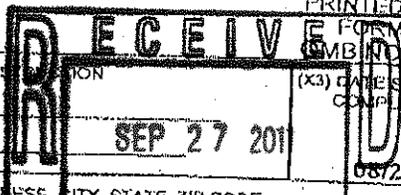


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/09/2011
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 105221	(X2) MULTIPLE COMPLETION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/25/2011
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, OHIO 43081 Division of Health Care Southern Enforcement Branch
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 242 SS=D	<p>A standard health survey was conducted on 08/23-25/11. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>An abbreviated standard survey (KY16644) was also conducted at this time. The complaint was substantiated with deficient practice identified.</p> <p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to accommodate the individual preferences of four residents. Residents #1, #4, and #35 had made the facility aware of food likes/dislikes; however, the facility served foods that the residents had indicated they disliked. Resident #8 had chosen to receive double portions at meals and the facility failed to provide the resident with the double portions.</p> <p>The findings include: A review of the facility's policy (revised 07/10) regarding admission documentation defining nutritional status revealed the Nutrition Service</p>	F 242	<p>F242</p> <p>1. Resident #1, #4 and #35 had their food preferences updated by the Dietary Service Manager(DSM) on 9/15/2011. Resident #8 is receiving double portions at each meal per preference.</p> <p>2. Dietary Service Manager(DSM), Director of Nursing(DON) and Unit Manager(UM) to audit all food preferences to identify if all residents have updated food preferences by 10/05/2011. Any resident that has not had an updated food preference within 30 days will immediately have one completed by the DSM, DON and UM. A one time record audit will be completed by the DSM, DON and UM by 10/05/2011 to identify any resident who has an order to receive double portions and the DON/DSM to ensure that the order is followed immediately.</p> <p>3. Education Training Director(ETD) to re educate nursing and dietary department regarding policy to complete and update food preferences, ensuring resident receives double portions as ordered, policy for C.N.A to read tray cards and ensure resident receives foods per preference by 10/06/2011.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sharon Welch TITLE: DDM (X6) DATE: 9/19/11

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.

FORM CMS-2567(02-00) Previous Versions Obsolete
Event ID: PHOB11 Facility ID: 100519 If continuation sheet Page 1 of 32

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

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 242 Continued From page 1
 Manager or designee was to complete a food preference record for each resident. The food preference record was to be completed within 48 hours of admission and placed in the resident's medical record as well as on file in the facility kitchen.

1. A review of the medical record for Resident #1 revealed the facility admitted the resident on 10/17/09, with diagnoses of Alzheimer's Disease, Senile Dementia, and Stroke with Hemiparesis (paralysis of one side), Chronic Obstructive Pulmonary Disease, and Pleural Effusion. A review of the physician's orders revealed an order dated 06/21/11, for a gastric tube feeding of Jevity 1.5 to be administered from 7:00 PM until 7:00 AM, at 60 cubic centimeters (cc) an hour. The orders further revealed Resident #1 was to receive a Dysphagia III diet (pureed enhanced foods) with pudding-thick liquids and staff was to feed the resident. A review of the facility's Food Preference Record for Resident #1 dated 04/25/11, revealed the resident was to receive a regular diet, ground, and the resident's dislikes were noted to be fish/tuna, rice, broccoli, Brussels sprouts, and cottage cheese. The resident's food preferences included eggs and toast, milk, and coffee.

An observation of the noon meal on 08/24/11, revealed Resident #1 was in the dining room at 11:35 AM, and received a pureed diet of pureed mashed potatoes, peas, a salmon patty with gravy on top of the meal, and pudding-thick fruit drink and water. The resident's tray card indicated the resident was to receive pureed enhanced foods and although the resident had reportedly liked milk and coffee, the card

F 242 Administrator and Dietary Service
 Manager to audit tray cards of 15 residents eating in the dining room and 15 residents eating in their rooms five(5) days a week x 4 weeks beginning week of 10/06/2011 to ensure food preferences are on the tray card, double portions are served if ordered and that the resident does not receive foods listed on their dislike list.
 DSM to re educate dietary staff regarding importance of reading tray card and ensure that foods listed on the residents dislike list is not served and that the instructions are followed, including double portions by 10/05/2011.
 Administrator and Dietician to audit 10 admissions beginning 10/06/2011 to ensure p/p for food preferences being completed is followed.
 Administrator and Dietician to audit 5 existing residents monthly x 3 months, beginning week of 10/05/2011 to ensure food preferences are updated as per policy and that any resident that has double portions ordered are receiving double portions.

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/26/2011
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER.	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 242 Continued From page 2

indicated the resident was not to receive caffeine and milk. Documentation on the meal card also indicated the resident's dislikes were noted to include fish and the resident was not to receive peas or gravy. The resident was observed to receive salmon, peas, and gravy during the meal. The CNA attempted to feed the resident the foods served but Resident #1 refused to eat. The resident's tray card was brought to the attention of the CNA and a new food tray was ordered for Resident #1 that included meatballs, noodles, and carrots. Further observation revealed the resident continued to refuse the meal until, after two unsuccessful attempts, a CNA applied butter, salt, and pepper to the resident's meal.

An interview with CNA #7 on 08/24/11, at 11:50 AM, revealed CNAs were to look at the tray card for likes and dislikes prior to delivering the tray to the resident. The CNA said she would normally review tray cards for the residents' likes and dislikes and had failed to review Resident #1's tray card for the noon meal. The CNA stated Resident #1 liked gravy and biscuits at breakfast, and breakfast was the resident's favorite meal. CNA #7 said Resident #1 changed likes and dislikes often and did not know why the dislike for gravy was on the tray card.

2. A review of the medical record for Resident #4 revealed the facility admitted the resident on 07/13/11, with diagnoses of Coronary Artery Disease, Gastroesophageal Reflux Disease, Diabetes, Hypertension, and Chronic Obstructive Pulmonary Disease. A review of the physician's orders revealed the resident was to receive a Consistent Carbohydrate Diet. Further review of the medical record revealed the Food Preference

F 242

4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.

5. Date of Compliance 10/08/2011.

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 242	<p>Continued From page 3</p> <p>Record, dated 07/20/11, indicated Resident #4 preferred vegetable soup, pimento cheese sandwiches, and buttermilk on the meal tray every day for lunch and supper. In addition, the resident did not like "grease."</p> <p>Observations of Resident #4's meal tray on 08/23/11, at the supper meal revealed the resident received a pulled pork barbecue sandwich. There was no vegetable soup, pimento cheese sandwich, or buttermilk on the resident's meal tray.</p> <p>An interview with Resident #4 on 08/23/11, at 5:45 PM, revealed the facility was "always sending me things I can't eat." Resident #4 further stated he/she was unable to eat spicy foods because they "give me heartburn."</p> <p>An interview with the Dietary Manager (DM) on 08/25/11, at 1:45 PM, revealed the DM was responsible for recording resident likes/dislikes and ensuring those preferences were honored. The DM further stated there was no one responsible to recheck the preference information to ensure accuracy. The DM stated she "just missed those preferences" on Resident #4's likes/dislikes form.</p> <p>3. Observations of the lunch meal on 08/24/11, at 11:35 AM, revealed Resident #35 was served meatballs with noodles and peas. A review of the tray card for Resident #35 revealed the resident did not like noodles. Further observation revealed the staff serving the tray did not check the resident's tray card to ensure accuracy.</p> <p>On 08/24/11, at 11:35 AM, an interview with</p>	F 242		
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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(X1) 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)	(X2) COMPLETION DATE	
F 242	<p>Continued From page 4</p> <p>Registered Nurse (RN) #1, who had served Resident #35's tray, revealed she should have, but failed, to check the resident's tray card.</p> <p>4. Observations on 08/23/11, at 6:00 PM, of the evening meal received by Resident #8 revealed the resident received a regular diet of one pulled pork sandwich, potato wedges, milk, iced tea, and watermelon. The resident's meal did not contain the coleslaw listed on the menu. The meal card on the resident's meal tray revealed the resident was to receive extra-large portions. Observations of the noon meal on 08/24/11, at 12:30 PM, revealed Resident #8 received one salmon patty, potatoes, green beans, one slice of bread, chocolate cupcake, and tea. The resident did not receive extra-large portions as indicated on the diet card.</p> <p>Review of the physician's orders for Resident #8 dated 07/29/11, revealed the resident was to have a regular diet with no restrictions. Review of the meal card used by dietary staff revealed Resident #8 was to receive two extra-large portions of meals.</p> <p>Interview on 08/23/11, at 6:00 PM, with Resident #8 revealed the resident does not receive extra-large portions with the meals. According to Resident #8, he/she requested extra portions but staff cannot bring the extra food until they have finished serving all the residents. The resident stated he/she does not receive the extra-large portions as indicated on the resident's meal card.</p> <p>Interview with Dietary Aide #1 on 08/25/11, at 2:20 PM, revealed dietary staff was to comply with the instructions on each resident's diet card.</p>	F 242			

DEPARTMENT OF HEALTH AND HUMAN 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 08/25/2011
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 242	Continued From page 5	F 242			
F 246 SS=D	<p>Dietary Aide #1 stated extra-large portions would mean two portions of the entree and the side dishes. The dietary aide stated if the instructions were on the card it should be on the tray.</p> <p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews and record reviews, it was determined the facility failed to accommodate the needs of four of thirty-five sampled residents. Resident #7's television was on the left side of the resident's bed, making it impossible to view when the resident was turned onto the right side. In addition, Residents #26, #27, #29, and #30 were unable to utilize beautician services, as the facility had no beautician contracted.</p> <p>The findings include:</p> <p>No policy was provided by the facility for accommodation of needs.</p> <p>1. A review of the medical record for Resident #7 revealed the facility admitted the resident on 04/01/11, with diagnoses of Stage IV Decubitus Ulcers to the buttocks and coccyx areas, Chronic</p>	F 246	<p>F246</p> <p>1. Resident #7 was interviewed by Social Services and refused to allow the T.V. to be moved. Social Services has notified family and a family meeting is scheduled the week of 9/26/2011 in an effort to ensure resident needs are met and all barriers to turning and repositioning are resolved. Resident #26, #27, #29 and Resident #30 have an appointment with the beautician the center has now employed and will utilize beautician services per their wishes by 9/30/2011.</p> <p>2. Administrator and Maintenance Director to review all rooms to identify any T.V that may be a barrier to turning and repositioned and /or that the resident cannot see on either side by 10/1/2011. Any issues identified will be immediately corrected if the resident agrees, if the resident does not Social Services will visit the resident in an effort to identify barriers to moving the T.V and assist the resident as needed to resolve by 10/4/2011.</p>		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 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 246	<p>Continued From page 6</p> <p>Obstructive Pulmonary Disease, Diabetes, and a Left Above the Knee Amputation. Documentation revealed a wound vacuum was utilized by staff for treatment of the decubitus ulcers. Further review of the medical record revealed an admission assessment dated 04/18/11, that indicated the resident's cognitive status was moderately impaired. The quarterly review dated 06/29/11, revealed staff had assessed the resident to be cognitively intact. A review of the care plan dated 06/29/11, for Resident #7 revealed the resident was to be turned from side to side only.</p> <p>An interview with Resident #7 on 08/23/11, at 3:45 PM, revealed the resident was recovering from a pressure wound on the buttocks and coccyx regions. The resident stated he/she went to the wound clinic weekly and the physician at the clinic had instructed the resident and the facility to completely stay off the wound area and the wound vacuum. Resident #7 stated he/she could only turn from side to side until the wound had completely healed which, according to the resident, could take several more months. According to Resident #7, because of the wound vacuum, he/she was only allowed to get up for short periods of time to utilize a bedside commode. Resident #7 also stated, "I turn from side to side like I am supposed to, but I do not like turning to the right side because I cannot see my television, and other than my puzzle books that's what I do to pass the time." Resident #7 stated, "It would be good if the facility could move my television so I could see it better."</p> <p>An interview with CNA #10 on 08/25/11, at 5:10 PM, revealed Resident #7 could not visualize the television when on the right side. CNA #10 stated</p>	F 246	<p>Social Services to notify all family members and cognitive residents that the center has retained the services of a beautician and when services will be available to identify all residents that wish to utilize those services in the center by 10/3/2011.</p> <p>Any issues identified will be immediately addressed by making an appointment for beautician services by 10/4/2011.</p> <p>3. Education Training Director to re educate maintenance and nursing staff regarding placement of T.V in room in an area that the resident can see if turned on either side as resident will allow by 10/4 2011.</p> <p>Regional Director of Clinical Services(RDCS) to re educate Administrator, DON and Social Services regarding policy for ensuring beautician services are available and advertising efforts to retain a beautician by 10/4/2011.</p> <p>Administrator to audit all rooms 1x week x 2 weeks beginning week of 10/4/2011 then 1x every 2 weeks x 2 to ensure the T.V. is placed in room to meet resident wishes/needs and can be seen if resident turns and monitor the grooming/hair length of residents to ensure they are able to utilize beautician services as they wish.</p> <p>Social services to audit to ensure that a sign is posted in a highly visible area that informs residents and staff when and where beautician services are available in the center 1 x week x 4 weeks beginning week of 10/4/2011.</p>		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 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 246	Continued From page 7 the resident could only turn from side to side, and even though the resident could not see the television when he/she was on his/her right, the resident kept the television on all day because it was "important" to him/her. An interview with RN #7 on 08/25/11, at 5:20 PM, revealed the television was very important to Resident #7 and stated the facility should have identified that the television was not visible for Resident #7 when he/she was turned to the right side. An interview with the DON and the Maintenance Director on 08/25/11, at 5:25 PM, revealed the television should have been assessed for accommodation of needs for Resident #7 and that the facility would try to move the television or rearrange the furniture to accommodate the resident's needs. 2. A group interview on 08/24/11, at 10:00 AM, with Residents #26, #27, #29, and #30 revealed the facility had no Barber or Beauty Services available for resident use. The residents stated they were notified at the time of admission to the facility they would have these services available. A review of the facility's admission form on 08/25/11, titled Your Lifestyle, last revised 03/11, revealed barber and beauty services would be available at the facility for resident use. A review of the Beauty and Barber charge ledger on 08/25/11, revealed the last time a licensed beautician provided services at the facility was on 07/13/11.	F 246	4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed. 5. Date of Compliance 10/08/2011.		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 246	Continued From page 8 Further interview with Resident #29 revealed his/her son came to the facility to transport him/her to a service outside the facility when the services of a licensed beautician were needed. An interview with Resident #27 revealed he/she had no family available for transportation to obtain a hair cut when needed. Further interview revealed one employee in the facility's Therapy Department, who is not a licensed barber or beautician, brought in hair clippers to the facility to cut Resident #27's hair due to the resident's inability to obtain the services from a licensed beautician/barber inside the facility. Interview with social worker #1 on 08/24/11, at 4:20 PM, confirmed the facility failed to provide the services of a licensed beautician/barber available for the residents. An interview with the facility's Regional Director of Operations (RDO) on 08/25/11, at 9:00 AM, revealed the facility's corporation charged the beauticians that provided services to the residents of the facility, a fee of 20 percent of their earnings. Although the facility had put forth efforts to recruit a beautician, the fee that was charged created a problem with recruiting/retaining a licensed beautician on a regular basis at the facility.	F 246			
F 248 SS-E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.	F 248	F248 1. Resident #8, #25, #26, #27, #28, #29 and Resident #30 will be notified of the updated activity schedule for weekends by the Life Enrichment Director (LED) by 10/4/2011. Beginning 8/27/2011 the LED did ensure weekend activities were offered and provided as per schedule.		

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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 248	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on interviews, review of policies, and a review of activity schedules, the facility failed to ensure activities were provided to accommodate the individual resident's interest and that would enhance the residents' physical, mental, and psychosocial needs. During the group interview conducted on 08/03/11, at 10:00 A.M., with seven alert and oriented residents (Residents #8, #25, #26, #27, #28, #29, and #30) it was revealed the facility failed to provide activities on the weekends and the residents were "bored." The findings include: A review of the activity policy (effective 01/09) revealed, "Support, maintenance, and empowerment activities are scheduled daily, seven days per week, and offered at least two evenings per week 6:00 PM or later, or more frequently to meet resident's needs. The activity staff will schedule and coordinate all activities." A review of the facility activity calendar(s) for the months of 06/11, 07/11, and 08/11, revealed the facility provided TV/Social Hour, Bingo and a Movie on Saturdays. In addition, based on a review of the activity calendar for 06/11, 07/11, and 08/11, the facility provided "1:1" visits on Sundays, and board games were provided on 06/05/11, 06/12/11, and 06/26/11. A review of documentation of activities for the month of 08/11 revealed no documentation that "1:1" activities had been provided on the	F 248	2. The L.E.D and the LED assistant will interview all cognitive/interview able residents and will randomly speak to five(5) un-interviewable cognitively impaired residents family members to identify what their activity interests are to implement a weekend activity schedule that the LED, LED Assistant or the Department Manager on Duty will conduct on the weekends by 10/4/2011. 3. The Education Training Director will re-educate the LED regarding the policy for recording activities and ensuring activities of interest are provided and offered to all residents everyday by 10/4/2011. Administrator and Social Services Department will interview at least 5 interviewable residents weekly x 6 weeks to ensure activities of interest are offered and provided on the weekend beginning the week of 10/4/2011. Administrator to review one on one activity log and weekend activity log at least weekly x 4 weeks beginning 10/1/2011 to ensure they are completed and recorded. The Administrator and LED to attend resident council meeting each month x 3 months to ensure activities meet resident needs and ask for suggestions to meet activity interests and review weekend activity calendar for the following month beginning 10/2011 meeting. Administrator to review activity calendar 1x month x 3 months to ensure activities are offered per policy beginning 9/30/2011.	

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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 08/25/2011
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465	
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F 248	Continued From page 10 weekends for the residents who had been assessed by facility staff to require "1:1" activities. During a group interview conducted on 08/24/11, at 10:00 AM, residents (Residents #8, #25, #26, #27, #28, #29, and #30) complained that there wasn't much to do on the weekends at the facility. The residents stated there were two volunteer residents (Residents #25 or #8) who "called" bingo on Saturdays. The residents stated they had never watched a movie on Saturdays or participated in board games on the weekends. In addition, residents stated the only activity provided on Sundays was "church" and if they didn't attend church, there was no activity available for the residents to attend. An interview conducted with the facility's Activity Director on 08/24/11, at 11:20 AM, revealed the Activity Director and the activity staff did not work on weekends and depended on residents and/or volunteers to provide activities on the weekends, to document the names of the residents that attended the activities on the activity record, and to provide the information to the Activity staff on Mondays. The Activity Director stated she did not have documentation related to "1:1" weekend visits, or the names of the residents that had attended church services because the volunteers/church members did not always document who attended the activities.	F 248	4. Quality Assurance team(Administrator, Director of Nursing(DON), Unit Managers(UM), Dietary Services Manager(DSM) Life Enrichment Director(LED), Environmental Services Manager and Business Office Manager(BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed. 5. Date of Compliance 10/08/2011.	
F 281 SS#D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality.	F 281	F281 1. Resident #4 physician was notified on 8/24/2011 that the mediport had not been flushed since admission and new orders noted to flush on 8/24/2011 and then once monthly. Resident and family made aware. Mediport flushed without issue on 8/24/2011. Resident #15 physician was notified on 8/25/2011 that phoslo was not given with meals and the dates that the medication was not given with meals and order to clarify medication times to ensure that medication was given with meals was received. Resident and family made aware.	

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F 281	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to provide services for two of thirty-five sampled residents to meet professional standards of quality. Resident #4 had a Mediport in place; however, there was no evidence that the facility provided routine maintenance care/services to maintain the Mediport site. The facility failed to follow the physician's order for Resident #15 to administer Phoslo with each meal and as a result the resident had an elevated phosphorus level.</p> <p>The findings include:</p> <p>1. A review of the facility/pharmacy policy (revised 03/10) related to Infusion Maintenance Table/Flush Protocols revealed implanted venous ports not being accessed were to be flushed monthly.</p> <p>Resident #4 was observed on 08/24/11, at 10:05 AM, to have a Mediport in place in the right upper chest area.</p> <p>A review of the medical record for Resident #4 revealed the Resident was admitted to the facility on 07/13/11, with diagnoses including Coronary Artery Disease, Gastroesophageal Reflux Disease, Diabetes, Hypertension, and Chronic Obstructive Pulmonary Disease.</p> <p>A review of the physician's orders revealed an undated order, "monitor for signs and symptoms of infection at Mediport site each shift." Further review of the physician's orders revealed there was no physician's order to perform monthly</p>	F 281	<p>2.DON and UM completed a 100% one time record audit on 8/25/2011 to identify any resident that had a mediport/any implanted venous access device in place without an order to flush at least monthly or per policy recommendation. Any issue identified was immediately corrected.</p> <p>DON and UM completed a one time 100% record audit on 8/26/2011 to identify any resident with an order for phoslo that was not given with meals. Any issue identified was immediately corrected.</p> <p>3.Education Training Director(ETD) to re educate licensed personnel by 10/3/2011 regarding policy to flush mediport, caring for mediports or any implanted venous access device, exactly how and what to flush with and how to write order immediately upon device being implanted, ETD to re educate licensed personnel by 10/3/2011 regarding policy to administer phoslo with meals, what phoslo is used for and mechanism of action.</p> <p>Intordisciplinary Team(DON,UM, Dietary Manager, Dietician and Life Enrichment Director) to ensure all mediports and any implanted venous access device has the correct order to flush per policy upon device being implanted and that phoslo is has an order to administer with meals in DCR(Daily Clinical Review) 5x per week beginning 8/26/2011.</p> <p>UM to ensure that phoslo is being administered with meals by auditing/observing when medication given</p>		

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F 281	<p>Continued From page 12 flushes for the Mediport.</p> <p>In an interview with the resident on 08/24/11, at 10:05 AM, the resident stated, "My port hasn't been flushed since I've been here, over a month now. When I was at home, the home health nurse flushed it every week." Resident #4 further stated he/she had told facility staff, but no one had flushed it yet.</p> <p>An interview with Registered Nurse (RN) #1 on 08/24/11, at 10:40 AM, revealed the Clinical Review Team had reviewed Resident #4's medical record and care needs but somehow missed there was no physician's order for flushing the Mediport.</p> <p>An interview with the Director of Nursing (DON) on 08/24/11, at 12:25 PM, revealed Resident #4 had been reviewed several times in the "Daily Clinical Review" meeting but the Mediport flush had been overlooked.</p> <p>2. Review of the medical record of Resident #16 revealed the resident had been admitted to the facility on 09/05/07, with diagnoses that included End Stage Renal Disease, Hepatitis C, Diabetes Mellitus Type II, and Congestive Heart Failure. Review of the physician's order for Resident #16 revealed an order dated 07/01/11, for Phoslo (calcium acetate) 667 milligrams (mg) one capsule by mouth three times a day with meals. Phoslo is indicated for control of hyperphosphatemia in end stage renal failure by binding the phosphorus in food.</p> <p>Review of the facility meal times revealed breakfast service started at 7:00 AM, lunch</p>	F 281	<p>10/3/2011. Then RDCS will audit any new admission x 30 d from 9/3/2011 to 10/3/2011 that is receiving dialysis and phoslo to ensure orders are written to administer with meals and the resident is receiving with meals. RDCS to audit all residents with mediports and/or implanted device beginning 9/3/2011 to 10/3/2011 to ensure orders specify when/how and what to flush device with and is being flushed. RDCS re educated DON and UM regarding policy for administering phoslo and flushing mediports/implanted venous devices on 8/26/2011.</p> <p>4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>	

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F 281	<p>Continued From page 13</p> <p>service started at 11:00 AM, and the evening meal service started at 5:00 PM. Review of the Medication Administration Record (MAR) for Resident #15 revealed the resident's Phoslo was to be administered at 8:00 AM, 11:30 AM, and 5:30 PM. Further review of the MAR revealed during the month of 08/11 facility staff did not administer the resident's Phoslo on 08/04/11, 08/05/11, 08/08/11, 08/09/11, 08/10/11, 08/11/11, 08/12/11, 08/15/11, 08/17/11, 08/18/11, 08/19/11, and 08/22/11 for two of the three meals on those days.</p> <p>Review of the laboratory results for Resident #15 dated as collected on 08/03/11, revealed a phosphorus level of 8.4 milligrams/deciliter (reference range 2.5-5.0 mg/dl). Increased phosphorus levels can lead to coronary artery calcifications.</p> <p>Interview on 08/25/11, at 1:30 PM, with Licensed Practical Nurse (LPN) #5, revealed staff did not administer the Phoslo to Resident #15 on the stated dates because the resident had been at the dialysis center and did not receive the noon meal until 2:00 PM. LPN #5 was aware of the physician's order to give the medication with food but did not give the Phoslo with lunch because the meal was late. According to LPN #5, the medication could not be given at 2:00 PM, because it was too close to the 5:30 PM dose. LPN #5 confirmed she was unaware of what the medication was for or any contraindications for the medication. LPN #5 was unaware the medication was to be given with food to be effective.</p> <p>Interview on 08/25/11, at 1:40 PM, with the Unit</p>	F 281			

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F 281	Continued From page 14 Supervisor for Blue Hall revealed the Unit Supervisor did not know why the resident was receiving Phoslo or what the indications were for the medication. The Unit Supervisor was aware the physician's order stated the medication was to be given with meals but the Unit Supervisor was unaware of the reason for administering the medication with meals.	F 281		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the necessary services to maintain personal hygiene/grooming for one of thirty-five sampled residents. Resident #11 was observed on 08/23/11, 08/24/11, and 08/25/11, to have long unkempt fingernails. The findings include: An interview conducted with the facility's Regional Nurse Consultant on 08/25/11, revealed the facility did not have a policy/procedure related to Nail Care. Resident #11 was admitted to the facility on 08/18/10, with diagnoses of Diabetes, Dementia, and Cardiovascular Accident. Review of Resident #11's Quarterly Assessment dated	F 312	F312 1. Resident #11 nails were cleaned and trimmed by the Unit Manager (UM) on 8/25/2011 with the residents permission. 2. D.O.N/UM, Education Training Director (ETD) and Restorative Nurse to audit all residents fingernails and toenails by 10/3/2011 to identify any resident who needs their nails trimmed and/or cleaned. Any issue identified will be immediately corrected. 3. ETD to re educate nursing staff regarding center system to ensure all residents nails are trimmed and cleaned regularly which is that all residents nails are to be checked on shower days by the Licensed Nurse and trimmed as resident will allow/cleaned by the C.N.A if resident is not diabetic, if resident is diabetic the Licensed Nurse will trim as resident will allow/clean nails on shower days by 10/3/2011. If a podiatry referral is needed the primary MD will be notified by the Licensed Nurse.	

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F 312	<p>Continued From page 16</p> <p>08/24/11, revealed the facility assessed the resident to have severe cognitive impairment related to daily decision-making and required extensive assistance with personal hygiene.</p> <p>Review of Resident #11's care plan, updated on 08/15/11, revealed the resident's diabetic nail care was to be provided by a licensed professional on an as-needed basis.</p> <p>Resident #11 was observed on 08/23/11 at 3:25 PM and 5:00 PM, on 08/24/11 at 10:00 AM, 2:05 PM, 3:35 PM, and 5:00 PM, and on 08/25/11 at 9:00 AM, to have long fingernails. A brown substance was observed underneath the resident's nails.</p> <p>An interview with certified nursing assistant (CNA) #7 on 08/25/11, at 9:00 AM, revealed she was assigned to care for Resident #11 on the 7:00 AM to 3:00 PM shift on 08/25/11. The CNA stated she had assisted another staff member, had not assessed Resident #11, and was unaware that Resident #11's fingernails needed to be cleaned/trimmed.</p> <p>An interview with CNA #6 on 8/25/11, at 10:20 AM, revealed he was assigned to care for Resident #11 on 08/24/11, during the 7:00 AM to 3:00 PM shift. CNA #6 stated he had not noticed that Resident #11's nails needed to be cleaned/trimmed and, if the resident was diabetic, the CNAs were to make the nurse aware.</p> <p>An interview with CNA #11 on 08/25/11, at 3:15 PM, revealed she had provided care for Resident #11 on the 3:00 PM to 11:00 PM shift on 08/24/11. CNA #11 stated she had noticed</p>	F 312	<p>4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>		

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F 312	Continued From page 16 Resident #1's nails were long and needed to be cleaned and trimmed but because Resident #11 was a diabetic she was unable to trim his/her fingernails and forgot to tell the nurse. An interview with Licensed Practical Nurse (LPN) #7 on 08/25/11, at 9:10 AM, revealed nurses were responsible for diabetic nail care. The LPN stated she had not been instructed on how often the nail care was to be provided and was not aware that Resident #11's fingernails needed to be trimmed/cleaned. An interview with the Unit Manager, Registered Nurse (RN) #5, on 08/25/11, at 9:20 AM, revealed that the nurse performing the resident's weekly skin assessment should provide nail care. RN #5 also stated there were no systems in place to ensure residents with diabetes received routine nail care. An interview conducted with the Director of Nurses (DON) on 08/25/11, at 3:25 PM, revealed nail care should be provided by the CNAs during the resident's bath/shower. However, according to the DON, if a resident needed nail care and was diabetic, the CNAs should report the information to the nurse and the nurse would provide the nail care. The DON also stated there were no systems in place to ensure residents who were diabetic received routine nail care.	F 312			
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional	F 325			

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F 325	<p>Continued From page 17</p> <p>status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of medical records, and review of facility dietary documentation, it was determined the facility failed to ensure therapeutic diet menus were assessed to ensure no repetition of meals for two of thirty-five sampled residents (Residents #9 and #16). The facility failed to ensure one of thirty-five sampled residents (Resident #2) received supplements with meals as ordered.</p> <p>The findings include:</p> <p>The facility had no policy/procedure specific to repetition of meals or ensuring supplements were on meal trays.</p> <p>1. Observations on 08/23/11, at 6:00 PM, revealed Resident #9 received a renal diet that included plain noodles with the meal.</p> <p>Review of the medical record of Resident #9 revealed the resident was to receive a liberalized renal diet. Review of the medical record of Resident #16 revealed the resident was to receive a no-added-salt renal diet. Review of the dietary meal card for Resident #16 revealed one of the resident's dislikes was noodles.</p>	F 325	<p>F325</p> <p>1. Resident #2 physician was notified on 8/26/2011 by the DON that the resident did not receive the Mighty Shake per physicians order with the evening meal on 8/25/2011. No new orders were noted. Resident #9 and Resident #16 had their food preferences updated by the Dietary Manager (DM) on 9/19/2011. Dietician to review and revise the meal plan offered to prevent repetition of food by 9/23/2011.</p> <p>2. Dietician to complete a one time review of meals offered for all diets to identify any repetition of foods and any resident that does not have an updated food preference by 9/23/2011. Any food repetition will be immediately changed to offer a variety of foods. Any resident receiving food on their dislike list will be immediately changed. DON and UM to complete a 100% record review to identify any resident with order to receive Mighty Shakes or nutritional supplement that should be on meal tray by 9/30/2011. DM and DON to ensure dietary department has an order to provide supplement and it is on tray card by 10/1/2011.</p>		

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F 325	Continued From page 18 Review of the facility's menus for the liberalized renal diet revealed for week one of the menu rice and/or noodles were served at the noon and evening meals on Tuesday through Sunday. Week two of the menu included rice and/or noodles at the noon and evening meals Tuesday through Sunday with rice served at the lunch and evening meals on Sunday. Week three of the menu revealed rice and/or noodles served at the noon and evening meals on Monday through Friday. Week four of the menu revealed rice and/or noodles were served at the lunch and dinner meals on Monday, Tuesday, Thursday, and Friday. Interview with Resident #9 on 08/23/11, at 6:00 PM, revealed the resident received rice and/or noodles for lunch and dinner each day. The resident stated he/she had refused the meals at times and was tired of rice and/or noodles every day. Interview on 08/25/11, at 1:20 PM, with Resident #16 revealed the resident received rice and/or noodles "all the time." The resident stated he/she became so tired of the rice/noodles that he/she did not eat them. According to the resident, he/she had indicated a dislike for noodles but the facility served them to him/her. Interview on 08/24/11, at 1:20 PM, with the Registered Dietitian (RD) revealed the facility's menus are received from the corporate offices. According to the RD, he could change the menus to accommodate the facility's residents. The RD stated he had not audited the renal diet menus for repetition of foods. The RD stated he was	F 325	3. Education Training Director to re educate nursing staff and dietary staff regarding policy to administer supplements per physicians order and ensuring that the supplement is on the tray and that resident does not receive foods on dislike list at point of service by 10/1/2011. DM to audit entire tray line for random meals at least 4x by 10/2/2011 to ensure dietary aides are providing meals and supplements per physicians order and foods that are not on their dislike list. DON or Department Manager monitoring tray pass on hall and in dining room to ensure residents receive diet as ordered, not receiving foods on their dislike list and supplements per order on tray at least 3 x by 10/1/2011 then DON or UM to audit at least 10 residents receiving their meals at random times each week x 4 weeks beginning 10/3/2011. Dietician to monitor tray line for at least 3 meals by 10/2/2011 to ensure no food repetition and that food likes and dislikes are honored, then will randomly monitor at least 5 trays per week beginning week of 10/3/2011 to ensure residents receive a variety of foods, do not receive foods on their dislike list and that supplements are given to resident on meal tray as ordered. DM and Dietician to complete an updated food preference for all existing residents and all new admits per current policy by 10/1/2011.		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 325	<p>Continued From page 19</p> <p>unaware of the repetition of rice and noodles on the renal diet menus.</p> <p>2. Review of the medical record of Resident #2 revealed the facility admitted the resident on 02/02/11, with diagnoses that included Right Hip Fracture, Diverticulitis, Osteoarthritis, and Hypothyroidism. Review of the physician's orders for Resident #2 dated 07/27/11, revealed the resident was to receive a Mighty Shake three times a day with meals. Review of the nutrition notes dated 07/19/11, revealed the resident had sustained an 8.8 percent weight loss in three months to a weight of 113 pounds. On 08/08/11, the RD documented a five percent weight loss in one week resulting in a weight of 109 pounds. The RD documented the resident was consuming 85-90 percent of meals and received a shake three times a day.</p> <p>Observations of the evening meal on 08/23/11, at 6:10 PM, revealed Resident #2 did not receive a Mighty Shake with the evening meal. Observations of the noon meal on 08/24/11, at 11:45 AM, revealed the resident did not receive a Mighty Shake with the meal. Review of the dietary card received with the resident's meal revealed the resident was to have a Mighty Shake with each tray.</p> <p>Interview with the Dietary Manager on 08/24/11, at 11:58 AM, revealed the resident should receive the Mighty Shake on the resident's meal tray received from the Dietary Department. The Dietary Manager was unaware the Mighty Shakes had not been placed onto the resident's meal tray.</p>	F 325	<p>4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>		

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F 325	Continued From page 20 Interview on 08/25/11, at 3:10 PM, with Dietary Aide #1 revealed staff followed the diet card to load the resident's trays during meal service. According to Dietary Aide #1, if something is on the diet card it should be on the resident's meal tray.	F 325		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that --	F 334	F334 1. Resident #4 has received the pneumococcal vaccine as requested. The physician was made aware that the resident had previously requested and the date the resident requested, no new orders were received. Family made aware when administered. Resident #13 and family have been educated regarding risk and benefits of receiving the flu and pneumococcal vaccine and residents has declined both vaccines. Will re offer flu and pneumonia by 11/1/2011 during flu vaccine season. Physician notified with no new orders. Resident #17 and family has been educated regarding risk and benefits of pneumococcal vaccine and resident has declined. Will re offer by 11/1/2011 during flu vaccine season. Physician notified with no new orders. 2. A one time 100% record audit will be completed by the DON, UM, ETD and Medical Records Clerk will be completed by 9/30/2011 to identify any resident that has not been educated on risk versus benefit for receiving the flu and pneumococcal vaccine and to identify any resident that requested either vaccine and did not receive per wishes.	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465
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F 334

Continued From page 21
(i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and
(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:
(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and
(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.
(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.

F 334

Any issues identified will be immediately reported to the physician and family. All residents will be re offered and educated regarding risk versus benefit related to both flu and pneumonia vaccine by 10/6/2011 and if resident wishes they will receive vaccine if not contraindicated.

3.ETD to re educate all licensed personnel and Daily Clinical Review Team(DON,UM,Dietary Manager, Dietician and Life Enrichment Director) regarding policy and procedure that every resident is offered both the flu and pneumonia vaccine unless contraindicated by 10/1/2011
DON to audit all new admissions with 72 hrs of admission to ensure they have been offered the flu vaccine and pneumonia vaccine and it is administered per wishes beginning 10/2/2011.
RDGS to audit at least 5 new admissions monthly beginning week of 10/2/2011 to ensure vaccines are being offered.

residents and families are being educated and residents are receiving vaccines if he/she wishes timely.
DCR Team to audit all admits to ensure policy for flu/pneumonia vaccine is followed beginning 10/3/2011.

This REQUIREMENT is not met as evidenced by:
Based on interview and record review, it was determined the facility failed to ensure

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY. 41465	
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F 334	<p>Continued From page 22</p> <p>pneumococcal and flu vaccines were provided for three of thirty-five sampled residents (Residents #4, #13, and #17). The facility further failed to provide evidence the resident/responsible party had been informed of the health risks related to the immunizations.</p> <p>The findings include:</p> <p>A review of the facility's Immunization policy/procedure (revised 10/10) revealed all residents, regardless of age and medical condition, would receive the Pneumococcal Polysaccharide Vaccine (PPV) at least once unless there was documentation the vaccine was medically contraindicated, the resident refused, or there was no physician's order. Further review of the policy revealed facility residents were to be screened upon admission to determine if they were current on adult immunizations, the resident's immunization status would be documented on the nursing admission assessment, the resident and/or family would be counseled on the benefits and adverse reaction of the vaccine, and the resident's consent/refusal would be documented on the Pneumococcal and Annual Influenza Vaccine-Information and Request form.</p> <p>1. A review of the Minimum Data Set (MDS) dated 10/12/11, revealed Resident #17 was offered the pneumococcal vaccine on 10/06/11, upon readmission to the facility. The MDS completed on 10/12/11, revealed the resident refused the Pneumococcal vaccine, however, there was no evidence the facility had offered the resident or responsible party (R/P) information regarding the risks/benefits of the pneumococcal</p>	F 334	<p>4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2, beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>	

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F 334	<p>Continued From page 23 vaccine.</p> <p>An interview conducted with RN #7 on 08/25/11, at 10:50 AM, revealed the admission nurse was responsible to complete the immunization screening process when a resident was admitted/readmitted to the facility. Furthermore, RN #7 stated the admission nurse was responsible to provide/discuss the risks/benefits related to the pneumococcal vaccine to the resident or the resident's R/P when a resident refused a vaccination.</p> <p>2. A review of the medical record for Resident #4 revealed the facility admitted the resident on 07/13/11, with diagnoses of Coronary Artery Disease, Hypertension, Diabetes, and Chronic Obstructive Pulmonary Disease. Further review of the medical record revealed the resident had requested the pneumococcal vaccine on 07/13/11, but there was no documentation the vaccine had been administered. A notation on the "Pneumococcal & Annual Influenza Vaccine Information and Request" indicated the vaccine would be administered "when time."</p> <p>An interview conducted with the Director of Nursing (DON) on 08/25/11, at 1:55 PM, revealed the admissions nurse was responsible to determine if/when the resident had the pneumococcal vaccine and if it was time for a booster. According to the DON, no one followed up to ensure Resident #4 received the vaccine timely.</p> <p>3. A review of the medical record for Resident #13 revealed the facility admitted the resident on 12/25/10, with diagnoses of Chronic Obstructive</p>	F 334			

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F 334	Continued From page 24 Pulmonary Disease, Hypertension, and Muscular Atrophy. There was no evidence in the medical record that Resident #13 or his/her R/P had been offered or educated on the influenza/pneumonia vaccination and no documentation the resident received these vaccinations. An interview with the Regional Director of Operations (RDO) on 08/25/11, at 10:15 AM, revealed the facility was unable to locate evidence the resident/R/P had received education regarding the vaccinations or that the resident had been vaccinated since admission.	F 334			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS 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.	F 431	F431 1.No specific resident was identified. All residents have the potential to be affected. 2. Director of Nursing (DON) to complete a one time audit of all medication rooms, all medication/treatment carts and all medication refrigerators to identify any medication opened and not dated per policy by 10/3/2011. Any medication opened and not dated will be discarded, reordered and dated by the UM upon arrival from pharmacy. 3. Education Training Director to re educate licensed personnel regarding p/p for storage of biologicals, dating of opened liquids/medications and following manufactures recommendation for all opened medications by 10/4/2011.		

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F 431	<p>Continued From page 25</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, review of facility policy/procedure, and review of manufacturer's recommendations, it was determined the facility failed to ensure expired medications were not available for resident use. The facility had an opened vial of Purified Protein Derivative (PPD) available for use that had not been dated when opened.</p> <p>The findings include:</p> <p>Review of the facility policy/procedure "Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles" (dated as revised 05/10/10) revealed once any medication or biological package was opened, the facility should follow manufacturer/supplier guidelines with respect to expiration dates for opened medications. The policy/procedure stated staff should record the dated opened on the medication container when the medication had a shortened expiration date once opened.</p> <p>Review of the manufacturer's guidelines on the</p>	F 431	<p>Regional Director of Clinical Services to re educate DON and UM regarding p/p for storage of biologicals, dating opened medications and following manufactures recommendation for all opened medications by 10/3/2011.</p> <p>Pharmacy representative to audit at least all three(3) medication rooms and medication refrigerators for expired or undated opened medications by 10/4/2011. DON to audit all medication refrigerators 2 x week x 4 weeks to ensure all medications are dated if opened and discarded per manufactures recommendation beginning 10/6/2011.</p> <p>UM to audit medication and treatment carts to ensure opened liquids are dated and discarded per manufactures recommendation 1 x week x 4 weeks beginning 10/6/2011.</p> <p>4. Quality Assurance team(Adminstrator, Director of Nursing(DON), Unit Managers(UM), Dietary Services Manager(DSM) Life Enrichment Director(LED), Environmental Services Manager and Business Office Manager(BOM) to meet overy 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>		

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F 431	Continued From page 26 package of the PPD revealed once the vial has been entered the medication was to be discarded after 30 days. Observations of the medication refrigerator on the Green Hall on 08/25/11, at 5:30 PM, revealed a vial of PPD available for use. The vial had been opened but there was no date to indicate when the vial had been opened. Interview with Registered Nurse (RN) #6 on 08/25/11, at 5:30 PM, revealed staff was required to date all vials when they were opened to ensure the medication would be discontinued after 30 days. RN #6 confirmed the vial should have been dated when it was opened.	F 431		
F 441 SS=D	4B3.65 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 determines that a resident needs isolation to	F 441	F441 1.No specific resident was identified. All residents have the potential to be affected. 2.Administrator ,Director of Nursing, Unit Managers and Education Training Director to monitor entire meal being served both in dining room and on all halls at least 2 x by 10/2/2011 to identify any staff member not following infection control policy specifically monitoring handwashing. Any issue identified will be immediately corrected. Education Training Director(ETD) to monitor six(6) Certified Nursing Assistance providing direct resident care to identify any staff member not following infection control policy/handwashing policy by 10/2/2011. Any issue identified will be immediately corrected.	

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41466
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F 441 Continued From page 27
prevent the spread of infection, the facility must isolate the resident.
(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.
(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.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and review of the facility policy, it was determined the facility failed to maintain an infection control program designed to prevent the development and transmission of disease. During the evening meal on 08/23/11, at 6:45 PM, staff failed to wash/sanitize hands during the delivery of resident meals on the Peach Hall.

The findings include:
A review of the facility policy for Hand Hygiene (effective 04/99 and revised 01/06 and 04/10) revealed hands should be washed with soap and water before and after direct contact with a resident, and after contact with inanimate objects in the immediate vicinity of a resident.

F 441

3. ETD to re educate nursing staff regarding policy for infection control/handwashing during all resident care, and modes of infection transmission by 10/3/2011.
ETD to complete handwashing competency on at least 25% of all C.N.A staff by 10/4/2011 to ensure correct.
Unit Manager to monitor at least 3 trays being passed at 2 meals 5 x week x 3 weeks then 3 x week x 2 weeks on their respective unit to ensure infection control policy is followed beginning 10/4/2011.
Administrator to monitor tray pass in dining room at least 1 meal 5 x week x 2 weeks then 1 meal 2 x week x 2 weeks to ensure infection control policy is followed beginning 10/4/2011.

4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.

5. Date of Compliance 10/08/2011.

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 441	Continued From page 28 Observations of the evening meal on 08/23/11, at 5:45 PM, revealed a CNA delivered four unsampled residents their meal trays. The CNA assisted the residents with positioning in bed, removed pillows from behind the residents' heads, and cleared the residents' overbed tables in preparation for the meal. The CNA then removed the plate covers from the meal trays, cut meats, and opened/applied condiments to the foods without washing hands or utilizing hand gel before, during, or after assisting each resident. An interview with CNA #8 on 08/23/11, at 5:45 PM, revealed the CNA knew to wash hands before and after assisting residents. The CNA acknowledged she should have washed her hands after she touched each resident, between each resident contact, and after touching other articles in the resident's room. The CNA stated she was nervous and forgot to wash her hands. An interview with the DON on 08/23/11, at 6:00 PM, revealed all staff was to wash hands before and after direct contact with residents. According to the DON, during the delivery of meal trays staff was permitted to utilize sanitizing hand gel between residents, but should wash their hands with soap and water if they touched a resident or items in the residents' rooms.	F 441			
F 514 SS=D	483.75(I)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and	F 514			

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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 08/25/2011
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 29 systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to ensure an accurate clinical record for one of thirty-five sampled residents (Resident #9). The resident had a physician's order for the central venous catheter dressing to be changed every forty-eight hours. Interviews with staff revealed they documented the dressing change but did not actually perform the dressing change.</p> <p>The findings include: Observations of Resident #9 on 08/23/11 and 08/24/11, revealed the resident had a dressing in place on the right chest wall. The dressing was covering a central venous catheter (CVC) used for vascular access during hemodialysis treatment.</p> <p>Review of the medical record of Resident #9 revealed the resident was admitted to the facility on 11/25/08, with diagnoses that included End Stage Renal Disease, Gout, Late Effect Hemiplegia, Diabetes Mellitus, and Hypertension. Review of the physician's orders dated 06/16/11, revealed staff was to cleanse the CVC site with</p>	F 514	<p>F514</p> <ol style="list-style-type: none"> 1. Resident #9 physician was notified by the Unit Manager on 8/26/2011 and the order has been clarified to indicate that the Central Venous Catheter(CVC) dressing is to be reinforced only. 2. Unit Manager(UM) to audit all records to identify any resident with a CVC and ensure the order is written and completed per physicians order by 9/30/2011. Any issue identified will be immediately corrected by the UM per physicians order. 3. Education Training Director to re educate Licensod personnel regarding following physicians orders, documenting that order was followed and p/p for changing CVC dressings on patients receiving dialysis by 10/2/2011. UM to audit all orders for changing CVC dressings at least weekly x 4 weeks to ensure order is correct and that the physician order is performed and documented correctly beginning week of 10/3/2011. UM to call the dialysis center for each dialysis patient and ensure any dressing change orders are correct beginning 10/3/2011. 		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	<p>Continued From page 30.</p> <p>normal saline, pat dry, and apply Tegaderm every 48 hours and as needed.</p> <p>Review of the treatment record for Resident #9 for the month of August revealed staff documented the CVC dressing was changed as ordered every 48 hours.</p> <p>Interview on 08/23/11, at 3:20 PM, with Resident #9 revealed the CVC dressing was changed at the dialysis clinic each dialysis day (three times a week).</p> <p>Interview on 08/24/11, at 4:20 PM, with the dialysis clinic manager revealed facility staff should not be performing dressing changes of the CVC. According to the dialysis clinic manager, dialysis staff changed the CVC dressing at each hemodialysis treatment.</p> <p>On 08/24/11, at 4:30 PM, an interview was conducted with the Unit Supervisor for the Green Hall. According to the Unit Supervisor, Resident #9 returned from the hospital with the order to perform a dressing change every 48 hours. The Unit Supervisor stated staff should be performing the dressing change in accordance with the physician's orders and documenting that the dressing change was completed.</p> <p>An interview with Registered Nurse (RN) #6 on 08/24/11, at 4:35 PM, revealed the RN did not perform dressing changes. According to RN #6, she applied extra tape if the dressing was loose or placed gauze on top of the dressing. RN #6 stated she documented on the treatment record to indicate she had checked the dressing. RN #6 stated the dressing was changed at the dialysis</p>	F 514	<p>4. Quality Assurance team (Administrator, Director of Nursing (DON), Unit Managers (UM), Dietary Services Manager (DSM), Life Enrichment Director (LED), Environmental Services Manager and Business Office Manager (BOM) to meet every 2 weeks x 2 beginning week of 10/05/2011 then monthly to evaluate audit findings and revise plan as needed.</p> <p>5. Date of Compliance 10/08/2011.</p>		

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41466		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 514	Continued From page 31 clinic on each dialysis day. Interview with Licensed Practical Nurse (LPN) #3 on 08/24/11, at 4:15 PM, revealed the dialysis clinic changed Resident #9's CVC dressing. LPN #3 stated she documented that the dressing was checked. According to the LPN, she added tape if the dressing was loose.	F 514			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 MAIN BUILDING 01 B. WING		<div style="border: 2px solid black; padding: 5px; text-align: center;"> <p>RECEIVED</p> <p>SEP 26 2011</p> <p>08/24/2011</p> </div>
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, Division of Health Care Southern Enforcement Branch		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY		(X3) DATE SURVEY COMPLETED
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR §483.70 (a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type III (000)</p> <p>SMOKE COMPARTMENTS: Seven</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLED, SUPERVISED (WET & DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 08/24/11. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p>	K 000			
K 056 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>If there is an automatic sprinkler system, it is</p>	K 056			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: <i>Sharon Welch</i>					
				TITLE: <i>ADM</i>	DATE: <i>9/19/11</i>

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

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NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 671 PARKWAY DRIVE SALYERSVILLE, KY 41465	
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K 056	<p>Continued From page 1</p> <p>installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure all areas of the facility were sprinkler protected as required. This deficient practice affected one of seven smoke compartments. The facility has the capacity for 147 beds on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code survey conducted on 08/24/11, at 9:45 AM, with the Director of Maintenance (DOM) a 6' by 10' storage room located next to the laundry room was observed not to be sprinkler protected. An interview with the DOM on 08/24/11, at 9:45 AM, revealed the DOM did not know when the addition was added or that the addition was required to be sprinkler protected.</p>	K 056	<ol style="list-style-type: none"> The 6' by 10' storage room located next to the laundry room will be sprinkler protected by 10/8/2011. All other storage rooms and or buildings connected to facility were assessed to ensure that they were sprinkler protected, done by ADM and DOM by 10/8/2011. Inservice with maintenance department related to policy for sprinkler use, done by 10/6/2011 per EDT. ADM to monitor q week x 4 weeks to ensure that any and all storage rooms attached to facility are sprinkler protected. QA q mth x 3 mths with QA findings. 	