

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

PRINTED: 08/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/29/2010
--	--	--	---

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
F 465	Continued From page 25 -the privacy curtains in resident rooms 119 and 213 were off the track, -the tile in resident room 113 and at the doorway of the dining room was chipped/broken, -the baseboard was loose in resident room 113, -the faucet was loose in resident room 114, -the wall was marred with black marks in resident bathroom 109, -a screw was protruding/exposed from the commode in the bathroom in resident rooms 109, 113, 114, 119, 121, 122, 128, 211, 219, 220, 305, 306, and 410, and in the shower rooms on the Green and Blue Halls, -the drywall was chipped/marred at the air conditioner in resident room 302 and at the corner of the women's shower on the Peach Hall, -the drywall was chipped/marred in resident bathrooms 220 and 305, -the drywall was chipped/marred on the corner at the sink in resident rooms 105 and 306 and between the beds in resident room 103.	F 465	The baseboard in room 113 was repaired on 8/20/2010. The faucet in room 114 was repaired on 8/16/2010. The wall in the bathroom in room 109 was repaired on 8/16/2010. The screw exposed around the commodes in rooms 109, 113, 114, 119, 121, 122, 128, 211, 219, 220, 305, 306 and 410 as well as shower rooms on the Green and Blue hall were fixed and screws are not exposed on 8/6/2010. The drywall near air conditioner in room 302 was repaired on 8/13/2010. The drywall at corner of women's shower room on Peach hall was repaired and painted on 8/17/2010. The drywall in rooms 220 and 305 were repaired on 8/16/2010. The drywall in rooms 105 and 306 were repaired and painted on 8/17/2010. The drywall in room 103 between beds was repaired on 8/23/2010. 2.Adminrator and Maintenance Supervisor to complete one time environmental audit of all shower rooms, resident rooms and common areas to identify any maintenance or housekeeping concerns. 3.Regional Director of Operations to re educate Administrator regarding policy to provide a safe, functional sanitary and comfortable environment by 8/31/2010. Administrator to re educate the maintenance Supervisor regarding policy to provide a safe, functional sanitary and comfortable environment by 9/03/2010.	
	Interview on July 29, 2010, at 1:30 p.m., with the Maintenance Supervisor (MS) revealed the Maintenance Department conducted morning rounds every day to detect any items in need of repair. The MS stated it was the responsibility of all staff to report any items in need of repair. The MS stated the blank work orders were kept in the supply room/employee bathroom near the time clock so they were easily accessible to all employees. The MS stated items identified had not been reported and apparently had been missed on the daily rounds; however, the MS stated the screw anchors protruding from the commodes and anything that could cause injury to the residents would be a priority. The MS stated blinds were being purchased to replace the curtains; however, only four per month would be			

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

PRINTED: 08/11/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 07/29/2010
--	--	--	---

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

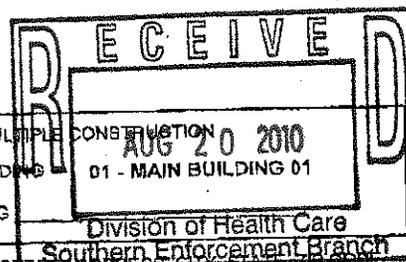
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 465	Continued From page 26 purchased.	F 465	Administrator to complete an audit of resident rooms, shower rooms and common areas to identify concerns 1 x week x 4 weeks, then bi monthly x 2 weeks.	
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.	F 514	ETD to re educate Department Managers housekeeping department and nursing regarding policy for completion of work orders upon identification of any area in need of repair by 9/03/2010. 4. Quality Assurance Committee to review and revise plan as needed bi monthly beginning week of 9/03/2010. 5. Date of Compliance 9/03/2010.	
	This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain accurate clinical records for one (1) of thirty-seven (37) sampled residents. Resident #8 had physician's orders to indicate the resident was to receive nothing by mouth (NPO). However, the facility allowed resident #8 to eat and drink if the resident desired. The findings include: A review of the medical record for resident #8 revealed the resident received food and fluid via Gastrostomy Tube. Further review revealed		1. Resident #8 physician was contacted on 7/29/2010 and orders for food and fluid intake was clarified. 2. DON/ADON/ETD/UM to complete a one time audit of all records to identify any resident with NPO order, clarify whether a diet order is recommended and ensure all diet orders are correct by 9/03/2010. 3. DON/ADON/ETD/UM to review diet orders monthly to ensure all residents are receiving the correct diet and order reflects the correct diet. RDCS to re educate DON/ETD/UM/ADON regarding policy for ensuring diet orders are correct and ensuring diets/fluids are provided per physicians order by 9/03/2010. ETD to re educate nursing and dietary regarding policy for ensuring residents receive food and fluids per physicians orders by 9/03/2010.	

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

PRINTED: 08/11/2010
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 G 07/29/2010
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	
F 514	Continued From page 27 resident #8 was evaluated by Speech Therapy related to pleasure feedings on May 14, 2010. The evaluation determined the resident to have no potential for resuming a diet by mouth and treatment was not indicated. An interview conducted with the Speech Therapist on July 28, 2010, at 10:25 a.m., revealed that resident #8 had been evaluated by Speech Therapy for not eating. According to the speech therapist, the resident would not eat related to cognition and required the use of a Gastrostomy Tube. However, it was recommended by Therapy that resident #8 have a water pitcher in the room due to resident #8's previous diet of pureed food with thin liquids. An interview conducted with the Blue Wing Unit Manager on July 28, 2010, at 1:50 p.m., revealed that resident #8's diet order was transcribed incorrectly and that resident #8 had always had a water pitcher available at the bedside.	F 514	4. Quality Assurance Committee to review and revise plan as needed bi monthly beginning week of 9/03/2010. 5. Date of Compliance 9/03/2010.		

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



PRINTED: 08/11/2010
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 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED 07/27/2010
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 000	INITIAL COMMENTS	K 000		
K 144 SS=F	<p>A Life Safety Code survey was initiated and concluded on July 27, 2010. The facility was found not to meet the minimal requirements with 42 Code of Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that the emergency generator was maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on July 27, 2010, at 1:33 p.m., revealed that the facility did not have an annunciator panel for the emergency generator. An annunciator panel must be located in an area that is constantly monitored. This practice has the potential to affect all residents and staff. This was confirmed with the Director of Maintenance at the time of discovery.</p> <p>Interview on July 27, 2010, at 1:33 p.m., with the</p>	K 144	<p>1. An annunciator panel alarm for the emergency generator will be installed by Whyne Supply by 8/31/2010 and will be continuously monitored per NFPA standards. All residents have the potential to be affected.</p> <p>2. An annunciator panel alarm for the emergency generator will be installed by Whyne Supply by 8/31/2010 and will be continuously monitored per NFPA standards.</p> <p>3. Administrator to ensure that the annunciator panel alarm is functioning 2 x week x 4 weeks and that emergency generator is functioning according to NFPA standards. Administrator to re educate Maintenance Supervisor regarding policy to maintain generator and ensure annunciator alarm is functional by 9/03/2010 and is continuously monitored per NFPA standard.</p> <p>4. Quality Assurance Committee to review and revise plan as needed beginning week of 9/03/2010.</p> <p>5. Date of Compliance 9/03/2010.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Sharon Welch* TITLE: *Administrator* (X6) DATE: *8/20/2010*

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

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

PRINTED: 08/11/2010
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 07/27/2010
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 144	Continued From page 1 Director of Maintenance, revealed that the facility has never had an annunciator panel for the emergency generator. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually.	K 144		

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

PRINTED: 08/11/2010
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 07/27/2010
--	--	--	--

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 144 K 147 SS=D	<p>Continued From page 2 (110: 3-5.5.2)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure wiring was maintained according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on July 27, 2010, at 1:40 p.m., revealed an oxygen concentrator was plugged into a power strip in resident room 105. Further observation revealed a feeding tube was plugged into a power-strip-in resident room 116. The medical equipment found plugged into the power strips was removed from them and plugged into a wall socket at the time of discovery by the Director of Maintenance.</p> <p>Interview on July 27, 2010, at 1:40 p.m., with the Director of Maintenance, revealed that no medical equipment is to be on power strips in the facility per policy.</p> <p>Reference: NFPA 99</p> <p>Chapter 3 Electrical Systems 3-3.2.1.2 D 2. Minimum number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall</p>	K 144 K 147 K 144	<p>K147</p> <p>1. Medical equipment plugged into power strip in rooms 105 and 116 were unplugged and plugged into wall socket immediately 7/27/2010 by maintenance supervisor. Maintenance supervisor removed the power strips from rooms 105 and 116 on 7/27/2010.</p> <p>2. Maintenance Supervisor and Administrator to complete a one time audit of all rooms to identify any medical equipment plugged into power strip by 8/31/2010.</p> <p>3. ETD to re educate staff regarding policy to plug medical equipment into wall socket by 9/03/2010. Administrator/Maintenance Supervisor and /or Department Managers to audit all rooms 3 x week x 4 weeks to ensure policy for not using power strips for medical equipment is followed. Beginning week of 9/03/2010.</p> <p>4. Quality Assurance Committee to review and revise plan as needed bi monthly beginning week of 9/03/2010.</p> <p>5. Date of Compliance 9/03/2010.</p>	

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

PRINTED: 08/11/2010
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 07/27/2010
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 147	Continued From page 3 be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		