RECEIVED
JUL 29 2010
Division of Health Care
Southern Enforcement Branch

PRINTED: 07/22/201
FORM APPROVE
OMB NO. 0938-039

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185304	A. BUILDING B. WING	07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTONSBURG HEALTH CARE CENTER	147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653

(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) COMPLETIO DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on July 6-8, 2010. Deficient practice was identified with the highest scope and severity at a 'D' level.	F 000	Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 272 SS=D	483.20, 483.20(b) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the RAI specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed through the resident assessment protocols; and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced	F 272		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Lynn Fletcher
TITLE: Administrator
(X6) DAT: 7-29-

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined t other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 d 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 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continu program participation.

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(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 272	Continued From page 1 by: Based on interview and record review, the facility failed to comprehensively assess two (2) of thirteen (13) sampled residents using the Resident Assessment Protocol Summary (RAPS). There was no evidence the facility assessed risk/causal factors related to a decline in bladder incontinence for residents #7 and #10. The findings include: 1. A review of the medical record for resident #7 revealed the resident was admitted to the facility on December 22, 2008, with diagnoses that included Hypertension and Alzheimer's Disease. A quarterly Minimum Data Set (MDS) assessment completed by the facility on August 17, 2009, revealed resident #7 was continent of bladder. A comprehensive annual MDS assessment completed on November 2, 2009, revealed the resident had become occasionally incontinent of bladder and a comprehensive significant change assessment completed on January 27, 2010, revealed the resident had declined in continence to total incontinence. Further review of each of these assessments revealed the resident had moderately impaired cognitive skills for daily decision-making with no decline identified in cognitive skills. A data collection for bowel/bladder management completed by the Assistant Director of Nursing (ADON) on November 3, 2009, revealed the resident was able to locate the toilet area, able to make needs known at times, able to toilet using the commode or bedpan, but had functional incontinence due to cognitive impairment. A data collection form for bowel/bladder management	F 272	**F 272 483.20(b)** **COMPREHENSIVE ASSESSMENTS** **Corrective Action for Resident(s) Affected:** The MDS nurse will do an addendum Raps for resident #7 and #10 on 7-28-10. Both residents will be placed on bowel and bladder retraining on 7-28-10. **How the facility will act to protect residents in similar situation** The MDS nurse will review all MDS's for change in continence pattern in the last year by 8-1-10. Residents that have had change will be placed on bowel and bladder retraining. Raps will have addendum added for the causal factors. **Measures to prevent reoccurrence:** Inservice will be done to all nursing staff by the ADM/DON starting	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(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 272	Continued From page 2 completed on January 27, 2010, by the ADON revealed resident #7 was still able to locate the toilet, still able to make needs known at times, and still able to toilet using the commode or bedpan. The data collection form further stated the resident had increased cognitive impairment and staff would provide incontinence care using briefs. A review of the Resident Assessment Protocols (RAPs) dated January 27, 2010, revealed there was no Urinary Incontinence RAP completed for resident #7. According to the RAP guidelines, incontinence should be assessed to attempt to improve incontinence. An interview with the MDS Nurse conducted on July 7, 2010, at 3:05 p.m., and on July 8, 2010, at 1:40 p.m., revealed the MDS Nurse did not complete the RAP to assess resident #7's decline in urinary continence. The MDS Nurse stated resident #7 was not referred to Therapy for further evaluation and the five criteria required for completing the RAP was not utilized. The MDS Nurse stated he/she was not sure what distracted her/him, but the RAP to further assess resident #7's decline in continence was not completed. During the interview the MDS Nurse printed the partial RAP from her/his computer for review by the surveyor. An interview conducted with the Facility Administrator on July 7, 2010, at 3:40 p.m., revealed the Administrator and the Director of Nursing (DON) were responsible to monitor the MDS Coordinator to ensure the Resident Assessment Instrument (RAI) process was followed correctly. However, the Administrator stated they did not review every assessment	F 272	7-28-10 on the difference between continence and incontinence and if there is a change in a resident's bowel and bladder function, nursing and therapy will be notified. Changes reported will be discussed in Clinical meeting. **Monitoring of Corrective Action:** DON will audit change in bowel and bladder continence weekly for 3 months then every two weeks for 3 month, then monthly for 3. **Completion date: 8-1-10**	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185304		07/08/2010

NAME OF PROVIDER OR SUPPLIER: PRESTONSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 147 NORTH HIGHLAND AVENUE, PRESTONSBURG, KY 41653

(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 272	Continued From page 3 completed by the MDS Coordinator. 2. A review of resident #10's medical record revealed an annual assessment dated December 9, 2009. According to the assessment, the resident's bladder continence was assessed as frequently incontinent with some control present. A quarterly review assessment dated May 19, 2010, revealed resident #10's bladder function had declined and the resident was assessed to be incontinent. The Resident Assessment protocols dated December 9, 2009, revealed resident #10 was frequently incontinent of bladder and used briefs as needed. A data collection form for bowel or bladder management was completed for resident #10 on March 13, 2009, April 23, 2009, December 7, 2009, February 23, 2010, and on May 19, 2010, which indicated resident #10 was continent of bowel and bladder. An interview with resident #10 on July 8, 2010, at 10:30 a.m., revealed resident #10 could tell when he/she needed to urinate; however, the resident stated he/she would often wait for the CNAs to take him/her to the bathroom. An interview with the Assistant Director of Nursing (ADON)/Restorative Nurse on July 8, 2010, at 3:00 p.m., revealed the ADON completed the data collection form for bowel or bladder management for resident #10, however, did not assess the causative factors for resident #10's decline in bladder continence.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279 483.20(d) 483.20(k)(1) DEVELOP COMPRESHENSIVE CARE PLANS	

Received Time Jul. 29. 2010 8:25AM No. 1681

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER: PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 147 NORTH HIGHLAND AVENUE, PRESTONSBURG, KY 41653	

(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 279	Continued From page 4 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observations, interview, and record review, the facility failed to develop comprehensive care plans for two (2) of thirteen (13) sampled residents. Residents #7 and #10 experienced a decline in continence; however, no care plan was developed to address the residents' toileting needs or to restore as much bladder function as possible. The findings include: 1. A review of the medical record for resident #7 revealed the resident was admitted to the facility on December 22, 2008, with diagnoses that included Hypertension and Alzheimer's Disease.	F 279	**Corrective Action for Resident(s) Affected:** The MDS nurse will update urinary incontinence care plans on resident #7 and #10 on 7-28-10. **How the facility will act to protect residents in similar situation** MDS/DON will update care plans on all residents that have had a change in bowel and bladder incontinence in the last year by on 8-1-10. Residents that have had a change in their incontinence will be placed on bowel and bladder retraining.	

Received Time Jul. 29. 2010 8:25AM No. 1681

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010

NAME OF PROVIDER OR SUPPLIER: PRESTONSBURG HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 147 NORTH HIGHLAND AVENUE, PRESTONSBURG, KY 41653

(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 279	Continued From page 5 A quarterly Minimum Data Set (MDS) assessment completed by the facility on August 17, 2009, revealed resident #7 was continent of bladder. A comprehensive annual MDS assessment completed on November 2, 2009, revealed the resident had become occasionally incontinent of bladder and a comprehensive significant change assessment completed on January 27, 2010, revealed the resident had declined in continence to total incontinence. A review of the Resident Assessment Protocols (RAPs) dated January 27, 2010, revealed the facility had not assessed the resident's decline in bladder function and there was no Urinary Incontinence RAP completed for resident #7. A review of the comprehensive care plan originally dated November 3, 2009, and reviewed on January 28, 2010, April 15, 2010, and July 2, 2010, revealed the resident had been assessed to have occasional incontinence episodes; however, a line had been drawn through that entry and totally incontinent was written on the care plan. There was no date given for the change in continence. The approaches listed were: offer fluids with and between meals, monitor need for/schedule appropriate diagnostic procedures, report any changes in bladder status to the physician and the nurse, monitor labs as ordered, and toilet the resident every two hours and as needed per the toileting schedule. The intervention of "toileting every two hours" had been marked through and "may use pull-ups" had been added but no date was listed for that intervention. An interview with the MDS Nurse conducted on July 7, 2010, at 11:30 a.m. and 3:05 p.m., and on	F 279	**Measures to prevent reoccurrence:** Inservice will be done to all nursing staff by the ADM/DON starting 7-28-10 on the difference between continence and incontinence and if there is a change in a resident's bowel and bladder function, nursing and therapy will be notified. Changes reported will be discussed in Clinical meeting. **Monitoring of Corrective Action:** DON will audit bowel and bladder incontinence care plans weekly for 3 months then every two weeks for 3 month, then monthly for 3 month. Any concerns will be addressed immediately	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PRESTONSBURG HEALTH CARE CENTER	147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653

(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 279	Continued From page 6 July 8, 2010, at 1:40 p.m., revealed the MDS Nurse did not complete the RAP to assess resident #7's identified decline in urinary continence. The MDS Nurse stated he/she was not sure what distracted her/him, but further assessment was not done and was not considered in the development of a plan of care for resident #7. 2. A review of resident #10's annual assessment dated December 9, 2009, revealed the resident was assessed to be frequently incontinent of bladder with some control present. The annual assessment further revealed resident #10 was moderately impaired with decision-making. A quarterly assessment dated May 19, 2010, revealed resident #10 was incontinent of bladder function, with moderately impaired decision-making. The Resident Assessment Protocols dated December 9, 2009, revealed resident #10 was alert and oriented to self and place and was forgetful at times. A data collection form for bowel or bladder management was completed for resident #10 on March 13, 2009, April 23, 2009, December 7, 2009, February 23, 2010, and on May 19, 2010, which indicated resident #10 was continent of bowel and bladder. A review of resident #10's comprehensive care plan dated December 10, 2009, and updated February 25, 2010 and May 20, 2010, revealed resident #10 was totally incontinent of bladder related to cognitive deficit. The care plan further stated that the resident would be kept clean and dry, and would not develop complications	F 279		

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER: PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE: 147 NORTH HIGHLAND AVENUE, PRESTONSBURG, KY 41653	

(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 278	Continued From page 7 associated with incontinence. Approaches listed on the care plan included: provide/ monitor intake of diet and fluids and offer fluids with and between meals; monitor need for/schedule appropriate diagnostic procedures; report any changes in bladder status to the physician and the nurse; check the resident every two hours and as needed for incontinence episodes; and may use briefs as needed. An interview with the Assistant Director of Nursing (ADON) on July 8, 2010, at 3:00 p.m., revealed the data collection form for bowel or bladder management completed by the ADON had not been correctly completed. According to the ADON, the form should have included the facts that resident #10 frequently had episodes of incontinence and utilized briefs as needed. The ADON further stated that even though the ADON had reviewed the assessments for resident #10, a referral for resident #10 related to bladder training was not completed. Bladder training was not considered related to the resident being 100 years old and was cognitively impaired. The ADON stated no care plan was developed for resident #10 related to bladder training.	F 279		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315	**F 315 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER** **Corrective Action for Resident(s) Affected:** The MDS nurse will do an	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide appropriate treatment and services to maintain/restore as much bladder function as possible for two (2) of thirteen (13) sampled residents. Resident #7 and resident #10 had a decline in bladder continence. There was no evidence the facility had assessed residents #7 and #10 to identify the possible causative factors related to the residents' decline in continence and there was no evidence the facility had developed/implemented an individualized bladder care plan for these residents. The findings include: 1. Observation of resident #7 on July 6, 2010, at 1:55 p.m., revealed the resident propelling her/himself in the hallway. The resident stated, "I'm looking for a place to pee." An interview with Certified Nursing Assistant #1 (CNA #1) conducted on July 7, 2010, at 1:35 p.m., revealed resident #7 was often aware of the need to toilet and would ask for assistance from staff. An interview with CNA #2 conducted on July 7, 2010, at 1:40 p.m., revealed the resident would often tell staff when he/she needed to urinate. A review of the medical record for resident #7 revealed the resident was admitted to the facility on December 22, 2008, with diagnoses that included Hypertension and Alzheimer's Disease.	F 315	addendum Raps for resident #7 and #10 on 7-28-10. Both residents will be placed on bowel and bladder retraining on 7-28-10. The MDS nurse will update urinary incontinence care plans on resident #7 and #10 on 7-28-10. **How the facility will act to protect residents in similar situation** The MDS nurse will review all MDS's for change in continence pattern in the last year by 8-1-10. Residents that have had change will be placed on bowel and bladder retraining.. Raps will have addendum added for the causal factors. MDS/DON will update care plans on all residents	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 9 A quarterly Minimum Data Set (MDS) assessment completed by the facility on August 17, 2009, revealed resident #7 was continent of bladder. A comprehensive annual MDS assessment completed on November 2, 2009, revealed the resident had become occasionally incontinent of bladder and a comprehensive significant change assessment completed on January 27, 2010, revealed the resident had declined in continence to total incontinence. Further review of each of these assessments revealed the resident had moderately impaired cognitive skills for daily decision-making with no decline identified in cognitive skills. A data collection form for bowel/bladder management completed by the Assistant Director of Nursing (ADON) on November 3, 2009, revealed the resident was able to locate the toilet area, able to make needs known at times, able to toilet using the commode or bedpan, but had functional incontinence due to cognitive impairment. A data collection form for bowel/bladder management completed on January 27, 2010, by the ADON revealed resident #4 was still able to locate the toilet, still able to make needs known at times, and still able to toilet using the commode or bedpan. The data collection further stated the resident had increased cognitive impairment and staff would provide incontinence care using briefs. A review of the Resident Assessment Protocols (RAPs) dated January 27, 2010, revealed the facility failed to assess resident #7's incontinence. An interview with the MDS Nurse conducted on July 7, 2010, at 11:30 a.m. and 3:05 p.m., and on July 8, 2010, at 1:40 p.m., revealed the MDS	F 315	that have had a change in bowel and bladder incontinence in the last year by 8-1-10. Residents that have had a change in their incontinence will be placed on bowel and bladder retraining. **Measures to prevent reoccurrence:** Inservice will be done to all nursing staff by the ADM/DON starting on 7-28-10 on the difference between continence and incontinence and if there is a change in a resident's bowel and bladder function, nursing and therapy will be notified. Changes reported will be discussed in Clinical meeting.	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 10 Nurse did not complete the RAP, or any other means, and no interventions were implemented to improve the resident's continence. 2. A review of resident #10's medical record revealed resident #10 had diagnoses that included Senile Dementia and Depression. An annual assessment dated December 9, 2009, revealed resident #10 was frequently incontinent of bladder with some control present and had moderately impaired decision-making. A quarterly assessment dated May 19, 2010, revealed resident #10's bladder continence had declined and was moderately impaired with decision-making. The Resident Assessment Protocols dated December 9, 2009, revealed resident #10 was alert and oriented to self and place and was forgetful at times. The comprehensive care plan initiated on December 10, 2009, and updated February 25, 2010, and May 20, 2010, revealed resident #10 was totally incontinent related to cognitive deficit. The care plan further stated the resident would be kept clean and dry, and would not develop complications associated with incontinence. However, a data collection form for bowel or bladder management completed for resident #10 on March 13, 2009, April 23, 2009, December 7, 2009, February 23, 2010, and May 19, 2010, indicated resident #10 was continent of bowel and bladder. An interview with the Assistant Director of Nursing (ADON) on July 6, 2010, at 3:00 p.m., revealed the data collection form for bowel or bladder management completed by the ADON had not been correctly completed. According to the ADON, the form should have included the facts	F 315	**Monitoring of Corrective Action:** DON will audit change in bowel and bladder continence weekly for 3 months then every two weeks for 3 month, then monthly for 3. DON will audit bowel and bladder incontinence care plans weekly for 3 months then every two weeks for 3 month, then monthly for 3 month. Any concerns will be addressed immediately. **Completion date: 8-1-10.**	

PRINTED: 07/22/2010
FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165304	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/08/2010
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 11 that resident #10 frequently had episodes of incontinence, and utilized briefs as needed. The ADON further stated that even though the ADON had reviewed the assessments for resident #10, and realized the assessment revealed a decline in the bladder function for resident #10, a referral for resident #10 related to bladder training was not completed/considered related to the resident being 100 years old, and being cognitively impaired.	F 315		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to dispose of garbage properly. Observation of the dumpster on July 7, 2010, revealed the dumpster was so full the lid could not close. The findings include: An environmental tour conducted on July 6, 2010, at 4:40 p.m., revealed the facility dumpster to be so full the dumpster lid was not able to close. An interview with the Maintenance Supervisor conducted at 4:40 p.m. on July 6, 2010, revealed the dumpster was scheduled to be emptied each morning between 5:00 a.m. and 6:00 a.m.	F 372	**F 372 483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY** **Corrective Action for Resident(s) Affected:** The garbage dumpster was emptied on 7-8-10. **How the facility will act to protect residents in similar situation** The maintenance director will make rounds of dumpster area twice daily until new dumpster arrives. **Measures to prevent reoccurrence:** Inservice staff on when the dumpster lid wont close and when they are garbage around dumpster to report to Maintenance Director or Administrator. **Monitoring of Corrective Action:** Maintenance will audit the dumpster to make sure the lid is closing and the dumpster will hold all of the garbage weekly for 3 months then every two weeks for 3 month, then monthly for 3 months. Any concerns will be addressed immediately. **Completion date: 8-9-10.**	

Received Time Jul. 29. 2010 8:25AM No. 1681