served at the same time per table and room, cart covers in use, and temperature being tested in 30 minutes intervals while food is on steam table. Completion Date 7/31/12 please see attachment 3 <u>F386</u>	7/31/12
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy, the facility failed to provide effective housekeeping/maintenance services to ensure a sanitary, comfortable interior. Wax buildup was	F 253	Medical Director James Duncan was contacted. The facility meet in an emergency session of QA on 7/25/12, 7/26/12, 7/27/12, and again on 7/30/12 to identify and monitor other residents having the potential deficient practice. Dr. James Duncan wrote letters to physicians that had affected residents. In addition an audit on 8/2/12 including physician rounds, signed orders, and progress notes was accomplished. Physician Clark	

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F 253	<p>Continued From page 9</p> <p>observed in the B Wing hallway near the nurses' station, overbed tables in resident rooms 21 and 104 were noted with a rough edge, and the sink in resident room 21 was noted with a rough edge.</p> <p>The findings include:</p> <p>1. An interview conducted with the Facility Maintenance Director on 07/19/12, at 10:30 AM, revealed the facility did not have a written maintenance policy. According to the Maintenance Director if an item needed repair staff would log the item in maintenance logs at the nurses' station or inform the Maintenance Director if he was in the building.</p> <p>Observations of the facility during an environmental tour on 07/19/12, at 10:30 AM, revealed the following areas were in need of maintenance services:</p> <p>-Resident overbed tables in rooms 21 and 104 were noted with rough edges. -A sink in resident room 21 was observed to have rough chipped edges.</p> <p>An interview with the Maintenance Director conducted on 07/19/12, at 10:30 AM, revealed the Maintenance Director or his assistant made rounds daily in the facility to identify items in need of repair but had not identified and was not aware that the overbed tables and the sink had rough edges.</p> <p>2. A review of the facility floor-stripping procedure (undated) revealed old wax and heavy soil was to be removed before applying a new sealer/wax or finish to the floor.</p>	F 253	<p>Enlow was in on 7/19/12 before state surveyors left.</p> <p>No other resident were found or noted by Cooperate Nurse Consultant Joyce Andros.</p> <p>Medical Director is going to help monitor weekly through quality assurance. In addition systemic changes were put into place to ensure the deficient practice would not recur. Physician rounds log was made and put into place 8/3/12. The log sheet will help the facility monitor its performance to ensure that the solution is sustained. All results of the log will be reported to quality assurance committee weekly.</p> <p>To ensure timely rounds adopted log will help facility and medical director call physicians and remind physician of rounds orders that must be accomplished timely. <i>8/3/12</i></p> <p>Corrected 8/3/12 <i>please see attachments</i> F428</p> <p>A facility audit was conducted and completed on 7-30-12 with on other omissions found. MD of effected resident was notified on 7-20-12, about suggested recommendation after 3 attempts</p>	

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F 253	Continued From page 10 Observations conducted on 07/19/12, at 10:45 AM, during an environmental tour with the facility Housekeeping Supervisor, revealed a heavy buildup of old wax/soil on the floor of the B Wing hallway near the nurses' station. A review of the facility floor-stripping schedule revealed the B Wing hallway was stripped three times yearly and was last stripped in April 2012. An interview conducted with the Housekeeping Supervisor on 07/19/12, at 10:45 AM, revealed the staff had not removed the old wax from corners or low areas in the floor and the wax had turned dark.	F 253	physician agreed to pharmacy recommendation. August 14, 2012 Pharmacist is due for monthly MMR. During that visit she will be using a new log adopted to ensure each recommendation gets communicated to the physician in a timely fashion. A copy of log will also be reported to quality assurance committee for review. Systemic changes went into place to ensure deficient practice did not recur. Facility now has one person delegated to complete pharmacy recommendation within one week of receiving pharmacist recommendations. On 7/30/12 Beth Coyle was included in an emergency session of quality assurance with Medical Director Jim Duncan present to approve and monitor changes to achieve compliance. Completed 7/30/12 please see attachment F464	
F 364 SS=F	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and a review of the facility's policy/procedures, it was determined the facility failed to serve food at a palatable temperature. During the initial tour of the facility and a group interview conducted with alert residents, it was revealed the survey team received complaints from alert residents that the breakfast foods were served cold most mornings. The findings include:	F 364	An extended quality assurance meeting with DM, SRNA's and Restorative aid's helped identify a better dynamic seating chat to ensure deficient practice wouldn't happen again.	7/30/12

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F 364	<p>Continued From page 11</p> <p>A review of the facility's dietary policy/procedure for Serving of Meals (Dining Room and Resident Rooms), dated 01/04/10, revealed trays would be placed on the cart in sequence for the most efficient service to the residents, and nursing personnel would be responsible for distributing the trays to the residents promptly.</p> <p>Review of the steam table temperature log for July 2012 revealed the steam table temperatures were consistently above the holding range of 135 degrees Fahrenheit.</p> <p>Observations of the breakfast meal on 07/18/12, revealed an open cart containing 29 trays was transported to the A Wing at 7:38 AM.</p> <p>Observation at 8:00 AM on 07/18/12, revealed the State Registered Nurse Aides (SRNAs) on the A Wing were not removing the meal trays in the order they were placed on the cart. The last tray was removed from the open cart at 8:02 AM, and a palatability test was conducted with a SRNA present. The test tray revealed the following: sausage with gravy tasted cold, oatmeal tasted barely warm, eggs tasted cold, toast tasted cold, and the coffee tasted too cold to drink. The SRNA agreed the food was not warm.</p> <p>Continued observations of the breakfast meal on 07/18/12, revealed an open cart containing 19 trays was transported to the B Wing from the kitchen at 7:49 AM. The last tray was removed at 8:09 AM, and a palatability test was conducted with dietary staff. The test revealed the following: oatmeal tasted barely warm, sausage with gravy tasted cold, eggs tasted cold, toast tasted cold, the coffee was barely warm, and the milk tasted</p>	F 364	<p>Employees were in serviced on 7-31-12 at approximately 7 am, 10 am, and 2 pm. During the in-service education and training, corrective and systemic changes were discussed to prevent and ensure the deficient practice would not recur. Key employoc Carric Byrd DM discussed and taught several areas including but not limited to:</p> <ul style="list-style-type: none"> * serving of tray's * appropriate tray pass * Not standing while feeding * Dignity and respect of individuality * timed trays * Equipment in dining room * following seating charts * New revised policy <p>During the training each participant received a copy on the new policy, seating chart and dining room lists to keep for referenc.</p> <p>A binder has been placed in the dining room to use as a reference to the seating chart</p> <p>Systemic changes were put into place to ensure that the deficient practice would not recur. Daily monitoring of administrative staff as well as charge nurses, and dietitian will be necessary during meals to</p>	

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F 364	Continued From page 12 cool. The dietary staff agreed with the palatability test results. Interview with dietary staff at 8:15 AM on 07/18/12, revealed the breakfast toast was placed on top of the steam table instead of into a steam table well. In addition, the dietary staff stated the plates were not heated prior to placing food on the plates. Interview with the Dietary Manager (DM) at 2:15 PM on 07/18/12, revealed the residents' meal trays were loaded onto the open cart by room number, and the trays should have been removed in the same order.	F 364	help monitor with quality assurance and compliancc. Weekly audits will be completed on ensure compliance and reported to quality assurance committee. A new policy was adopted and effective 7/25/12. Lastly to monitor all dietary performance a weekly quality assurance form has been adopted and effective 7-31-12. This tool will be used to monitor tray completion, appropriate temperature and palatability, tray order on carts in residents room and dining room, residents being served at the same time per table and room, cart covers in use, and temperature being tested in 30 minutes intervals while food is on steam table.	
F 386 SS=B	483.40(b) PHYSICIAN VISITS - REVIEW CARE/NOTES/ORDERS The physician must review the resident's total program of care, including medications and treatments, at each visit required by paragraph (c) of this section; write, sign, and date progress notes at each visit, and sign and date all orders with the exception of influenza and pneumococcal polysaccharide vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure all physician's orders were signed and dated as required for eleven of eighteen sampled residents (Residents #1, #2, #4, #5, #6, #9, #10, #13, #14, #17, and #18). Review of the medical record for these residents revealed monthly physician's orders and/or telephone	F 386	Completion Date 7/31/12 please see attachments F468 Handrail was securely tightened and fixed before survey team exited on 7-19-12. Maintenance supervisor did a walk-through of entire facility to ensure no other hand rails were secured In addition systemic changes to prevent handrails from becoming loose and ensure that they are firmly	7/31/12

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F 388	<p>Continued From page 13</p> <p>orders were not signed timely by the physician.</p> <p>The findings include:</p> <p>Review of the policy for Physician Services (dated 10/11/11) revealed the facility would ensure that the physician would sign and date all orders with the exception of the influenza and pneumococcal vaccines. These vaccines could be administered per physician-approved facility policy after an assessment for contraindications had been completed.</p> <p>1. A review of the medical record for Resident #2 revealed the facility admitted the resident on 05/26/06, with diagnoses that included Depression, Dementia, Congestive Heart Failure, and Hypertension. Continued review of the medical record revealed the physician failed to sign and date the monthly orders dated 05/01/12, 06/01/12, and 07/12/12.</p> <p>2. A review of the medical record for Resident #6 revealed the facility admitted the resident on 05/16/03, with diagnoses that included Paranoid Psychosis, Behavior Disturbance, Dementia, Anxiety, Depression, and Diabetes Type II. Continued review of the medical record revealed the physician failed to sign and date the monthly orders dated 05/01/12, 06/01/12, and 07/12/12.</p> <p>3. A review of the medical record for Resident #1 revealed the facility admitted the resident on 09/14/10, with diagnoses that included Chronic Obstructive Pulmonary Disease, Schizophrenia, Depression, Hypertension, Stroke with Left Sided Weakness, and Urinary Retention. Continued review of the medical record revealed the</p>	F 388	<p>secured in the future have been put</p> <p>in place. Weekly quality assurance checks have been designed to monitor safety and compliance. New policy pertain to repaired items was adopted and effective 8/1/12. In addition facility will monitor and check during monthly maintenance inspection. Inspection results will be communicated to the quality assurance committee.</p> <p><i>please see attachment 3</i></p> <p>Completion Date 8/1/12.</p> <p>8/1/12</p> <p>The facility was in substantial compliance on August 8, 2012.</p>	

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F 386	<p>Continued From page 14</p> <p>physician failed to sign and date the monthly orders dated 06/01/12 and 07/01/12</p> <p>4. A review of the medical record for Resident #5 revealed the facility admitted the resident on 09/30/10, with diagnoses that included Dementia with Lewy Bodies, Paralysis, Diabetes, Hypertension, Raynaud's Syndrome, and Parkinson's Disease. Continued review of the medical record revealed the physician failed to sign the monthly orders dated 07/02/12.</p> <p>5. A review of the medical record for Resident #9 revealed the facility readmitted the resident on 06/23/12, with diagnoses that included Diabetes, Confusion, Chronic Kidney Disease, Hypertension, Osteoporosis, and a Fractured Left Collar Bone. Continued review of the medical record revealed the physician failed to sign the monthly orders dated 06/23/12 and 07/02/12.</p> <p>6. A review of the medical record for Resident #13 revealed the facility admitted the resident on 01/09/09, with diagnoses that included Hypertension, Dementia, Anxiety, Depression, Chronic Back Pain, and a Cystocele. Continued review of the medical record revealed the physician failed to sign and date the monthly orders dated 05/01/12, 06/01/12, and 07/01/12.</p> <p>7. A review of the medical record revealed the facility admitted Resident #4 on 02/03/12, with diagnoses including Hypertension, Dementia, Left Hip Fracture, Gastroesophageal Reflux, Deep Vein Thrombosis, Heart Failure, Anxiety, and Insomnia. Based on documentation, the physician conducted a visit to the facility on 04/25/12, to assess Resident #4. However, the</p>	F 386		

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F 386	<p>Continued From page 15</p> <p>monthly physician's orders for April, May, June, and July, had not been signed by the physician.</p> <p>8. A review of the medical record revealed the facility admitted Resident #14 on 09/02/04, with diagnoses including Hypertension, Alzheimer's Disease, Osteoarthritis, Parkinson's Disease, Expressive Aphasia, and Dysphagia. Review of the medical record revealed the attending physician assessed Resident #14 at the facility on 05/30/12. However, the monthly physician's orders for May, June, and July had not been signed by the physician.</p> <p>9. A review of the medical record revealed the facility admitted Resident #10 on 06/14/06, with diagnoses of Osteoarthritis, Psychosis, Hypertension, Coronary Artery Disease, and Dementia. Review of the medical record revealed the attending physician visited Resident #10 at the facility on 05/23/12; however, none of the physician's monthly orders had been signed since 04/02/12. In addition, telephone orders dated 05/23/12 and 06/06/12, had not been signed by the attending physician.</p> <p>10. Review of the closed medical record revealed Resident #17 was transferred to another facility for extensive rehabilitation therapy on 07/12/12. A review of the physician's orders revealed telephone orders dated 06/24/12, 06/25/12, 06/26/12, 06/28/12, 07/01/12, 07/02/12, 07/03/12, 07/04/12, and 07/12/12, had not been signed by the resident's attending physician.</p> <p>11. Review of the closed medical record revealed Resident #18 expired at the facility on 04/23/12. However, telephone orders dated 04/5/12,</p>	F 386		

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F 388	<p>Continued From page 16</p> <p>04/08/12, 04/09/12, 04/21/12, 04/22/12, and 04/23/12, had not been signed by the resident's attending physician.</p> <p>Interview with the Director of Nurses (DON) on 07/19/12, at 2:35 PM, revealed the physicians were responsible for signing all orders when conducting visits at the facility. The DON stated the Consultant Nurse was responsible for conducting chart audits to ensure all physician's orders were signed timely. The DON stated she did not know how often the Consultant Nurse did the audits and was not aware the physician's orders had not been signed. The DON stated the Consultant Nurse also made rounds with the physicians and should remind the physician to sign all orders during the visit. In addition, the DON stated the office staff was responsible for taking the telephone orders to the physician to be signed and nursing staff was responsible for putting the original telephone orders on the resident's charts after the physician had signed the orders. The DON stated the Consultant Nurse was on vacation and could not be contacted for interview.</p> <p>Interview conducted with an office staff member on 07/19/12, at 3:30 PM, revealed she was responsible for taking the telephone orders to the physician's office to be signed. The office staff member stated she delivered and picked up telephone orders at the physician's office weekly. The office staff member stated she did not know who was responsible for putting the orders on the resident's chart after they had been signed.</p>	F 388		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON	F 428		

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F 428	<p>Continued From page 17</p> <p>The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.</p> <p>The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review, interview, and a review of facility policies, the facility failed to ensure pharmacy irregularities were reported to the attending physician and acted upon for one of eighteen sampled residents (Resident #10).</p> <p>The findings include:</p> <p>A review of the Medication Regimen Review policy (dated October 2011) revealed the Consultant Pharmacist (RPh) would conduct a medication regimen review (MRR) for all residents in the facility monthly. The policy noted the RPh would document his/her findings and recommendations on the monthly drug/medication regimen review report and provide a written report listing the irregularities found with recommendations for their solutions to the DON and the resident's physician. The policy further noted copies of the MRR reports, including physician response, would be maintained as part of the resident's permanent medical record.</p> <p>Review of the medical record revealed the facility</p>	F 428		

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F 428	Continued From page 18 admitted Resident #10 on 06/14/06, with diagnoses including Osteoarthritis, Psychosis, Hypertension, Ischemic Heart Disease, Dementia, Coronary Artery Disease, and Anxiety. A review of the July 2012 physician's orders revealed Resident #10 had orders to receive Pradaxa (blood thinner) 150 milligrams (mg) once a day and Seroquel (antipsychotic) 50 mg at bedtime. A review of the MRR conducted on 06/01/12, revealed the RPh made recommendations to the physician to increase Pradaxa 150 mg to twice a day. In addition, the MRR conducted on 07/05/12, revealed the RPh recommended a gradual dose reduction for Seroquel for Resident #10 and noted the last dosage change was done in 2011. However, there was no evidence the physician or Nursing Services had reviewed/acted upon these recommendations. An interview conducted with the DON on 07/18/12, at 4:00 PM, revealed the Consultant Nurse was responsible for removing the RPh recommendations from the chart after the RPh conducted the monthly MRR. The DON stated the pharmacy recommendations were faxed to the resident's physician for review. However, the DON stated she could not provide evidence the RPh recommendations dated 06/01/12 and 07/05/12, had been faxed to the physician for review. The Consultant Nurse was out of town on vacation and not available for interview.	F 428		
F 464 SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms	F 464		

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

PRINTED: 08/24/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/19/2012
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 464	<p>Continued From page 19 designated for resident dining and activities.</p> <p>These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policy it was determined the facility failed to prevent crowding in the resident dining room. Observations of the evening meal service conducted on 07/17/12, revealed thirty residents seated in the dining room. Staff was observed to move residents and disrupt meals to allow residents to exit the dining room.</p> <p>The findings include: A review of the facility dining policy entitled Serving of Meals (Dining Room), undated, revealed the dining room was required to be adequately furnished with tables at appropriate heights to accommodate wheelchairs. Additional review of the facility dining room seating chart revealed the facility had two seatings in the dining room with 32 residents scheduled for the first seating and 7 residents scheduled for the second seating.</p> <p>Observations of the facility dining room conducted on 07/17/12, at 5:15 PM, revealed staff requested an unsampled resident to move each time another resident had to enter or exit the dining room. The unsampled resident was</p>	F 464		

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F 464	<p>Continued From page 20</p> <p>observed to stop eating and physically get up from a chair each time other residents entered and exited the dining room. In addition, staff was observed to lift resident equipment (a walker) above residents' heads and remove the equipment from the dining room.</p> <p>Observations of the evening meal service on 07/17/12, at 5:30 PM, revealed 30 residents seated in the facility dining room. Four staff members were observed assisting residents to eat. Resident #8 was observed to be seated at a table and was being assisted to eat by staff. The resident finished eating and requested to leave the dining room. The resident was unable to leave the dining room independently in his/her wheelchair. The resident was observed to attempt to move other residents and pull at residents' chairs when attempting to exit the dining room. The staff had to ask two residents to stop eating and move so that Resident #8 could exit the dining room in his/her wheelchair.</p> <p>An interview conducted with the Dietary Manager (DM) on 07/19/12, at 3:45 PM, revealed the Facility Nurse Consultant and the Dietary Manager decided the seating arrangements for the dining room and the number of residents for each meal. The DM was not aware of resident crowding in the dining room during the first seating nor that residents could not enter and exit the dining room without other residents having to stop eating and physically move.</p> <p>An interview with the Executive Director (ED) on 07/19/12, revealed the ED was not aware of any concerns with the number of residents in the dining room during the first seating and had not</p>	F 464	

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F 464	Continued From page 21	F 464		
F 468 SS=D	received any complaints from residents or families regarding the dining room being crowded. 483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure handrails in the facility were firmly secured. During the survey conducted on 07/17-19/12, a handrail was loose on the B Wing hallway. The findings include: An interview with the Maintenance Director on 07/19/12, at 10:30 AM, revealed the facility did not have a written maintenance policy and staff was required to document items in need of repair in the maintenance log or notify Maintenance. The Maintenance Director stated the handrails were checked randomly every other day and tightened as needed. Observations of the B Wing hallway on 07/17/12, at 12:10 PM, revealed a loose handrail that was not securely attached to the wall. In addition, the same handrail continued to be loose during an environmental tour conducted with the Maintenance Director 07/19/12, at 10.30 AM. An interview with the Maintenance Director on 07/19/12, at 10.30 AM, revealed the Maintenance	F 468		

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F 468	Continued From page 22 Director was not aware of the loose handrail and had not noticed the handrail being loose during maintenance rounds.	F 468			

F221/N103**Criterion #1**

Medical symptoms were identified for the use of restraints for resident #5 and resident #7.

On a clarification or order dated 7-18-12 it stated Resident #7 had gait instability, history of anemia, and cognitive deficits which impairs the ability to make appropriate decisions. The order was re-done on 8-8-12. Previous restraints interventions were unsuccessful to become less restrictive pertaining to Resident #5. Resident #5's Physician wrote a new clarification order on 8/8/12. It stated Resident #5 was a fall risk, marked for weakness, that Posey Vest allows safe upright positioning. Previous use of lap buddy resulted in Resident #5 fall and removal. Resident #5 is currently in the least restrictive restraint device at the present time with no further falls, no further decline and no adverse effects.

Resident #7 initially had a lap buddy which caused increased agitation and increase fall risk with resident removal. Resident #7 even became one on one care for a time period when lab buddy was in place. Resident #7 is currently in the least restrictive restraint device possible at the present time with no further decline, and no adverse effects.

To achieve compliance and enforce systemic changes a chart audit was completed, clarification of physician order received, restraint documentation was confirmed and up to date, pre-assessment screen was revised, care plan up to date and revised, & nurse aid information sheet was revised to reflect compliant changes for both resident #5 and resident #7. To achieve further compliance one consent form and one pre-assessment screen with reflecting physician order and care plan will be used. A new consent was signed reflecting the current restraint usage, a pre-assessment screen was completed, care plan and personal SRNA sheet updated for both residents #5, and #7. Physician clarification order's received which included medical necessity for resident #5 of gain instability, history of anemia, and cognitive deficits which impairs the ability to make appropriate decisions. Resident #7 clarification order of medical necessity listed fall risk, marked weakness, allows safe upright positioning.

Criterion #2

An audit was performed to ensure and review all medical conditions and cognitive impairments. During Restraint Audit completed on 8-8-12 medical conditions, medical symptoms, cognitive impairment were all assessed. Including proper restraint consent signed, physician order including medical necessity was obtained, documentation that the least restrictive restraint was currently being used, care plan updated, personal information updated.

All residents that the facility had identified to utilize restraints have all been assessed for medical symptoms during the audit process. Justification for use of each restraint for each resident using a restraint. In combination with confirmation that each resident using a restraint was currently on the least restrictive restraint to treat that resident's medical symptoms. Joyce Andros RN Cooperate Nurse Consultant conducted the audit and reported her findings to Marlin Sparks Administrator.

Criterion #3

The facility believes that the deficient practice was corrected by reviewing all medical conditions and cognitive impairments. A Restraint Audit completed on 8-8-12 and reviewing information and documentation to ensure compliance such as; medical conditions, medical symptoms, cognitive impairment, proper restraint consent signed, pre-restraining assessment, physician order including medical necessity were obtained, documentation that the least restrictive restraint were currently being used, care plan updated, personal information updated. The audit went on to check all residents that the facility had identified to utilize restraints were assessed for medical symptoms. Justification was determined for each restraint for each resident using a restraint. In combination with confirmation that each resident using a restraint was currently on the least restrictive restraint to treat that resident's medical symptoms.

On Friday August 17 2012 at 7 am, 10am, and 2 pm Miranda Ruggles RN Director of Nursing lead an educational in-service for all nursing department facility members including RN's, LPN's, KMA's, and SRNA's. During the in-service each staff member was educated on but not limited to the following topics; proper restraint usage, proper application of restraint, proper tying of restraints,

where to identify residents that currently have restraints, restraint usage tool, application, who, what, where, care plans, when in doubt ask, releasing, safety checks, exercise and activity with restraint's. Each newly educated staff member received and reviewed documentation on when and how to release. A question and answer time was held during the in-service with. A group discussion was held going over each type of restraint and positioning device and the why and when the appropriate time of usage would be. During each session Miranda Ruggles choose participants to properly demonstrate application and use of restraints and or positioning device. It is important to note this skill was completed with 100% accuracy. Restraints and positioning devise that were discussed during the educational in-service are but not limited to foot box, lap buddy, vest, palmol cushion, foam lap belt, gel cushion, protective sleeves, posey hipster briefs, skin saver sleeves. Equipment was also demonstrated that could be used for resident positioning to prevent injury.

Criterion #4

Weekly Quality Assurance documentation was developed to ensure solutions are sustained relating to restraints. The facility now has a safety committee that meets each week. This is conducted and reported back to the Quality Assurance Committee weekly. Please see attached Safety Committee Policy.

The purpose of the weekly safety committee meetings is to outline and monitor each resident that has a restraint and therefore subject for increase agitation and decrease function to develop skin integrity monitor each resident that falls and each resident that has skin issues.

Each resident that has a restraint, skin issue, or fall will be monitored each week. A log is being kept; in addition each resident has a calendar and detailed sheet that specifies event, time, date, treatment, and intervention. The safety committee review each event each week and reports to the Quality Assurance Committee. In most events Medical Director James Duncan has been involved with resident's care. In addition extra medication reviews have been conducted by pharmacist Beth Coyle the Medicine Shoppe, review of safety committee request.

Immediate action will be taken as problems are identified during the monitoring process to assure the corrective action process continues to be accomplished.

F241/N113

Criterion #1

SRNA were counseled and re-educated on resident rights and dignity. SRNA's were educated not to stand while feeding, to keep eye contact with resident and at their level while feeding. To be attentive to residents at all time and carry on a conversation with the resident not each other (co-workers). SRNA's providing care for Resident #5 and Resident E was counseled and written documentation was placed in corresponding employee file. SRNA's also had duties signed off by a superior regarding table order, trays served in room, table order (residents to be served at the same time per table) and seated while feeding residents with good eye contact. Excellent dignity was witnessed by each SRNA.

Family and or Guardian of Resident #5 and Resident D were called or talked to about the identified deficient practice. An apology from the facility was forthcoming, in addition we asked and gave the family/guardian of resident #5 and resident D the opportunity to identify other concerns or deficient practices. No negative findings to report.

To continue to monitor corrective action a daily check will be in place in dining room and resident's rooms to make sure all SRNA's are treating residents with dignity including meal times. Each day during meal times key employees consisting of but not limited to Charge Nurse, LPN Designee, RN Designee, DON, Cooperate Nurse Consultant, HR Coordinator, Social Services, Activity Director, Dietary Manager, Admissions Coordinator, Administrator, & Executive Director will be making rounds in the facility focusing on dignity to identify problems, to monitor corrective action.

A weekly Quality Assurance check was implemented on 7/31/12. Sample residents will be selected and specific systemic changes will be monitored for compliance by Dietary Manager or designee. Residents will be selected by care plan and MDS assessment dates each week to ensure timely compliance.

Therefore, weekly residents may vary from 5-12 for example. Please see attached form.

Daily checks will be monitored consisting of test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. These will be done in addition to the daily rounds of key employees. During the daily rounds of key employees rounds will be completed at meal time to identify tray order on carts, room, and table order, trays served in room, and table order, staff seated while feeding residents, cart covers in use, temperatures appropriate, and food palatability.

Each day the purpose of key employee rounds is to monitor for compliance and immediately rectify negative findings. Weekly quality assurance log will be reviewed each week by the quality assurance committee to identify additional problems corrective action, or policy changes as needed.

Criterion #2

The facility started daily checks on 7/19/12 when the deficient practice was identified. The daily checks were performed to identify other residents that had the potential to be affected by staff's failure to provide care that promote dignity and respect. In addition a sample selection of resident's family members or guardians were called and interviewed to help correct the deficient practice. During the interview each member was given the opportunity to file grievance, and no

negative findings were reported. All results were reported to the Quality Assurance Committee.

Criterion #3

The facility made systemic changes to ensure the deficient practice would not re-occur. The facility completed an audit on 7/30/12 which consisted of ensuring each staff member provided care for residents in a manner and environment that maintains & enhances each resident's dignity and respect in full recognition of each resident's individuality. By checking each resident at different meal times, confirming resident's meals were served timely as other residents were served at the same table. If resident was a feeder that dignity was given by ensuring proper seating was taken, eye contact and SRNA was given each resident proper attention. The audit showed compliance with no negative findings.

The facility feels confident that the deficient practice was corrected and will not recur. The confidence stems from daily rounds from key employees consisting of but not limited to Charge Nurse, LPN Designee, RN Designee, DON, Cooperate Nurse Consultant, HR Coordinator, Social Services, Activity Director, Dietary Manager, Admissions Coordinator, Administrator, & Executive Director will be making rounds in the facility focusing on dignity to identify problems, to monitor corrective action.

In addition weekly Quality Assurance checks that were implemented on 7/31/12. Sample residents will be selected and specific systemic changes will be monitored for compliance by Dietary Manager or designee. Please see attached form.

The facility started daily checks on 7/19/12 when the deficient practice was identified. The daily checks were performed to identify other residents that had the potential to be affected by staff's failure to provide care that promote dignity and respect. In addition a sample selection of resident's family members or guardians were called and interviewed to help correct the deficient practice. During the interview each member was given the opportunity to file grievance, and no negative findings. All results were reported to the Quality Assurance Committee.

The facility made systemic changes to ensure the deficient practice would not re-occur. The facility completed an audit on 7/30/12 which consisted of ensuring each staff member promoted care for residents in a manner and environment that maintains & enhances each resident's dignity and respect in full recognition of each residents individuality. By checking each resident at different meal times, confirming resident's meals were served timely as other residents were served at the same table. If resident was a feeder that dignity was given by ensuring proper seating was taken, eye contact and SRNA was given each resident proper attention. The audit showed compliance with no negative findings.

On 7/31/12 all nursing department employees consisting of SRNA's, KMA's, LPN's, and RN's in addition to Dietary Employees consisting of Dietary Aids & Cooks were all educated by Carrie Byrd Dietary Manager.

Criterion #4

Daily checks will be monitored consisting of test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. These will be done in addition to the daily rounds of key employees. During the daily rounds of key employees rounds will be completed at meal time to identify tray order on carts, room, and table order, trays served in room, and table order, staff seated while feeding residents, cart covers in use, temperatures appropriate, and food palatability.

Each day the purpose of key employee rounds is to monitor for compliance and immediately rectify negative findings. Weekly quality assurance log will be

reviewed each week by the quality assurance committee to identify additional problems corrective action, or policy changes as needed.

F364/N273

Criterion#1

Resident trays that were used for the sample palatability test on 7/18/12 were given fresh trays at the correct temperature. All other residents on 7/18/12 were asked and given the opportunity for a new breakfast tray.

Criterion #2

The facility identified other residents that had the potential to be affected by the same deficient practice by interviews and quality assurance testing. Interviews were conducted by Jill Brown Executive Director and Carrie Byrd Dietary Manager. Cognitive residents were interviewed and asked to identify dietary problems, concerns, complaints, resident asked about temperature of meals, food that is served. All result's reported to quality assurance committee for compliance. Quality Assurance Log checks test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. During

interview process 1 resident complained of temperature. Resident is now served first tray pass with no more complaints.

Criterion #3

On 7/31/12 all nursing department employees consisting of SRNA's, KMA's, LPN's, and RN's in addition to Dietary Employees consisting of Dietary Aids & Cooks were all educated by Carrie Byrd Dietary Manager.

The facility started daily checks on 7/19/12 when the deficient practice was identified. The daily checks were performed to identify other residents that had the potential to be affected by staff's failure to provide nutritive value at a palatable preferred temperature. In addition a sample selection of resident's family members or guardians were called and interviewed to help correct the deficient practice. During the interview each member was given the opportunity to file grievance, and no negative findings. All results were reported to the Quality Assurance Committee.

Daily checks will be monitored consisting of test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. These will be done in addition to the daily rounds of key employees. During the daily rounds of key employees rounds will be completed at meal time to identify tray order on carts, room, and table order, trays served in room, and table order, staff seated while feeding residents, cart covers in use, temperatures appropriate, and food palatability.

The facility implemented several interventions to ensure all residents received their meals at an acceptable temperature. Starting with immediately correcting the deficient effected trays, and getting residents new fresh trays. Investigating by talking to residents and family/guardian members for problems. Daily quality assurance, followed by weekly quality assurance checks by committee members. Education and training to nursing staff and dietary employee by Carrie Byrd Dietary Manager. Dietary will ultimately responsible for food temperatures and palpability. Toast is now kept in steam table, to help ensure proper temperature. Cart covers were implicated to help with isolation. An additional cart was ordered and put into use 7/30/12 when division of carts was performed to keep trays from being on the halls for a shorter period, and at a satisfactory temperature.

Criterion #4

Daily checks will be monitored consisting of test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. These will be done in addition to the daily rounds of key employees. During the daily rounds of key employees rounds will be completed at meal time to identify tray order on carts, room, and table order, trays served in room, and table order, staff seated while feeding residents, cart covers in use, temperatures appropriate, and food palatability.

Each day the purpose of key employee rounds is to monitor for compliance and immediately rectify negative findings. Weekly quality assurance log will be

reviewed each week by the quality assurance committee to identify additional problems corrective action, or policy changes as needed.

F386/N290

Criterion #1

Corrective action was taken for Resident #1, #2, #4, #5, #6, #9, #10, #13, #14, #17, and #18. Physicians were contacted by medical Director James Duncan. In addition Physician of effected resident reviewed resident's total program of care, including medications and treatments, wrote, signed and dated a progress note for each effected resident and signed and dated all orders on 7/19/12 and 8/5/12.

Criterion #3

Systemic changes were put into place to ensure the deficient practice would not recur. Medical Director will be at facility weekly to monitor any physician's that needs to make rounds and see residents. Dr. Duncan will call and or write a letter to remind physicians. If unsuccessful, Dr. Duncan will accept resident' and see resident review resident's total program of care, including medications and treatments, write, sign and date a progress note for each potentially effected resident and sign and date all orders. If the same physician's continue deficient practice that physician privilege will be revoked by the facility.

Physician rounds log was put into place on 8/3/12. The goal of the log sheet is to communicate with physician's weeks in advance so they may see residents timely.

Criterion #4

Physician rounds log was put into place on 8/3/12 to identify physicians that have or need to make rounds. Administration will be in charge of completing physician rounds log. DON and or designee will complete the log each time a physician makes rounds. Each week when Medical Director James Duncan is in he will be quickly able to see which physician he needs to contact if any. Dr. Duncan or his designee will communicate by phone, text, or letter to remind physician's to see residents at facility timely.

If problems arise, Dr. Duncan will accept resident' and see resident review resident's total program of care, including medications and treatments, write, sign and date a progress note for each potentially effected resident and sign and date all orders. If the same physician's continue deficient practice that physician privilege will be revoked by the facility.

All results will be communicated each week with the Quality Assurance Committee.

F464/N74

Dining room seating was divided into equal groups. There is a binder in the dining room for each seating for SRNA's to go by. Dietary Manager Carrie Byrd took systemic changes to revise dining room seating. She interviewed SRNA's and Restorative aides to implement a dining seating that would be compatible for all residents. Daily checks by DON or designee, & Dietary Manager or designee are completed to ensure dining room has sufficient space and is accommodating all residents during each meal time.

Daily checks will be monitored consisting of test tray completed, appropriate temperature and palatability, tray order on carts, tray order in room, table order, trays served in room, residents served at the same time per table, aides & nurses seated while feeding residents, cart covers in use, temperature being tested in 30 minute intervals while food is on steam table. These checks will be completed each day and reported back to the quality assurance committee weekly for compliance. Each staff that is on duty will be subject for monitoring. Dietary Manager or designee will be monitoring this process using the weekly quality assurance log (see attached). Monitoring will take place each day during meal times. There will be a sample list given to each department head to check for weekly quality assurance compliance checks. See Attached. This will ensure each resident is monitored on every systemic change possible, and monitored timely. These will be done in addition to the daily rounds of key employees. During the daily rounds of key employees rounds will be completed at meal time to identify tray order on carts, room, and table order, trays served in room, and table order,

staff seated while feeding residents, cart covers in use, temperatures appropriate, and food palatability.

F468/N121

Systemic changes were put into place to ensure deficient practice did not recur. A safety committee was put into place in 7/12. Each fall which is what caused the loose hand rail in the listed deficient practice will be identified and carefully documented for patterns, trends, time, and date. Any equipment that was used so maintenance can be notified.

In addition weekly checks from maintenance is to be reported to the safety committee including environment to be free of sharp and rough edges, room and problems needing to be addressed, environment free of pest, environment free of clutter including power cords, electrical panels to be free of obstruction- within 36 inches, door closers functioning, no door stoppers, environment clean, room inspected for cleanliness, no hazards, any potential cross contaminated patterns and clutters, hand rails secure additional comment/concerns. This log is to be completed by Maintenance Supervisor or designee, and completed log submitted to safety committee. Safety Committee reports to quality assurance committee weekly.

A weekly Maintenance quality assurance log is to be completed and reported to the quality assurance committee weekly, residents bed working properly and brakes on, bed rails are secure, call light system working, a/c-heating system working properly, electrical outlets/lights,/fixtures working properly and in good condition, night stand in good condition, over bed table wheels rolling properly , bath rails secure, toilet, sink, bathe working properly, water temperature adequate, private curtains working correctly, soap dispenser/towel holder/toilet paper holder/glove holder attached, room furniture in good condition, light bulbs working, effective pest control observed, room walls free from dents & scrapes. This log is to be completed by Maintenance Supervisor or designee, and completed log submitted to quality assurance committee weekly.

Criterion #4

Weekly checks from maintenance are to be reported to the safety committee including: environment to be free of sharp and rough edges, room and problems needing to be addressed, environment free of pest, environment free of clutter including power cords, electrical panels to be free of obstruction-nothing within 36 inches, door closers functioning, no door stoppers, environment clean, room inspected for cleanliness, no hazards, any potential cross contaminated patterns and clutters, hand rails secure additional comment/concerns. This log is to be completed by Maintenance Supervisor or designee, and completed log submitted to safety committee. Safety Committee reports to quality assurance committee weekly.

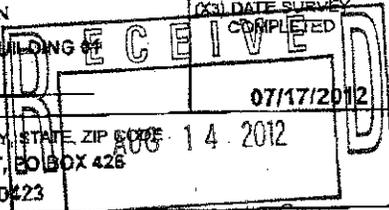
A weekly Maintenance quality assurance log is to be completed and reported to the quality assurance committee weekly, residents bed working properly and brakes on, bed rails are secure, call light system working, a/c-heating system working properly, electrical outlets/lights/fixtures working properly and in good condition, night stand in good condition, over bed table wheels rolling properly, bath rails secure, toilet, sink, bathe working properly, water temperature adequate, privacy curtains working correctly, soap dispenser/towel holder/toilet paper holder/glove holder attached, room furniture in good condition, light bulbs working, effective pest control observed, room walls free from dents & scrapes. This log is to be completed by Maintenance Supervisor or designee, and completed log submitted to quality assurance committee weekly.

The monitoring will be taking place each day. Maintenance Director or designee will immediately rectify any negative findings and report to administrator and or executive director. Also, negative findings will be reported to safety committee weekly and quality assurance committee to change protocol and or policy at any time or as needed.

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING # B. WING	(X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, BOX 426 DANVILLE, KY 40423	



(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)
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K 000 INITIAL COMMENTS

CFR: 42 CFR 483.70(a)

BUILDING: 01

PLAN APPROVAL: 1990

SURVEY UNDER: 2000 Existing

FACILITY TYPE: SNF/NF

TYPE OF STRUCTURE: 1 story, Type III (200)

SMOKE COMPARTMENTS: 6

FIRE ALARM: Complete automatic fire alarm system.

SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.

GENERATOR: Type II diesel generator.

A life safety code survey was initiated and concluded on 07/17/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.

Deficiencies were cited with the highest deficiency identified at "F" level.

K 026 NFPA 101 LIFE SAFETY CODE STANDARD
SS=F

Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may

K 000

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law.

K025

On July 19, 2012 LCI Intumescent Fire Stop Sealant was ordered. The deficient areas were treated with approved fire stop sealant.

Systemic changes were put into facility practice to ensure the deficient practice would not recur by maintain smoke barriers with at least one-half hour fire resistance rating; ensuring that penetrations about fire/smoke barriers doors were properly sealed.

The facility plans to monitor these systemic changes by inspecting smoke barriers monthly and performing any repairs to the fire/smoke barriers; with approved fire sealant as needed. Results of the inspection will be submitted to the quality assurance committee as well as any repairs.

K 025

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *M. K. ...* TITLE: *Pres.* (X5) DATE: *8-10-12*

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.

Received Time Aug. 14, 2012 10:46AM No. 0126

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 1</p> <p>terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barriers with at least a one-half hour fire resistance rating as required. The facility failed to ensure that penetrations above fire/smoke barrier doors were properly sealed. This deficient practice affected six of six smoke compartments, staff, and all the residents. The facility has the capacity for 90 beds with a census of 89 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey on 07/17/12, at 10:40 AM, with the Director of Maintenance (DOM), the fire/smoke barrier wall in the A Wing attic area was observed to have a gap around electrical conduit and water piping that was penetrating this wall. Fire/smoke barrier walls must be properly maintained to prevent fire and smoke from spreading to other areas of the facility in a fire situation. During the survey two B Wing fire/smoke barrier walls, another A Wing wall, and the laundry area fire/smoke barrier walls were observed to have the same type of penetrations and/or holes. Unapproved</p>	K 025	<p>A inspection of facility smoke/fire barriers was conducted on 7/26/12 to identify other areas needing correction that would possible effect residents with same deficient practice. No further smoke/fire barriers were noted deficient at that time. Results were communicated to the quality assurance committee.</p> <p>The deficient practice was corrected by 7/27/12, making the facility in substantial compliance.</p>	

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NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 428 DANVILLE, KY 40423		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 025	<p>Continued From page 2</p> <p>expansion foam was observed to be filling areas in the B Wing fire/smoke barrier wall.</p> <p>An interview with the DOM on 07/17/12, at 10:40 AM, revealed he was aware these walls are required to be properly sealed. The DOM was unaware that unapproved expansion foam could not be used in these walls. The facility was cited for the same deficient practice on 06/08/10 and 08/30/11.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.</p> <p>8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:</p> <p>(a) The space between the penetrating item and the smoke barrier shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall</p> <ol style="list-style-type: none"> 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. <p>(c) Where designs take transmission of vibration</p>	K 025		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185264	(X2) MULTIPLE CONSTRUCTION A. BUILDING D1 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/17/2012
NAME OF PROVIDER OR SUPPLIER CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT, PO BOX 426 DANVILLE, KY 40423		
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K 025	Continued From page 3 into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025			