

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

PRINTED: 09/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 08/20/2010
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078		
(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 An annual survey was conducted on 08/18/10 through 08/20/10 to determine the facility's compliance with Federal requirements. The facility failed to meet minimum requirements for recertification with the highest S/S of "D". Additionally, an abbreviated survey (KY #15188) was conducted on 08/18/10 through 08/20/10 and was unsubstantiated with no deficiencies cited.	F 000	The statements contained in this plan of corrections are not an admission and do not constitute agreement with the alleged deficiencies herein. To remain compliant with all federal and state regulations the facility has taken or will take the following actions set forth within the following corrections. The following corrections constitute the facility's compliance such that all deficiencies cited will be corrected by 9/3/10.		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.	F 225	1. Nurse aide registry and criminal background check for employee #2, #3, and completed on 8/19/10. Criminal background check completed for employee #4 was also completed on 8/19/10. 2. All residents have the potential to be affected. 3. All potential hires, new or re-hire will be screened on the state nurse aide registry and for criminal background check prior to hire. A new hire checklist (Exhibit A) will be followed and signed by the Administrator or designee after seeing the records are completed prior to hire. 4. This practice will continue indefinitely and will be evidenced by the signature of the administrator or designee. This will be reviewed and discussed quarterly in the Quality Patient Care Committee meetings. Date corrective action completed for F 225.	9/03/10	

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

TITLE

(X8) DATE

Hett C. [Signature]

Administratrix

09-17-10

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 SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078		
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F 225	<p>Continued From page 1</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to conduct Nurse Aide Abuse Registry checks for two employees and a criminal records check for one employee, prior to employment in the facility (#2, #3 and #4), of eight employee personnel records reviewed. Findings include:</p> <ol style="list-style-type: none"> 1. A review of the personnel record of Employee #2, a State Registered Nursing Assistant (SRNA), revealed a hire date of 04/19/10; however, the Nurse Aide Abuse Registry check was not completed until 04/20/10. 2. A review of the personnel record for Employee #3, a SRNA, revealed a hire date of 05/20/10; however, the Nurse Aide Abuse Registry check was not completed. 3. A review of the personnel record for Employee #4, a SRNA, revealed a rehire date of 05/04/10; however, the Criminal Records check was not completed until 12/07/07. The facility was unable to provide a current criminal records check for SRNA #4 following her rehire. <p>An interview with the Employee Relations</p>	F 225			

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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078		
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F 225	Continued From page 2 Coordinator, on 08/19/10 at 1:35 PM, revealed she was responsible for conducting the Abuse Registry checks. She completed the checks when she received confirmation from the Director of Nursing (DON) that the prospective employee was hired. The Employee Relations Coordinator stated she should have conducted the abuse check on Employee #2 prior to her start date on 04/19/10 and could not explain why she had never conducted a check on Employee #3. Additionally, she stated she did not know why a current criminal records check was not completed on Employee #4. She stated the facility's policy and procedure required the Nurse Aide Registry checks be completed prior to employees' date of hire. An interview with the DON, on 08/20/10 at 1:27 PM, revealed the Employee Relations Coordinator conducted the drug screens, criminal records checks, and abuse registry checks for all applicants. She stated the applicant could not be hired until the drug screen results and background check results were received. After the results were received, then she would make a decision about hiring the individual and the employee would return to the facility to start his/her employment. The DON stated, "I don't know what happened with the abuse checks on Employee #2 and #3. The checks have to be completed on all new employees before they come to the building to work. I don't know why Employee #4 did not have a criminal records check completed."	F 225			
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			

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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078		
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F 281	<p>Continued From page 3</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 services provided by the facility met professional standards of quality for one resident (#1) in the selected sample of 15 and one resident (#16) not in the selected sampled. On 08/18/10 at 5:00 PM during a medication pass, Licensed Practical Nurse (LPN) #1 failed to administer in accordance with physician orders the residents' medications. Findings include:</p> <p>1. Resident #1 was admitted to the facility with diagnoses to include Heart Failure, Depression, Anxiety, Peripheral Vascular Disease, and Diabetes.</p> <p>A review of physician's orders, dated August 8, 2010, revealed an order for fasting blood sugar four times a day to include before meals and at bedtime. The times indicated were 6:00 AM, 11:00 AM, 4:00 PM and 8:00 PM with Regular Insulin one unit for every 10 above 200 and call the physician if reading greater than 400.</p> <p>An observation during the medication pass, on 08/18/10 at 5:00 PM, revealed LPN #1 administered the resident's medication (Regular Insulin 6 units) at 5:15 PM to his/her abdomen.</p> <p>2. Resident #16 was admitted to the facility with diagnoses to include Diabetic Foot Ulcers, Diabetes, and Severe Paranoid Schizophrenia.</p> <p>A review of the physician's orders, dated 08/01/10 through 08/31/10, revealed an order for Novolin R</p>	F 281	<ol style="list-style-type: none"> Residents # 1 and # 16 was not negatively affected by the deficient practice. LPN administering medication outside of time frame was counseled on 8/19/10 regarding medication administration guidelines. Any resident that receives insulin have the potential to be affected. The Licensed nurse was counseled on 8/19/10 on deficient practice and the remainder of the Licensed staff and medication aides were educated on 8/20/10 and 8/21/10. Audits (Exhibit B) of the medication pass will be conducted weekly for 4 weeks, then monthly for 3 month, then quarterly by Nursing Director or designee to ensure compliance. All findings will be reported to the Director of Nursing Service. The Director of Nursing Service will report findings at the Quality Patient Care Committee meeting. <p>Date corrective action completed for F 281.</p>	9/03/10	

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NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 609 NORTH HAYDEN AVE. SALEM, KY 42078		
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F 281	<p>Continued From page 4</p> <p>100 units/milliliter (ml), sliding scale as follows: four times daily at 6:00 AM, 11:00 AM, 4:00 PM and 9:00 PM, inject subcutaneous per sliding scale give one unit for every 10 greater than 200.</p> <p>An observation during the medication pass, on 08/18/10 at 5:00 PM, revealed LPN #1 administered the resident's medication (Novolin R 8 units) at 5:20 PM to Resident #16's right arm.</p> <p>An interview with LPN #1, on 08/19/10 at 4:40 PM, revealed she had an hour before or after to administer th medication. She reviewed Residents #1 and #16's orders and stated the Insulin was ordered at 4:00 PM. LPN #1 stated she did not administer the medication as ordered. "I gave the medication outside the time frame and that is my fault."</p> <p>An interview with the Director of Nursing (DON), on 08/20/10 at 1:27 PM, revealed the staff have an hour before or after to administer the residents' medications. She stated there had been no reported problems of staff not being able to administer the medications within the time frame. The DON stated, "If the staff are running behind, then they should be asking for help." She reported LPN #1 informed her the medications were given outside the time frame and she expected the staff to administer the medication as ordered.</p>	F 281			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185046	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 08/24/2010
NAME OF PROVIDER OR SUPPLIER SALEM SPRINGLAKE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 509 NORTH HAYDEN AVE. SALEM, KY 42078	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and conducted on 08/24/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.</p>	K 000		

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

TITLE

(X6) DATE

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