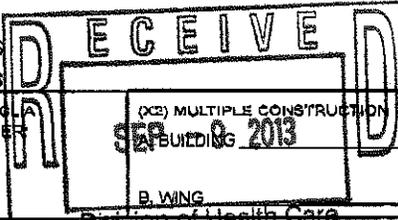


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185221

(X2) MULTIPLE CONSTRUCTION
BUILDING 2013

B. WING

(X3) DATE SURVEY
COMPLETED

C
08/16/2013

NAME OF PROVIDER OR SUPPLIER

SALYERSVILLE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
571 PARKWAY DRIVE
SALYERSVILLE, KY 41465

(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 000	INITIAL COMMENTS An abbreviated standard survey (KY20562) was initiated on 08/13/13 and concluded on 08/16/13. The complaint was substantiated. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	F163 483.10 (d)(1) RIGHT TO CHOOSE A PERSONAL PHYSICIAN 1. Resident #1 has been given physician choice by the Director of Nursing on 8/15/2013.	
F 163 SS=D	483.10(d)(1) RIGHT TO CHOOSE A PERSONAL PHYSICIAN The resident has the right to choose a personal attending physician. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure the resident had the right to choose his/her personal attending physician for one of six sampled residents (Resident #1). Interview with Resident #1's physician on 08/14/13, at 5:55 PM, revealed he had informed Resident #1 that if the resident chose to have a second opinion from another physician regarding his/her care, the resident would be discharged from the facility. The findings include: A review of the facility's policy titled, "Bill Of Resident Rights," dated 07/01/09, revealed the resident has the right to choose a personal attending physician; to be fully informed in advance about care and treatment and of any changes in care or treatment that may affect the resident's well-being; and to participate in planning care and treatment or changes in care and treatment, unless the resident has been	F 163	He received a second opinion per an outside physician of his choice on 8/21/2013. The Medical Director is his physician and is aware. 2. All interviewable residents were interviewed by a Department Manager (Administrator, Director of Nursing, Education Training Director, Social Worker, Housekeeping Manager, Activity Director, Unit Manager, Medical Records Clerk, Ancillary Clerk, Admissions, or Chaplain) regarding their physician choice and informed of all the physician choices available at the center by 9/4/2013 to identify if any resident wanted to change physicians. Any issue noted was immediately addressed. All non interviewable residents' families were contacted by a Department Manager and informed of all physicians practicing in the center by 9/4/2013 to identify any family who wanted to change physicians. No issues were noted.	

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

Administrator

TITLE

8/16/13

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.

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466
--	--

(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 163	<p>Continued From page 1</p> <p>adjudged incompetent or found to be incapacitated under state law.</p> <p>A review of the list of physicians with privileges at the facility reveal the facility had three physicians on staff who provided care to the residents.</p> <p>A review of the medical record for Resident #1 revealed the facility admitted the resident on 02/01/12, with diagnoses including Diabetes Mellitus, Morbid Obesity, Left Lower Extremity Joint Pain, Muscle Weakness, Diabetic Neuropathy, and Coronary Artery Disease. A review of the last Minimum Data Set (MDS) quarterly assessment dated 07/29/13, revealed the facility had assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 which revealed the resident was alert, oriented, and interviewable.</p> <p>An interview conducted with Resident #1 on 08/13/13, at 2:00 PM, revealed the resident had requested a second opinion regarding his/her care. The resident stated he had felt his/her physician did not listen to his/her requests and had wanted a second opinion regarding his/her care and possibly even a change in his/her physician. Resident #1 stated he/she had asked his/her physician if he/she could have a second opinion. According to Resident #1, his/her physician became angry with the request, told the resident "no," and informed the resident if he/she wanted a second opinion and chose to pursue the second opinion, the resident would be discharged from the facility. The resident stated he/she was not given the option of choosing another physician, or to see another physician for a second opinion to see if the physician agreed with the care being provided by Resident #1's</p>	F.163	<p>3. Re education was completed by the Regional Nurse Consultant (RNC) for Department Managers regarding resident and family right to physician choice on 9/4/2013.</p> <p>ETD re educated licensed nurses regarding resident right to physician choice by 9/3/2013.</p> <p>Department Manager to interview 5 existing residents weekly x 3 weeks then 5 residents monthly x 2 months starting week of 9/4/2013 to ensure they are satisfied with their physician choice.</p> <p>Admissions personnel to inform all families and residents in writing of the available physicians practicing in the center on admission beginning 9/5/2013 and this will be ongoing.</p> <p>Administrator or ETD to audit 3 admissions weekly x 3 weeks then 2 admissions monthly x 2 months beginning week of 9/7/2013 to ensure that the choice of physicians is given to all new residents/families in writing.</p>	
-------	--	-------	---	--

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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41455		
(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 163	Continued From page 2 physician. An interview conducted with Resident #1's physician on 08/14/13, at 5:55 PM, confirmed he/she told Resident #1 that if the resident chose to have a second opinion, the resident would be discharged from the facility. The physician stated he felt that if the resident did not trust him it would put him (the physician) at risk should the resident choose to obtain a second opinion. An interview conducted with the Administrator on 08/16/13, at 1:50 PM, revealed she had not been aware of the conflict between Resident #1 and the resident's physician. The Administrator stated residents in the facility have the right to seek a second opinion should they desire to do so. The Administrator stated no resident would be discharged from the facility related to seeking a second opinion.	F 163	4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director and Admission Personnel to meet weekly x 2 weeks beginning week of 9/4/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved. 5. Date of Compliance 9/13/2013.		
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure services provided by the facility met professional standards of quality for one of six sampled residents (Resident #1). A review of the medical record for Resident #1 revealed a physician's order dated 07/16/13, at 12:30 PM for the resident to receive physical therapy services. However, the facility failed to	F 281	F281 1. Resident #1 was evaluated by Physical Therapy Department on 7/25/2013. Physician was made aware of evaluation date being 7/25/2013 by the DON and no new orders were noted.		

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 281	Continued From page 3 provide the services ordered by the physician prior to the resident going to the hospital on 07/19/13, at 5:00 PM (76 1/2 hours after the order was received). The findings include: A review of the facility's policy titled, "Regarding Physician's Orders," dated 09/01/10, revealed initial physical therapy orders would be obtained for evaluation, and/or evaluation and treatment prior to rendering services and evaluations will be initiated within 72 hours of receipt of such an order or authorization by the physician. A review of the medical record for Resident #1 revealed the resident was admitted by the facility on 02/01/12, with diagnoses including Morbid Obesity, Left Lower Extremity Joint Pain, Muscle Weakness, Diabetic Neuropathy, and Coronary Artery Disease. A review of the physician's orders for Resident #1 revealed a physician's order dated 07/16/13, at 12:30 PM, for the resident to receive physical therapy services for range of motion and strengthening exercises to the left leg related to the weakness of the extremity. A review of the nurse's notes for Resident #1 revealed the resident was transferred to the hospital on 07/19/13, at 6:00 PM. However, based on documentation, the facility failed to ensure the resident received physical therapy services prior to being transferred to the hospital, 76 1/2 hours after the physician's order was received. The resident returned to the facility on 07/22/13, at 4:00 PM. A review of the physical therapy notes revealed the resident was not evaluated by Physical Therapy until 07/25/13, at 12:24 PM.	F 281	2. An audit of all records was completed by the DON, Administrator or the UM by 9/3/2013. This audit reviewed all therapy orders received for the prior 30 days 8/2/2013 thru 9/2/2013 to identify any physician order for a therapy evaluation that was not completed per policy. No issues were noted. DON reviewed nurse's notes for prior to 30 days 8/1/2013 thru 9/1/2013 to identify any issues with nurses not following professional standards. No issues were identified. 3. Reducation was completed by the ETD or the RNC for the Department Managers, therapy department and the licensed nurses by 9/4/2013 regarding timely completion of therapy evaluation physician orders per policy and professional standards of care. Beginning 9/5/2013 any order for a therapy evaluation will be brought to the triage meeting held Monday thru Friday with the clinical team and a therapy department representative will be present. Therapy orders will be logged and followed up on daily to ensure all evaluations are completed per policy and no later than 72 hours or per policy. DON/UM or QA Nurse to audit 9 records randomly each week x 4 weeks beginning week of 9/7/2013 to ensure professional standards are followed. Administrator, DON or QA Nurse to audit therapy evaluation log at least 2 x weekly x 3 weeks then at least weekly x	
-------	---	-------	---	--

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 281	Continued From page 4 An interview conducted with the Physical Therapist (PT) on 08/16/13, at 11:30 AM, revealed when the nurse received an order for physical therapy services he/she would complete a communication form and send it to the Therapy Department. The PT stated she had received the physician's order for Resident #1 on 07/16/13, and should have completed the evaluation for physical therapy services by 07/19/13, at 12:30 PM. The PT stated she had not attempted the evaluation of Resident #: until 07/20/13, after the resident had already been sent out to the hospital. The PT stated she had just missed the evaluation and was unsure how it had happened. The PT stated she did not track to ensure evaluations were being completed timely.	F 281	3 weeks to ensure all orders are logged and followed up with completion dates that follow policy beginning week of 9/7/2013. 4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director and RSM to meet weekly x 2 weeks beginning week of 9/4/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved. 5. Date of Compliance 9/13/2013.		
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 363	F363 483.35 © MENUS MEET RESIDENT NEEDS/PREP IN ADVANCE FOLLOWED 1. No specific resident was identified. All residents have the potential to be affected. Medical Director is aware of issues identified with no new orders.		

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 363	<p>Continued From page 5</p> <p>facility policy review, and facility recipes, it was determined the facility failed to ensure menus were followed for the lunch meal on 08/14/13. A test tray placed on the Peach Wing lunch cart was obtained and a taste test was conducted with facility staff and revealed the mashed potatoes were bland with little taste, and the macaroni was mushy with no taste.</p> <p>The findings include:</p> <p>An interview conducted with the Registered Dietitian (RD) on 08/14/13, at 12:50 PM, revealed the facility did not have a policy related to following a recipe.</p> <p>A review of the facility's recipe titled, "Plain Macaroni," undated, revealed 3 pounds and 2 ounces of macaroni would be cooked in 3 1/4 gallons of boiling water, with 1/4 cup vegetable oil until tender (approximately 10 to 15 minutes), and would then be held at 140 degrees Fahrenheit or higher for serving.</p> <p>A review of the facility's recipe titled, "Mashed Potatoes," undated, revealed staff was required to use 2 pounds and 12 ounces of potato granules, 1 1/2 gallons of water, and 4 ounces of margarine, prepare according to package instructions, and hold at 140 degrees Fahrenheit or higher for serving.</p> <p>Observation of the lunch meal service on the Peach Wing of the facility on 08/14/13, at 12:17 PM, revealed a closed lunch cart containing resident lunch trays was taken to the unit. The last resident tray was removed from the cart at 12:27 PM, and a test tray, which had been placed on the cart by the dietary staff, was tested with</p>	F 363	<p>2. RD complete a one time audit of the lunch meal on 8/27/2013 to identify if recipes were followed. No issue noted. RD reviewed recipe book to identify any item that did not have a written recipe on 9/4/2013. No issues noted.</p> <p>Administrator and some department managers did a one time tasting of breakfast, lunch, and super on 8/28/2013 to identify palatability and if recipe was followed to ensure taste. No issue was identified</p> <p>3. Re education was completed on 9/3, 9/4, and 9/6 by the RD, dietary manager or ETD regarding following recipes to ensure food palatability and where recipe book is. This was completed for dietary staff.</p> <p>Department manager, administrator, dietary manager, or RD to taste food (all foods on tray) for at least one meal daily 5 times a week times 3 weeks starting the week of 9/4/2013 to ensure recipe is followed and food is palatable.</p> <p>RD or dietary manager to audit recipe book at least once a week times 3 weeks to ensure recipes are available and being used beginning week of 9/4/2013.</p> <p>Department manager or dietary manager to interview 5 residents randomly 5 times a week times 3 weeks beginning</p>	
-------	--	-------	---	--

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 363	<p>Continued From page 6</p> <p>the Dietary Manager. The mashed potatoes were bland with very little taste, and the plain macaroni had no taste and was mushy.</p> <p>An interview with the Cook on 08/14/13, at 1:35 PM, revealed she had prepared the mashed potatoes and plain macaroni for the lunch meal on 08/14/13. The Cook stated she had not used a recipe when preparing the mashed potatoes and the plain macaroni. The Cook stated she had not used vegetable oil in the macaroni but had used a "big hunk of margarine" and had not measured it. The Cook stated she was aware the facility had recipes but had been cooking a long time and just knew how much of the ingredients to put in the dishes.</p> <p>An interview with the Dietary Manager (DM) on 08/14/13, at 12:45 PM, revealed she had not been aware the facility had recipes for mashed potatoes and plain macaroni.</p> <p>An interview conducted with the RD on 08/14/13, at 12:50 PM, revealed the facility has recipes for plain macaroni and for mashed potatoes and staff was required to follow the recipes. The RD stated the facility does not have a policy regarding following the recipes. The RD stated he or the DM do five test trays a week and had not identified any concerns with staff not following the recipes.</p>	F 363	<p>week of 9/4/2013, then they will interview 2 residents 3 times a week x 3 weeks to ensure food is palatable and recipes are followed and being used.</p> <p>A food committee meeting will be conducted monthly and all residents will be invited starting in September and will be ongoing to ensure food preferences are honored, food is palatable, and temperatures are acceptable. A department manager or Administrator will attend and follow up on any issues identified.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, and Medical Director to meet weekly times 2 weeks beginning week of 9/4/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance 9/13/2013.</p>	
F 364 SS=D	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>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</p>	F 364	<p>F364 483.35 (d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>1. No specific resident was identified. All residents have the potential to be affected. Medical Director is aware of issues identified with no new orders noted.</p>	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 364	<p>Continued From page 7 temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure foods were palatable and at the proper temperature for residents on the Peach Wing of the facility for the lunch meal on 08/14/13.</p> <p>The findings include:</p> <p>A review of the facility's policy titled, "Food Temperatures," undated, revealed foods leaving the steam table would be at 140 degrees Fahrenheit or greater. The policy also stated cold food items would leave the kitchen at 41 degrees Fahrenheit or below. The policy revealed once a week the Dietary Manager (DM) or her designee would monitor test tray temperatures to ensure proper food temperatures were being maintained.</p> <p>An interview with the Registered Dietitian (RD) on 08/14/13, at 12:50 PM revealed the facility did not have a policy related to the palatability of foods served to residents.</p> <p>Observation during the lunch meal on 08/14/13, at 12:17 PM revealed the lunch trays were delivered to the Peach Wing of the facility with the last tray being delivered to the resident at which time a test tray was observed and tested with the DM for palatability. The country fried steak with gravy was cool and was 110 degrees Fahrenheit, the mashed potatoes were bland with little taste and were cool at 115 degrees Fahrenheit, the plain macaroni had no taste, was mushy, and cold at 90 degrees Fahrenheit, the milk was cool</p>	F 364	<p>2. A one time audit by Department Manger of every food temperature was completed on 8/22/2013 for breakfast, lunch and super to identify any food that temperatures per policy was not on the tray line. Any issue was immediately corrected.</p> <p>A one time audit of 3 random trays to test food temperature was completed by a department manager on 8/29/2013 this was completed to identify and food at point of service that did not meet temperature policy. Any issue identified was immediately corrected. The maintenance supervisor completed a check on the plate warmer in the kitchen on 8/30/2013 to identify if plate warmer was holding temperature. Any issue identified was immediately corrected.</p> <p>3. Re education was completed by the ETD, RNC, or RD/dietary manager for dietary employees and department manager by 9/6/2013 to ensure policy for food temperature at holding and point of service is within regulatory guidelines.</p>	
-------	---	-------	--	--

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41455
--	--

(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 364	Continued From page 8 but not cold at 52 degrees Fahrenheit. An interview with the Dietary Manager (DM) on 08/14/13, at 12:45 PM, revealed she does test tray observations for palatability with five trays every week and had not identified any concerns. An interview was conducted with the RD on 08/14/13, at 12:50 PM. The RD stated the temperatures of all the tested foods were too low. The RD stated the amount of time the trays were on the floor (11 minutes) should not have caused that much of a drop in the temperature of the foods that were tested. The RD stated he or the DM do five test trays a week and had not identified any concerns with palatability or with temperatures of foods sent to the residents.	F 364	Dietary department employee to test food temperature and record for all foods every meal beginning 8/14/2013 to ensure temperatures before point of service meet regulatory requirements. Dietary Manager or department manager to monitor dietary log 5 times a week x 2 weeks beginning week of 8/29/13 then 3 times a week times 3 weeks to ensure food temperature in the kitchen and holding temperature are within regulatory guidelines. A Department manager will randomly audit at least 2 trays (one at 2 meals a day) 5 times a week times 2 weeks beginning week of 8/29/2013 then randomly audit 1 tray daily 2 times a week times 3 weeks to ensure food temperatures at point of service meets regulatory compliance. Department manager to interview 3 resident 3 times a week times 2 weeks beginning week of 9/4/2013 to ensure there is no issue with food temperatures at point of service. This will include both residents that eat in room and dining room. A food committee meeting will be conducted monthly and all residents will be invited starting in September and will be ongoing to ensure food preferences are honored, food is palatable, and temperatures are acceptable. A department manager or Administrator will attend and follow up on any issues identified.	
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to honor food preferences for one of six sampled residents (Resident #1) and one of nine unsampled residents (Resident A). Observation of a lunch tray for Resident #1 on 08/13/13, revealed Resident #1 had coffee on the lunch tray, however, a review of Resident #1's tray card revealed the resident had a dislike for coffee. A review of the lunch tray for Resident A at the noon meal on 08/15/13, revealed the	F 366	4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, and Medical Director to meet weekly times 2 weeks beginning week of 9/4/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved. 5. Date of Compliance 9/13/2013. F366 483.35 (d)(4)SUBSTITUTES OF SIMILAR NUTRITIVE VALUE 1. Resident number 1 coffee was removed from tray on 8/13/2013 per residents request. Resident A was offered a substitute for rice on 8/13/2013. No other residents were identified.	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 366	Continued From page 9 resident had been served a bowl of rice, however, a review of the tray card for Resident A revealed the resident had a dislike of rice. The findings include: A review of the facility's policy titled, "Procedure For Food Preferences," undated, revealed food preferences would be noted upon admission and at least annually. The policy stated the food preferences would be noted on the tray card in an effort to assist staff with honoring food preferences. The policy stated it was the goal of the facility to attempt to meet all residents' food preferences in accordance with their physician ordered diet. 1. Observation on 08/13/13, at 2:00 PM of an untouched food tray on Resident #1's overbed table revealed the lunch tray contained a cup of coffee. A review of the tray card revealed the resident had a dislike for coffee. An interview conducted with Resident #1 on 08/13/13, at 2:00 PM, revealed he/she had not requested coffee on his/her lunch tray. The resident stated the kitchen sent things frequently that he/she had told the facility he/she did not like. An interview with Dietary Aide #1 on 08/14/13, at 2:05 PM, revealed she had been responsible for sending the coffee to Resident #1. The Dietary Aide stated she checked for food likes and dislikes prior to sending trays from the kitchen. The Dietary Aide stated she was unsure why Resident #1 got coffee on his/her lunch tray on 08/13/13. 2. Observation during the lunch meal on	F 366	Food preferences for resident #1 and resident A were updated on 8/19/2013. The Medical Director was notified of findings on by the DON. No new orders were noted. 2. Food preferences for all residents in the center was updated by the department managers by 9/5/2013 to identify food preferences (likes/dislikes). Any issue was immediately addressed. A one time audit by Department Managers of every tray was completed on 8/30/13 to identify any issues with food preferences being honored. Any issue identified was immediately corrected. 3. Re education was completed by the ETD, RNC, or RD/dietary manager regarding honoring food preferences, serving food preferences and offering food substitutes. This was completed on 9/6/2013 for dietary staff, department managers and nursing staff. Department manager, RD or dietary manager to randomly audit 5 trays 5 times a week times 3 weeks beginning week of 9/4/2013 then 5 trays once a week times 3 weeks to ensure that individual food preferences are honored. A Department manager or dietary manager will interview 5 residents 5	
-------	--	-------	---	--

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41485		
(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 366	<p>Continued From page 10</p> <p>08/15/13, at 11:22 AM of a lunch tray which had been served to Resident A revealed the lunch tray contained a bowl of rice. A review of the tray card for Resident A revealed he/she had a dislike listed for rice.</p> <p>An interview conducted with Resident A on 08/15/13, at 11:23 AM, revealed he/she had told the facility staff numerous times that he/she did "not like rice and they continue to send it to me anyway."</p> <p>An interview with Cook #1 on 08/15/13, at 1:10 PM, revealed she was responsible for sending the rice to Resident A. The Cook stated she always checked the dislikes prior to preparing a tray, and that the rice sent to Resident A had been a mistake.</p> <p>An interview with the Dietary Manager (DM) on 08/15/13, at 1:15 PM, revealed both she and the Registered Dietitian (RD) were responsible for checking a resident's likes/dislikes. The DM stated she conducted five test trays a week and checked for dislikes at that time. The DM stated they had not identified any concerns with residents receiving foods that had been listed as dislikes.</p> <p>An interview with the Administrator on 08/16/13 revealed the RD was terminated by the facility. The Administrator stated she was aware there were problems previously with food dislikes being served to residents. The Administrator stated all Department Managers had been required to check two resident trays for accuracy daily Monday through Friday, and had not identified any concerns in the last week.</p>	F 366	<p>times a week times 3 weeks beginning week of 9/4/2013 then 2 residents 3 times a week times 3 weeks to ensure food preferences are honored.</p> <p>A food committee meeting will be conducted monthly and all residents will be invited starting in September and will be ongoing to ensure food preferences are honored, food is palatable, and temperatures are acceptable. A department manager or Administrator will attend and follow up on any issues identified.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, and Medical Director to meet weekly times 2 weeks beginning week of 9/4/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance 9/13/2013.</p>		

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 441 F 441 SS=E	<p>Continued From page 11</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441 F 441	<p>F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>1. Resident number F and G's family and physician were notified that the nurse performing the glucose monitored did not follow completely the infection control protocol for such monitoring. The Medical Director was notified the nurse did not follow the infection control policy relative to glucose monitoring. MD was notified of ice pass issues and no specific resident was identified. No new orders were received.</p> <p>2. The ETD completed a one time audit of ice being passed on 8/26/2013 to identify any issues with infection control and any issue noted was immediately resolved.</p>	

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465	
(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 441	Continued From page 12 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to establish and maintain an effective infection control program designed to provide a safe and sanitary environment to prevent the transmission of disease and infection for four of six sampled and nine unsampled residents (unsampled Residents F, G, H, and I). Observation of facility staff passing ice to residents on the Peach Wing on 08/14/13, at 3:00 PM, revealed staff touched the inner portion of the ice pitcher with the ice scoop handle that staff had come into direct contact with, while filling Resident H and Resident I's water pitchers with ice. In addition, observation of medication administration on the Green Wing on 08/15/13, beginning at 11:05 AM, revealed Licensed Practical Nurse (LPN) #1 performed blood glucose testing without wearing gloves and also failed to appropriately cleanse/sanitize the blood glucose monitoring device after performing blood glucose testing on Resident F and Resident G. The findings include: 1. A review of the facility's policy titled, "Blood Glucose Monitoring Technique," undated, revealed staff was required to apply disposable gloves to their hands prior to beginning the blood glucose testing of residents. A review of the manufacturer guidelines for the Assure Platinum blood glucose monitoring device (used by facility staff to perform glucose testing of residents), revealed health care professionals	F 441	The ETD monitored 5 glucose checks on 8/27/2013 to identify any issue with glucometer cleaning or any issues with infection control. Any issues identified were immediately reported to the MD and staff was retrained by the ETD. ETD monitored staff providing care to 10 residents to identify issues with hand washing, use of gloves, and ice pass for any infection control issue on 8/27/2013. No issues were identified. ETD reviewed cultures for last 30 days to identify any resident who would require contact precautions per CDC guidelines. No issues identified. DON reviewed all infections for past 60 days to identify and track any issues by 9/6/2013. No issues were identified. 3. The ETD has inserviced all nursing staff on ice pass on 9/2/2013. The education and training director completed infection control re education for all nursing staff by which included hand washing, glucometer cleaning and CDC guidelines to ensure infection control is followed by 9/6/2013.	

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 441	<p>Continued From page 13</p> <p>should wear gloves when cleaning the blood glucose monitoring device and were required to cleanse/disinfect the device with a commercially available Environmental Protection Agency (EPA) registered disinfectant detergent or germicide wipe.</p> <p>Observation of medication administration on 08/15/13, at 11:05 AM, revealed LPN #1 washed/sanitized her hands and proceeded to cleanse the blood glucose monitoring device with an alcohol prep; however, the LPN failed to apply gloves after washing her hands and prior to cleansing the monitoring device. After the LPN had cleansed the monitoring device with alcohol, the LPN washed/sanitized her hands and proceeded to obtain the blood specimen for glucose testing of Resident F; however, the LPN failed to apply gloves after washing her hands and prior to obtaining the blood specimen for testing. The LPN was then observed to wash/sanitize her hands after the testing, failed to put on gloves, and proceeded to cleanse the blood glucose monitoring device with an alcohol prep.</p> <p>After completing the blood glucose testing for Resident F, the LPN proceeded to conduct blood glucose testing for Resident G. The LPN washed/sanitized her hands and proceeded to cleanse the blood glucose monitoring device with an alcohol prep; however, the LPN failed to apply gloves after washing her hands and prior to cleansing the monitoring device. After the LPN had cleansed the monitoring device with alcohol, the LPN washed/sanitized her hands and proceeded to obtain the blood specimen for glucose testing of Resident G; however, the LPN failed to apply gloves after washing her hands</p>	F 441	<p>ETD reviewed cultures for last 30 days beginning 8/26/2013 to ensure all infections are reviewed and resident is placed in isolation. ETD/UM to monitor 2 licensed nurses completing glucometer monitoring to ensure all infection control procedures are followed weekly times 4 weeks beginning week of 8/26/2013. DON and ETD or unit manager to monitor 5 staff weekly times 3 weeks beginning the week of 8/26/2013 to ensure hand washing is completed correctly. ETD to review all infections from 8/26-9/26 to ensure no trends were identified and then will review monthly.</p> <p>Ice passes will be monitored 2 times weekly times 4 weeks beginning 8/26 to ensure hand washing has occurred correctly and that staff doesn't touch the ice pitcher with the scoop handle.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, and Medical Director will review audit findings and make revision where needed to ensure compliance each week for 2 weeks beginning 9/4/2013 and then monthly as needed or until resolved.</p> <p>5. Date of Compliance 9/13/2013.</p>		

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/16/2013
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(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 441	<p>Continued From page 14</p> <p>and prior to obtaining the blood specimen for testing. The LPN was then observed to wash/sanitize her hands after the testing, failed to put on gloves, and proceeded to cleanse the blood glucose monitoring device with an alcohol prep.</p> <p>An interview with LPN #1 on 08/15/13, at 12:05 PM, revealed she was aware she should have worn gloves and should have cleansed the blood glucose monitoring device with a bleach wipe. The LPN stated she had been nervous and had forgotten. The LPN stated she had attended a facility in-service regarding infection control and blood glucose monitoring.</p> <p>An interview with the Director of Nursing (DON) on 08/16/13, at 12:55 PM, revealed the facility provided in-services regarding blood glucose monitoring on an annual basis and stated nurses were required to successfully demonstrate a performance of blood glucose monitoring after completion of the in-service. The DON stated LPN #1 was a new nurse and had successfully completed a demonstration of blood glucose monitoring upon her employment at the facility. The DON stated the facility had not previously identified any concerns with blood glucose monitoring.</p> <p>2. A review of the facility's policy titled, "Standard Precautions," undated, revealed all residents must be treated as if he/she was infected with a bloodborne pathogen and standard precautions must be taken with each resident and must be used consistently to prevent cross-contamination from one resident to another.</p> <p>Observation of staff passing ice to residents on</p>	F 441			

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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 441	<p>Continued From page 15</p> <p>the Peach Wing on 08/14/13, at 3:00 PM, revealed State Registered Nursing Assistant (SRNA) #2 was observed to touch the inner portion of the ice pitcher with the ice scoop handle that staff had come into direct contact with, while filling Resident H's water pitcher with ice.</p> <p>An interview conducted with SRNA #2 on 08/14/13, at 3:20 PM, revealed she had attended in-services related to infection control and was aware she should not have touched the inside of the ice pitcher with the handle of the ice scoop that she had touched. The SRNA stated she was in a hurry and had failed to follow the infection control precautions.</p> <p>Observation of staff passing ice on 08/14/13, at 3:02 PM, revealed SRNA #1 touched the handle of the ice scoop that she had touched to the inner portion of Resident I's water pitcher.</p> <p>An interview conducted with SRNA #1 on 08/14/13, at 3:15 PM, revealed she had attended in-services given by the facility related to infection control. The SRNA stated she was aware she should not have touched the inside of Resident I's water pitcher with the handle of the ice scoop. The SRNA stated it was just an accident. The SRNA stated she should have replaced the resident's ice pitcher and scoop.</p> <p>An interview with the DON on 08/16/13, at 12:55 PM, revealed staff should not touch the inside portion of resident water pitchers with contaminated ice scoops. The DON revealed the facility monitored handwashing as part of the Quality Assurance program and had not identified any concerns with staff passing ice to residents.</p>	F 441		
-------	--	-------	--	--

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

PRINTED: 08/28/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/16/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
--	--

(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
--------------------	--	---------------	---	----------------------

--	--	--	--	--