



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

PRINTED: 09/03/2015  
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 08/20/2015
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 241	<p>Continued From page 1</p> <p>restrooms shared between two resident rooms were either not capable of being locked or had only one of two doors capable of being locked. Observation of rooms where neither restroom door locked included rooms 109, 111, 113, 115, 118, 120, 121, 122, 123, 124, 205, 206, 207, 208, 209, 211, 214, 218, 218, 220, 222, 224, 226, 228, 301, 303, 306, 308, 309, 310, 311, 312, 313, 315, 318, 320, 321, and 323. Observation of rooms that had one locking door on the restroom included rooms 116, 126, 212, 215, 219, 221, 307, and 317.</p> <p>Interview with Resident #7 on 08/20/15 at 2:45 PM revealed Resident #7's restroom was shared with an adjoining resident room, which was occupied by residents of the opposite sex. Continued interview with Resident #7 revealed residents of the opposite sex had walked in on the resident while trying to use the restroom and it made him/her feel "funny" and very embarrassed.</p> <p>Interview with Resident A on 08/20/15 at 4:00 PM revealed the restroom in his/her room did not lock and residents of the opposite sex had walked in on him/her while using the restroom. Continued interview with Resident A revealed he/she was embarrassed when residents of the opposite sex walked in on him/her while in the restroom.</p> <p>Interview with the Maintenance Director on 08/20/15 at 7:31 PM revealed residents of the opposite sex that could toilet themselves were not supposed to be placed in adjoining rooms. Continued interview with the Maintenance Director revealed the restroom doors had locked in the past, but during a mock survey he had been instructed to remove all of the locks from the resident room restrooms. Further interview</p>	F 241	<p>The maintenance director completed an audit of the bathroom door locks on 8/25/2015. Door locks were ordered for all of the bathroom doors that didn't have a lock and will be placed on the door by the maintenance department by 9/23/2015.</p> <p>3. The administrator will check 5 bathroom doors to ensure that they have a lock on them and that they work properly weekly times 4 weeks beginning the week of 9/20/2015. Any door identified on the administrator check as not having a lock or any issue with its functioning will be fixed immediately.</p> <p>4. Results of the administrators audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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F 241	Continued From page 2 with the Maintenance Director revealed he was not aware of any residents having an issue with their restroom doors not locking.  Interview with the Facility Administrator on 08/20/15 at 7:28 PM revealed she was not aware that restroom doors would not lock in residents' rooms. She stated she tried to make sure residents of the same sex were in rooms with adjoining restrooms.	F 241			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record	F 279	F279 483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  1. Resident # 13's care plan was updated on 8/19/2015 by the Director of Nursing to include interventions to address risk factors with indwelling urinary catheter including risk for injury to urinary tract related to pulling/pressure of catheter tubing including use of a leg strap.  2. All residents with a catheter care plan as indicated by those with catheter orders were reviewed and updated as needed by the DON and the unit managers to ensure that the elimination care plan included interventions to address risk factors with urinary tract including risk for injury to urinary tract related to pulling/pressure/catheter tubing such as a leg strap on 9/2/2015  3. The MDS Coordinator in serviced the interdisciplinary team including the DON, unit managers, social services, activities, and the dietary manager on developing a care plan for a catheter on 9/2/2015.		

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F 279	<p>Continued From page 3</p> <p>review, it was determined the facility failed to develop a comprehensive plan of care for one of (1) of twenty-three (23) sampled residents (Resident #13). Resident #13 was observed to have an indwelling urinary catheter; however, review of the resident's comprehensive care plan revealed the facility failed to develop a care plan to include interventions to address risk factors associated with the indwelling urinary catheter to include risk for injury to the urinary tract related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>The findings include:</p> <p>Review of a facility policy titled "Care Plans-Comprehensive," with a revision date of October 2010, revealed an individualized comprehensive care plan that included measurable objectives and timetables to meet the resident's medical, nursing, mental, and psychological needs would be developed for each resident.</p> <p>Review of the medical record for Resident #13 revealed the facility admitted the resident on 08/04/15, with diagnoses that include Cerebral Vascular Accident, Kidney Anomaly, Prostatitis, and a History of Urinary Tract Infection.</p> <p>Review of the physician's orders for Resident #13 revealed a physician's order dated 08/04/15, for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Review of an admission Minimum Data Set (MDS) assessment dated 08/11/15 revealed Resident #13 required the use of an indwelling urinary catheter.</p>	F 279	<p>The MDS Coordinator will review 3 residents with a catheter care plan per week times 8 weeks to ensure the elimination care plan includes interventions to address risk factors for a urinary catheter including risk for injury to urinary tract related to pulling/pressure of catheter tubing beginning the week of 9/20/2015.</p> <p>4. Results of the MDS Coordinator's review will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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F 279	Continued From page 4 Review of the comprehensive care plan dated 08/11/15, for Resident #13 revealed the resident had a care plan for an indwelling catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing.  Observation of Resident #13 on 08/20/15, at 10:40 AM, revealed the resident was lying on his/her back in bed with the urinary catheter tubing draped over the resident's right leg and the catheter bag secured to the bed. The urinary catheter tubing was not secured to the resident to prevent pulling of the urinary catheter tubing.  Interview with the Minimum Data Set (MDS) Coordinator on 08/20/15, at 8:07 PM, revealed she was responsible for developing resident care plans. The MDS Coordinator stated she should have developed interventions to secure catheters to prevent trauma/injury for residents who had indwelling urinary catheters.  Interview with the Director of Nursing (DON) on 08/20/15 at 3:45 PM revealed she attended meetings where care plans were developed. The DON stated residents who had indwelling urinary catheters should have interventions to address utilizing a leg strap to secure the urinary catheter tubing to prevent trauma/injury.	F 279			
F 282 SS=E	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.	F 282			

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F 282	<p>Continued From page 5</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 provide care in accordance with the Comprehensive Plan of Care for three (3) of twenty-three (23) sampled residents (Residents #5, #7, and #18). Resident #5's Comprehensive Care Plan contained interventions that included having palm protectors bilaterally; however, observations on 08/20/15 revealed Resident #5 to be without palm protectors. Resident #7's Comprehensive Care Plan contained interventions that included a resting hand splint on his/her left hand; however, observations on 08/18/15, 08/19/15, and 08/20/15 revealed Resident #5 to be without a hand splint on his/her left hand. Resident #18's Comprehensive Care Plan contained interventions that included a palm protector for his/her left hand; however, observations on 08/20/15 revealed Resident #18 to be without a palm protector in his/her left hand.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Using the Care Plan," dated August 2006, revealed the care plan shall be used in developing the resident's daily care routines and will be available to staff/personnel that have responsibility for providing care or services to the resident.</p> <p>1. Review of Resident #5's medical record revealed the facility admitted Resident #5 on 07/01/12 with diagnoses that include Diabetes Mellitus, Anoxic Brain Injury, Late Effect Cerebrovascular Disease, Idiopathic Peripheral</p>	F 282	<p>F282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>1. On 8/20/15 resident # 5's palm protector was placed back on her hand by the nursing staff and verified by the Director of Nursing. Resident # 18 refused to have palm protectors put on 8/20/2015 and verified by the Director of Nursing on 8/20/2015. The Occupational therapist re-evaluated resident # 7 on 8/20/15 for splint training to refer her to a restorative nursing program for splint management, no new issues were identified for resident #7's hand contracture.</p> <p>2. The unit managers completed an audit on 9/8/2015 for residents with physician orders and a comprehensive care plan for palm protectors or splints to ensure that they were on per plan of care. Any issues identified were immediately corrected.</p> <p>3. Nursing staff will be re-educated on placing palm protectors and hand splints per plan of care by the Staff Development nurse by 9/23/2015.</p> <p>The DON and/or unit managers will review 8 residents with a physicians order as well as a care plan for a palm protector or a splint to ensure that they are applied per plan of care weekly times 8 weeks beginning the week of 9/20/2015.</p>		

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F 282	<p>Continued From page 6</p> <p>Neuropathy, and Abnormal Posture. Review of Resident #5's most recent Annual Minimum Data Set (MDS) assessment dated 07/28/15 revealed the facility had not been able to interview Resident #5 for a Brief Interview for Mental Status (BIMS) score due to the resident's cognitive status. Review of Resident #5's Comprehensive Care Plan, dated 02/11/14, revealed an intervention for Resident #5 to have bilateral palm protectors as part of a restorative nursing program.</p> <p>Observation of Resident #5 on 08/20/15 at 2:00 PM revealed Resident #5 to have contractures to both hands and no palm protectors present. Continued observation of Resident #5 revealed two palm protectors lying on the overbed table.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7 on 08/20/15 at 2:40 PM revealed she had applied Resident #5's palm protectors in place at approximately 1:45 PM on 08/20/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 08/20/15 at 2:45 PM revealed he made rounds every two hours to ensure residents on his unit were getting the care required. Continued interview with LPN #3 revealed Resident #5 should have had palm protectors present to both palms.</p> <p>2. Review of Resident #7's medical record revealed the facility admitted Resident #7 on 01/08/15 with diagnoses that include Muscle Weakness, Chronic Airway Obstruction, Peripheral Vascular Disease, Paralysis, and Late Effects of Cerebrovascular Accident (CVA). Review of the quarterly MDS assessment dated 07/30/15 revealed the facility assessed Resident</p>	F 282	4. Results of the DON and/or unit managers audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.	9/24/2015	

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F 282	<p>Continued From page 7</p> <p>#7 to have Functional Limitation in Range of Motion on one side. Review of the physician's order dated 07/17/15 revealed Resident #7 was to use a hand splint to decrease risk of contracture development. Review of the Comprehensive Care Plan dated 07/16/15 revealed Resident #7 was to have a left resting hand splint.</p> <p>Observations on 08/18/15 at 5:44 PM and 6:45 PM, 08/19/15 at 9:45 AM and 12:40 PM, and 08/20/15 at 9:00 AM revealed Resident #7 to be without a resting hand splint on his/her left hand.</p> <p>3. Review of Resident #18's medical record revealed the facility admitted Resident #18 on 07/01/12 with diagnoses that include Senile Dementia, Convulsions, Muscle Weakness, Joint Contractures, and Lack of Coordination. Review of Resident #18's most recent Quarterly MDS dated 07/29/15 revealed the facility had assessed Resident #18 to have a BIMS score of 5, which indicated Resident #18 was severely impaired cognitively. Review of Resident #18's Comprehensive Care Plan dated 10/23/13 revealed an intervention for Resident #18 to have a palm protector to the left hand.</p> <p>Observation of Resident #18 on 08/20/15 at 6:07 PM revealed Resident #8 did not have a palm protector present to his/her left hand.</p> <p>Interview with LPN #1 on 08/20/15 at 6:07 PM revealed she was not for certain if Resident #18 was to wear the palm protector to his/her left hand all the time.</p> <p>Interview with LPN #2 on 08/20/15 at 6:26 PM revealed Resident #18 refused to let her put</p>	F 282			

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F 282	<p>Continued From page 8</p> <p>anything in his/her hand and that the palm protector should have been present to Resident #18's left hand. Continued interview with LPN #2 revealed she looked for splints and other devices at least once a day when providing care to residents.</p> <p>Interview with State Registered Nurse Aide (SRNA) #5 on 08/20/15 at 6:26 PM revealed Resident #18 had not had a palm protector present to his/her left hand all day. Continued interview with SRNA #5 revealed Resident #18 often refuses to wear the palm protector.</p> <p>Interview with the MDS Coordinator on 08/20/15 at 8:07 PM revealed the Interdisciplinary Team develops the care plan and after the MDS was completed, she made changes as needed. She further revealed she was not responsible to ensure staff was following the care plans.</p> <p>Interview with the Unit Manager on 08/20/15 at 8:15 PM revealed she was responsible to ensure that all staff was following the care plans. She further revealed she completed audits and observed staff during rounds to ensure staff was following the care plans and had not identified any concerns with staff not following the care plans.</p> <p>Interview with the Director of Nursing on 08/20/15 at 5:05 PM revealed staff had care plan meetings twice a week to verify all orders and to ensure interventions were added to the care plans. She further explained she did "walk throughs" daily to ensure staff was following the care plans. She further revealed she had not identified any concerns with staff not following the care plans.</p>	F 282		

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F 315 F 315 SS=D	Continued From page 9 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  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.  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 injury of the urinary tract for one (1) of twenty-three (23) sampled residents (Residents #13). The facility failed to ensure a care plan was developed with interventions to assure Resident #13's indwelling catheter was secured to prevent pulling/pressure/injury to the urinary tract in accordance with the facility's policy.  The findings include:  Review of the facility policy titled "Catheter Care, Urinary," with a revision date of October 2010, revealed staff was required to secure an indwelling urinary catheter with the use of a leg strap.  Review of Resident #13's medical record revealed the facility admitted the resident on	F 315 F 315	F315 483.25(d),NO CATHETER, PREVENT UTI, RESTORE  1. Resident # 13's indwelling urinary catheter was secured on 8/19/2015 with a leg strap by the LPN. The care plan was revised to include interventions to address the risk for injury related to pressure/pulling from the tube.  2. The Director of Nursing and unit managers assessed all residents with a urinary catheter to ensure that the urinary catheter was secured with a leg strap on 9/2/2015. The care plans were reviewed by the DON and the unit managers to ensure that the elimination care plan included interventions to address risk factors with urinary tract including risk for injury to urinary tract related to pulling/pressure/catheter tubing such as a leg strap.  3. The nursing staff will be re-educated on securing indwelling urinary catheters with a leg strap to prevent injury to urinary tract related to pulling/pressure/catheter tubing by 9/23/2015 by the Staff Development Nurse.  The DON and/or unit managers will review 4 residents with a catheter to ensure that it is secure with a leg strap to prevent injury to the urinary tract weekly times 8 weeks beginning the week of 9/20/2015.		

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F 315	<p>Continued From page 10</p> <p>08/04/15, with diagnoses that include Kidney Anomaly, Cerebral Vascular Accident (stroke), Prostatitis, and a History of Urinary Tract Infection.</p> <p>Review of Resident #13's physician's orders revealed a physician's order dated 08/04/15, for the resident to have an indwelling urinary catheter to bedside drainage.</p> <p>Review of Resident #13's admission Minimum Data Set (MDS) assessment dated 08/11/15 revealed the resident required the use of an indwelling urinary catheter.</p> <p>Review of Resident #13's care plan dated 08/11/15, revealed a care plan had been developed for an indwelling urinary catheter; however, the care plan did not include interventions to address the risk for injury related to pulling/pressure of the resident's urinary catheter tubing.</p> <p>Observation on 08/20/15, at 10:40 AM, of Resident #13 revealed the resident was lying on his/her back in bed with the urinary catheter tubing draped over the resident's right leg and the catheter bag secured to the bed. The urinary catheter tubing was not secured to the resident to prevent pulling/pressure from the urinary catheter tubing.</p> <p>Interview conducted with Licensed Practical Nurse (LPN) #3 on 08/20/15 at 2:40 PM revealed he was responsible for providing catheter care and for securing indwelling urinary catheters. LPN #3 stated he should have secured Resident #13's indwelling urinary catheter prior to leaving the resident to prevent trauma/injury.</p>	F 315	<p>4. Results of the DON/unit managers audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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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 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 315	Continued From page 11	F 315			
F 318 SS=E	<p>483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</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 ensure three (3) of twenty-three (23) sampled residents (Resident #5, Resident #7, and Resident #18) received appropriate treatment and services to increase range of motion and/or to prevent further risk of injury. Observations of Resident #5 during a skin assessment on 08/20/15 revealed Resident #5 to be without palm protectors as ordered by the physician. Observations of Resident #7 on</p>	F 318	<p>F318 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION</p> <p>1. On 8/20/15 resident # 5's palm protector was placed back on her hand by the nursing staff and verified by the Director of Nursing. Resident # 18 refused to have palm protectors put on 8/20/2015 and verified by the Director of Nursing on 8/20/2015. The Occupational therapist re-evaluated resident # 7 on 8/20/15 for splint training to refer her to a restorative nursing program for splint management, no new issues were identified for resident #7's hand contracture.</p> <p>2. The unit managers completed an audit on 9/8/2015 for residents with physician orders and a comprehensive care plan for palm protectors or splints to ensure that they were on per plan of care. Any issues identified were immediately corrected.</p>		

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F 318	<p>Continued From page 12</p> <p>08/18/15, 08/19/15, and 08/20/15 revealed Resident #7 to be up in a wheelchair without a hand splint on the left hand as prescribed by the physician. Observations of Resident #18 on 08/20/15 revealed Resident #18 to be lying in bed without a palm protector on his/her left hand as ordered by the physician.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Range of Motion Exercises," dated October 2010, revealed staff would verify the physician's orders and review the residents' care plans to assess for any special needs of the resident.</p> <p>1. Review of Resident #5's medical record revealed the facility admitted Resident #5 on 07/01/12 with diagnoses that include Diabetes Mellitus, Anoxic Brain Injury, Late Effect Cerebrovascular Disease, Idiopathic Peripheral Neuropathy, and Abnormal Posture. Review of Resident #5's most recent Annual Minimum Data Set (MDS) assessment dated 07/28/15 revealed the facility had not been able to interview Resident #5 for a Brief Interview for Mental Status (BIMS) score due to the resident's cognitive status. Continued review of Resident #5's MDS assessment revealed the facility had assessed Resident #5 to have functional limitation in Range of Motion in the upper extremities on both sides. Review of Resident #5's Comprehensive Care Plan dated 02/11/14 revealed an intervention for Resident #5 to have bilateral palm protectors as part of a restorative nursing program.</p> <p>Observation of Resident #5 on 08/20/15 at 2:00 PM revealed Resident #5 had contractures to both hands and no palm protectors present.</p>	F 318	<p>3. Nursing staff will be re-educated on placing palm protectors and hand splints per plan of care by the Staff Development nurse by 9/23/2015.</p> <p>The DON and/or unit managers will review 8 residents with a physicians order as well as a care plan for a palm protector or a splint to ensure that they are applied per plan of care weekly times 8 weeks beginning the week of 9/20/2015.</p> <p>4. Results of the DON and/or unit managers audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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F 318	<p>Continued From page 13</p> <p>Continued observation of Resident #5 revealed two palm protectors lying on the overbed table.</p> <p>Interview with State Registered Nurse Aide (SRNA) #7 on 08/20/15 at 2:40 PM revealed she stated she had placed Resident #5's palm protectors in the resident's hands at approximately 1:45 PM on 08/20/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 08/20/15 at 2:45 PM revealed he made rounds every two hours to ensure residents on his unit were getting the care required. Continued interview with LPN #3 revealed Resident #5 should have had palm protectors present to both palms to protect the resident from injury related to contractures of the hands.</p> <p>2. Review of Resident #7's medical record revealed the facility admitted Resident #7 on 01/08/15 with diagnoses that included Muscle Weakness, Chronic Airway Obstruction, Peripheral Vascular Disease, Paralysis, and Late Effects of Cerebrovascular Accident (CVA). Review of the quarterly MDS dated 07/30/15 revealed the facility assessed Resident #7 to have functional limitation in Range of Motion on one side. Review of the physician's order dated 07/17/15 revealed Resident #7 had an order to use a hand splint in the left hand to decrease the risk of contracture development. Review of the Comprehensive Care Plan dated 07/16/15 revealed Resident #7 had an intervention for a left resting hand splint.</p> <p>Observations on 08/18/15 at 5:44 PM and 6:45 PM, 08/19/15 at 9:45 AM and 12:40 PM, and 08/20/15 at 9:00 AM revealed Resident #7 to be without a resting hand splint on his/her left hand.</p>	F 318			

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F 318	Continued From page 14  Interview with the Staff Development/Restorative Nurse on 08/20/15 at 5:23 PM revealed she does random checks daily to ensure the Restorative Certified Nurse Assistants (CNAs) were following the care plans for the range of motion and applying splints.  Interview with the Occupational Therapist on 08/20/15 at 6:43 PM revealed Resident #7 was discharged from Occupational services on 08/06/15. He further revealed he had just started working at the facility on 08/01/15 and was not very familiar with the referral process for restorative nursing.  3. Review of Resident #18's medical record revealed the facility admitted Resident #18 on 07/01/12 with diagnoses that include Senile Dementia, Convulsions, Muscle Weakness, Joint Contractures, and Lack of Coordination. Review of Resident #18's most recent Quarterly MDS dated 07/29/15 revealed the facility assessed Resident #18 to have a BIMS score of 5, which indicated Resident #18 was severely impaired cognitively. Continued review of Resident #18's MDS assessment revealed the facility had assessed Resident #18 to have a functional impairment in Range of Motion with impairment to the upper extremities on one side. Review of Resident #18's Comprehensive Care Plan dated 10/23/13 revealed an intervention for Resident #18 to have a palm protector to the left hand.  Observation of Resident #18 on 08/20/15 at 6:07 PM revealed Resident #8 did not have a palm protector present to his/her left hand.  Interview with LPN #1 on 08/20/15 at 6:07 PM	F 318			

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F 318	Continued From page 15 revealed she was not for certain if Resident #18 was to wear the palm protector to his/her left hand all the time.  Interview with LPN #2 on 08/20/15 at 6:26 PM revealed Resident #18 refused to let her put anything in his/her hand and that the palm protector should have been present to Resident #18's left hand. Continued interview with LPN #2 revealed she looks for splints and other devices at least once a day when providing care to residents.  Interview with State Registered Nurse Aide (SRNA) #5 on 08/20/15 at 6:26 PM revealed Resident #18 had not had a palm protector present to his/her left hand all day. Continued interview with SRNA #5 revealed Resident #18 often refuses to wear the palm protector.	F 318			
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 interview, record review, and review of	F 333	F333 483.25(M)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS  1. Resident # 2 received her routine dose of insulin on 8/15/2015 at 6:30 a.m. The admitting nurse for resident #2 was re-educated on administering meds per physician's orders including getting meds from the emergency back up meds or call and get the medication from the back up pharmacy by the Staff Development nurse on 8/25/2015. The admitting nurse received a coaching and counseling on 9/4/2015 for not administering resident #2's insulin per physicians orders. A medication error report was completed by the Director of Nursing for resident #2 not receiving her insulin per physician orders on 9/4/2015.		

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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 333	<p>Continued From page 16</p> <p>the facility's policy, it was determined the facility failed to ensure one (1) of twenty-three (23) sampled residents (Resident #2) was free of significant medication errors. Resident #2 had physician orders for Novolin insulin to be administered at supper; however, there was no evidence the resident received the medication on 08/14/15 at 5:00 PM (supper dose).</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Medication and Treatment Orders," no date, revealed that the policy did not address missed medication doses.</p> <p>Review of Resident #2's medical record revealed the facility admitted the resident on 08/14/15 at 3:16 PM with diagnoses which included Neuropathy in Diabetes and Diabetes Mellitus.</p> <p>Review of Resident #2's Hospital Discharge Medication Summary and the Physician's Orders dated 08/14/15 revealed the resident was required to receive 50 units of Novolin 70/30 Insulin subcutaneously once a day at 7:00 AM, and Novolin 70/30 Insulin subcutaneously, 28 units with supper.</p> <p>Interview with Resident #2 on 08/18/15 at 3:47 PM, revealed the resident arrived at the facility on Friday afternoon on 08/14/15 and did not receive his/her insulin until Sunday. The resident stated his/her blood sugar was 581 on Sunday.</p> <p>Review of Resident #2's Medication Administration Record (MAR) revealed there was no documented evidence that staff administered the physician ordered 28 units of Novolin 70/30 Insulin on 08/14/15 at 5:00 PM (supper).</p>	F 333	<p>2. The DON completed an audit 9/4/2015 for new medication orders and new admissions from 8/20/2015 for significant medications that could cause acute health issues to a resident if not taken timely to ensure that they were administered per physician orders. No other discrepancies were noted.</p> <p>3. Licensed nursing staff will be re-educated on ensuring that residents including new admission received their medication as ordered by the physician including pulling medication from the emergency back up meds or calling to have the medication sent from the back up pharmacy by 9/23/2015 by the Staff Development nurse.</p> <p>Representatives from PharAmerica conducted an in-service for licensed nurses on 9/15 &amp; 9/16 on ordering and re-ordering medications.</p> <p>The DON and/or unit managers will review 12 residents per week including new admissions to ensure that they receive their medications timely times 8 weeks beginning the week of 9/20/2015.</p> <p>4. Results of the DON and/or unit managers audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015
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F 333	Continued From page 17  Review of Resident #2's finger-stick blood sugar results recorded on the MAR revealed that on 08/15/15 at 6:30 AM, the resident's blood sugar was 185, on 08/15/15 at 4:30 PM the blood sugar was 326, on 08/16/15 at 6:30 AM the blood sugar was 172, and on 08/16/15 at 4:30 PM Resident #1's blood sugar was 528.  Interview with Licensed Practical Nurse (LPN) #3 on 08/20/15 at 9:51 AM, revealed he was Resident #2's Primary Nurse on the 7:00 AM shift during the week. He stated the resident's medication had probably not arrived from the pharmacy when the 5:00 PM dose of Novolin 70/30 was due; however, staff could obtain the medication from the "backup" medication stock in the Medication Room. The LPN stated the resident should have received Insulin from the backup medications.  Interview with the Director of Nursing on 08/20/15 at 10:23 AM revealed it appeared that Resident #2 did not receive a dose of Novolin 70/30 on 08/14/15 at 5:00 PM. She stated she would expect a nurse to get the medication out of the Emergency "backup drugs" if the medication was not in stock. She stated she could not explain why the resident did not receive the 5:00 PM dose of Novolin 70/30 on 08/14/15.  Interview with the Administrator on 08/20/15 at 4:30 PM revealed that Resident #2 should not have missed his/her 5:00 PM dose of Insulin on 08/14/15. The administrator stated the nurse should have used Insulin from the Emergency Medication Kit if the medication was unavailable.	F 333			
F 363	483.35(c) MENUS MEET RES NEEDS/PREP IN	F 363			

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F 363 SS=D	<p>Continued From page 18 ADVANCE/FOLLOWED</p> <p>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, facility policy review, and review of the facility menu, it was determined the facility failed to ensure menus were followed for one (1) of twenty-three (23) sampled residents (Resident #4). Observation of the lunch meal on 08/19/15 in the main dining room revealed Resident #4 was served and fed by staff a regular pureed tray. Review of the tray card for Resident #4 revealed the resident was to receive mashed potatoes with gravy; however, observation of Resident #4's meal tray did not reveal any gravy on the resident's mashed potatoes.</p> <p>The findings include: Review of the facility policy titled "Diet Accuracy," undated, revealed tray cards would be utilized for service and checked for accuracy prior to leaving the kitchen. Observation of the lunch meal service in the main dining room on 08/19/15, at 12:50 PM, revealed Resident #4 was served a regular pureed food tray. Gravy was observed to be on the pureed pork loin but not on the mashed potatoes.</p>	F 363	<p>F363 483.350 MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED</p> <ol style="list-style-type: none"> <li>1. Dietary staff who worked on the tray line on 8/19/2015 was re-educated on following the tray cards and ensuring that the tray is correct prior to sending it to resident # 4 including putting gravy on her mashed potatoes by the dietary manager on 8/19/2015.</li> <li>2. The dietary manager observed tray line during lunch on 9/4/2015 to ensure that trays matched the tray card and that the tray was sent out accurately to the resident. No discrepancies were noted.</li> <li>3. Dietary staff was re-educated on following the tray cards for each resident and ensuring that the tray is accurate prior to sending the tray out to the residents on 9/2/2015.  The dietary manager will observe 30 trays per week to ensure that the tray matches the tray card and is correct prior to sending it out to the resident weekly times 8 weeks beginning the week of 9/20/2015.</li> <li>4. Results of the dietary manager's audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</li> </ol>	9/24/2015
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F 363	Continued From page 19 Review of the tray card for Resident #4 revealed the resident was to receive a pureed tray with gravy over both the pureed pork loin and the mashed potatoes.  Interview with Cook #1 on 08/19/15 at 1:20 PM, revealed she had prepared Resident #4's tray and must have forgotten to put the gravy on the mashed potatoes.  Interview with the Dietary Aide on 08/19/15 at 1:25 PM revealed she had been responsible for checking to ensure the tray was correct prior to leaving the kitchen during the lunch meal. The Dietary Aide stated she must have "just missed it."  Interview with the Dietary Manager (DM) on 08/19/15 at 1:30 PM revealed she observed the tray line to ensure tray accuracy. The DM stated Resident #4's mashed potatoes should have had gravy.  An interview conducted with the Registered Dietitian (RD) on 08/20/15 at 6:50 PM revealed the RD or the DM does test trays every week and had not identified any concerns with staff not following the menu. The RD stated Resident #4's mashed potatoes should have had gravy on them.	F 363			
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	F 371			

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F 371	<p>Continued From page 20 under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for thirty-two (32) of one hundred thirty-one (131) residents of the facility who received nutrition from the kitchen. Observations on 08/18/15 and 08/19/15 revealed the kitchen staff was not cleaning the "Robot-Coupe Blixer" (a food processor used to puree and grind food) blade correctly, and a Certified Nurse Aide (CNA) was observed transporting food items uncovered in the hallways.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Sanitation &amp; Infection Control - Required Cleaning and Sanitation (HAACP)," dated 1997, revealed equipment and utensils that are used for the preparation of potentially hazardous foods on a continuous or production line basis, and the food-contact surfaces of equipment shall be washed, rinsed, and sanitized at intervals throughout the day on a schedule based on food temperature, type of food, and amount of food particle accumulation.</p> <p>Review of the facility's policy, "Sanitation &amp; Infection Control," dated 1997, revealed the policy</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE,STORE/PREPARE/SERVE – SANITARY</p> <p>1. The robot coupe blixer blade was taken apart and cleaned on 8/19/2015 by the dietary manager.</p> <p>C.N.A. # 4 was re-educated on not transporting a tray down the hallway with drinks uncovered on 8/25/2015 by the Staff Development Director.</p> <p>2. The dietary staff was re-educated on the proper way to take apart and clean the blade in the robot coupe blixer by the dietary manager on 9/2/2015.</p> <p>The nursing staff will be re-educated on not transporting a tray down the hallway with drinks uncovered by 9/23/2015 by the staff development nurse.</p> <p>3. The dietary manger will observe the cooks take apart and clean the blade on the robot coupe blixer twice a week times 8 weeks beginning the week of 9/20/2015. The dietary manager will check the robot coupe blixer blade to ensure that it is clean twice a week times 8 weeks beginning the week of 9/20/2015.</p> <p>The DON/unit managers will observe the staff pass trays on the halls to ensure that they don't transport food or drink uncovered down the hallway twice a week times 8 weeks beginning the week of 9/20/2015.</p> <p>4. Results of the dietary manager and DON/unit managers audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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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 _____  B. WING _____		(X3) DATE SURVEY COMPLETED  C 08/20/2015
NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE NURSING AND REHABILITATION 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 371	<p>Continued From page 21</p> <p>did not address the transportation of food items.</p> <p>Review of the "Operation Manual for Robot Coupe Blixer" revealed, "The blade assembly should be taken completely apart and washed after each day's use for sanitary reasons."</p> <p>1. Observation on 08/18/15 at 6:23 PM Revealed CNA #4 transported a tray from the 100 Hall to the 400 Hall (approximately 50 feet in distance) with uncovered coffee and juice on the tray.</p> <p>Interview with CNA #4 on 08/18/15 at 6:44 PM revealed that she was not supposed to transport food or drink items uncovered, but stated she was very nervous and did not think about it.</p> <p>2. Observation and interview on 08/19/15 at 12:25 PM with Cook #1 revealed she was unable to explain or demonstrate how to properly take the "Robot-Coupe Blixer" blade assembly apart to properly clean and sanitize it. She stated a special tool was necessary, but did not know where the tool was located. Cook #1 asked for assistance from another dietary employee. They found the tool, but observations revealed they did not know how to utilize the tool to disassemble the blades. When the blade assembly was taken apart, a brown, green, and black substance slowly flowed out of the assembly. Further observation revealed a thick coating of food particles on the walls of the center assembly.</p> <p>Interview with Cook #1 on 08/19/15 at 1:00 PM revealed that she had never taken the blade assembly apart to clean it.</p> <p>Interview with Cook #2 on 08/19/15 at 1:20 PM revealed that she had never taken the blade</p>	F 371			

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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	
(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 22 assembly apart to clean it.  Interview with the Dietary Manager on 08/20/15 at 10:50 AM revealed that staff was not supposed to transport food in the hallways that was not covered. The Dietary Manager further stated that all of the cooks should have known how to take apart the Robot-Coupe Blade assembly to clean it correctly.  Interview with the District Dietary Manager on 08/20/15 at 9:08 AM revealed that staff should not transport food that was not covered. The District Dietary Manager further stated dietary staff had been trained to disassemble the blade on the Robot-Coupe Blixer and should have been breaking the blade down once a day for cleaning.	F 371		
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 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	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  1. C.N.A. # 2 & #4 was re-educated on donning PPE prior to going into a residents room who has a sign on the door and is in precautions including during meal service on by the staff development nurse on 8/19/2015. There were no negative outcomes for resident #2 and resident #D.  2. The nursing staff will be re-educated on donning PPE prior to going into a residents room that has a sign on the door and is in precautions including during meal service by 9/23/2015 by the staff development nurse.	

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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		
(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 441	<p>Continued From page 23</p> <p>determines that a resident needs Isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an effective Infection Control Program designed to help prevent the transmission of disease and infection for one (1) of twenty-three (23) sampled residents (Resident #2) and one (1) unsampled resident (Resident D). Observation on 08/18/15 during the evening meal service revealed Certified Nursing Assistants (CNAs) went into resident rooms that were on contact precautions without donning the appropriate Personal Protective Equipment (PPE).</p> <p>The findings include:</p>	F 441	<p>3. The DON/unit managers will observe 8 nurse aides enter into a residents room who has a sign on the door and is in precautions including during meal service weekly times 8 weeks beginning the week of 9/20/2015.</p> <p>4. Results of the DON/unit manager audit will be brought to the Quality Assurance Committee and will be reviewed on a monthly basis for further recommendation if warranted.</p>	9/24/2015	

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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		
(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 441	<p>Continued From page 24</p> <p>Review of the facility's policy, "Sanitation and Infection Control," dated 1997, revealed the policy did not address contact precautions.</p> <p>Observations of the evening Meal Service on 08/18/15 at 5:42 PM revealed CNA #2 entered Resident #2's room and set up a dinner tray for the resident. The room had a sign on the door informing staff and visitors of contact precautions and PPE was available at the door. CNA #2 did not don PPE before entering the room and preparing the tray for the resident.</p> <p>Interview with CNA #2 on 08/18/15 at 5:42 PM, revealed that she was not sure if Resident #2 was on contact precautions. She further stated, "We usually put gloves on and gown up before entering the room." CNA #2 stated, "I really did not pay attention."</p> <p>Further observation of the evening meal service on 08/18/15 at 6:23 PM revealed CNA #4 entered the room of Resident D. The room had a sign on the door informing staff and visitors to not enter the room without PPE. The PPE was available at the door. CNA #4 entered the room without donning PPE and set up the resident's dinner tray.</p> <p>Interview with CNA #4 on 08/18/15 at 6:44 PM revealed that she did not put on PPE because she could not put on the PPE while holding the tray.</p> <p>Interview with the Director of Nursing on 08/20/15 at 10:23 AM, revealed she expected that CNA #2 and CNA #4 should have put on whatever PPE the resident called for before going into the resident rooms, but at a minimum both CNAs</p>	F 441			

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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 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 441	Continued From page 25 should have had gloves on.  Interview with the Infection Control Nurse on 08/20/15 at 3:00 PM revealed that CNA #2 and CNA #4 should have both put on gowns and gloves before entering rooms where contact precautions were in place.  Interview with the Administrator on 08/20/15 at 4:30 PM revealed that both CNAs should have put gloves and gowns on before entering the contact precaution rooms.	F 441			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185221</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/19/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>SALYERSVILLE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>571 PARKWAY DRIVE SALYERSVILLE, KY 41465</b>		
(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	<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 (7)</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 Standard Life Safety Code Survey, using 2786S Short Form, was conducted on 08/19/15. The facility was found to be in compliance with Title 42, Code of Federal Regulations, 483.70(a) et seq., Life Safety from Fire, the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 122 residents with a bed capacity of 142.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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