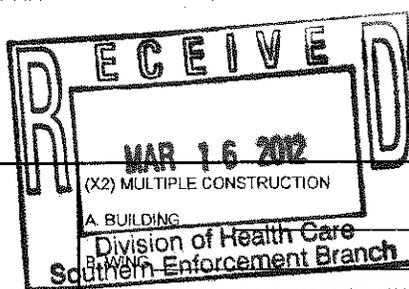


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 03/08/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185286	(X2) MULTIPLE CONSTRUCTION A BUILDING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 02/23/2012
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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629
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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	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law.	
F 282 SS=G	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 observation, interview, record review, and review of facility policies, it was determined facility staff failed to ensure care was provided in accordance with the written plan of care for one of three sampled residents (Resident #1). Facility staff assessed Resident #1 to be at risk for the development of pressure ulcers and developed care plan interventions that included observation/assessment of the resident's skin on a daily basis, during the provision of personal care, to determine skin breakdown. On 02/13/12, Resident #1's care plan was revised to apply soft hand rolls to the resident's hands and assess the resident's skin on a daily basis when care was provided. Record review revealed no documented evidence the resident's skin was assessed per the plan of care. On 02/15/12, Resident #1 was admitted to an acute care facility and was assessed to have pressure ulcers, with exposed tendon and bone to the right hand. However, interview and record review revealed	F 282	SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Fair Oaks Health Systems to determine that the services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care to Resident #1 and all other Residents. Criteria 1: Resident #1 has expired. Criteria 2: A head to toe observation/ Assessment was completed on all in house residents to determine all identified skin issues (skin tears, bruises, impaired skin integrity/ skin breakdown) were accurately documented with appropriate treatments in place and in accordance with each resident's care plan, as conducted by the DON/ ADON/ Unit Nursing Managers on March 2, 2012. Criteria 3: Facility Licensed Nursing staff have received inservice education on skin assessment protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin assessments; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin assessments prior to any transfer if not an emergency situation, as provided by facility's Wound Nurse consultant on March 6, 2012 and March 14, 2012.	

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

TITLE

Administrative

(X6) DATE

3/15/2012

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

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F 282	<p>Continued From page 1</p> <p>the facility was unaware Resident #1 had pressure ulcers to the right hand when transported to an acute care facility on 02/15/12 (refer to F314). The resident expired at the hospital on 02/20/12.</p> <p>The findings include:</p> <p>A review of the facility's undated "Patient Comprehensive Care Plans" policy revealed an interdisciplinary team would develop, review, and revise resident care plans after each resident assessment. The policy revealed the care plans would describe the services to be furnished to attain/maintain the resident's highest practicable physical, mental, and psychosocial well-being.</p> <p>A review of the closed medical record revealed Resident #1 was transferred and admitted to an acute care facility on 02/15/12, due to respiratory distress. A review of Resident #1's acute care record, and pictures of the resident's wounds obtained by the acute care staff, revealed upon admission to the acute care facility on 02/15/12, Resident #1 was assessed to have a Stage IV pressure ulcer to the right thumb with a white tendon exposed on the inner section of the thumb; a Stage IV pressure area to the right index finger with white bone exposed to the right side of the middle knuckle of the index finger; a Stage II pressure area to the resident's right middle finger with a darkened area to the left side of the middle knuckle of the finger; and an unstageable area to the resident's sacrum.</p> <p>A review of Resident #1's closed medical record revealed the facility admitted the resident on 06/24/10, with diagnoses of Dementia and</p>	F 282	<p>Continued from page 1</p> <p>Facility State Registered Nursing staff have received inservice education on skin observation protocols, including but not limited to: consistent implementation of careplan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Administrator, and Director of Clinical Services on March 1, 2012 and March 15, 2012.</p> <p>Facility phase II Restorative staff (specialty trained Restorative State Registered Nursing Assistant) have received inservice education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Facility Nurse Consultant on March 14, 2012.</p> <p>Facility phase III Restorative staff (all trained Phase III State Registered Nursing Assistant staff) have received inservice education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Administrator, Therapy Department Manager, and Director of Clinical Services on March 15, 2012.</p> <p>State Registered Nursing Assistant (SRNA) #1, SRNA #2, and SRNA#3 (SRNA #4 is no longer an employee of the facility as of 2/25/12) have received</p>	
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F 282	<p>Continued From page 2</p> <p>Cerebral Vascular Accident (CVA).</p> <p>A review of the resident's Comprehensive Minimum Data Set (MDS) Assessment dated 02/08/12, revealed the facility assessed Resident #1 to be at risk for the development of pressure ulcers. The Comprehensive MDS Assessment revealed Resident #1 was assessed to have an unstageable pressure ulcer to the coccyx upon readmission from an acute care facility on 12/30/11.</p> <p>A review of the resident's Care Area Assessment (CAA) Summary dated 02/09/12, revealed the facility assessed Resident #1 to require assistance with bed mobility, was incontinent of bowel and as a result was at risk for impaired skin integrity and pressures ulcers. According to the CAA, staff was to provide preventive skin care precautions and to observe for signs/symptoms of skin breakdown with daily care.</p> <p>A review of Resident #1's Comprehensive Care Plan dated 02/09/12, revealed Resident #1 was care planned for Potential for Alteration in Skin Integrity and was At Risk for Pressure Ulcers related to multiple risk factors which included the resident's fragile skin, his/her diagnoses of senile purpura, anemia, and a pressure ulcer to the coccyx. Interventions on the care plan revealed staff was to observe/assess Resident #1 for skin tears, bruises, impaired skin integrity/skin breakdown when providing daily care, and to provide preventive care precautions daily with care and as needed.</p> <p>Continued review of the care plan revealed, based on the facility's assessment, Resident #1</p>	F 282	<p>Continued from page 2</p> <p>inservice education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; and completion of head to toe skin observations prior to any transfer if not an emergency situation , as provided by the Facility Nurse Consultant on March 14, 2012.</p> <p>Licensed Practical Nurse #1, Director of Nursing, and Assistant Director of Nursing have received inservice education on skin assessment protocols, including but not limited to: consistent implementation of careplan interventions including correct completion and documentation of head to toe skin assessments; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin assessments prior to any transfer if not an emergency situation, as provided by facility's Nurse consultant on March 14, 2012.</p> <p>Criteria 4:</p> <p>The Continuous Quality Improvement (CQI) indicator for monitoring of head to toe skin assessments will be completed on 1 resident per unit weekly x 4 weeks, then monthly X 2 months then quarterly thereafter to determine accurate completion and documentation of skin assessment findings under the supervision of the Director of Nursing and Director of Clinical Services. The CQI indicator findings will be reviewed by the CQI committee in the quarterly CQI meetings, beginning with the March CQI meeting. An action plan will be developed by the committee for any indicator findings that fail to meet the established threshold.</p> <p>The DON or ADON or Wound Nurse or Consultant Nurse will conduct follow up head to toe skin assessments on 1 resident per unit weekly x 4 weeks.</p>		

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F 282	<p>Continued From page 3</p> <p>required a restorative nursing program due to stiffness of his/her joints, dysarthria (having problems with articulating), and the fact that the resident was nonambulatory. Documentation in Resident #1's closed medical record revealed staff updated the care plan on 02/13/12, and noted due to the stiffness in both of Resident #1's hands, staff was to apply soft hand rolls to the resident's hands and assess the resident's skin on a daily basis when they provided care.</p> <p>Continued review of documentation in the closed medical record of Resident #1 revealed from 02/08/12 through 02/15/12, staff assessed the resident's skin as "warm," "dry," and/or "pale." However, there was no documented evidence staff had observed/assessed Resident #1 for skin tears, bruises, impaired skin integrity/skin breakdown when providing daily care or that they had provided preventive care precautions when daily care was provided in accordance with the care plan. In addition, the review revealed no documentation after 02/13/12, following the addition of the soft hand rolls, of daily skin assessments of the hands as per the plan of care.</p> <p>Interviews conducted on 02/23/12, with State Registered Nursing Assistant (SRNA) #1 at 2:40 PM, with SRNA #2 at 3:00 PM, with SRNA #3 at 3:10 PM, and with SRNA #4 at 3:20 PM, revealed staff placed hand rolls or washcloths in the palm of Resident #1's right hand to prevent pressure areas to the resident's palm as a result of the resident "clenching" his/her fist. According to the SRNAs, Resident #1's hands were washed at least once per shift, a skin audit was performed on his/her hands at that time, and any skin issues</p>	F 282	<p>Continued from page 3</p> <p>then monthly X 2 months, then on 2 residents on a quarterly basis to determine the accuracy of documented head to toe assessments findings completed by the licensed nurses. Any discrepancies identified will result in re-education of the licensed nurse who completed the assessment. Results of these follow up assessments will be reviewed quarterly by the COI committee to determine if further interventions or education is indicated.</p> <p>Criteria 5: March 19, 2012</p>	3/19/12
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F 282	Continued From page 4 were to be reported to the nurse. In addition, the SRNAs stated they had not observed any skin breakdown to Resident #1's hands when they provided care to the resident. Interview conducted on 02/23/12, at 3:30 PM, with Licensed Practical Nurse (LPN) #1 revealed she had performed skin assessments on Resident #1 on the days she provided care to the resident and documented these assessments in the nurse's notes. LPN #1 stated she performed an assessment of Resident #1's skin on 02/15/12, prior to transporting the resident to the acute care facility, and had not observed any skin breakdown to the resident's hands. However, record review revealed no documented evidence the skin assessments were completed. Interviews conducted on 02/23/12, at 5:20 PM, with the Assistant Director of Nursing (ADON) and at 5:45 PM, with the Director of Nursing (DON) confirmed SRNAs were required to perform skin audits every day when they provided resident care and to report any identified concerns related to the resident's skin to the charge nurses. The interview revealed nurses were also required to perform a "head to toe" skin assessment every shift for all residents with gastrostomy tubes (G-tubes), with pressure ulcers, or that were identified to be a high level of care. According to the DON and the ADON, nurses were to document each skin assessment in the nurse's notes in the medical record. The interviews revealed random chart audits were completed weekly; however, the facility had failed to identify nurses were not documenting "head to toe" skin assessments.	F 282			
F 314	483.25(c) TREATMENT/SVCS TO	F 314	TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES		

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F 314 SS=G	Continued From page 5 PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure a resident who entered the facility without pressure sores did not develop pressure sores and that a resident having pressure sores received the necessary treatment and services to prevent the development of new pressure sores based on the resident's comprehensive assessment for one of three sampled residents (Resident #1). The facility assessed Resident #1 to have impaired skin integrity, a pressure sore to the coccyx, and was at risk for the development of pressure sores. The facility developed a care plan with interventions to observe and assess the resident for signs/symptoms of skin breakdown when daily care was provided. However, the facility failed to ensure policy and procedures and care plan interventions were implemented related to monitoring skin integrity for Resident #1. Resident #1 was transferred and admitted to an acute care facility on 02/15/12, and upon admission was assessed to have pressure ulcers	F 314	Continued from page 5 Based on the Comprehensive Assessment of Resident #1 and all other residents, Fair Oaks Health Systems to determine that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident who has an ulcer receives care and services to promote healing and to prevent additional ulcers. Criteria 1: Resident #1 has expired. Criteria 2: Head to toe skin observation/assessments were completed on all in house residents to determine that all identified skin issues (skin tears, bruises, impaired skin integrity/ skin breakdown) were accurately documented with appropriate treatments in place, as conducted by the DON/ADON/Unit Nursing Managers on March 2, 2012. Criteria 3: Facility Licensed Nursing staff have received in-service education on the policy and procedure of Skin Care Management, the prevention of pressure sores, and the treatment and services available to prevent the development of new pressure sores based on the resident's comprehensive assessment as provided by facility's Nurse consultant on March 14, 2012. Facility Licensed Nursing staff have received in-service education on skin assessment protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin assessments; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin assessments prior to any transfer if not an emergency situation, as provided by facility's Wound Nurse consultant on March 6, 2012 and March 14, 2012.		

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F 314	<p>Continued From page 6</p> <p>to the right hand with bone and tendons exposed. Interview and record review revealed facility staff was unaware Resident #1 had pressure ulcers to the right hand and there was no documented evidence the resident's hand had been assessed per the plan of care (refer to F282). The resident expired at the hospital on 02/20/12.</p> <p>The findings include:</p> <p>A review of the facility's undated Preventive Skin Protocol revealed staff was responsible to assess the resident's skin integrity every shift and monitor for discoloration, irritation, and breaks in the skin.</p> <p>A review of the facility's undated policy, Prevention of Pressure Ulcers, revealed as a preventive action staff was to inspect the resident's skin at least once per shift.</p> <p>Review of Resident #1's nurse's notes revealed the resident was transferred and admitted to an acute care facility on 02/15/12, due to Respiratory Distress. A review of Resident #1's acute care nurse's notes and pictures of the resident's wounds obtained by the acute care staff on 02/15/12, revealed upon admission to the acute care facility Resident #1 was assessed to have a Stage IV pressure ulcer to the right thumb with a white tendon exposed on the inner section of the thumb; a Stage IV pressure area to the right index finger with white bone exposed to the right side of the middle knuckle of the index finger; a Stage II pressure area to the resident's right middle finger with a darkened area to the left side of the middle knuckle of the finger; and an unstageable area to the resident's coccyx.</p>	F 314	<p>Continued from page 6</p> <p>Facility State Registered Nursing Assistant staff have received in-service education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Administrator and Director of Nursing on March 1, 2012 and March 15, 2012.</p> <p>Facility phase II Restorative staff (specialty trained Restorative State Registered Nursing Assistant) have received in-service education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Facility Nurse Consultant on March 14, 2012.</p> <p>Facility phase III Restorative staff (all trained Phase III State Registered Nursing Assistant staff) have received in-service education on skin observation protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by Administrator, Therapy Department Manager, and Director of Clinical Services on March 15, 2012.</p> <p>State Registered Nursing Assistant (SRNA) #1, SRNA #2, and SRNA#3 (SRNA #4 is no longer an employee of the facility as of 2/25/12) have received inservice education on skin observation protocols,</p>		

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F 314	<p>Continued From page 7</p> <p>Review of Resident #1's closed medical record revealed the facility admitted the resident on 06/24/10, with diagnoses of Dementia and Cerebral Vascular Accident (CVA). A review of Resident #1's Comprehensive Minimum Data Set (MDS) Assessment dated 02/08/12, revealed the facility assessed the resident to be at risk for development of pressure ulcers. The assessment revealed Resident #1 had an unstageable pressure ulcer to the coccyx that had been assessed upon the resident's readmission from an acute care facility on 12/30/11.</p> <p>Review of the resident's Care Area Assessment (CAA) Summary dated 02/09/12, revealed the facility assessed Resident #1 to be at risk for impaired skin integrity and pressures ulcers due to the resident's bowel incontinence and the resident's need for assistance with bed mobility. In accordance with the resident's CAA, staff was to provide preventive skin care and was to observe for signs/symptoms of skin breakdown when they provided daily care.</p> <p>Review of Resident #1's care plan dated 02/09/12, revealed the facility addressed the resident's Potential for an Alteration in Skin Integrity and had identified the resident to be At Risk for the Development of Pressure Ulcers. The facility identified the resident's risk factors for the development of pressure sores as the resident's fragile skin, his/her diagnoses of senile purpura, anemia, and the presence of a pressure ulcer to the coccyx. Based on the identified risk factors, the facility developed interventions for staff to utilize to aid in the prevention of pressure sores which included daily observations of the</p>	F 314	<p>Continued from page 7</p> <p>including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin observation; observations of skin during care with immediate reporting of all findings to the charge nurse; and completion of head to toe skin observations prior to any transfer if not an emergency situation, as provided by the Facility Nurse Consultant on March 14, 2012.</p> <p>Licensed Practical Nurse (LPN) #1, Director of Nursing (DON), and Assistant Director of Nursing (ADON) have received in-service education on skin assessment protocols, including but not limited to: consistent implementation of care plan interventions including correct completion and documentation of head to toe skin assessments; observations of skin during care with immediate reporting of all findings to the charge nurse; completion of head to toe skin assessments prior to any transfer if not an emergency situation, as provided by facility's Nurse consultant on March 14, 2012.</p> <p>Criteria 4:</p> <p>The Continuous Quality Improvement (CQI) indicator for monitoring of head to toe skin assessments will be completed on 1 resident per unit weekly x 4 weeks, then monthly X 2 months then quarterly thereafter to determine accurate completion and documentation of skin assessment findings under the supervision of the Director of Nursing and Director of Clinical Services. The CQI indicator findings will be reviewed by the CQI committee in the quarterly CQI meetings, beginning with the March CQI meeting. An action plan will be developed by the committee for any indicator findings that fail to meet the established threshold.</p> <p>The DON or ADON or Wound Nurse or Nurse Consultant will conduct follow up head to toe skin assessments on 1 resident per unit weekly x 4 weeks, then monthly X 2 months, then on 2 residents on a</p>		

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NAME OF PROVIDER OR SUPPLIER FAIR OAKS HEALTH SYSTEMS, LLC	STREET ADDRESS, CITY, STATE, ZIP CODE 1 SPARKS AVENUE, P O BOX 740 JAMESTOWN, KY 42629
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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 314	<p>Continued From page 8</p> <p>resident for skin tears, bruises, impaired and/or breakdown of skin, and the provision of care as needed.</p> <p>Continued review of the care plan revealed Resident #1 required a restorative nursing program due to the resident's inability to ambulate, stiffness of his/her joints, and dysarthria (having problems to articulate). Further review of Resident #1's closed medical record revealed staff updated the care plan on 02/13/12, and noted, due to the stiffness in both of Resident #1's hands, staff was to apply soft hand rolls to the resident's hands and assess the resident's skin on a daily basis when they provided care.</p> <p>A review of nurse's notes in Resident #1's medical record from 02/08/12 through 02/15/12, revealed staff assessed the resident's skin as "warm," "dry," and/or "pale," however, there was no documented evidence facility staff had performed a skin observation/assessment every shift as required. The review revealed no documentation after 02/13/12, following the addition of the soft hand rolls of daily skin assessments of the hands. There was no documented evidence the facility had identified skin breakdown to the resident's hand. According to the nurse's notes, Resident #1 was transported to the local hospital on 02/15/12, at 12:30 PM, for respiratory distress.</p> <p>Interviews conducted on 02/23/12, at 2:40 PM, with State Registered Nursing Assistant (SRNA) #1 and at 3:00 PM with SRNA #2, revealed the SRNAs worked the first shift on the D Wing, the unit where Resident #1 resided prior to his/her</p>	F 314	<p>Continued from page 8</p> <p>quarterly basis to determine the accuracy of documented head to toe assessments findings completed by the licensed nurses. Any discrepancies identified will result in re-education of the licensed nurse who completed the assessment. Results of these follow up assessments will be reviewed quarterly by the CQI committee to determine if further interventions or education is indicated.</p> <p>Criteria 5: March 19, 2012</p>	3/19/12

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: 185286	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/23/2012
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F 314	<p>Continued From page 9</p> <p>hospitalization. Interviews conducted on 02/23/12, at 3:10 PM, with SRNA #3 and at 3:20 PM, with SRNA #4 revealed the SRNAs worked the second shift on the D Wing. The interviews revealed the SRNAs performed skin audits each time care was provided to the residents. The interviews revealed if skin issues were identified the SRNA would report the skin issue to the charge nurse and document the skin issue in the communication book. In addition, the interviews revealed the SRNAs placed hand rolls or washcloths in the palm of Resident #1's right hand to prevent the development of pressure areas to the resident's hand as a result of the resident "clenching" his/her fist. According to interview with the SRNAs, Resident #1's hands were washed at least once per shift and a skin audit was performed of his/her hands at that time. The SRNAs denied any skin breakdown to Resident #1's hands.</p> <p>Interview conducted on 02/23/12, at 3:30 PM, with Licensed Practical Nurse (LPN) #1 revealed nursing staff was to conduct a "head to toe" skin assessment of residents with pressure ulcers or G-tubes or residents that received skilled services and were to document the assessment in the nurse's notes. LPN #1 stated she had assessed Resident #1 on a daily basis and, based on documentation, had noted the resident's skin was pale or pink, warm, and dry. The interview revealed the LPN had not assessed the resident to have skin breakdown on the hands. LPN #1 stated she performed a skin assessment on Resident #1 on 02/15/12, prior to the resident's transfer to the acute care facility and there was no skin breakdown to the resident's hands at that time. However, there</p>	F 314		
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F 314	Continued From page 10 was no documented evidence of a skin assessment being completed. Interviews conducted on 02/23/12, at 5:45 PM, with the Director of Nursing (DON) and at 5:20 PM, with the Assistant Director of Nursing (ADON) revealed SRNAs were required to perform skin audits every day when they provided personal care to residents and were to report any skin issues to the charge nurses. In addition, the interview revealed the nurses were also required to perform a "head to toe" skin assessment each shift for all residents with pressure ulcers or G-tubes or who received skilled services and document the skin assessments in the nurse's notes. The interviews revealed random chart audits were completed weekly; however, the facility failed to identify that nurses were not documenting the skin assessments.	F 314			