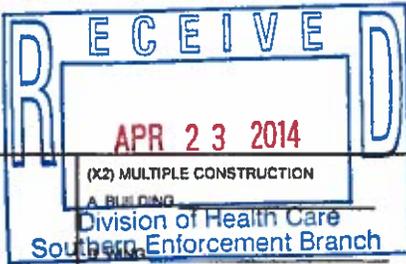


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 04/16/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING Division of Health Care Southern Enforcement Branch	(X3) DATE SURVEY COMPLETED C 04/02/2014
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE NURSING AND REHABILITATION 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 000	INITIAL COMMENTS An abbreviated standard survey (KY21480) was conducted on 04/02/14. The complaint was unsubstantiated, but deficient practice was identified at "E" level.	F 000	F 514 483.75(1)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE	
F 514 SS=E	483.75(1)(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 systematically organized. 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and a review of the facility policy, it was determined the facility failed to ensure clinical records were complete, accurate, and maintained in accordance with accepted professional standards and practices for one (1) of three (3) sampled residents (Resident #3) and one (1) unsampled resident (Resident A). A review of the medical record for Resident #3 and Resident A revealed physician's orders for facility staff to administer medicated respiratory treatments to the residents on a daily	F 514	"Submission of this Plan of Correction is neither an admission to nor an agreement with the Deficient Practices noted below, but provided as required under the Conditions of Participation." 1. The respiratory treatments were not documented for residents # 3 and resident A. however both residents were reassessed on 4/10/2014 by the unit manager and showed no signs of respiratory distress; the MD was notified with no new orders by the unit manager on 4/10/14. 2. All residents who have a respiratory treatment record were reassessed for respiratory distress by the unit managers on 4/10/2014; the MD was notified with new orders received if indicated by the unit managers on 4/10/14. 3. All of the nurses and respiratory therapist will have completed an in-service on Silver Chair on Medication Administration and Documentation by 4/21/2014. The unit managers/designee will check the respiratory treatment records for missing documentation daily Monday through Friday and will address any issues found. The DON/designee will audit the respiratory treatment records twice weekly times four weeks then weekly times eight weeks. Results will be made available to the quality assurance committee for review.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Elaine Jones TITLE: Administrator (X6) DATE: 4/23/14

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 NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
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F 514	<p>Continued From page 1</p> <p>basis. However, a review of documentation on the Respiratory Treatment Records dated February, March, and April of 2014 revealed staff failed to document the administration of the respiratory treatments as ordered by the physician for Resident #3 and Resident A.</p> <p>The findings include:</p> <p>A review of the facility policy titled Charting and Documentation, with a revision date of April 2008, revealed staff was required to document all services provided in the resident's clinical record including the administration of medications and services.</p> <p>1. A review of the medical record for Resident #3 revealed the facility admitted the resident on 11/22/13 with diagnoses of Chronic Pulmonary Heart Disease, Pneumothorax, and end stage Chronic Obstructive Pulmonary Disease (COPD). A review of a quarterly Minimum Data Set (MDS) assessment dated 01/29/14 revealed facility staff assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 13, which indicated the resident's cognition was intact.</p> <p>Review of Resident #3's physician's orders dated 02/26/14 revealed facility staff was to administer Pulmicort (corticosteroid), one nebulizer treatment every 12 hours and DuoNeb (bronchodilator), one nebulizer treatment every 6 hours. Review of a physician's order dated 03/31/14 revealed the resident was to also receive Albuterol (bronchodilator), one nebulizer treatment every 2 hours as needed for shortness of breath. However, review of the resident's Medication Administration Record (MAR) for March 2014 and 04/01/14 revealed the facility</p>	F 514	<p>4. Quality Assurance Committee will meet weekly x four weeks beginning week of 4/21/14 then monthly times 3 months to review audit findings and revise plan as needed ongoing until this issue is resolved.</p> <p>5. Date of Compliance: 4/30/2014</p>		

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F 514	<p>Continued From page 2</p> <p>failed to accurately document respiratory treatments during the 7 PM-7 AM shifts.</p> <p>An interview with Resident #3 on 04/02/14 at 1:12 PM revealed the resident became short of breath during his/her smoke break and needed a breathing treatment. Resident #3 stated the Respiratory Therapist (RT) was at the facility during the day and the resident had no problem getting treatments when needed.</p> <p>An interview with the Respiratory Therapist (RT) on 04/02/14 at 1:15 PM revealed the facility employs three additional RTs and they work seven days a week, twelve hours a day, from 7:00 AM to 7:00 PM. The Respiratory Therapist stated the therapists administer breathing treatments to the residents during the day and the nurses cover at night.</p> <p>An interview with Resident # 3 on 04/02/14 at 8:35 PM revealed, "I used to have trouble getting my breathing treatments at night but now I can get them every two hours and they give them to me when I want them."</p> <p>2. Review of Resident A's medical record revealed the facility admitted the resident on 10/28/13 with a diagnosis of Chronic Obstructive Pulmonary Disease (COPD).</p> <p>A review of Resident A's physician's orders dated 02/28/14, revealed the resident was to receive Pulmicort, one nebulizer treatment every 12 hours; DuoNeb, one nebulizer treatment every 6 hours; and DuoNeb, one nebulizer treatment every 6 hours as needed for shortness of breath. However, review of the resident's MAR for 02/14-28/14, 03/01-31/14, and 04/01/14 revealed</p>	F 514			

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F 514	<p>Continued From page 3</p> <p>the facility failed to accurately document the resident's respiratory treatments during the 7 PM-7 AM shifts.</p> <p>An interview with Licensed Practical Nurse (LPN) #1 on 04/02/14 at 5:10 PM revealed she had been assigned to provide care and to administer respiratory treatments to Resident #3 and unsampled Resident A in February, March, and April 2014. The LPN stated she had administered the respiratory treatments as ordered by the physician but had failed to document the administration of the respiratory treatments as required on the resident's Respiratory Treatment Record. The LPN stated she had been trained to document treatments provided to facility residents, but "forgot" to document respiratory treatments administered to Resident #3 and Resident A in February, March, and April 2014.</p> <p>An interview with LPN #2 on 04/02/14 at 5:44 PM revealed she had been assigned to provide care and to administer respiratory treatments to Resident #3 and Resident A in March and April 2014. The LPN stated she had administered the respiratory treatments to Resident #3 and Resident A as ordered by the physician. However, the LPN stated she failed to document the administration of the respiratory treatments as required on the resident's Respiratory Treatment Record. The LPN stated she had been trained to document treatments that were administered to facility residents in the resident's medical record and was "unsure why" she had not documented the treatments. The LPN stated she should have documented respiratory treatments provided to Resident #3 and Resident A in March and April 2014.</p>	F 514			

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F 514	<p>Continued From page 4</p> <p>An interview with Unit Manger (UM) #1 on 04/02/14 at 6:51 PM revealed she reviewed Medication Administration Records (MARs) monthly for accuracy of documentation. The UM stated even though she reviewed MARs for accuracy, she had not reviewed Respiratory Treatment Records for accuracy. The UM stated she "could not recall" being instructed to review the resident's Respiratory Treatment Records but "probably" should have.</p> <p>An interview with the Director of Nursing (DON) on 04/02/14 at 6:00 PM revealed staff had been trained to document respiratory treatments provided to facility residents on the resident's Respiratory Treatment Record at the time treatments were provided. The DON further stated she ensured medical records were complete and accurate by having Unit Managers conduct random "spot checks." According to the DON, staff had not reported any concerns related to documentation to her.</p> <p>An interview with the Administrator on 04/02/14 at 7:04 PM revealed facility staff was required to accurately document when care was provided to facility residents. The Administrator further stated she "typically don't look at MARs or Respiratory Treatment Records for accuracy," and was not aware there was a concern related to the accuracy of documentation, in the resident's medical record.</p>	F 514		