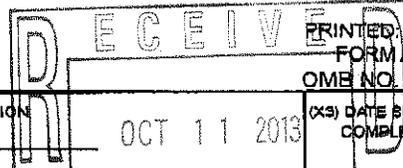


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 10/03/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  OCT 11 2013
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465	Division of Health Care Southern Enforcement Branch 09/19/2013
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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 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p>	F 157	<p>F157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM,ETC)</p> <p>1. The physician of resident #15 was notified of her allergy of aspirin on 9/19/2013. A clarification order was received to d/c aspirin. Resident #15 allergies were updated to reflect physician orders on 9/19/2013 by Medical Records. No other resident was identified.</p> <p>2. DON, Unit Manager, ETD, or QA nurse audited all MAR versus physician orders, nurses notes, labs, and 24 hour shift report to identify any issue with physician notification from a period of 8/1/2013-9/22/2013 this was completed 10/4/2013. Any issues identified were immediately reported to the physician and family. DON/Social Services will review last 10 room changes to identify if family was notified promptly of room change. This will be completed by 10/17/2013. Administrator/DON and /or ETD to review 10 face sheets to identify if any have not been updated periodically and to identify if any did not have correct information by 10/11/2013. No issues were identified.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: Administrator DATE: 10/11/13

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 157	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to ensure the physician was notified when there was a need to alter treatment due to possible adverse consequences for one of twenty-four sampled residents (Resident #15). A review of documentation revealed Resident #15 was noted to have an allergy to Aspirin; however, facility staff failed to notify the resident's physician of the resident's possible adverse consequence to Aspirin when the physician prescribed the medication to the resident on 08/29/13. Even though the physician had prescribed the medication for Resident #15, the pharmacist notified the facility staff of the resident's allergy to the medication on 09/05/13 and the resident did not receive the medication.</p> <p>The findings include:</p> <p>A review of the facility policy, "Procedure for Transcription of MD Orders," revealed physician's orders could be given verbally or in writing to the facility. According to the policy, physician's orders were to be transcribed immediately by the nurse that received the order and then placed on the Medication Administration Record/Treatment Administration Record (MAR/TAR).</p> <p>A review of Resident #15's medical record revealed documentation on the MAR dated August 2013 that Resident #15 had an allergy to Aspirin. Continued review of the medical record revealed a computerized copy of physician's orders printed and dated September 2013 and revealed the physician had prescribed 325</p>	F 157	<p>3. Re education was completed by the Education Nurse for all licensed nursing staff regarding physician notification, D/C medication per physician order by written order immediately, to d/c medication per MD order by written order immediately and to follow all physician orders by 10/11/2013.</p> <p>Beginning the week of 10/6/2013 the DON/Unit Manager/QA/ETD will audit 10 records weekly x 6 weeks for physician notification issues including labs, nurses notes, 24 hour shift report and compare Mar's to physician orders to ensure all orders are correct and that residents are receiving medications and care per the physician orders. Medical Records to review 10 records weekly to ensure face sheet is current and updated and to ensure that allergies listed on the physician order are listed on the record correctly. This will begin the week of 10/14/2013 x 6 weeks. UM/ETD to audit every room change x 2 weeks beginning the week of 10/14/2013 to ensure family notified promptly, at the end of 2 weeks audits will decrease to 3 room changes monthly x 2 months, beginning 11/2013.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director Unit Managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed this will be ongoing until this issue is resolved.</p> <p>5. Date of Compliance 10/25/2013.</p>	
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 157	Continued From page 3 facility for Resident #15 from the pharmacy due to the resident's documented allergy to the medication.  LPN #2 acknowledged in interview conducted on 09/19/13 at 2:35 PM that normally if a nurse received a call from the pharmacist of a need to clarify a physician's order, the nurse would contact the physician and write any clarification of the order. However, LPN #2 stated she did not "remember" being contacted by the pharmacist about the physician's order for Aspirin for Resident #15 or of the resident's allergy to the Aspirin.  Interview with the facility's Nurse Consultant on 09/19/13 at 2:45 PM revealed no evidence staff had identified or contacted Resident #15's physician of Resident #15's allergy to Aspirin or of the need to discontinue the Aspirin.	F 157		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observations conducted during the initial tour on 09/17/13 and 09/19/13 revealed an overbed table frame was soiled and had not been cleaned in resident room 318-2,	F 253	F253 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  1. The overbed table in room 318-2 was cleaned on 9/19/2013 by housekeeping department. The door covers/skins were fixed on the entry door to rooms 222 and 303 9/19/2013 by the maintenance department. The fall mat in room 222-1 was replaced on 9/19/2013 by the housekeeping department. The Medical Director was notified about this issue on 9/19/2013 by the Administrator. No specific resident was identified.	

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 253	<p>Continued From page 4</p> <p>door covers/skins were pulled away from the entry door in rooms 222 and 303, and a fall mat was observed to have a torn edge in room 222-1.</p> <p>The findings include:</p> <p>1. Interview conducted with the Maintenance Supervisor on 09/19/13 at 1:45 PM revealed the facility did not have a written policy for maintenance services. According to the Maintenance Supervisor, it was facility procedure for staff to fill out maintenance requests when items were in need of repair. The Maintenance Supervisor stated he made rounds daily to review maintenance requests and identify items in need of repair.</p> <p>Observations conducted during the initial tour on 09/17/13 at 11:20 AM and again on 09/19/13 at 1:35 PM revealed entry doors in resident rooms 222 and 303 had door covers/skins that were loose and sharp edges were exposed.</p> <p>An interview conducted with the Maintenance Supervisor on 09/19/13 at 1:45 PM revealed the Maintenance Supervisor made rounds daily to identify areas in need of repair. However, the Maintenance Supervisor was not aware of the loose door covers/skins in rooms 222 and 303.</p> <p>A review of new maintenance requests and hand written notes of the Maintenance Supervisor for items needing repair revealed no evidence the doors had been identified as needing repair.</p> <p>2. According to an interview with the Housekeeping Supervisor on 09/19/13 at 2:05 PM, the facility did not have a written policy regarding housekeeping services. Further</p>	F 253	<p>2. On 9/19/2013 all of the over bed tables were cleaned by housekeeping and inspected by the housekeeping supervisor to identify any over bed table that was dirty, cracked, chipped or had frayed edges. Any issue identified was immediately corrected.</p> <p>On 10/1/2013 maintenance completed a door audit for every door in the building to identify any doors or door covers/skin that needed repair. Any doors that were found to need any type of repair were repaired on 10/1/2013.</p> <p>On 9/19/2013 all fall mats were inspected to identify tears and cleanliness. Any issue identified was immediately addressed and all fall mats were cleaned by housekeeping department. Fall mats that had any type of tears will be replaced by 10/25/2013 by the housekeeping department.</p> <p>All rooms/bathrooms were audited by the housekeeping department and the Administrator on 10/9/2013 to identify any areas that required cleaning. Any issue identified was immediately cleaned and corrected.</p> <p>3. Re education was completed by the housekeeping supervisor for all housekeeping staff regarding cleaning over bed tables, inspecting over bed tables and monitoring the overall cleanliness of the room and the center on 9/20/2013 and a schedule was developed to clean and inspect over bed tables for cleanliness and any needed repair as well as monitoring the general cleanliness of the resident rooms and the center common areas.</p>	

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 253	<p>Continued From page 5</p> <p>interview revealed it was facility procedure for housekeepers to clean each resident room daily using a checklist.</p> <p>Observations conducted during the initial tour on 09/17/13 at 11:20 AM, and on 09/19/13 at 1:00 PM, revealed an overbed table frame in resident room 318-2 was soiled.</p> <p>Interview conducted with Housekeeper #1 on 09/19/13 at 1:05 PM revealed she had cleaned room 318 on 09/17/13, 09/18/13, and 09/19/13; however, the housekeeper stated she had not cleaned the overbed table frame.</p> <p>Observation of a fall mat in resident room 222-1 on 09/17/13 at 11:20 AM during the initial tour and on 09/19/13 at 1:00 PM revealed the fall mat was torn.</p> <p>Interview conducted with Housekeeper #2 on 09/19/13 at 1:10 PM revealed the housekeeper had cleaned room 222 on 09/17/13, 09/18/13, and 09/19/13. According to Housekeeper #2, she was responsible for cleaning the fall mat and if the mat was torn she was required to report it to the supervisor so the mat could be replaced. Housekeeper #2 stated that she had not noticed the tear being "that bad" and did not report it to the supervisor.</p> <p>An interview conducted with the Housekeeping Supervisor on 09/19/13 at 2:05 PM, revealed the Housekeeping Supervisor was not aware of the torn fall mat or the soiled frame of the overbed table. Additional interview revealed the Housekeeping Supervisor made rounds daily in the facility to ensure rooms were cleaned but did not check each resident room to ensure the</p>	F 253	<p>Re education was completed by the administrator for maintenance regarding checking and keeping doors repaired on 9/19/2013. A scheduled was developed to check all doors monthly for repair needs.</p> <p>Re education was completed by the administrator for all department managers to check fall mats for cleanliness and tears during room rounds on 9/19/2013.</p> <p>Beginning the week of 10/6/2013 the administrator/housekeeping supervisor/maintenance will check 20 over bed tables for cleanliness, frays or chipped areas and 3 rooms for cleanliness; 20 floor mats for cleanliness and tears; and 20 doors to ensure they don't need any type of repair 5 times a week times 3 weeks. Over bed tables and 3 rooms for cleanliness; 20 floor mats for cleanliness and tears; and 20 doors to ensure they don't need any type of repair 5 times a week times 3 weeks. Then the administrator/housekeeping supervisor/maintenance will check 3 over bed tables for cleanliness, frays or chipped areas and 3 rooms for cleanliness; 3 floor mats for cleanliness and tears; and 3 doors to ensure they don't need any type of repair 5 times a week times 3 weeks.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director unit managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed this plan will be ongoing until this issue is resolved.</p> <p>5. Date of Compliance 10/25/2013</p>	

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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 253  F 315 SS=D	<p>Continued From page 6 rooms were cleaned.</p> <p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure appropriate treatment and services were provided to prevent an infection of the urinary tract for one of twenty-four sampled residents (Resident #3). Facility staff failed to clean the resident's perineal area after removing a soiled brief and applying a clean brief for the resident.</p> <p>The findings include:  Review of the policy for Female Perineal Care (no data) revealed facility staff was required to use a washcloth, wet with soap and water, to clean the resident's perineal area moving from the pubic area to the anal area after removing a soiled incontinence brief. The policy further directed staff to clean down each side of the labia using a different section of the wash cloth and then to</p>	F 253  F 315	<p>F315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>1. Resident #3 physician was notified by the UM on 9/17/2013 to report that pericare did not occur. No new orders were received. No other residents were identified.</p> <p>2. ETD to complete a one time audit observing 10 C.N.As providing pericare to random incontinent residents will be completed by 10/9/2013 to identify any C.N.A that does not provide pericare or does not perform pericare per facility protocol. DON/UM/QA Nurse to audit all residents with urinary catheters to identify if physician order is in place and resident clinical condition is consistent with the use of the urinary catheter. This will be completed by 10/21/2013. Any issue identified will be immediately reported to the physician. DON/UM/ETD to randomly audit 10 residents who are incontinent of bowel and /or bladder to identify any resident who is not on a bowel or bladder program to restore function, if it is deemed by their clinical condition that a program would possibly restore function. This will be completed by 10/21/2013. Any issue identified will be reported to the physician and corrected. DON to review all infections from a period of 8/1/2013 thru 9/22/2013 to identify any infection that was not addressed per CDC guidelines and/or any infection trends. This will be completed by 10/08/2013.</p>	

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F 315	<p>Continued From page 7</p> <p>wash downward over the urethra and vaginal openings before placing a clean dry incontinence brief on the resident.</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 07/01/12 with diagnoses including Senile Dementia, Paralysis Agitans, Hypertension, and Osteoarthritis. Review of the Minimum Data Set (MDS) dated 06/20/13 revealed the facility assessed Resident #3 to be frequently incontinent of urine and to require extensive assistance with toileting needs.</p> <p>Certified Nursing Assistant (CNA) #1 was observed to provide incontinence care for Resident #3 on 09/17/13, at 4:15 PM. Observation revealed the CNA washed her hands, put on gloves, and removed the resident's incontinence brief that was soiled with urine. The CNA was then observed to apply a clean incontinence brief for Resident #3 without washing/cleaning the resident's perineal area. CNA #1 then proceeded to remove the soiled gloves and wash her hands.</p> <p>Interview conducted with CNA #1 on 09/19/13, at 12:55 PM revealed the CNA had been trained to clean the resident's perineal area after removing a soiled brief and before applying a clean brief for a resident. CNA #1 stated she had been trained to use warm water, soap, and washcloths to clean the resident's perineal area after removing the soiled brief. CNA #1 stated she got "nervous" and forgot to clean Resident #3 after removing the soiled incontinence brief.</p> <p>The Director of Nursing (DON) confirmed in an interview conducted on 09/19/13, at 1:50 PM, the CNA should have cleaned the resident's perineal</p>	F 315	<p>3. Re education was completed by the Education Nurse for all nursing staff regarding incontinent care, hand washing, bowel and bladder incontinence and programs to restore, if warranted by clinical condition, use of urinary catheters and prevention of infection by 10/11/2013.</p> <p>The DON will review all infection for trends and to ensure that all infections have been addressed per CDC recommendations and this will be ongoing.</p> <p>The ETD or DON will watch 4 people perform hand washing, incontinent care or urinary catheter care weekly 6 weeks beginning the week of 10/14/2013.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director unit managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed this plan will be ongoing until this issue is resolved.</p> <p>5. Date of Compliance 10/25/2013.</p>	
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F 315	Continued From page 8 area after removing the soiled incontinence brief and before applying the clean brief. The DON stated routine in-service training was provided to the CNAs at least annually and a skills competency check was conducted annually. The DON stated no problems had been identified related to the staff's performance of incontinence care.	F 315		
F 504 SS=D	483.75(j)(2)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN  The facility must provide or obtain laboratory services only when ordered by the attending physician.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy it was determined the facility failed to provide or obtain laboratory services as ordered by the physician for one of twenty-four residents (Resident #9). Resident #9 had a physician's order for laboratory tests that included a Thyroid Stimulating Hormone (TSH) and T4 (tests to check thyroid functioning) to be obtained every three months. A review of the medical record on 09/18/13 revealed the most recent TSH and T4 tests had been obtained on 01/29/13. However, facility staff failed to ensure the TSH or T4 tests were obtained every three months in April 2013 and July 2013 as prescribed.  The findings include:  Review of the facility policy, "Procedure related to Labs," revealed labs were performed per the physician's orders.	F 504	F504 483.75(j)(i) LAB SVCS ONLY WHEN ORDERED BY PHYSICIAN  1. Resident # 9's physician was notified that the TSH/T4 levels had not been obtained in April or July 2013 on 9/18/2013, by Stacy Binkowski RN, unit manager with no new orders at this time.  2. DON, Unit Manager, ETD and or RNC completed an audit of all records to identify labs that were ordered for July, August, and September on 10/6/2013 and to identify any lab order that was not followed. Any issues identified were immediately reported to physician and family.  3. The RNC re educated the DON, QA nurse, ETD, and unit managers on following physician orders, lab process, obtaining labs, and ensuring lab results are obtained on 9/24/2013. Re education was completed by the Education Nurse for all licensed nursing staff regarding following physician orders, lab process, obtaining labs, and ensuring lab results are obtained by 10/11/2013.	

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F 504	<p>Continued From page 9</p> <p>Review of Resident #9's physician's orders dated September 2013 revealed TSH/T4 levels were to be obtained every three months. A review of the laboratory test results revealed a TSH/T4 was obtained on 01/29/13. However, further review revealed no evidence the TSH and T4 laboratory tests had been obtained every three months as prescribed. There was no documentation the laboratory tests TSH and T4 had been obtained in April 2013. In addition, there was a notation in the record for July 2013 that revealed Resident #9 was "out to hospital" and there were no laboratory results reported at that time.</p> <p>Interview with the Unit Manager of the Blue Wing on 09/19/13 at 2:30 PM revealed Resident #9 was out to the hospital in July and should have had TSH/T4 tests obtained upon his/her return; however, the tests were not obtained in July. According to the Unit Manager, staff made notations on the calendar for when to obtain laboratory tests and the nurse would "normally" check the calendar for laboratory tests that were due. According to the Unit Manager, if a resident was out of the facility when laboratory tests were due, collection of the laboratory tests would be completed upon the resident's return to the facility.</p> <p>The facility's Nurse Consultant confirmed in interview on 09/18/13 at 3:30 PM that Resident #9 had physician's orders for a TSH/T4 to be obtained every three months and the most recent TSH and T4 tests were from 01/29/13. The Nurse Consultant stated nurses placed laboratory tests that have been ordered on a calendar as a reminder to staff to ensure the laboratory tests were obtained. According to the Nurse</p>	F 504	<p>Beginning the week of 10/6/2013 the DON/Unit Manager/QA/ETD will audit labs for 10 residents on each hall weekly x 3 weeks. Then the DON/Unit manager/QA/ETD will audit labs for 5 residents on each hall x 3 weeks. Then the DON/Unit manager/QA/ETD will audit labs for 5 residents monthly times 3 months.</p> <p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director unit managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed this plan will be ongoing until this issue is resolved.</p> <p>5. Date of Compliance 10/25/2013</p>	

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

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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  09/19/2013
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 504	Continued From page 10 Consultant, although Resident #9 was out of the facility when his/her laboratory tests were due, the nurses should have obtained the laboratory tests after the resident's return from the hospital.	F 504	F514	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of facility policy, it was determined the facility failed to have an effective system to maintain clinical records that were complete and accurately documented in accordance with accepted professional standards and practices for one of twenty-four sampled residents (Resident #11). Facility staff transmitted Resident #11's quarterly assessment dated 07/15/13; however, facility staff was aware the assessment was inaccurate and failed to correct or amend the assessment by transmittal.  The findings include:	F 514	1. Resident #11 MDS assessment was corrected on 10/8/2013 by Jennifer Rowe. The Medical Director was made aware of this issue and no new orders were noted. No other residents were identified.  2. MDS assessments transmitted and completed from a period of 10-1-2013 thru 10-10-2013 will be reviewed by the Regional Reimbursement nurse to identify any issue with coding or any issues with ADL documentation. This will be completed by 10/10/2013. Any issues identified will be immediately corrected.  3. The ETD (Education Training Director) to re educate nursing staff regarding correct documentation of ADLs and correctly documenting all care. This will be completed by 10/11/2013. The Regional Reimbursement nurse to re educate the MDS staff to accurately code all MDS assessments transmitted. This will be completed by 10-10-2013. The Regional Reimbursement nurse to review 2 MDS assessments weekly for accurate coding beginning week of 10/14/2013 x 4 weeks then 2 MDS assessments monthly x 2 months.	

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F 514	<p>Continued From page 11</p> <p>A review of the facility policy, "Procedure to maintain medical records accurately," (undated) revealed any and all records related to residents were filed in the resident's medical record.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment dated 07/15/13 revealed Resident #11 had been assessed to require the assistance of two staff members for transfers both in and out of bed; to require the assistance of staff with ambulation on the unit and off the unit; to require the assistance of two for dressing and hygiene; that the resident was occasionally incontinent, had an increase of pain, a decrease in weight, and the development of a pressure sore. Based on the assessment, Resident #11's health and abilities had declined since the annual assessment dated 05/22/13. A review of the Interdisciplinary Team (IDT) note on 07/11/13 revealed the resident required the assistance of one staff member with all activities of daily living, was continent of bowel and bladder, used an electric wheelchair for mobility, and continued to have Stage II pressure to coccyx area.</p> <p>Interview with the MDS Coordinator on 09/18/13 at 2:30 PM revealed the quarterly assessment was inaccurate related to the requirement for transfers of the resident, the requirement for two staff members to assist Resident #11 with ADLs, and that the resident was incontinent of bladder. The MDS Coordinator stated facility staff began using the "accu nurse" system for charting in July 2013. According to the MDS Coordinator, there were discrepancies in documentation at times which caused errors on the MDS assessments; however, the MDS Coordinator stated the errors could be corrected through the interdisciplinary</p>	F 514	<p>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director unit managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance 10/25/2013</p>	
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F 514	<p>Continued From page 12</p> <p>Team (IDT) meetings. The MDS Coordinator further stated corrections to the assessments could be made at any time on the system and was unsure why the assessment was not corrected and a new transmittal performed with the discrepancies that were identified.</p> <p>Interview with the facility's Nurse Consultant on 09/19/13 at 2:30 PM revealed the MDS assessment should have been corrected when the discrepancies were identified.</p>	F 514		
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NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE Division of Health Care SALYERSVILLE, KY 40385 Enforcement Branch
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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: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (WET &amp; DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 09/19/13. 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. The census on the day of the survey was 117 residents with a bed capacity of 142 beds.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p>	K 000	<p>K 000 Life Safety</p> <ol style="list-style-type: none"> <li>1. No resident was found to be affected. The emergency generator was reset with a transfer time of 10 seconds of main power failure on 9/19/2013 with no issues noted.</li> <li>2. The administrator did a one time audit on 9/19/2013 to ensure that the generator was on a 10 second transfer time.</li> <li>3. The Administrator re-educated the maintenance department on the appropriate transfer time for the emergency generator on 9/19/2013. The administrator/ DON will audit the transfer time for the emergency generator weekly times 4 weeks. Then monthly times 2 months. To ensure that the appropriate time is set on the generator.</li> <li>4. Quality Assurance Team consisting of at least Administrator, DON, QA Nurse, ETD, Medical Director Unit Managers to meet weekly x 2 weeks beginning week of 10/6/2013 then monthly to review audit findings and revise plan as needed this will be ongoing until this issue is resolved.</li> <li>5. Date of Compliance 10/25/2013.</li> </ol>	
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Elaine Jones</i> Administrator	TITLE Administrator	(X8) DATE 10/11/13
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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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K 144 SS=F	Continued From page 1  Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.  This STANDARD is not met as evidenced by: Based on record review and interviews, it was determined the facility failed to ensure generators were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect seven of seven smoke compartments, 142 residents, all staff, and visitors.  The findings include:  Record review of the facility's monthly generator maintenance records on 09/19/13 at 11:39 AM, revealed the transfer time for the emergency generator was 20 seconds. The observation was confirmed with the Maintenance Director. Transfer time for the emergency generator must be within 10 seconds of main power failure.  Interview on 09/19/13 at 11:39 AM, with the Maintenance Director, revealed the emergency generator was programmed to transfer at 20 seconds and the Maintenance Director was not aware the emergency generator transfer time needed to be within 10 seconds of main power	K 144			

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K 144	<p>Continued From page 2 failure.</p> <p>The findings were confirmed with the Administrator at the exit conference.</p> <p>Reference: NFPA 99 (1999 Edition).</p> <p>3-4.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>a. Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-4.3.1. Maintenance shall be performed in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>b. Inspection and Testing.</p> <p>1. Test Criteria. Generator sets shall be tested twelve (12) times a year with testing intervals between not less than 20 days or exceeding 40 days. Generator sets serving emergency and equipment systems shall be in accordance with NFPA 110, Standard for Emergency and Standby Power Systems, Chapter 6.</p> <p>2. Test Conditions. The scheduled test under load conditions shall include a complete simulated cold start and appropriate automatic and manual transfer of all essential electrical system loads.</p> <p>3. Test Personnel. The scheduled tests shall be conducted by competent personnel. The tests are needed to keep the machines ready to function and, in addition, serve to detect causes of malfunction and to train personnel in operating procedures.</p>	K 144			