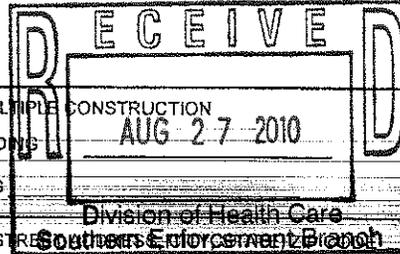


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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 BUILDINGS A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED  C 07/29/2010
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS 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 000	INITIAL COMMENTS	F 000		
F 170 SS=B	<p>483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL</p> <p>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews, it was determined the facility failed to promptly deliver resident mail. Interviews conducted with eleven (11) of eleven (11) alert/oriented residents attending the group interview on July 27, 2010, revealed the facility failed to deliver mail to the residents on Saturday after mail was delivered to the facility. The residents stated no staff was available to deliver the mail on Saturdays.</p> <p>The findings include: Eleven alert/oriented residents that attended the group interview on July 27, 2010, at 3:00 p.m., stated that residents did not always receive their mail on Saturdays after the mail was delivered to the facility. The residents stated that they had to wait until the following Monday to receive mail that had been delivered to the facility on Saturday. The residents further stated that no staff was</p>	F 170	<p>F170</p> <ol style="list-style-type: none"> <li>1.No resident was identified as being affected. All residents have the potential to be affected.</li> <li>2.Social Services personnel to interview all cognitive residents to identify any resident not receiving mail by 9/03/2010.</li> <li>3.All Department Managers (Administrator, Director of Nursing, Assistant Director of Nursing, Unit Manager, Education Training Director, Business Office Manager, Dietary Manager, Maintenance Supervisor, Life Enrichment Director and Social Services) to be re educated regarding policy to deliver unopened mail to residents receiving mail six days a week by Regional Director of Clinical Services by 8/20/2010. Administrator to randomly interview residents 2 x week x 4 weeks to ensure mail is delivered to residents per policy, beginning week of 9/03/2010. Residents to be interviewed by Life Enrichment Director monthly regarding mail delivery occurring per policy beginning September meeting.</li> <li>4.Quality Assurance Committee to review and revise plan bi monthly beginning week of 9/03/2010.</li> <li>5.Date of Compliance 9/03/2010.</li> </ol>	

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 _____ 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)	(X6) COMPLETION DATE
F 170	<p>Continued From page 1</p> <p>available on Saturdays to distribute the mail to the residents.</p> <p>An interview conducted on July 29, 2010, at 9:50 a.m., with the Activities Director (AD) revealed the residents' mail was delivered to the mailbox located outside the facility Monday through Saturday. The AD stated one of the administrative staff members was assigned to work on weekends and was responsible to deliver the residents' mail.</p> <p>An interview conducted with the Assistant Director of Nurses (ADON) on July 30, 2010, at 2:30 p.m., revealed the ADON had been at the facility for approximately six months and had acted as the weekend manager during one rotation. The ADON stated the weekend manager was responsible to conduct resident rounds to ensure resident care needs were being met. The ADON stated the weekend managers did not have access to the front business office and were not responsible for distributing the mail to residents on Saturday.</p>	F 170		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282		

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 282	Continued From page 2  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services in accordance with the written plan of care for two (2) of thirty-seven (37) sampled residents (residents #2 and #13). According to residents #2 and #13's plan of care, the residents were assessed to require the use of a Broda chair when out of bed. However, observations of resident #2 on July 28, 2010, revealed the resident was out of bed in a wheelchair with no foot rests and the resident's feet were observed to be dangling with no support. Resident #13 was observed out of bed in a geri-chair on July 29, 2010.  The findings include:  1. A review of the admission comprehensive assessment completed on February 1, 2010, revealed resident #2 was assessed to be nonambulatory and to require the total assistance of two staff persons for transfers. Resident #2 was also assessed to have bilateral limitation in range of motion with partial loss of voluntary movement and to have a Stage II pressure sore. In addition, resident #2 was assessed to be blind, deaf, and unable to communicate verbally.  A review of resident #2's care plan dated May 11, 2010, revealed the facility identified the resident to require a plan of care to address safety devices due to fall risks. According to the care plan, resident #2 was to be transferred to a Broda chair or a reclining back wheelchair with a full tray, leg rests, and rear anti-tippers when out of bed due to incoordination, abnormal posture, and decreased	F 282	F282  1. Resident # 2 and Resident #13 were immediately placed in chair per physicians order upon identification on 7/29/2010. Resident #2 was placed in chair per physicians order on 7/28/2010. Physician and family/Guardian was notified of resident #2 being placed in the wheelchair and resident #13 being placed in the Geri-chair on 7/29/2010, with no new orders. Ten Broda chairs were ordered with purchase requisition attached on 8/25/2010.  2. DON/ADON and FRC(Facility Rehab Coordinator) to audit physicians orders for residents with orders for Geri-chairs, Broda chairs and wheelchairs to ensure resident does or does not require foot rests and that chair is appropriate for optimal functioning and comfort by 9/03/2010. DON/ADON/UM to complete a one time visual audit to ensure all residents are in chair per physicians order and per plan of care by 9/01/2010.  3. RDCS to re educate DON, ADON, UM, ETD regarding policy related to following physician orders for use of assistive devices/chairs to meet residents optimal functioning and comfort by 9/01/2010. ETD to re educate nursing to follow physicians orders per plan of care as relates to appropriate chairs by 9/03/2010. DON/ADON/UM and ETD to audit at least ten residents weekly to ensure they are out of bed in appropriate chair and plan of care is followed per physician order beginning week of 9/03/2010 x 4 weeks then bi monthly x 4 weeks.		

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 282	<p>Continued From page 3 range of motion of the lower extremities.</p> <p>Resident #2 was observed on July 28, 2010, at 10:00 a.m., 11:10 a.m., and 12:25 p.m., to be sitting in a high-back reclining wheelchair with a lap tray in place. The wheelchair was observed to have no foot rests in place and the resident's feet were dangling approximately ten inches from the floor. At 1:30 p.m., resident #2 was observed in a low bed with an abductor pillow between the resident's knees.</p> <p>A review of the medical record revealed a referral was made by facility nursing staff on April 13, 2010, for a Therapy evaluation to be conducted for resident #2 to evaluate the absence of the elevated foot rests from the resident's wheelchair. According to the multidisciplinary therapy screening notes, the foot rests were located; however, the Occupational Therapist (OT) believed the foot rests might not be appropriate for resident #2 due to bilateral knee contractures and an assessment was conducted to evaluate for an appropriate wheelchair.</p> <p>A review of the OT evaluation conducted on May 5, 2010, revealed the OT recommended a Broda chair to be more appropriate to meet the resident's needs. The OT noted resident #2 should use a Broda chair for out-of-bed activities and pressure relief.</p> <p>A review of the physician's orders revealed a telephone order was obtained from resident #2's physician on May 10, 2010, for the use of a Broda chair for out-of-bed/room activities for optimal positioning and regular changes in the seat tilt for preserving skin integrity through pressure relief.</p>	F 282	<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  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 282	<p>Continued From page 4</p> <p>Interviews conducted with direct care staff (CNAs #1 and #2) on July 29, 2010, at 3:15 p.m., revealed each resident's individual care needs were identified on the CNA assignment sheets, including the type of chair/device the resident was assessed to need. The CNAs stated they were aware resident #2 was to be out of bed in a Broda chair, but there were not enough Broda chairs in the facility to get the resident out of bed as directed.</p> <p>An interview conducted with the Unit Manager (UM) on July 28, 2010, at 2:25 p.m., revealed the Broda chairs that had been purchased by the facility were to be shared by the residents throughout the facility. The UM stated resident #2 had a physician's order to be out of bed in a Broda chair; however, the resident continued to be transferred out of bed to the reclining wheelchair daily.</p> <p>An interview conducted with the OT on July 28, 2010, at 1:10 p.m., revealed resident #2 needed to have bilateral foot support. However, the OT stated the foot rests were not appropriate on the reclining wheelchair due to the resident's bilateral knee contractures and the Broda chair provided additional support to prevent further contractural development/worsening.</p> <p>The facility provided a list of twelve residents who had been assessed to require a Broda chair; however, only four Broda chairs were available for resident use.</p> <p>2. A review of the annual comprehensive assessment completed on April 2, 2010, revealed resident #13 was assessed to require extensive assistance of staff for transfers, was</p>	F 282		

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 282	Continued From page 5 nonambulatory, and had no limitations in range of motion identified. The resident was assessed to have cognitive impairment and to have aphasia.  A review of the comprehensive care plan dated June 15, 2010, for resident #13 revealed the facility addressed a problem related to safety/fall precautions. Interventions included to use a Broda or geri-chair when out of bed due to weakness and to increase socialization. A review of the care plan progress notes dated July 20, 2010, revealed new orders were received to discontinue the geri-chair, and the Broda chair was to be used when the resident was transferred out of bed.  A review of therapy notes revealed a referral was made by nursing staff on July 19, 2010, for the OT to evaluate resident #13 due to the resident leaning to the right side with the right arm tucked into the resident's side when the resident was out of bed in the geri-chair.	F 282		
	A review of the OT evaluation conducted on July 19, 2010, revealed the resident was assessed to be leaning to the right side with the resident's right upper extremity "trapped" between the geri-chair arms. The evaluation revealed the Broda chair was recommended for resident #13 to correct dysfunctional sitting postures, to support joint integrity, promote feeding activities, and to prevent contractures. The OT recommended the geri-chair be discontinued for resident #13.  Resident #13 was observed on July 28, 2010, at 10:00 a.m., 11:10 a.m., and 12:15 p.m., sitting up in a Broda chair with bilateral hand splints in place. However, on July 29, 2010, at 9:50 a.m.,			

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 282	Continued From page 6 resident #13 was observed to be in a reclined geri-chair next to the nurses' station.  An interview conducted with CNA #3 on July 29, 2010, at 10:10 a.m., revealed the CNA was aware the CNA assignment sheet directed resident #13 to be out of bed in a Broda chair. CNA #3 stated there was a limited number of Broda chairs available for resident use.  Interviews conducted with CNAs #1 and #2 on July 29, 2010, at 3:15 p.m., revealed they had transferred resident #13 to the geri-chair on July 29, 2010. The CNAs stated there was no Broda chair available to use for resident #13.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary care and services to attain or maintain the highest practical physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care for two (2) of thirty-seven (37) sampled residents (residents #2 and #13). Residents #2 and #13 were assessed to require the use of a Broda chair when out of bed for proper positioning and for pressure relief.	F 309	F309 1. Resident # 2 and Resident #13 were immediately placed in chair per physicians order upon identification on 7/29/2010. Resident #2 was placed in chair per physicians order on 7/28/2010. Physician and family/Guardian was notified of resident #2 being placed in the wheelchair and resident #13 being placed in the Geri-chair on 7/29/2010, with no new orders. Ten Broda chairs were ordered with purchase requisition is attached 8/25/2010.  2. DON/ADON and FRC(Facility Rehab Coordinator) to audit physicians orders for residents with Geri-chairs, Broda chairs and wheelchairs to ensure resident does or does not require foot rests and that chair is appropriate for optimal functioning and comfort by 9/03/2010. DON/ADON/UM to complete a one time visual audit to ensure all residents are in chair per physicians order and per plan of care by 9/01/2010.	

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  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 309	<p>Continued From page 7</p> <p>However, observations of resident #2 on July 28, 2010, revealed the resident was out of bed in a wheelchair with no foot rests and the resident's feet were observed to be dangling with no support. Resident #13 was observed out of bed in a geri-chair on July 29, 2010.</p> <p>The findings include:</p> <p>1. Resident #2 was observed on July 28, 2010, at 10:00 a.m., 11:10 a.m., and 12:25 p.m., to be sitting in a high-back reclining wheelchair with a lap tray in place. The wheelchair was observed to have no foot rests in place and the resident's feet were dangling approximately ten inches from the floor.</p> <p>A review of the medical record revealed a referral was made by facility nursing staff on April 13, 2010, for a Therapy evaluation to be conducted for resident #2 to evaluate the absence of the elevated foot rests from the resident's wheelchair. According to the multidisciplinary therapy screening notes, the foot rests were located; however, the Occupational Therapist (OT) believed the foot rests might not be appropriate for resident #2 due to bilateral knee contractures and an assessment was conducted to evaluate for an appropriate wheelchair.</p> <p>A review of the OT evaluation conducted on May 5, 2010, revealed the OT recommended a Broda chair would be more appropriate to meet the resident's needs. The OT noted resident #2 should use a Broda chair for out-of-bed activities and pressure relief.</p> <p>A review of the physician's orders revealed a telephone order was obtained from resident #2's</p>	F 309	<p>3.RDCS to re educate DON,ADON, UM,ETD regarding policy related to following physician orders for use of assistive devices/chairs to meet residents optimal functioning and comfort by 9/01/2010.</p> <p>ETD to re educate nursing to follow physicians orders per plan of care as relates to appropriate chairs by 9/03/2010.</p> <p>DON/ADON/UM and ETD to visually audit at least ten residents weekly to ensure they are out of bed in appropriate chair and plan of care is followed per physician order beginning week of 9/03/2010 x 4 weeks then bi monthly x 4 weeks.</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 _____ 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 309	<p>Continued From page 8</p> <p>physician on May 10, 2010, for the use of a Broda chair for out-of-bed/room activities for optimal positioning and regular changes in the seat tilt for preserving skin integrity through pressure relief.</p> <p>Interviews conducted with direct care staff (CNAs #1 and #2) on July 29, 2010, at 3:15 p.m., revealed each resident's individual care needs were identified on the CNA assignment sheets, including the type of chair/device the resident was assessed to need. The CNAs stated they were aware resident #2 was to be out of bed in a Broda chair, but there were not enough Broda chairs in the facility to get the resident out of bed as directed.</p> <p>An interview conducted with the UM on July 28, 2010, at 2:25 p.m., revealed the Broda chairs that had been purchased by the facility were to be shared by the residents throughout the facility. The UM stated resident #2 had a physician's order to be out of bed in a Broda chair; however, the resident continued to be transferred out of bed to the reclining wheelchair daily.</p> <p>An interview conducted with the OT on July 28, 2010, at 1:10 p.m., revealed resident #2 needed to have bilateral foot support. However, the OT stated the foot rests were not appropriate on the reclining wheelchair due to the resident's bilateral knee contractures and the Broda chair provided additional support to prevent further contractural development/worsening.</p> <p>The facility provided a list of twelve residents who had been assessed to require a Broda chair; however, only four Broda chairs were available for resident use.</p>	F 309			

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 309	<p>Continued From page 9</p> <p>2. Resident #13 was observed on July 28, 2010, at 10:00 a.m., 11:10 a.m., and 12:15 p.m., sitting up in a Broda chair with bilateral hand splints in place. However, on July 29, 2010, at 9:50 a.m., resident #13 was observed to be in a reclined geri-chair next to the nurses' station.</p> <p>A review of the medical record revealed a referral was made by nursing staff on July 19, 2010, for the OT to evaluate resident #13 due to the resident leaning to the right side with the right arm tucked into the resident's side when the resident was out of bed in the geri-chair.</p> <p>A review of the OT evaluation conducted on July 19, 2010, revealed the resident was assessed to be leaning to the right side with the resident's right upper extremity "trapped" between the geri-chair arms. The evaluation revealed the Broda chair was recommended for resident #13 to correct dysfunctional sitting postures, to support joint integrity, promote feeding activities, and to prevent contractures. The OT recommended the geri-chair be discontinued for resident #13.</p> <p>An interview conducted with CNA #3 on July 29, 2010, at 10:10 a.m., revealed the CNA was aware the CNA assignment sheet directed resident #13 to be out of bed in a Broda chair. CNA #3 stated there was a limited number of Broda chairs available for resident use.</p> <p>Interviews conducted with CNAs #1 and #2 on July 29, 2010, at 3:15 p.m., revealed they had transferred resident #13 to the geri-chair on July 29, 2010. The CNAs stated there was no Broda chair available to use for resident #13.</p>	F 309		
F 371	483.35(i) FOOD PROCURE,	F 371		

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 371 SS=E	<p>Continued From page 10</p> <p>STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store food under sanitary conditions. The walk-in cooler/refrigerator floor and shelf posts were observed to have an excessive amount of rust.</p> <p>The findings include:</p> <p>An initial tour was conducted of the kitchen at 11:15 a.m. on July 27, 2010. Upon entering the walk-in cooler, a black mat was observed to be covering the floor of the walk-in cooler. The surveyor stepped inside the walk-in cooler and the floor was soft underneath the mat. Further observation revealed the entire floor and around the bottom edges of the wall of the walk-in cooler had an excessive amount of rust. In addition the shelving posts were also observed to have an excessive amount of rust and a rust odor could be smelled upon entrance into the walk-in cooler.</p> <p>Interview with dietary staff at the time of the initial tour revealed the floor had been rusty for a long time. Interview with the Dietary Manager (DM) at</p>	F 371	<p>F371</p> <p>1.The floor of the walk in cooler in the kitchen will be repaired by 9/03/2010 by Prater Cooling. Shelving post in the cooler will be repaired and cleaned of rust by maintenance supervisor by 9/03/2010.</p> <p>2.Adminstrator /Maintenance Supervisor and Dietary Services Manager to complete a one time audit of kitchen and cooler to identify any rusted areas, soft or rusted flooring by 9/03/2010.</p> <p>3.Administrator to complete audit of kitchen and cooler to identify any rust and soft flooring 2 x week x 4 weeks then 1 x week x4 weeks beginning week of 9/03/2010. Administrator to re educate Dietary Services Manager regarding policy for safe and sanitary area for food storage and to complete maintenance work order upon identification of rust or floor changes by 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 _____ 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 371	Continued From page 11 5:10 p.m. on July 27, 2010, revealed the walk-in cooler had been rusty for approximately one year (at least). The DM stated that the floor of the walk-in cooler had progressively gotten rustier. The DM stated that the black mat had been placed in the walk-in cooler floor to cover the bad spots. The DM agreed with the surveyor that the floor under the mat was soft when stepped on. The DM stated that she/he had not noticed that the shelving posts were rusty.	F 371		
F 387 SS=D	483.40(c)(1)-(2) FREQUENCY & TIMELINESS OF PHYSICIAN VISIT  The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.  A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.	F 387	F387  1. Resident #13 was seen by the physician on 7/29/2010 with no new orders.  2. Medical Records Clerk to review all records to identify when last physician visit was made by 8/31/2010.  3. RDCS to re educate Medical Records Clerk, DON, ADON, Administrator and UM regarding policy for timely physician visits and physician visit tracking log by 8/29/2010. Medical Records and Administrator to contact all physicians in writing regarding policy for physicians visits by 9/03/2010. Administrator to audit physician visit log to ensure policy being followed 2 x week x 4 weeks then at least monthly x 2. All physician visits to be made and current per policy by 9/03/2010.  4. Quality Assurance Committee to review and revise plan 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 record review and interview, it was determined the facility failed to ensure that residents were seen by a physician at least once sixty (60) days after admission for one (1) of thirty-seven (37) sampled residents.  The findings include:  A review of the medical record revealed resident #13 was admitted to the facility on September 21, 2000, with diagnoses to include Alzheimer's Disease, Anemia, Cardiomegaly, Coronary Artery Disease, Chronic Obstructive Pulmonary Disease, and Congestive Heart Failure.			

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 387	Continued From page 12  A review of the medical record for resident #13 revealed there was no evidence the resident's physician conducted a visit or had written a progress note every 60 days after the resident was admitted to the facility.  A review of the physician progress notes revealed resident #13 was evaluated by the physician on August 18, 2009, but was not reevaluated until November 25, 2009, resulting in 99 days the resident was not seen by the physician. Further review of the medical record revealed the resident was seen by the physician on January 21, 2010, but was not seen again until April 1, 2010. As of July 29, 2010, there was no documented evidence the resident had been evaluated by the physician since April 1, 2010 (120 days).  A review of the facility policy/procedure related to physician visits (dated January 2005) revealed the attending physician was required to visit and make a progress note at least once every 30 days for the first 90 days of admission and then every 60 days thereafter. The policy noted a log was to be maintained to track the physician's visits.  An interview conducted with the Unit Manager (UM) on July 29, 2010, at 1:40 p.m., revealed the physician on call visited the facility weekly. The UM stated if a resident needed to be seen, the on-call physician would see the resident during the weekly visit to the facility. The UM stated the physician visits for resident #13 had been overlooked. The UM stated the tracking system had failed to identify physician's visits for resident #13.	F 387		
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		

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  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 431	Continued From page 13  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to	F 431	F431  1. Resident #1 did not receive medication that was dropped and medication was disposed of immediately. Resident #27 Liquid Tears were discarded and a new bottle obtained from pharmacy. Resident #6, #26, and #27 Robafen was discarded and a new bottle obtained from pharmacy. Resident #26 Mylanta was discarded and a new bottle was obtained from pharmacy. Resident #25 Liquid Tears were discarded and a new bottle was obtained from pharmacy. Resident #28 Lovaza was discarded and a new vial was obtained from pharmacy. Resident #33 Mylanta was discarded and a new bottle obtained from pharmacy. Resident #34 Enulose was discarded and a new bottle was obtained from pharmacy. Resident #35 Acid Gone was discarded and a new bottle obtained from pharmacy. Resident #36 Milk of Magnesia was discarded and a new bottle obtained from pharmacy. Resident #37 Lidocaine 1% was discarded and a new vial was obtained from pharmacy. The two vials of PPD serum found on Peach Wing were discarded and new vials were obtained from pharmacy. The identified vials of 0.09% Normal Saline and Lidocaine 1% were discarded and new vials were obtained from pharmacy. No resident was affected by the medication cart being left unlocked. All medications that were identified as being stored above 77degrees was discarded and was replaced by pharmacy.	

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 431	<p>Continued From page 14</p> <p>store all drugs and biologicals in locked compartments and under proper temperature controls. The medication cart was left unlocked in the hallway during initial tour and again unlocked with the keys lying on top of the cart in the hallway during medication pass. In addition, the medication room on the Green Unit was 80 degrees Fahrenheit, and medications in all three (3) medication rooms were not dated when opened, and remained available for resident use.</p> <p>The findings include:</p> <p>1. Observation during the medication pass on July 27, 2010, at 3:30 p.m., revealed the Licensed Practical Nurse (LPN) unlocked the medication cart and laid the keys on top of the cart. The LPN was observed to go into resident #32's room with his/her back turned away from the cart during administration of the medications.</p> <p>Interview with the LPN on July 27, 2010, at 3:30 p.m., revealed the LPN stated, "I forgot my keys and did not lock the cart." The LPN revealed this was not acceptable practice at the facility.</p> <p>Record review of the facility policy (6.0 General Dose Preparation and Medication Administration) revealed facility staff should not leave medications or chemicals unattended.</p> <p>2. Observation of the Blue Wing medication cart on July 29, 2010, at 3:15 p.m., revealed one 30-cubic centimeter (cc) vial of 0.9% normal saline opened with a date of July 10, 2010, available for resident use. Further observation of the medication cart also revealed three 50cc vials of Lidocaine 1% opened and undated as to when opened, available for resident use.</p>	F 431	<p>The air conditioner was adjusted to a temperature range of 68 degrees to 77 degrees in each medication room immediately by maintenance. Any medication not labeled with a pharmacy label that identified resident name, directions for use, medication name, date and physician name was discarded immediately and was obtained from pharmacy. Medical Director was notified of all findings identified on 7/30/2010 with no new orders.</p> <p>2.DON(Director of Nursing), ADON(Assistant Director of Nursing), U.M.(Unit Manager) and R.D.C.S.(Regional Director of Clinical Services)completed a one time audit all medication carts, treatment carts, medication storage refrigerators and medication rooms to ensure all medications were labeled by pharmacy with resident name , directions for use, medication name , date and physician name, all open liquid medications were dated and initialed by staff member opening, and that medications are stored within acceptable temperature ranges(68-77degrees) by 9/03/2010. D.O.N,A.D.O.N, U.M completed a one time medication pass audit on each shift to identify any licensed nurse or certified medication aide left medication cart unlocked or dropped medications by 9/03/2010. Pharmacy to complete a random medication pass observation of at least one licensed nurse and one certified medication aide on each shift and E.T.D(Education Training Director) by 9/03/2010 to ensure medication carts are locked when not attended, all liquid medications are dated and initialed if opened,disposed of per policy and procedure,all medications are labeled</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  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 431	Continued From page 15  An interview conducted on July 29, 2010, at 3:20 p.m., with the Licensed Practical Nurse (LPN) assigned to the medication cart revealed that the LPN had no knowledge of when the vials of Lidocaine were opened. The LPN stated the vials should have been discarded within 24 hours after opening and was not aware of why the vials remained in the cart.  3. Observation of the Blue Wing medication cart on July 29, 2010, at 3:20 p.m., revealed one 30-cubic centimeter (cc) vial of 0.9% normal saline that was opened and undated as to when the vial was initially opened. The vial of normal saline was available for resident use. Further observation of the medication cart also revealed one 50cc vial of Lidocaine 1% that had been opened and was dated July 15, 2010, and was available for resident use. Additional observation revealed the medication cart also contained one 20cc vial of heparin that had been opened on June 13, 2010, and was available for resident use.  An interview conducted on July 29, 2010, at 3:35 p.m., with the Licensed Practical Nurse (LPN) assigned to the medication cart revealed the LPN had no knowledge of when the vial of normal saline was opened. The LPN stated the vial should have been discarded within 24 hours after opening and the LPN was not aware of why the vials remained in the cart.  Additionally, observation during the initial tour on July 27, 2010, at 11:30 a.m., revealed the Certified Medication Aide (CMA) left the medication cart unattended and unlocked in the hallway of the Blue Wing. The CMA entered a	F 431	per policy, all medications are stored at temperature range of 68-77 degrees and licensed nurses are checking and recording temperature daily. E.T.D to observe a random medication pass for licensed nurses and certified medication aides by 9/03/2010 to ensure medication carts are locked when not attended, all liquid medications are dated and initialed if opened, disposed of per policy and procedure all medications are labeled per policy and stored at a temperature range of 68-77 degrees and licensed nurses are recording temperatures daily.  3.R.D.C.S. to re educate DON, U.M,E.T.D and ADON regarding policy and procedure for medication storage, temperature for storage,checking temperature in medication room daily, and recording daily policy for medication labels, medication disposal, and ensuring medication carts are locked and secure by 8/26/2010. Licensed staff member who dropped pill on MAR was re educated on 7/28/2010 by ET.D. D.O.N, E.T.D, ADON and UM to reeducate licensed nurses and certified medication aides regarding policy and procedure for medication storage, temperature for storage and recording temperature daily, policy for medication labels, medication disposal and ensuring medication carts are locked and secure by 9/03/2010. Consultant pharmacist to complete a re education for DON,ADON, ET.D and U.M regarding policy and procedure for medication storage, temperature for storage and recording temperature daily, policy for medication labels and medication disposal policy by 8/31/2010. DON, ADON, ET.D, UM and /or RD.C.S to audit medication carts for medications labeled, liquid	
-------	---	-------	--	--

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:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185221	A. BUILDING B. WING	C 07/29/2010

NAME OF PROVIDER OR SUPPLIER <b>SALYERSVILLE HEALTH CARE CENTER</b>	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 431	<p>Continued From page 16</p> <p>resident room on the Blue Wing and was out of sight of the unlocked medication cart.</p> <p>Interview with the CMA on July 27, 2010, at 11:29 a.m., revealed the CMA "just forgot to lock the medication cart." The CMA was aware the medication cart was required to be locked if unattended.</p> <p>Review of the facility policy related to Medication Administration (dated July 2010) revealed facility staff was required to keep the medication cart locked when not in use.</p> <p>4. Observation on July 27, 2010, at 12:45 p.m., revealed a pink tablet in a blister pack (manufacturer's packaging) lying outside the facility entrance door. Further observation revealed the medication label identified the unopened blister pack as being Diphenhydramine 25 milligrams (mg). Observation revealed a resident was sitting on the covered entrance near the unsecured medication. Further observation revealed a prescription was lying near the Diphenhydramine tablet.</p> <p>Interview on July 27, 2010, at 1:45 p.m., with the Social Worker (SW) (name on the prescription) revealed the SW had exited the facility earlier to go to the SW's car. The SW said the prescription must have fallen out of the SW's pocket. The SW stated the SW had never taken Diphenhydramine and the SW had no idea how the medication got to the front entrance near the prescription.</p> <p>5. Observation on July 27, 2010, at 4:00 p.m., of the medication pass revealed LPN #1 prepared four medications for administration to resident</p>	F 431	<p>medications being dated, and initialed if opened, medications being disposed of per policy, and medication carts are being locked and are secure if not in use and within view of staff member 3x week x 4 weeks, then 2x week x 2weeks, then 1 x week x 4 weeks beginning week of 9/03/2010. RDCS and /or DON to observe medication pass 2 x week x 4 weeks beginning week of 9/03/2010 to ensure medications are labeled per policy, any opened liquid medications are dated and initialed , medicatios are being disposed of per policy, medication carts are being locked and secure per policy.</p> <p>DON,ADON,UM and /or ETD to audit medication room to ensure temperatures are kept between 68-77 degrees per policy and licensed nurses are checking temperatures every day 5x week x 2 weeks, then 3 x week x 4 weeks , then 1 x week x 2 weeks.</p> <p>4. Quality Assurance Committee to review and revise plan bi monthly for recommendation 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 _____ 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 431	<p>Continued From page 17</p> <p>#29. LPN #1 retrieved an Aricept 10-milligram tablet from resident #29's medication drawer. LPN #1 opened the blister pack and accidentally dropped the Aricept tablet on the hallway floor in front of resident room 207. LPN #1 retrieved a second Aricept tablet from resident #29's medication drawer and administered the four medications to resident #29. LPN #1 left the Aricept lying on the hallway floor, proceeded down the hall, and continued the medication pass to other residents. The surveyor removed the Aricept tablet from the hallway after the LPN left the hallway.</p> <p>Interview on July 27, 2010, at 4:20 p.m., with LPN #1 revealed the LPN was aware that medications should never be left where residents or visitors could access a medication. LPN #1 stated when the LPN dropped the Aricept pill in the hallway that the LPN was concentrating on getting another pill and the LPN forgot to pick up the pill that was dropped.</p> <p>Interview on July 27, 2010, at 4:30 p.m., with the Unit Coordinator (UC) revealed if medications were contaminated, such as being dropped on the floor, the medication should be crushed and immediately discarded in the sharps container.</p> <p>Review of the facility policy dated December 1, 2007, revealed if a medication which is not in a protective container is dropped, facility staff should discard the medication. The policy further directed staff to never leave medications or chemicals unattended and to dispose of single-dose medications in the trash or sharps container.</p>	F 431		
	6. Observation of the Peach Unit medication			

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 431	<p>Continued From page 18</p> <p>room on July 29, 2010, at 3:15 p.m., revealed the following:</p> <ul style="list-style-type: none"> <li>-two vials of Tuberculin skin test serum were not dated when opened and remained available for resident use,</li> <li>-two vials of Lidocaine 1% 10 mg/ml were not properly labeled and were not dated when opened. One Lidocaine vial revealed a small typed label with resident #37's name; however, the label failed to include the directions for use for resident #37. The second vial failed to have a label from the pharmacy.</li> <li>-one bottle of liquid Colace, one bottle of liquid Potassium Chloride, and one bottle of liquid tears issued for resident #27 were not dated when opened and remained available for resident use,</li> <li>-two bottles of Robafen (118 ml) issued for residents #6, #26, and #27 were not dated when opened and remained available for resident use,</li> <li>-one bottle of Mylanta issued for resident #26 was not dated when opened and remained available for resident use,</li> <li>-one bottle of Liquid Tears issued for resident #25 was not dated when opened and remained available for resident use,</li> <li>-one bottle of Lovaza issued for resident #28 was not dated when opened and remained available for resident use.</li> </ul> <p>Interview on July 29, 2010, at 3:30 p.m., with LPN #1 revealed all staff had been instructed to date the multiple-dose vials and liquid medications when opened.</p> <p>Interview on July 29, 2010, at 3:40 p.m., with the Unit Manager (UM) revealed that all vials and liquid medications were to be dated when opened. The UM stated the night shift staff</p>	F 431			

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 431	<p>Continued From page 19</p> <p>should clean and check medication rooms and carts for expired medications or medications with improper labeling. The UM stated the UM was newly hired and had not specifically assigned the task of checking the medication carts and medication rooms to a particular shift.</p> <p>7. Observation of the Green Unit medication room on July 29, 2010, at 3:15 p.m., revealed the following:</p> <ul style="list-style-type: none"> <li>-the medication room temperature was 80 degrees Fahrenheit,</li> <li>-six Advair Diskus Inhalers were stored in the medication cart. The medication label noted the medication should be stored at temperatures of 68 to 77 degrees Fahrenheit,</li> <li>-one Ventolin HFA Inhaler was stored in the medication cart. The medication label noted the medication should be stored at temperatures of 68 to 77 degrees Fahrenheit,</li> <li>-one Flovent HFA 220mcg Inhaler was stored in the medication cart. The medication label noted the medication should be stored at temperatures of 68 to 77 degrees Fahrenheit,</li> <li>-two Flovent HFA 110mcg Inhalers were stored in the medication cart. The medication label noted the medication should be stored at temperatures of 68 to 77 degrees Fahrenheit,</li> <li>-two Spiriva Handihalers were stored in the medication cart. The medication label noted the medication should be stored at temperatures of 68 to 77 degrees Fahrenheit,</li> <li>-one bottle of Mylanta for resident #33 was not dated when opened and remained available for resident use,</li> <li>-one bottle of Enulose for resident #34 was not dated when opened and remained available for resident use,</li> </ul>	F 431		

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 431	Continued From page 20 -one bottle of Acid Gone for resident #35 was not dated when opened and remained available for resident use, -one bottle of Milk of Magnesia for resident #36 was not dated when opened and remained available for resident use.  A review of the facility's policy/procedure related to medication storage (dated May 10, 2010) revealed the facility was required to store medications and biologicals at the appropriate temperatures. The policy/procedure also noted the facility was required to date medications when opened. However, the policy/procedure was not specific regarding how long the medication could be used for the resident after the medications had been opened/dated.  An interview conducted with the DON on July 29, 2010, at 3:40 p.m., revealed eye drops, liquids, and ointments were required to be dated when opened. The DON stated the facility did not have a system in place to monitor the temperatures in the Green Hall Medication Room.	F 431		
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,	F 441	F441  1. Resident who received medication dropped on M.A.R was not identified. Resident #3 physician was notified on 7/31/2010 regarding gloved hands touching curtain and opening drawer and proceeding to provide incontinence care, no new orders noted.  2. E.T.D/DON/ADON/UM to randomly observe at least five aides on each shift providing peri care to identify other affected residents by 8/31/2010.	

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  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 441	<p>Continued From page 21</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program 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</p> <p>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, and record review, it was determined the facility failed to ensure proper infection control practices were maintained for two (2) of thirty-seven (37) sampled residents. The staff failed to discard medication after dropping the medication onto the medication administration record (MAR).</p> <p>The findings include:</p> <p>1. Observation of the medication administration for resident #32 on July 27, 2010, at 3:30 p.m.,</p>	F 441	<p>ETD to randomly monitor at least one licensed nurse and one certified medication aide on each shift during medication pass to identify any dropped medications being administered by 8/31/2010.</p> <p>3.DON/ADON/ETD to re educate licensed nurses and certified medication aides regarding policy for removing medications from unit dose pack by 9/03/2010.</p> <p>DON/ADON/ETD to re educate nursing staff regarding policy for handwashing, focus on handwashing during peri care by 9/03/2010.</p> <p>DON/ADON/ETD/UM to monitor at least one medication pass weekly x 4 weeks, then bi monthly x 4 weeks to ensure policy for administering medications for removing medications from unit dose pack is followed, beginning week of 9/03/2010.</p> <p>DON/ADON/ETD/UM to observe three certified nurse aides performing peri care to ensure handwashing policy is followed 1 week x 4 weeks, then bi monthly x 4 weeks beginning week of 9/03/2010.</p> <p>4.Quality Assurance committee to review and revise plan 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  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 441	<p>Continued From page 22</p> <p>revealed the Licensed Practical Nurse (LPN) opened a unit-dose pack containing one Motrin. The LPN was observed to drop the Motrin onto the MAR and then pick the Motrin up with his/her bare hands and place in the medicine cup. The LPN finished placing the rest of the ordered medications in the medication cup. The LPN was observed to enter resident #32's room and administer the medications.</p> <p>An interview conducted on July 27, 2010, at 3:30 p.m., revealed the LPN was aware the medication should not have been administered after he/she dropped the medication on the MAR.</p> <p>Review of the facility policy titled (6.0 General Dose Preparation and Medication Administration) revealed facility staff should not touch the medication when opening a bottle or unit-dose package.</p> <p>2. Observation of incontinence care for resident #3 on July 28, 2010, at 10:00 a.m., revealed Certified Nurse Assistant (CNA) #4 donned gloves and performed incontinence care for resident #3. CNA #4 opened bedside table drawers with the same gloves on and then opened the privacy curtain while wearing the same gloved hands used for incontinence care for resident #3.</p> <p>An interview conducted on July 28, 2010, at 10:10 a.m., with CNA #4 revealed they had received in-services on the infection control policy. CNA #4 further stated the CNA was aware staff was required to remove gloves and wash hands after performing incontinence care.</p> <p>An interview conducted on July 29, 2010, at 2:40</p>	F 441		

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 441	Continued From page 23 p.m., with the Director of Nursing (DON) and the Nurse Consultant revealed CNA #4 should have removed the soiled gloves and washed hands after the CNA performed incontinence care.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe, functional, sanitary, and comfortable environment for residents, staff, and the public. The hems of window curtains were unsewn, drywall was chipped/marred in resident rooms, commode basins were stained, and screws were protruding from commode bases.  The findings include:  1. Observation of the facility during the environmental tour on July 27-29, 2010, revealed the following items were in need of maintenance/repair:  -the ceiling drywall of the women's shower room on the Green Hall had water stains and was cracked/peeling, -in the men's shower room on the Green Hall the drywall was cracked/peeling at the sink, an ink pen was protruding from a ceiling vent, the emergency call bell was loose from the wall, and a hole was in the wall behind the entry door,	F 465	F465  1. Ceiling drywall in the shower room on Green Hall was repaired and painted on 8/13/2010. Drywall in the men's shower room on Green hall was repaired and covered with wall protection on 8/12/2010 and the ink pen was removed from the ceiling vent on 7/29/2010. Emergency call bell identified as loose was repaired on 7/29/2010. Hole in wall behind entry door to men's shower room on Green Hall was repaired on 8/12/2010. The curtains in room 211, 212, 214 and 228 were replaced on 8/17/2010. The curtains in rooms 103, 301 and 310 were replaced with blinds on 8/20/2010. The commode basins in rooms 103, 113, 121, 206 211, 213, 219, 220 and 301 and Green hall men's shower room will be cleaned by housekeeping by 9/03/2010. Water stains on the wood below paper towel holders in resident rooms 109, 114, 119, 121, 122, 128, 206, 213, 218, 219, 220, 301 and 310 will be repaired by placing a Formica guard below all identified paper towel holders by 9/03/2010. Stains observed on the floor at the commode in rooms 113, 211, and 305 were cleaned and floor was stripped by housekeeping department 8/19/2010.	

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  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 24 -curtains in resident rooms 103, 211, 212, 214, 228, 301, and 310, were observed with unsewn hems which were hanging uneven, -the commode basins were stained in resident bathrooms 103, 113, 121, 206, 211, 213, 219, 220, and 301, and the Green Hall men's shower room, -water stains were noted on the wood below the paper towel holders in resident rooms 109, 114, 119, 121, 122, 128, 206, 213, 218, 219, 220, 301, and 310, -stains were observed on the floor at the commodes in resident rooms 113, 211, and 305, -formica was chipped at the sink in resident rooms 113 and 302, -the commode tank in resident room 302 was loose, -the non-skid strips on the floor in resident room 211 were loose/peeling, -the fire security doors on the 400 Hall were splintered and had sharp edges, -the windows in resident rooms 305 and 306 were discolored/clouded, -the window screen was bent and protruding outward in resident room 105, -the water sprayed outward, wetting the clothing of the person who turned the water on in the sink in resident room 206, -the chair rail in the dining room was chipped/splintered, -a toilet paper dispenser bar was missing in resident room 128, -a fall mat had torn edges in resident room 316, -a chair arm had chipped/splintered edges in resident room 128, -the wall bumper at the head of the bed in resident room 219 was loose, -the bedside tables in resident rooms 103, 119, and 211 had rough/chipped edges,	F 465	The Formica that was chipped in sink in resident rooms 113 and 302 have been repaired on 8/17/2010. The loose commode tank in room 302 was repaired on 8/17/2010. The non skid strips in resident room 211 were replaced on 8/16/2010. The fire security doors on the 400 hall were repaired on 8/12/2010. The windows in rooms 305 and 306 were ordered and arrived on 8/19/2010 and will be replaced by 9/03/2010. The window screen in room 105 was repaired on 8/15/2010. The faucet was repaired in room 206 to avoid spraying outward on 8/05/2010. The chair rail in Dining room will be completely repaired by maintenance department by 9/03/2010. The toilet paper dispenser bar that was missing in room 128 was replaced on 7/29/2010. The fall mat in room 316 was replaced on 7/29/2010. The chair arm in room 128 was repaired on 8/13/2010. The wall bumper in room 219 was repaired on 8/17/2010. Bedside tables in rooms 103, 119, and 211 have been ordered and splintered areas covered, until arrival of new bedside tables by 9/03/2010. The privacy curtains in rooms 119 and 213 had new rollers and hooks placed on 8/19/2010. The tile in resident room 113 was repaired on 8/19/2010. The tile in dining room doorway will be repaired by 9/03/2010.	