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

PRINTED: 07/29/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010
NAME OF PROVIDER OR SUPPLIER: PROFESSIONAL CARE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 114 MCMURTRY AVE. HARTFORD, KY 42347	

RECEIVED AUG 2 2010 OFFICE OF INSPECTOR GENERAL

(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 A standard recertification survey was conducted, on 07/13/10 through 07/15/10, to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D".	F 000		
F 222 SS=D	483.13(a) RIGHT TO BE FREE FROM CHEMICAL RESTRAINTS The resident has the right to be free from any chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure one resident (#6), in the selected sample of 20, had the right to be free from chemical restraints, imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. Findings include: A record review revealed Resident #6 was admitted to the facility, on 07/07/10, with diagnoses to include Dementia With Behavioral Disturbances and a History of Cerebral Vascular Accidents (CVA,) Transient Ischemic Attacks (TIA) and Falls. A review of physician's orders, dated 03/03/10 through 07/15/10, revealed an order for "Valium 5 milligrams (mg)/1 milliliter (ml) intramuscularly (IM) every eight (8) hours as needed (pm) for acute agitation." Physician's orders, dated 03/24/10, revealed the Valium was discontinued	F 222	It is the practice of this facility for all residents to be free from chemical restraints for the purpose of discipline or convenience, and not the resident's medical symptoms. Prior to the exit conference with the State Survey team, the physician provided the facility with a verbal order to discontinue the PRN order for Vistaril for Resident # 6. All physicians 'orders were reviewed on 7-14-10 by the Director of Nursing and the only PRN order for injections related to behavior management was for Resident #6. We have reviewed our policy and educated all nursing staff on 8-3-10 that there are to be no PRN IM orders related to behavior management. All behaviors that are not manageable by routine pharmacological interventions or non-pharmacological measures will be reported to the physician.	8-15-10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Patricia D. Donald | TITLE: Administrator | (X6) DATE: 8-25-10

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 222	Continued From page 1 and an order for "Ativan 0.5 mg by mouth (PO) every eight hours prn agitation or anxiety and Ativan 0.5 mg IM, if the resident refuses PO," was written. Physician's orders, dated 05/25/10, revealed the Ativan prn order was discontinued and an order was written for "Vistaril 25 mg IM every four hours prn agitation." A review of the medication administration records (MARs), dated 03/10 through the 07/15/10, revealed Resident #6 received Valium 5 mg/1 ml IM prn, on 03/04/10 and 03/06/10, and Valium 2 mg IM, written as a "now" dose, on 06/01/10. An interview with the consultant pharmacist, on 07/15/10 at 2:50 PM, and a review of the Consultant Pharmacist Drug Regime, dated 03/08/10, revealed a alert recommendation was made concerning the use of Valium 5 mg IM. The pharmacist stated she sent the recommendation related to the Valium and the Vistaril to the physician. The physician agreed to discontinue the Valium, but never responded to the the recommendation for the the use of Vistaril. An interview with Registered Nurse (RN) #1, on 07/15/10 at 9:10 AM, revealed she did not consider the use of the injections a chemical restraint. The resident exhibited behaviors of striking out at other residents and hitting and biting staff and the injections were used as an intervention to protect the resident from injury. An interview with the Director of Nursing (DON), on 07/15/10 at 1:25 PM revealed nurses carried out the physician's orders and the injections were not considered a chemical restraint.	F 222	Any orders for pharmacological intervention will be written as a one time order, and subsequent behaviors will be reported to the physician. The Director of Nursing will audit all resident charts monthly for 6 months to ensure that no PRN orders for injections related to behavior management have been written and that all behaviors requiring physician notification have been managed appropriately. She will report any findings to the facility Quality Assurance committee no less than quarterly.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	

(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 222	Continued From page 2 A review of the facility's undated policy/procedure for "Chemical Restraints," revealed licensed staff were supposed to initiate a Behavioral Observational Profile (BOP) Sheet and monitor the length of time a resident exhibited a behavior, document all measures taken to redirect the resident, assess the resident's current physical status, assess for the potential danger to the resident or others, evaluate the behaviors and administer psychopharmacological medication. The last intervention stated, "Emergency incidents occur which might override the above mentioned steps to be taken" and "Call the physician, as necessary."	F 222		
F 241 SS=D	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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined that the facility failed to promote care for one resident (#13), in a selected sample of 20, in a manner and environment that enhanced the resident's dignity. Resident #13 was incontinent of bowel and required assistance during the breakfast meal. Staff were aware and failed to immediately intervene and provide prompt incontinent care for the resident. Findings include: Record review revealed Resident # 13 was admitted to the facility, on 09/12/08, with diagnoses which included Senile Dementia and a	F 241	It is the practice of this facility to provide care to our residents in a manner and in an environment that maintains or enhances the resident's dignity and respect in full recognition of his or her individuality. Care was provided to Resident #13 following staff notification of the residents need. Rounds were made by staff on 7-13-10 and no other residents were found to be in need of assistance. Rounds are made by the licensed staff no less than twice per shift and nurse aides make rounds no less than every two hours to ensure that residents who are incontinent or need assistance with toileting, are having their needs met.	8-19-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 241	Continued From page 3 history of TIA/Stroke. A review of the Minimum Data Set (MDS) assessment, dated 06/11/10, revealed the facility identified Resident # 13 as moderately cognitively impaired and required supervision and set-up assistance with eating and extensive assistance of one or more staff members for bed mobility, transfers, toilet use and personal hygiene. Resident #13 was identified as frequently incontinent of bowel and bladder. A review of the care plan, dated 09/12/2008, for the problem Self Care Deficit revealed interventions included assistance with meals by setting up the resident's tray with cues and encouragement. Additionally, care plan interventions included provision of toileting assistance upon rising , after meals at bedtime and as needed. Resident #13 required extensive assistance with incontinent care and personal hygiene and wore an incontinent pad. Further review of the nursing assistant care plan, dated 07/2010, revealed Resident #13 required two staff to assist for bowel and bladder incontinence and the use of briefs. Incontinent checks were to be provided every two hours and as needed. An observation, on 07/14/10 at 8:45 AM, revealed a family member informed Licensed Practical Nurse (LPN) #1 that Resident #13 needed incontinent care as he/she had a bowel movement. At 8:50 AM, Resident #13 was observed sitting upright in bed, holding a wet soiled washcloth, covered with a dark green foul smelling substance, identified by the family member as feces. The resident was attempting to clean his/her own hands and fingernails which	F 241	On 7-15-10 a new Bowel and Bladder Assessment for Resident # 13 was initiated to determine if we could anticipate needs more closely to try and reduce Resident # 13 incontinent episodes. As a result has been placed on a check and change before each meal. Resident #13 is also now on a scheduled bowel management program where resident is placed on the bedside commode to attempt to minimize her bowel incontinent episodes. The care plan for Resident #13 was reviewed and updated by the Minimum Data Set Coordinator 7-15-10 to ensure that the new plan was communicated to staff. The nurse aide care plan was updated on 7-30-10 to include the scheduled bowel program with specific times. These times are 9:30am and 1:30pm. The nurse aide care plan was also updated on 7-30-10 to include the plan to check and change before each meal. In order to ensure that for Resident # 13, all staff are aware of the changes in the care plan, we copied the care plan and attached it to the nurses communication sheet with instructions to ensure all staff caring for the resident is aware of the changes prior to caring for resident. This will remain with the communication sheet for one week to ensure all staff are aware.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185276	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER PROFESSIONAL CARE HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 114 MCMURTRY AVE. HARTFORD, KY 42347	

(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 241	Continued From page 4 were covered with feces. The distinct smell of feces filled the room. The family member proceeded to pull the bed covers back, which revealed the resident was soiled with feces and in need of incontinent care and personal hygiene. The family member stated she told LPN#1 the resident needed incontinent care and LPN #1 responded by saying she would inform LPN #2. An observation, at 8:55 AM, revealed LPN #2 entered the room and passed by Resident #13 and approached the resident's room mate, who was seated by the bed in a wheelchair. She told the room mate, she would get help to assist the resident back to bed and left the room, without any interaction with Resident #13, who was awaiting assistance with incontinent care. An observation at 9:00 AM , revealed Certified Nurse Aid (CNA) #1 entered Resident #13's room and also passed by Resident #13, approaching the room mate and offered to assist the room mate to bed. The room mate requested to be assisted to the toilet. CNA#1 assisted the room mate to the toilet. There was no interaction with Resident #13. An observation, at 9:15 AM, revealed CNA#1 wheeled the room mate back into the room and LPN#2 re-entered the room. CNA#1 and LPN#2 were observed to assist the room mate to bed and then leave the room again, without any interaction with Resident #13. An observation, at 9:30 AM, 45 minutes after staff were informed of the resident's need for incontinent care, revealed CNA#2 entered Resident #13's room to provide incontinent care.	F 241	This was started on 8-13-10. Education was provided to all staff on 8-3-10 by the Director of Nursing and is included in new employee orientation as well as annual "Back to Basics" in-services. As requested a copy of this in-service, content and sign in sheet is attached. For those employees not present on 8-3-10 a copy of the inservice material is available for review at the nurses' station. This was made available on 8-13-10. The memo was posted on 8-13-10. All employees reading the memo have signed once read. A copy is attached as requested. The Director of Nursing checked to ensure that all nursing staff have read the memo. LPN #1, LPN #2 and the Director of Nursing discussed and evaluated their action in regards to the issues with Resident # 13. The bowel and bladder assessment for all residents identified as incontinent will be reviewed by the Minimum Data Set Coordinator and Bowel and Bladder Assessment Nurse to ensure that appropriate plans are in place for either toileting or check and change plans. The care plans and nurse aide care plans will be reviewed to ensure that staff are aware of the plans, any plans that change will be noted on the communication sheet for appropriate communication to staff. This will be completed by 8-16-10.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 241	Continued From page 5 An interview with CNA #2, on 07/14/10 at 9:50 AM, revealed she assisted residents in the dining room during breakfast and CNA#1 monitored the hall and answered call lights. CNA #2 stated she returned from break at 9:10 AM and answered Resident #13's call light. At that time, she was told by a family member the resident had "pooped all over his/her self." An interview with CNA #1, on 07/14/10 at 10:10 AM, revealed he/she did not notice Resident #13"s call light was on, and didn't know the resident needed assistance with incontinent care. An interview with LPN #2, on 07/14/10 at 10:25 AM, revealed she gave Resident #13 the wet wash cloth to wash his/her hands that morning, but did not know the resident needed incontinent care. She further stated LPN #1 had informed her the resident's family member requested to see her, but when she went to the room and saw the surveyor present, she decided not to interrupt. LPN#2 stated Resident #13 was " bad about putting her hands down there and he/she has long nails that she refuses to have cut". An interview with LPN #1, on 07/14/10 at 11:10, revealed the family member stopped her in the hallway, at 8:45 AM. and stated "somebody better get in here and do so something soon, or I'm going to start talking to the survey people." LPN#1 stated the family member had numerous complaints, but did not request incontinent care for Resident #13. LPN#1 stated she immediately informed LPN#2 twice. LPN #1 stated the breakfast trays were served "a little after 8:00 AM. An interview with Resident #13, on 07/14/10 at 2:40 PM, revealed he/she didn't eat when in need	F 241	The unit nurse is to check Resident #13 prior to each meal for one week to ensure that the nurse aides are following the check and change plan then at least three times per week for three months to ensure that the check and change program residents is effective. All programs and plans are reviewed daily by the Director of Nursing and then three times per week for three months. In addition she is to monitor the bowel management program for results each day for one week to help evaluate the effectiveness of the program. The programs will then be evaluated no less than monthly for three months to ensure that this resident needs are being met, then will be evaluated no less than quarterly per facility program. The bowel and bladder programs for each resident are reviewed no less than quarterly to ensure that no changes are necessary to meet the needs of each resident. The Director of Nursing/Unit Nurse will make rounds weekly for one month to determine compliance with the check and change program in place. These rounds will be documented to present to the facility Quality Assurance Committee no less than quarterly to determine if any ongoing issues are noted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 241	Continued From page 6 of incontinent care, because "it burns me." The resident stated it was upsetting to his/her family and he/she felt embarrassed. Resident #13 stated, "it has happened before, but the girls do the best they can, they're busy". An interview with the Director of Nursing, on 07/15/10 at 9:40 AM, revealed she was not aware of the problem until 11:00 AM, on 07/14/10 and she expected staff to have provided the care as soon as was possible.	F 241	In addition the Minimum Data Set Coordinator/will audit all bowel and bladder assessments for those residents identified as incontinent, monthly for three months, to ensure appropriate updates and reviews are completed. These audits will be presented to the facility Quality Assurance Committee no less than quarterly to evaluate if any ongoing problems are noted.	
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure one resident (#13), in the selected sample of 20, received a therapeutic diet which honored the resident's dining preferences. An observation revealed the facility served Resident #13 two fried eggs, which were identified as a dislike on the resident's diet card. Finding include: Record review revealed Resident #13 was admitted to the facility, on 09/12/08, with diagnoses which included Senile Dementia and a history of TIA/Stroke.	F 246	It is the practice of this facility to provide reasonable accommodations of individual needs and preferences. Resident # 13 was re-interviewed regarding her dietary preferences on 7-16-10 by the Certified Dietary Manager. There were no changes in her preferences noted. Her tray card was reviewed to ensure that all preferences were noted. The tray cards for all residents were reviewed to ensure that tray cards were current with each residents preferences. All dietary staff were in-serviced on 8-03-10 on compliance with each residents tray card instructions by Certified Dietary Manager. As requested a copy of in-service, content and sign in sheet is attached.	8-19-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 246	Continued From page 7 A review of the Nutritional Assessment, dated 09/12/08, revealed recommendations included no egg or egg products. An observation of the resident's dietary card, dated 07/14/10, listed eggs as a dislike. An observation, on 07/14/2010 at 8:50 AM, revealed the dietary staff served Resident #13 the breakfast meal, which included two fried eggs. An interview, on 07/14/10 at 8:50 AM with a family member revealed Resident #13 disliked eggs and the smell of eggs made the resident sick. The family member stated she spoke to dietary staff on several occasions and had requested eggs the resident not be served eggs. An interview with the Dietary Manager, on 07/15/10 at 1:15 PM, revealed meal trays were prepared using dietary cards to ensure compliance with resident food preferences. She stated she was not aware Resident #13 had complained.	F 246	The Certified Dietary Manager will audit a minimum of twenty trays each day for one week beginning 8-12-10. The Certified Dietary Manager will audit across all three meals to ensure that all staff are compliant with tray card instructions. Following this week the Certified Dietary Manager or Consultant Dietician will perform tray audits of at least twenty trays at least one meal per week for three months. Any noted problems will be addressed at point of discovery. We will continue to discuss dietary concerns with the Resident Council. The Certified Dietary Manager will ask each resident on their quarterly reviews if there are issues with their dietary preferences being honored or of any changes to their dietary preferences. These will be corrected or noted at the point of notification. The Consultant Dietician will include tray audits in her monthly report and will present these reports to the facility Quality Assurance Committee no less than quarterly to review.	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based observation, interview and record review, it was determined the facility failed to ensure one resident (#13), in a selected sample of 20,	F312	It is the practice of this facility that all residents receive the necessary services to maintain good nutrition, grooming, personal and oral hygiene.	8-19-10

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 312	Continued From page 8 received the necessary services to maintain good hygiene. An observation revealed Resident #13 waited for approximately 45 minutes for assistance with bowel incontinence, which occurred during the breakfast meal. Findings included: Resident #13 was admitted with diagnoses to Senile Dementia and History of Stroke. Review of the Minimum Data Set (MDS) assessment, dated 06/11/10, revealed Resident #13 was identified as cognitively impaired and requiring extensive assistance with toileting and personal hygiene. Resident #13 was frequently incontinent of bowel and bladder, wore a pad with panties and care plan interventions included the resident be checked and changed every two hours and as needed. An observation, on 07/14/10 at 8:45 AM, revealed a family member requested assistance for incontinent and hygiene for Resident #13. The resident was sitting upright in bed, with a breakfast tray on the over the bed table. The resident held a soiled washcloth in his/her hands and was attempting to remove feces from his/her hands. A very strong odor of feces was noted in the room. The family member was present and pulled back Resident #13's bed linens, which revealed Resident #13 was soiled with feces. An interview with the family member, at the time of the observation, revealed she had informed Licensed Practical Nurse (LPN) #1, that Resident #13 needed incontinent care, at 8:45 AM, and the nurse stated she would inform LPN #2. An observation, at 8:55 AM, revealed LPN #2 entered the resident's room and provided assistance to the room mate and left the room	F 312	Care was provided to Resident #13 following staff notification of the residents need. Rounds were made by staff on 7-13-10 and no other residents were found to be in need of assistance. On 7-15-10 a new Bowel and Bladder Assessment for Resident # 13 was initiated to determine if we could anticipate her needs more closely to try and reduce her incontinent episode. As a result resident has been placed on a check and change before each meal and now on a scheduled bowel management program. Resident #13 is placed on the bedside commode to attempt to minimize incontinent episodes. The care plan for Resident #13 was reviewed and updated by the MDS Coordinator to ensure that the new plan was communicated to staff Education was provided to all staff on 8-3-10 by the Director of Nursing regarding dignity and resident's rights.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185275		07/15/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 312	Continued From page 9 without any interaction with Resident #13. At 9:00 AM. observation revealed Certified Nurse Aide (CNA) #1 entered Resident #13's room and assisted the room mate out of the room via wheel chair, with no interaction with Resident #13. At 9:15 AM, observation revealed CNA #1 and LPN #2 returned to the room and assisted the resident's room mate back to bed and again left the room with no interaction with the resident. At 9:30 AM, 45 minutes after care had been requested, CNA #2 entered the room and provided Resident#13 the needed assistance with incontinent care. An interview with CNA #1, on 07/14/10 at 10:10 AM, revealed she had not noticed Resident #13's call light and had no knowledge of the fact the resident needed incontinent care. An interview with LPN #2, on 07/14/10 at 10:25 AM, revealed she gave Resident #13 the wet wash cloth to wash his/her hands. She denied she was aware the resident was in need of incontinent care. LPN #2 stated LPN #1 had informed her the family member requested to speak with her and when she entered the room, she noticed the surveyor and didn't want to interrupt. An interview with LPN #1, on 07/14/10 at 11:10 AM, revealed Resident #13's family member stopped her in the hallway, at 8:45 AM, and stated, "Somebody had better get in here and do something soon or I am going to talk to the survey people". LPN #1 stated she immediately informed LPN #2. An interview with the Director of Nursing (DON), on 07/15/10 at 9:40 AM, revealed staff should	F 312	This inservice is repeated annually and the facility policy on respect and dignity related to resident right is included in the new employee orientation and reinforced in our annual "Back to Basics" inservice. The unit manager is to check resident #13 prior to the serving of meals weekly for one week then at least three times per week for three months to ensure that the resident's check and change program is complete and effective. All programs and plans are reviewed daily by Director of Nursing and then three times per week for three months. Any problems noted will be referred to the Director of Nursing for investigation and action. The Bowel and Bladder assessment for Resident # 13 will be reviewed monthly to determine the effectiveness of the program and changes will be made as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185275	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/15/2010

NAME OF PROVIDER OR SUPPLIER
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
114 MCMURTRY AVE.
HARTFORD, KY 42347

(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 312	Continued From page 10 have provided incontinent care as soon as possible.	F 312	All Bowel and Bladder assessments for all residents are reviewed no less than quarterly to ensure the resident's needs are being evaluated and addressed. As per the assessment, resident may be placed on a scheduled toileting plan, a scheduled bowel management program or check and change program. Check and Change programs are based on the resident's individual assessment. These assessments are all audited by the Minimum Data Set Coordinator no less than quarterly to ensure compliance with our policy and any problems are reported to our facility Quality Assurance Committee for review no less than quarterly.	

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

PRINTED: 07/15/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185275	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	07/14/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PROFESSIONAL CARE HEALTH & REHABILITATION CENTER	114 MCMURTRY AVE. HARTFORD, KY 42347

(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 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 07/14/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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.