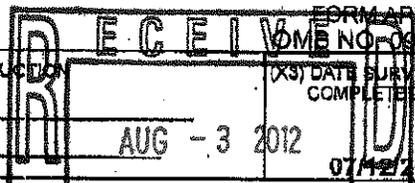


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/28/2012
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 07/22/2012
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVEDivision of Health Care SALYERSVILLE, KY 40463 Southern Enforcement Branch
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(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	F 000	F 164	
F 164 SS=B	<p>A standard health survey was conducted on 07/10-12/12. Deficient practice was identified with the highest scope and severity at 'F' level.</p> <p>483.10(a), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	<p>F 164</p> <p>1. Resident #5 and Resident #12: The physician was notified by the Unit Manager (UM) that the Medication Administration Record was left open during medication pass on 7/10/12. No new orders noted. No other resident was identified.</p> <p>2. The Education Training Director (ETD) will complete a one time audit of 2 nurses on each shift administering medications to at least 3 residents by 8/18/2012 to identify any privacy/confidentiality issues with medication administration. Any issue identified will be immediately corrected. The Director of Nursing (DON), ETD and/or UM will randomly monitor residents at least one time by 8/15/2012 while using the telephone, while personal care is being provided and while records are being used at Nurses Station to identify any issues with providing personal privacy and maintaining confidentiality of records.</p> <p>3. The ETD will re-educate nursing department by 8/18/2012 regarding resident right to personal privacy and confidentiality of medical records. The ETD and UM will randomly monitor at least one resident weekly being provided personal care, receiving medications, using the telephone and staff using medical</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jim Cox</i>	TITLE Administrator	(X6) DATE 08/03/12
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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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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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(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
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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and facility policy review, the facility failed to ensure resident health information was maintained in a private and confidential manner during medication administration. Observation of medication pass on 07/10/12, revealed the Medication Administration Record (MAR) was open and visible on the medication cart in the hallway for two residents (Residents #5 and #16) and as a result the residents' health information in the MAR was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's Confidentiality of Protected Health Information policy (dated October 1999) revealed facility staff was responsible to protect the resident through appropriate use of resident health information.</p> <p>Observation during medication pass on 07/10/12, at 4:15 PM, revealed Registered Nurse (RN) #1 entered Resident #16's room to administer medications to the resident. Further observation revealed the MAR located on top of the medication cart in the hallway had been left open and the resident's personal and confidential information was exposed to anyone in the area of the hallway where the cart was located. At 4:25 PM, RN #1 administered medications to Resident #5; the MAR was again observed to be left open and exposed to the public on top of the medication cart in the hallway. Several staff members were observed to walk past the medication cart while the MAR was left exposed. The RN failed to ensure confidentiality of the resident's health information located in the MAR</p>	F 164	<p>records weekly beginning week of 8/20/2012 x 4 weeks.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance: 8/23/2012</p>	
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 164	Continued From page 2 while she administered medications to Residents #16 and #5. Interview conducted on 07/10/12, at 4:35 PM, revealed RN #1 had been trained to maintain confidentiality of residents' medical information. The RN stated she was responsible to cover the MAR during medication administration. The RN acknowledged she had left the residents' health information exposed.	F 164		
F 241 SS=B	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 and interview the facility failed to promote the dignity and independence for twenty-three residents in the dining room during lunch and fourteen residents in the dining room during dinner on 07/10/12. Observation revealed the facility failed to provide residents with knives that would allow the residents to cut their meat and/or to butter the bread received on resident meal trays. The findings include: The Dietary Department Procedure, Dining Service, dated November 2003, does not include the use and position of the flatware provided at meal time to the residents.	F 241	F 241 1. Neither Resident #14 nor Resident F experienced any decline or change in status related to not being served knives. Since 7/12/2012, Resident #14 and Resident F have been served knives at each meal. 2. The Dietician and DON will monitor 3 meals by 8/5/2012 to identify if any resident is not served knives. Any issue identified will be immediately corrected. The ETD will randomly monitor 10 residents being provided care by 8/15/2012 to identify any issue with treating residents in a manner that maintains and enhances dignity and respect. Any issue identified will be immediately corrected. The Administrator completed a one time audit of knives and flatware on 8/2/2012 to identify if there was an	

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Received Time Aug. 3, 2012 6:32PM No. 9894

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 241	Continued From page 3 Observation of the noon meal on 07/10/12, revealed 23 residents were eating in the facility dining room. The 23 residents received cubed steak and rolls for lunch. In addition, observation conducted during the evening meal revealed 14 residents were eating in the dining room. The 14 residents received salmon patties and bread. Based on the observations, the facility failed to ensure the residents were provided knives to cut the meats served and/or to spread condiments on the rolls/bread. Interviews were conducted with Resident #14 and Resident F on 07/10/12, at 11:55 AM and 5:30 PM. The residents stated they would like to have a knife to cut the meat and spread butter on the bread. The residents stated they had requested a knife and the staff in the dining room told the residents the Dietary Department does not have any knives. An interview was conducted with the Dietary Manager (DM) on 07/10/12, at 11:56 AM. The DM stated the Dietary Department had knives in a desk drawer of the Dietary office. The DM stated the residents observed eating in the dining room had not been assessed by the nursing staff to have restrictions related to the use of a knife at meal time.	F 241	adequate amount of flatware including knives to be served at each meal. No issue was identified. 3. The Dietary Manager was re-educated one-on-one by the Dietician on 7/12/2012 regarding knives being served to residents at each meal. The ETD will re-educate nursing staff by 8/20/2012 regarding resident right to have knives at each meal and resident dignity and respect policy. The Dietician and Dietary Manager will audit at least 15 trays each week x 4 weeks to ensure knives are on each tray beginning week of 8/20/2012. The ETD will monitor at least 2 residents receiving care weekly x 4 weeks beginning 8/20/2012 to ensure all residents receive care in a manner to enhance resident dignity and provide privacy. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 242 SS=D	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices	F 242		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465	
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F 242	<p>Continued From page 4</p> <p>about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to accommodate the individual preferences for two of twenty-four sampled residents. Residents #13 and #15 had made the facility aware of food likes/dislikes; however, the facility served foods to the residents that the residents had indicated they disliked.</p> <p>The findings include:</p> <p>A review of the facility's policy (revised December 2008) regarding nutritional assessments revealed the dietician or nursing staff was to complete a food preference record for each resident within 24 hours of admission. The resident's likes/dislikes were to be documented in the resident's clinical record.</p> <p>1. A review of the medical record for Resident #13 revealed the facility admitted the resident on 12/10/10, with diagnoses that included Transient Ischemic Attacks, Arteriosclerotic Heart Disease, Hypertension, and Gastroesophageal Reflux Disease. A review of physician's orders revealed the resident was to receive a Controlled Carbohydrate Diet. The Food Preferences Card included with the resident's meal tray revealed Resident #13 did not like carrots.</p> <p>Observations of the noon meal on 07/12/12, revealed carrots had been included on Resident</p>	F 242	<p>F 242</p> <ol style="list-style-type: none"> 1. Resident # 13 and Resident #15 were offered an alternative food choice by the Certified Nursing Assistant that was on their preference list immediately upon identification of dislike. 2. All records and tray cards will be audited by the Dietician, Dietary Manager, and DON and UM by 8/20/2012 to identify any record or tray card that does not have food likes/dislikes as per the resident's personal preference. Any issue identified will be immediately corrected by the Dietician or Dietary Manager. A one time audit of 25% of residents will be completed by the Activity and Social Services Department by 8/20/2012 to identify if resident choices are identified for activities and care that is significant to them. Any issue identified will be immediately resolved by the Activity or Social Services Department. 3. The Distician/Dietary Manager re-educated dietary staff on 7/11/2012 regarding ensuring tray cards are accurate and followed to allow resident to make choices that are significant to them. The ETD will re-educate nursing staff, social services department, maintenance department and 	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465	
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F 242	<p>Continued From page 5 #13's lunch tray.</p> <p>In an interview with Resident #13, the resident stated, "I don't like carrots and I'm not going to eat them. They know that."</p> <p>An interview with the Dietary Aide (DA) on 07/12/12, at 12:05 PM, revealed the DA was aware she was supposed to check the tray cards to ensure accuracy, however, the DA stated, "I just didn't look at it."</p> <p>2. A review of the medical record for Resident #15 revealed the facility admitted the resident on 09/27/04, with diagnoses that included Coronary Artery Disease, Diabetes, Hypertension, and Chronic Obstructive Pulmonary Disease. A review of the physician's orders revealed the resident was to receive a Controlled Carbohydrate Diet with limited high fat foods. Further review of the medical record revealed the resident's tray card indicated Resident #15 disliked fish/tuna.</p> <p>Observations of Resident #15's meal tray on 07/10/12, at the supper meal revealed the resident received a salmon patty on his/her tray.</p> <p>An interview with Resident #15 on 07/10/12, at 5:45 PM, revealed the facility was "always sending me things I don't like and I usually send it back."</p> <p>An interview with the facility cook on 07/10/12, at 6:00 PM, revealed the cook was aware of Resident #15's dislike of fish. The cook further stated, "I knew [he/she] does not like fish, but I have sent [him/her] salmon before and [he/she]</p>	F 242	<p>housekeeping department by 8/20/2012 regarding resident right to make choices that are significant to them including food choices. The Dietician/Dietary Manager will monitor 2 meals daily x 3 days beginning 8/6/2012 and then 5 meals weekly x 3 weeks beginning the week of 8/13/2012 to ensure food preferences are honored. The Social Services Department will interview at least 5 cognitive residents weekly x 4 weeks beginning week of 8/20/2012 to ensure all choices are being honored including food choices.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance: 8/23/2012</p>	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 242	Continued From page 6 ate it."	F 242		
F 246 SS=D	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure individual needs were accommodated for one unsampled resident (Resident B). Resident B was unable to adjust the thermostat in the resident's bedroom because the control knobs had been removed. Resident B stated the bedroom was cold and uncomfortable.</p> <p>The findings include:</p> <p>An interview with the Director of Nursing (DON) on 07/11/12, at 4:55 PM, revealed the facility does not have a policy related to accommodation of needs for residents and no policy related to the resident's individual control of room temperature.</p> <p>Observation in the dining room on 07/10/12, at</p>	F 246	<p>F 246</p> <p>1. Resident B: The thermostat knob on the resident room air conditioning unit was immediately fixed by the Maintenance Supervisor on 7/11/2012 to accommodate the resident's individual temperature preference.</p> <p>2. A one time audit of every room was completed by the DON, UM and the Regional Nurse on 7/11/2012 to identify any air conditioning units without a thermostat knob. No other issues were identified. The Social Services Department will complete a one time audit of every room by 8/20/2012 to identify any resident that is not comfortable in their room and if the temperature is per their preference. Any issue identified will be immediately corrected to ensure the residents are receiving accommodations that meet their individual preference and needs.</p> <p>3. The ETD will re-educate Maintenance Department and nursing</p>	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 246	Continued From page 7 2:55 PM, revealed Resident B was observed sitting in a wheelchair dressed in a thick long-sleeved shirt. A group interview on 07/10/12, at 3:00 PM, revealed Resident B complained of his/her bedroom being cold and unable to change the temperature in the bedroom because the control knobs had been removed, and was not sure how long ago but that it had been at least a month. Observation of Resident B's bedroom on 07/11/12, at 4:25 PM, revealed the control knobs had been removed from the air conditioner unit. An interview conducted with the Maintenance Supervisor (MS) on 07/11/12, at 4:30 PM, revealed the MS had not been aware the knobs were missing. The MS stated he did not monitor to ensure knobs were in place on the air conditioner units. An interview with the Corporate Nurse (CN) on 07/11/12, at 4:55 PM, revealed the facility had not been aware of the issue. The CN stated the knobs should have been reported to the MS and replaced immediately.	F 246	department by 8/20/2012 regarding policy for accommodation of resident needs and residents right to reside and receive services in the center with reasonable accommodation of individual needs and preferences. The Maintenance department will audit all rooms weekly beginning week of 8/20/2012 ongoing to ensure thermostat is set per resident preference and all units have knobs to control the thermostat. The UM will randomly monitor 5 residents receiving care and monitor temperature in room to ensure that residents right to accommodation of needs and preferences are being observed weekly x 4 weeks beginning the week of 8/20/2012. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 253 SS=E	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	F 253	1. No specific resident was identified. All residents have the potential to be affected. The smoking room walls were	

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F 253	<p>Continued From page 8</p> <p>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. The facility's smoking room contained several torn chairs, soiled, stained walls, and an oily film on the air conditioner cover. Walls in several resident rooms were observed to have paint missing. Chipped vanities were observed in three resident rooms, doors in two resident rooms were observed to be soiled/stained, and a resident lift was observed to be dusty/dirty.</p> <p>The findings include:</p> <p>A review of the facility's Maintenance Policy, dated 11/01/97, revealed the facility would maintain the facility and its equipment to provide the best environment for residents, staff, and visitors. According to the policy, work orders were to be submitted to the Maintenance Department to ensure communication between departments.</p> <p>Observations of the facility for 07/10-12/12, revealed the following areas were in need of maintenance services:</p> <ol style="list-style-type: none"> The smoking room walls were discolored and stained/soiled with an oily film and the air conditioner cover was yellowed and greasy to the touch. Some areas of the smoke room walls were gouged and missing paint. Five chairs in the smoke room had torn areas on the seats and backs. The air filters were soiled. Vanities in resident rooms 407, 408, and 409 	F 253	<p>cleaned by housekeeping on 7/24/2012.</p> <p>The air conditioner cover in the smoke room was cleaned by housekeeping on 7/24/2012.</p> <p>The walls in the smoke room were repaired and painted on 7/27/2012.</p> <p>The 5 chairs in the smoke room were replaced with new chairs on 07/27/2012.</p> <p>The air filters were replaced in the smoke room on 7/16/2012.</p> <p>Vanities in rooms 407, 408 and 409 were repaired by the Maintenance Department on 8/2/2012.</p> <p>Resident room walls in rooms 115, 304, 307, 316 and 415 were repaired and painted on 8/1/2012.</p> <p>All resident lifts were cleaned by the housekeeping department on 7/16/2012.</p> <ol style="list-style-type: none"> A one time audit of all rooms in the center will be conducted by the Maintenance Department/Housekeeping Department by 8/15/2012 to identify any area in need of repair or cleaning. Any issues identified will be immediately corrected. The Maintenance Department and Housekeeping Department will be re-educated by the ETD regarding policy to ensure all areas of facility are clean, orderly and comfortable by 8/18/2012. The Maintenance and Housekeeping Department will make room rounds. 	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE 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 253	Continued From page 9 were observed to have chipped edges. 3. Resident rooms 115, 304, 307, 316, 319, and 415 were observed to have walls with scrapes and paint missing. 4. A resident lift in resident room 312 was observed to be soiled. An interview with the Maintenance and Housekeeping Supervisors on 07/12/12, at 2:00 PM, revealed neither of the supervisors had been notified of the areas needing attention. According to the Maintenance Supervisor, no one had submitted work orders and he did not have a schedule to make regular rounds to observe for maintenance/housekeeping needs.	F 253	weekly x 4 weeks beginning week of 8/20/2012 and then at least monthly to ensure any repairs are completed timely, all rooms and common areas are clean, orderly and comfortable. The Administrator will audit 10 rooms weekly x 4 weeks beginning week of 8/20/2012 then monthly to ensure all areas are clean, orderly and comfortable. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5: Date of Compliance: 8/23/2012	
F 282 SS=D	483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and observation the facility failed to ensure services were provided in accordance with the plan of care and physician's orders for one of twenty-four sampled residents (Resident #4). A review of Resident #4's medical record revealed the resident's physician requested a body alarm be used for the resident to promote the resident's safety while in bed; observations conducted of Resident #4 throughout the day on 07/10/12,	F 282	1. Resident # 4: The alarm was immediately applied per the Certified Nurse Assistant (C.N.A) on 7/10/2012. Resident # 4: The physician was notified on 7/10/2012 by the DON that the alarm was not on the resident. No new orders were received. No other resident was identified. 2. A one time audit of all residents with alarms was completed on 7/10/2012 by the DON/UM and	

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F 282	<p>Continued From page 10</p> <p>revealed facility staff failed to ensure the body alarm was in use for Resident #4 as requested by the physician and identified on the plan of care.</p> <p>The findings include:</p> <p>A review of the facility's Plan of Care Policy (dated January 2012) revealed the plan of care was to be utilized as an interdisciplinary communication tool and would have measurable objectives, with timeframes, and would describe the services to be provided to attain/maintain the resident's highest practical physical, mental, and psychosocial well-being. The care plan was to be reviewed and revised according to the Resident Assessment Process.</p> <p>A review of the medical record revealed the facility admitted Resident #4 on 01/22/03, with diagnoses of anoxic brain injury, diabetes mellitus II, aphasia, psychosis, and weight loss. Staff assessed Resident #4 to have abnormal involuntary movements and identified an intervention to use a body alarm on 06/01/12, to ensure the resident's safety while in bed. In addition, Resident #4's physician ordered a body alarm to be used while the resident was in bed to alert facility staff when the resident managed to get too close to the side of the bed.</p> <p>Resident #4 was observed to be in bed on 07/10/12, at 3:00 PM and 5:00 PM. Based on the observations, a body alarm was not in use for Resident #4.</p> <p>An interview was conducted with the Restorative Nurse on 07/10/12, at 5:00 PM. The Restorative Nurse acknowledged the alarm was not in use for</p>	F 282	<p>Regional Nurse to identify any resident with an order for an alarm and if it was on per the plan of care. No issues were identified. The DON/ETD/UM and/or the Regional nurse will complete a one time audit by 8/17/2012 of all residents' plan of care to identify that all care plans reflect each resident's individual needs. Any issue identified will be immediately corrected.</p> <p>3. The ETD will re-educate nursing staff regarding policy to develop an individual, written plan of care and policy to ensure that all care is provided according to their individual plan of care by 8/18/2012. The ETD/UM will complete an audit of 5 residents on each wing to ensure the plan of care is in place and being followed by visualizing the resident weekly x 4 weeks beginning week of 8/18/2012 then 5 residents monthly x 2 months. The Interdisciplinary team (consisting of the DON, UM, SS and Dietary Manager) will audit 3 records weekly x 4 weeks beginning week of 8/20/2012 to ensure all plan of care is meeting residents individual needs.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will</p>		

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F 282	Continued From page 11 Resident #4 and stated the facility's Certified Nursing Associates (CNAs) must have left the resident's alarm off when the resident's linens were changed.	F 282	review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.		
F 309 SS-D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to ensure residents were monitored when a change in condition occurred. The facility failed to monitor one of twenty-four sampled residents following a change in resident condition. Resident #1 experienced a change in condition at 9:00 AM, but there was no evidence the facility monitored the resident for further changes until 4:00 PM, a period of seven hours. The findings include: A review of the facility's policy, dated January 2004, revealed staff was to make all entries into the medical record as soon as possible after an observation, assessment, or intervention occurred. A review of the medical record for Resident #1	F 309	5. Date of Compliance: 8/23/2012 F 309 1. Resident #1: The physician was notified of the change in condition at the time it occurred and Resident #1 was sent to the hospital later that day, Resident #1 is presently in the center and has experienced no decline. The facility Medical Director was notified on 7/12/2012 that monitoring was not documented on 7/4/2012 related to identify "chest pain". No new orders were noted. No other residents were identified. 2. The DON/ETD/UM will complete a 100% audit by 8/18/2012 of nurses' notes from a period of 7/1/2012-7/31/2012 to identify any monitoring needs that were not documented. Any issue identified will be immediately reported to the physician by the DON or Unit Manager. The DON/UM is to be notified of any acute change in condition by the charge nurse x 30d beginning 8/3/2012 to assist with monitoring needs to identify any other resident that may be affected.		

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F 309	<p>Continued From page 12</p> <p>revealed the facility admitted the resident on 04/11/11, with diagnoses that included Coronary Artery Disease, Status/Post Myocardial Infarction, Hypertension, Peripheral Vascular Disease, and Chronic Obstructive Pulmonary Disease.</p> <p>A review of the nurse's notes dated 07/04/12, at 9:00 AM, revealed Resident #1 complained of chest pain but told the nurse that it was "just gas" and refused to go to the Emergency Department of the hospital. The resident's vital signs were obtained and recorded, the physician was notified, and a "stat" electrocardiogram (EKG) was ordered. Further review of the nurse's notes revealed the next entry in the resident's medical record was at 4:00 PM, seven hours after documentation of the resident's initial complaint, and at that time staff documented the resident complained of "heaviness in the chest, but not as intense as earlier." The physician was notified and the resident was transported to the hospital for evaluation. There was no evidence in the medical record that facility staff had assessed Resident #1 for continued complaints of pain, an improvement in the pain, or for any changes in condition from 9:00 AM until 4:00 PM, a timeframe of seven hours.</p> <p>An interview with Registered Nurse (RN) #1 on 07/10/12, at 6:10 PM, revealed she was on duty when Resident #1 complained of pain on 07/04/12. RN #1 stated she had assessed the resident frequently throughout the day between 9:00 AM and 4:00 PM, but she failed to document any of the assessments/observations she made or to obtain the resident's vital signs.</p> <p>An interview with the Unit Manager (UM) on</p>	F 309	<p>3. The ETD will re-educate all licensed nurses by 8/14/2012 regarding policy for reporting change in condition to the physician and monitoring/documenting when a change of condition occurs. The DON/UM will audit 5 records weekly x 4 weeks beginning week of 8/20/2012 to ensure any change of condition was reported to the physician and monitoring and documentation of monitoring was completed to ensure that each resident is receiving the necessary care and services to maintain the highest practicable mental, physical and psychosocial well being.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance: 8/23/2012</p>	

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F 309	Continued From page 13 07/10/12, at 6:30 PM, revealed RN #1 should document her observations when she reassessed the resident. The UM further stated she was unaware that there was no documentation in the medical record for the period of time between 9:00 AM and 4:00 PM, and stated she had failed to monitor the RN to ensure the nurse documented her assessments/observations. An interview with the Director of Nursing (DON) on 07/11/12, at 1:45 PM, revealed the DON was aware of Resident #1's complaint of chest pain on 07/04/12, and stated she thought RN #1 observed the resident at frequent intervals throughout the day. The DON also stated she failed to monitor the situation to ensure staff was documenting their observations/assessments.	F 309			
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medication package insert, and review of the facility's policy, it was determined the facility failed to ensure one of twenty-four sampled residents was free of significant medication errors (Resident #16). A Registered Nurse (RN) was observed to mix two insulins together in the same syringe (which was not in accordance with manufacturer's directions) and administer the insulin to Resident #16. The findings include:	F 333	F 333 1. Resident #16: The physician and family were notified by the Unit Manager (U.M.) on 7/10/2012 that Novolin 70/30 and Novolin R were mixed in the same syringe and given. No new orders were noted. No other residents were identified. 2. The ETD will complete a one time audit by 8/14/2012 of all licensed nursing staff to identify any nurse that is not aware of manufactures recommendation for mixing insulin. Any issue identified will be immediately corrected by the ETD. The DON/UM and/or ETD will randomly review 15 residents' physician's orders and compare to the Medication Administration Record by		

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F 333	<p>Continued From page 14</p> <p>Review of the facility's Insulin Injection policy (dated January 2001) revealed facility staff was responsible to verify the correct dosage, form, route, and time of medications a total of three times prior to administration to ensure insulins were administered correctly. The policy noted "to mix insulin as indicated."</p> <p>Review of the medication package insert for Novolin 70/30 Insulin revealed the insulin should not be mixed with any other insulins. The package insert did not identify the potential risks to individuals when Novolin 70/30 insulin was mixed with other insulins.</p> <p>Observations during a medication pass conducted with Registered Nurse (RN) #1 on 06/10/12, revealed the RN administered Novolin Regular Insulin (8 units) and Novolin 70/30 Insulin (34 units) subcutaneously to Resident #16 at 4:20 PM. The RN was observed to mix both the insulins in the same syringe prior to administration.</p> <p>Interview conducted with the facility's Registered Pharmacist (RPh) on 06/10/12, at 11:05 AM, confirmed Novolin 70/30 Insulin should not be mixed with any other insulin and should be administered to the resident in different syringes. The RPh stated insulins with a 70/30 concentration should not be mixed with other insulins. The RPh further stated when the two insulins are mixed together in the same syringe the 70/30 Insulin could potentially be diluted with the Regular Insulin and alter the concentration of the insulin. The RPh stated this could result in hyperglycemia or hypoglycemia for a resident.</p>	F 333	<p>8/15/2012 to identify any medication error and ensure residents are free of any medication error.</p> <p>3. The ETD will re-educate licensed nurses by 8/15/2012 related to the 5 rights of medication pass, mixing insulin's, transcribing medications and policy related to medication errors. The UM will audit at least 3 nurses administering insulin at least one time weekly x 4 weeks then 3 nurses monthly x 2 months beginning week of 8/20/2012 to ensure that all insulin's are administered per manufactures recommendation. The ETD will monitor 4 nurses administering at least 5 medications one time weekly x 4 weeks beginning week of 8/20/2012 then 1 nurse administering 5 medications monthly x 2 months. The DON/UM will audit 5 physicians orders weekly, x 4 weeks beginning week of 8/20/2012 to ensure that resident medication administration records reflect current and correct physician's orders for medications.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing</p>	

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F 333	Continued From page 15 Interview with RN #1 on 06/10/12, at 1:25 PM, revealed the RN was not aware of the information provided in the medication package insert and did not know the two insulins should not be mixed together. Interview with the Director of Nurses (DON) on 06/12/12, at 4:30 PM, revealed the nurses were responsible to review the information from the medication package insert to ensure medications were administered correctly. The DON stated random observations were conducted of the medication pass and no problems had been identified.	F 333	until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 364 SS=E	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, interview, and policy review, it was determined the facility failed to provide foods that were palatable and attractive during the evening meal on 07/10/12. Observation revealed the evening meal on 07/10/12, was not prepared in accordance with the planned menu and as a result, the foods tasted bland, unusual, and were not attractive. The findings include:	F 364	F 364 1. Residents A, B, C, D, E and Resident #21 have experienced no change related to bland food. No other resident was identified and all residents have the potential to be affected. 2. The Dietician will audit meal preparation for 3 meals by 8/6/2012 to identify any food item that is not prepared per menu instructions that include spices to eliminate bland taste. Any issue identified will be immediately corrected. The Dietary Manager will audit 6 meals by 8/7/2012 to identify any tray that does not appear attractive, and is not prepared to conserve nutrient value, flavor and is not palatable.	

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F 364	<p>Continued From page 16</p> <p>A review of the facility's planned menu for the evening meal on 07/10/12, revealed the residents were to receive salmon patties, mixed vegetables, tri-color spiral pasta, and sunny pear slices.</p> <p>Observation of the evening meal on 07/10/12, at 6:15 PM, on the Blue Hall, revealed the residents received a salmon patty, mixed vegetables (yellow and green), white spiral noodles (instead of tri-color spiral noodles), cut up pears in a yellow sauce, milk, water, coffee, and juice.</p> <p>An interview with Residents A, B, C, D, E, and #21 on 07/10/12, at 3:00 PM, revealed the food served at the facility did not look appetizing and did not always taste good. The residents stated meat often tasted like it had fillers (cereal) in it and tasted bland.</p> <p>A test tray of the evening meal (regular diet tray) on 07/10/12, with the Dietary Manager and Licensed Practical Nurse on the Blue Hall, revealed the salmon patty from the test tray tasted good and the mixed vegetables were seasoned well and tasted good. However, the white spiral noodles were bland and the diced pears in yellow gelatin sauce tasted unusual. The meal was also observed to appear all the same color and unattractive.</p> <p>An interview with the cook on 07/12/12, at 3:30 PM, revealed the cook did not follow the recipe for the noodles or the pears dessert for the evening meal on 07/10/12.</p> <p>An interview with the Dietary Manager (DM) on 07/10/12, at 6:15 PM, revealed the pasta was</p>	F 364	<p>3. The Dietician and Dietary Manager re-educated dietary staff on 7/13/2012 regarding policy to prepare all foods according to menu to ensure that food is palatable, attractive and not bland.</p> <p>The Dietician or the Dietary Manager will monitor 2 meals daily x 3 days beginning 8/6/2012 then 5 meals weekly x 3 weeks beginning week of 8/13/2012 to ensure all foods are prepared according to menu are palatable, attractive and prepared to conserve nutrient value.</p> <p>The Dietary Manager will interview 5 people weekly x 4 weeks beginning week of 8/20/2012 regarding the taste and attractiveness of meals.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance: 8/23/2012</p>	

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F 364	Continued From page 17 supposed to be tri-colored pasta; however, there was no tri-colored pasta and the white spiral pasta had been substituted. The DM also stated the recipe for the pasta called for butter or chicken broth in the noodles, but according to the DM, the butter or broth was not added to the noodles. The DM acknowledged the noodles lacked flavor and color. In addition, the DM stated the kitchen staff had not followed the recipe for the dessert and had used too much of the gelatin and the desert had not congealed, making it soupy.	F 364		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility failed to store, prepare, and serve food in a sanitary manner. During the meal tray assembly service conducted at 5:30 PM on 07/10/12, the facility cook was observed to leave the tray assembly line wearing the food service gloves utilized to maintain cleanliness during the tray assembly. The facility cook returned to the tray assembly line and was observed holding an ink pen. The cook did not remove the food service gloves or wash her/his hands after	F 371	F 371 1. No specific resident was identified. The metal shelf in the kitchen was cleaned by the Dietary Manager on 7/13/2012. 2. The Dietician /Dietary Manager will monitor 3 meals by 8/6/2012 to identify any staff member not washing hands according to facility policy and/or changing gloves as needed to ensure food is handled, stored and served under sanitary conditions. Any issue identified will be immediately corrected. A one time audit of all equipment in the kitchen will be conducted by the Dietician/Dietary Manager by 8/10/2012 to identify any equipment and /or area that needs cleaning. Any issue identified will be immediately corrected.	

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F 371	<p>Continued From page 18</p> <p>handling the soiled ink pen, and continued with the meal tray assembly. In addition, during the final sanitation audit conducted on 07/12/12, at 2:10 PM, the metal shelves in the Dietary Department that contained clean stainless steel cooking pans were observed to have a buildup of rust and greasy soil.</p> <p>The findings include:</p> <p>A review of the facility Personal Hygiene Policy (dated July 2012) revealed the staff was to wash their hands when returning to the work area and before applying gloves for working with food.</p> <p>Observation of the meal tray assembly production line on 07/10/12, at 5:30 PM, revealed the facility cook had not recorded the food temperatures obtained prior to initiating the evening meal tray line assembly. The facility cook left the tray line on 07/10/12, at 5:35 PM, while wearing the plastic food service gloves worn to prepare the meal trays, to obtain the documented food temperatures. The dietary cook returned to the tray line with the recorded food temperatures in her gloved right hand. The facility cook was observed to have an ink pen in her gloved left hand and proceeded to record the food temperatures in a temperature log. At 5:39 PM on 07/10/12, the facility cook returned to the tray line while wearing the same food service gloves, and continued to place food items on the plates and serve the residents' food. The facility cook failed to remove the gloves, wash her hands, and apply clean gloves prior to returning to the food service area to continue preparing the food items.</p> <p>An interview was conducted with the dietary cook</p>	F 371	<p>3. The Dietician/Dietary Manager re-educated dietary staff on 7/13/2012 regarding policy to handle, store and serve food under sanitary conditions that includes hand washing and equipment cleaning.</p> <p>The ETD will re-educate nursing department by 8/8/2012 regarding policy to handle, store and serve food under sanitary conditions that includes hand washing.</p> <p>The Dietician/Dietary Manager will monitor 3 meals/day x 3 days being served beginning 8/6/2012 then 5 meals weekly x 3 weeks beginning week of 8/13/2012 to ensure all food is served, handled and stored under sanitary conditions focusing on hand washing and glove use.</p> <p>The ETD will observe trays being served to at least 5 residents weekly x 3 weeks beginning week of 8/20/2012 to ensure food is served under sanitary conditions, focusing on hand washing.</p> <p>The Dietary Manager will audit all equipment and storage shelves for cleanliness at least weekly beginning week of 8/13/2012 to ensure all equipment and shelves are clean and sanitary.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will</p>		

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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 07/12/2012
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE 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 371	Continued From page 19 on 07/10/12, at 5:30 PM. The dietary cook stated she forgot to change the gloves and wash her hands. In addition, observation on 07/12/12, at 2:30 PM, of the metal storage shelves containing clean stainless steel holding/cooking pans revealed the shelves had areas of red/rust and a buildup of grease on the end shelves and metal rods. An interview was conducted with the facility cook on 07/12/12, at 3:00 PM. The facility cook stated the shelves had not been cleaned in a "long time." The dietary cook further stated he/she was unsure which of the dietary staff was responsible to clean the shelves to ensure the shelves' cleanliness.	F 371	review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 372 SS=E	483.35(l)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility failed to dispose of garbage and refuse as required by the Kentucky Retail Food Code (KRS 217.127). Observation of the facility dumpsters on 07/10/12, at 2:15 PM, revealed two of the three dumpsters had lids that were too large to provide a tight seal at the top of the two dumpsters. The ill-fitting lids allowed the garbage bags to be exposed and, as a result, promoted harborage and feeding of rodents, flies, roaches, and wildlife. The findings include:	F 372	1. No specific resident was identified. The ill-fitting lids on the dumpsters were repaired by maintenance staff on 07/17/12. 2. An environmental review and audit was completed by the Administrator on 8/2/2012 to identify any equipment and/or area that needs addressed to ensure proper disposal of garbage and refuse. Any issue identified was immediately addressed. The housekeeping/maintenance staff will clean and disinfect the three (3) dumpsters by 08/10/12. 3. The Maintenance Department, Dietary Department, and	

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F 372	Continued From page 20 A review of the facility Waste Storage and Disposal Policy (dated July 2012) revealed waste was to be in covered containers so as not to provide a safe haven for rodent and pest infestations. The policy revealed the area around the external waste containers was to be kept in a neat, orderly, and sanitary manner and the container lids were to be closed at all times when not in use. Observation of the three facility dumpsters, during the initial tour on 07/10/12, at 11:15 AM, revealed two of the dumpsters, placed in close proximity to the facility, had lids that were two long in length to close properly and provide a seal around the exterior edges of the dumpster. The bags of refuse were accessible to flies, rodents, roaches, and other wildlife. A large number of flies were observed to be flying in and around the inside of the dumpster. An interview conducted with the Dietary Manager on 07/10/12, at 2:15 PM, revealed the dumpster lids were damaged by a storm in March 2012. The Dietary Manager further stated the old lids were torn and had to be replaced. The Dietary Manager stated the new lids did not fit the dumpsters properly because the lids were longer than the lids originally on the waste container. The Dietary Manager stated no one had called the garbage company to get better fitting lids for the dumpsters.	F 372	Housekeeping Department will be re-educated by the ETD regarding policy to ensure proper disposal of garbage and refuse by 8/18/2012. The Maintenance and Housekeeping Department will make environmental rounds weekly x 4 weeks beginning week of 8/20/2012 and then at least monthly to ensure proper disposal of garbage and refuse. The Administrator will conduct environmental audits weekly x 4 weeks beginning the week of 8/20/2012 then monthly to ensure proper disposal of garbage and refuse. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441	F 441 1. Resident # 7 has had no change related to staff "blowing" on food. Food temperatures were within	

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F 441	Continued From page 21 safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by:	F 441	recommended limits on 7/10/2012. The Medical Director was notified of staff "blowing" on food by the DON on 7/10/2012 with no new orders noted. 2. An audit of 3 meals will be completed by the Dietary Manager and DON by 8/10/2012 to identify any staff member "blowing" on food, not washing their hands and maintaining safe food handling procedures. Any issue identified will be immediately corrected. The ETD will randomly monitor staff providing care to at least 10 residents by 8/18/2012 to identify any hand washing issues, linens being handled and transported properly to ensure residents are provided care in sanitary and comfortable conditions and in a manner that prevents infections. Any issue identified will be immediately corrected. The ETD will complete a one time audit of all residents with infections that require isolation by 8/5/2012 to identify if any resident is not in isolation per policy. Any issue identified will be immediately corrected. 3. The ETD will re-educate nursing staff by 8/20/2012 regarding infection control policy, focusing on hand washing, handling linens, not "blowing" on food and ensuring	

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F 441	Continued From page 22 Based on observation and interview, the facility failed to ensure infection control guidelines were followed during the residents' noon meal service on 07/10/12, at 12:30 PM. A member of the facility staff was observed to blow air from her mouth on each spoonful of food offered to Resident #7 in an attempt to "cool" Resident #7's food. The findings include: The facility provided infection control policies for review. The policies included guidelines to maintain sanitation in the facility. During observations of the noon meal on 07/10/12, at 11:30 AM, 11:55 AM, and 12:30 PM, Licensed Practical Nurse (LPN) #3 was observed to assist Resident #7 with the meal. The LPN was observed to blow air from her mouth onto each spoonful of food offered to Resident #7 and before placing the food into the resident's mouth. An interview with the LPN #3 on 07/10/12, at 12:30 PM, revealed Resident #7 had complained the food was too hot, and the LPN was trying to cool the food to prevent the food from burning the resident's mouth. An interview was conducted with the facility's Registered Dietitian (RD) on 07/10/12, at 12:30 PM. The facility RD acknowledged the method used by LPN #3 to cool the resident's food was unsanitary and should not be used.	F 441	isolation procedures are followed. The DON and/or Dietary Manager will monitor at least 3 meals weekly x 3 weeks beginning week of 8/20/2012 to ensure staff are not "blowing" on food and washing hands to prevent infections. The DON will review laboratory results 5 x weekly x 4 weeks beginning week of 8/20/2012 to ensure all residents with infections that require isolation are in isolation. The ETD will monitor at least 5 staff providing care to at least 10 residents monthly x 2 months beginning week of 8/20/2012 to ensure linens are handled per infection control policy and hand washing is performed per policy. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 456 SS=E	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION. The facility must maintain all essential	F 456	F 456 1. No specific resident was identified. The "ice cream" freezer was	

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F 456	<p>Continued From page 23</p> <p>mechanical, electrical, and patient care equipment in safe operating condition.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>The facility failed to ensure that all essential mechanical equipment was kept in safe operating condition. Observation of the facility ice cream freezer on 07/10/12, at 11:56 AM, and on 07/12/12, at 2:50 PM, revealed the ice cream freezer had a one-half inch layer of frost accumulated on the interior. Observation on 07/12/12, at 2:15 PM, of the facility's "reach-in cooler" in the Dietary Department revealed the cooler had a clear liquid dripping from the fan/condenser box. The clear liquid had the potential to drip on the foods stored on shelves below the fan/condenser.</p> <p>The findings include:</p> <p>The Dietary Manager stated on 07/12/12, at 2:30 PM, the facility had no policy on maintenance and defrosting of essential refrigeration equipment.</p> <p>During the initial sanitation audit conducted on 07/10/12, at 11:50 AM, the facility ice cream freezer was observed to have a one-half inch layer of frost/ice on the interior walls. The accumulated frost/ice had the potential to contaminate the ice cream stored inside, as well as affect the function of the freezer. The thermometer located inside the ice cream freezer registered -8 degrees. Further observation of the ice cream freezer on 07/12/12, at 1:46 PM, revealed the freezer contained the frost/ice buildup on the interior of the freezer.</p>	F 456	<p>defrosted on 7/13/2012 by the Dietary Manager.</p> <p>The facility's "reach in cooler" fan/condenser box was repaired by the Maintenance Department and is no longer leaking water.</p> <p>2. A one time audit of all freezers will be conducted by the Dietary Manager by 8/6/2012 to identify any freezer that has an ice build-up any freezer fan/condenser box has water leaking around it and /or any dietary equipment not in safe operating condition.</p> <p>Any issues identified will be immediately corrected or equipment removed until repaired.</p> <p>A one time audit of all patient care equipment will be conducted by the Maintenance Director and DON by 8/12/2012 to identify any equipment that is not in working condition.</p> <p>Any issue identified will be immediately repaired and/or removed from use until repair.</p> <p>3. The Dietary Manager will re-educate dietary staff by 8/12/2012 regarding policy to maintain all equipment in safe operating condition, following cleaning schedule, including freezer defrosting and maintaining cleanliness.</p> <p>The Dietary Manager will defrost/clean all freezers weekly beginning week of 8/20/2012 to ensure all food is stored under</p>	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41468	
(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 458	Continued From page 24 An interview was conducted with the Dietary Manager (DM) on 07/12/12, at 1:55 PM. The DM stated the ice cream freezer had not been defrosted/cleaned since she/he started working at the facility six weeks prior to 07/12/12. The DM further stated the ice cream freezer was not included on the routine Dietary Cleaning Schedule to ensure the ice cream freezer was cleaned on a routine basis. In addition, during the final sanitation audit conducted on 07/12/12, at 1:45 PM, the facility's "reach-in" refrigerator located in the dietary kitchen was observed to have a clear, liquid substance dripping from the condenser box/casing. The foods stored under the condenser box had the potential to be contaminated with the clear liquid dripping from the box's metal casing. The temperature on the thermometer located inside the reach-in refrigerator was noted to be 40 degrees Fahrenheit as required by the Kentucky State Food Code. Continued interview with the facility DM on 07/12/12, at 2:15 PM, revealed the DM had not been informed of the clear liquid forming/dripping from the outer metal casing of the condenser box.	F 456	sanitary conditions. The Dietary Manager will audit all equipment and shelves weekly beginning week of 8/20/2012 to ensure cleanliness and a staff schedule for cleaning equipment and shelves. The Maintenance Department and UM will audit nursing equipment monthly x 3 months beginning week of 8/20/2012. The Dietician will audit kitchen for cleanliness and freezer defrosting monthly beginning 8/2012. 4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved. 5. Date of Compliance: 8/23/2012	
F 469 SS=F	483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM The facility must maintain an effective pest control program so that the facility is free of pests and rodents.	F 469	F 469 1. Residents A, B, C, D, E and Resident #21 have experienced no change related to flying insects. Resident #2: Resident's room was treated for gnats by the Maintenance Supervisor on 07/11/12.	

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F 469	<p>Continued From page 25</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to maintain an effective pest control program to ensure the facility remained free of pests. Flying insects were observed throughout the facility during the survey from 07/10/12 through 07/12/12.</p> <p>The findings include:</p> <p>A review of the Pest/Insect Control policy (dated March 2011) revealed the facility would contract a pest control company, evaluate the effectiveness of those services, and contact the pest control agency for additional services as needed.</p> <p>Review of the pest control records revealed on 04/16/12, 03/29/12, 02/21/12, and 01/19/12, no pests were observed and the common areas were treated for preventative maintenance. On 05/31/12, based on the report, active pests (gnats/flyes) were observed in the dining room and kitchen areas and the areas were sprayed for pests. In addition, the report revealed on 06/18/12, the service had treated the facility for active pests (gnats and flies) in the kitchen and dining room areas.</p> <p>An Interview with Residents A, B, C, D, E, and #21 on 07/10/12, at 3:00 PM, revealed there were a lot of flies and gnats in the facility. The residents stated that a pest control company came and sprayed but they still had the flies and gnats.</p>	F 469	<p>All residents have the potential to be affected. The Maintenance Supervisor notified the pest control company on 7/12/12. The pest control company treated the facility on 7/24/12.</p> <p>2. An environmental review and audit was completed by the Administrator on 8/2/2012 to identify any areas not free of pests and rodents. Any issues identified was immediately addressed.</p> <p>3. The facility will add a new flying insect program from the pest control company by 8/10/12 consisting initially of 6 indoor lights and 2 outdoor lights. The Maintenance Department and Housekeeping Department to be re educated by the ETD regarding policy to ensure the facility remains free of pests by 8/18/2012. The Maintenance and Housekeeping Department will make environmental rounds weekly x 4 weeks beginning week of 8/20/2012 and then at least monthly to ensure the facility remains free of pests. Any issue identified will be immediately corrected. The Administrator will conduct environmental audits weekly x 4 weeks beginning the week of 8/20/2012 then monthly to ensure the facility remains free of pests.</p>	

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F 469	<p>Continued From page 26</p> <p>An observation on the Blue Hall on 07/10/12, at 6:00 PM, revealed a wasp was in the hallway and flew into the airflow vent on the ceiling. The Maintenance Supervisor was contacted and the wasp was removed from the building.</p> <p>An observation of the kitchen during tray line service on 07/10/12, at 5:45 PM, revealed flies were in the kitchen over the tray line area.</p> <p>An observation of the dining room on 07/10/12, from 11:20 AM through 12:00 PM, revealed flies were present during the meal service.</p> <p>An observation on the Green Hall in resident room 316 on 07/10/12, at 11:30 AM, revealed flies in the room.</p> <p>An observation on the Peach Hall on 07/10/12, at 11:45 AM, revealed flies in the hallway.</p> <p>Observations of Resident #2's room on 07/10/12, at 11:30 AM, 12:30 PM, 2:25 PM, 3:40 PM, 4:45 PM, 5:30 PM, and 6:00 PM, and on 07/11/12, at 9:30 AM, 9:45 AM, 11:00 AM, 1:00 PM, 3:00 PM, and 6:00 PM, revealed gnats, too numerous to count.</p> <p>Interview with a Certified Nursing Assistant (CNA) who worked with Resident #2 on 07/10/12, at 12:30 PM, revealed gnats were a problem in Resident #2's room because the resident chewed tobacco, often missed the cup, and the tobacco juice got on the floor and bed.</p> <p>An interview with housekeeping staff on the Blue Hall on 07/11/12, at 9:45 AM, revealed the housekeepers clean two to three times per day;</p>	F 469	<p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance 8/23/2012</p>	

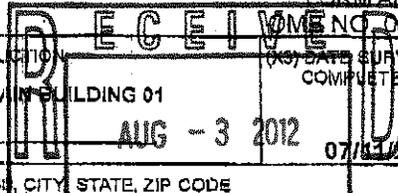
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41485		
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F 469	Continued From page 27 however, Resident #2 dipped and chewed and often missed the spit cup, and the gnats were drawn to the tobacco juice. The Housekeeper stated Maintenance had been notified of the gnat problem. An interview with the Maintenance Supervisor (MS) on 07/12/12, at 11:00 AM, revealed if a problem was reported concerning pests, the pest control company would be contacted and would spray the common areas (kitchen, dining room, hallways, and offices) for any pests. According to the Maintenance Supervisor, resident rooms were not sprayed but a gel was used for gnats and ants. The MS stated he was notified the morning of the observation on 07/11/12, of the gnat problem in Resident #2's room, had set up traps for the gnats, and had also asked Housekeeping to clean Resident #2's room. The MS said although there were no work orders for the problem related to the gnats, staff had verbally reported the problem with the gnats to another maintenance employee on 07/10/12. The MS also stated the pest control company had been in the facility and had sprayed for flies, gnats, and ants in the kitchen, dining room, hallways, and common areas on 06/18/12, after finding live pests in the kitchen and dining room areas.	F 469			

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

PRINTED: 07/26/2012
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 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/23/2012
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE Division of Health Care SALYERSVILLE, OH 45145 Enforcement Branch
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(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
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1989</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 1 story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 7</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet and dry) sprinkler system.</p> <p>GENERATOR: Type II propane generator.</p> <p>A life safety code survey was initiated and concluded on 07/11/12. 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.</p> <p>Deficiencies were cited with the highest deficiency identified at "D" level.</p>	K 000	<p>K 056</p> <p>1. A minimum of an 18 inch section of the wall in the Blue wing supply room will be removed by the Maintenance Supervisor by 8/10/12 to allow sprinkler coverage to all areas of the room.</p> <p>2. A one time audit of every room was completed by the Administrator on 8/2/12 to ensure complete sprinkler coverage for all portion of the building. No other issues were identified.</p> <p>3. The Maintenance department will audit all rooms weekly beginning week of 8/20/2012 ongoing to ensure all areas of the facility are sprinkler protected as required.</p> <p>4. The Quality Assurance Team (consisting of at least the Administrator, Medical Director, Director of Nursing, Social Services Director and Dietary Manager) will review all audit findings and revise current plan at least monthly beginning week of 8/20/2012 ongoing until issue is resolved.</p> <p>5. Date of Compliance: 8/23/2012</p>	
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard</p>	K 056		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Shirley Cox</i>	TITLE Administrator	(X6) DATE 08/03/12
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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.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 07/11/2012
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE 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	
K 056	<p>Continued From page 1</p> <p>for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all areas of the facility were sprinkler protected as required. This deficient practice affected one of seven smoke compartments, staff, and approximately 25 residents. The facility has the capacity for 147 beds with a census of 116 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey conducted on 07/11/12, at 2:30 PM, with the Director of Maintenance (DOM), observation of the Blue supply room revealed that due to the design of the room the sprinkler system in the Blue supply room was unable to cover all areas of the room. An interview with the DOM on: 07/11/12, at 2:30 PM, revealed the DOM planned to remove a section of a wall in the Blue supply room that was blocking the sprinkler pattern to allow sprinkler coverage to all areas.</p>	K 056			

Received Time Aug 3 2012 6:32PM No. 9894

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/11/2012
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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