

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

Second SOD

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	R E C E I V E D APR 15 2010 03/03/2010		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 718 INEZ, KY 41224 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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE		
F 000	INITIAL COMMENTS A standard health survey was conducted on March 1-3, 2010. Deficient practice was identified with the highest scope and severity being at an "F" level. An abbreviated standard survey (KY14471) was also conducted at this time and the allegation was not substantiated.	F 000	The Martin County Health Care Facility does not believe and does not admit that any deficiencies existed, either before, during or after the survey. The MCHCF reserves all rights to contest the survey findings through informal appeal proceedings, or any administrative or legal proceedings. This plan of corrections does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which responds, is not meant to establish any standard of care, contact obligation or position. The MCHCF 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 corrections should be considered as a waiver of any potentially applicable peer review, quality assurance or self-critical examination privileges which the MCHCF does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The MCHCF offers its responses, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to our residents.	3.25.10		
F 164 SS=E	483.10(e), 483.75(i)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.	F164	F164 *Interviewed all residents that were affected. Explained our facility privacy policy. No adverse harm was found to have been caused by def practice. *All residents receiving nursing services were identified to be affected by the def practice. *March 18, Pharmacy in-service on medication pass techniques and resident privacy policy. March 26 entire staff was in serviced on privacy policy. *The facility will conduct annual in-service with staff ou privacy policy. The QA team will do weekly random observations of staff during normal work routines,(ex: med pass, treatments, bathing, ADL care, etc.) to ensure that confidentiality of resident's privileged medical information is maintained and that privacy is afforded to residents during all ADL's.	3.26.10		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Beth Ornett, Administrator

3.26.10

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.

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to afford personal privacy to residents during the provision of care and failed to ensure confidentiality of residents' privileged medical information during medication observation pass conducted on March 1-2, 2010. Privacy for the residents was not maintained while providing care to residents #16 and #17's gastrostomy tubes (g-tube) or during the administration of subcutaneous injections for residents #10 and #18. During the medication observation pass, the Medication Administration Record (MAR) was left open on top of the medication cart in the hallway, exposing the residents' medical information to the public. Additionally, staff failed to knock on resident #3's door prior to entering the resident's room while a private conversation was being conducted with the resident's family.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of medication pass on March 1, 2010, at 3:35 p.m., revealed Licensed Practical Nurse (LPN) #1 entered resident #16's room to provide care to resident #16's g-tube. LPN #1 exposed resident #16's abdomen to check the placement of the resident's g-tube; however, LPN #1 failed to close the resident's door or pull the privacy curtain. LPN #1 flushed the g-tube with 120 milliliters of water and then connected Isosource 1.5 to infuse per Compaq pump at 60 milliliters per hour. Resident #16's roommate was present in the resident's room during the procedure. 	F 164		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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 164	<p>Continued From page 2</p> <p>Further observation on March 1, 2010, at 3:55 p.m., revealed LPN #1 prepared Dilantin three milliliters to be administered via resident #17's g-tube. LPN #1 failed to close resident #17's door or pull the privacy curtain during the g-tube medication administration and the resident's abdomen was exposed.</p> <p>Continued observation on March 1, 2010, at 4:18 p.m. and 4:30 p.m., revealed LPN #1 performed accuchecks (finger stick blood glucose monitoring) on resident #10 and resident #18. LPN #1 administered the prescribed dose of insulin to residents #10 and #18. In both instances, LPN #1 failed to close the resident's door or pull the privacy curtain during the procedures before exposing the resident's abdomen to administer the insulin.</p> <p>Interview on March 1, 2010, at 4:05 p.m., revealed LPN #1 was knowledgeable of the requirement to provide privacy for residents during any procedures. LPN #1 stated the LPN was just in a hurry.</p> <p>A medication observation pass conducted for resident #19 on March 2, 2010, at 11:05 a.m., revealed Certified Medication Tech (CMT) #1 prepared two medications and then entered the resident's room to administer the medications to resident #19. CMA #1 was observed to leave the MAR open and with the resident's medical information exposed to anyone (staff, visitors, and other residents) in the hallway, which included the resident's diagnoses and prescribed medications.</p> <p>Further observation of the medication observation pass conducted on March 2, 2010, at 11:15 a.m.,</p>	F 164		
-------	--	-------	--	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 164	<p>Continued From page 3</p> <p>revealed CMT #1 prepared resident #20's medications and went into the room to administer the medications to the resident. The MAR was left open and the resident's medical information was exposed to anyone (staff, visitors, other residents) who passed by the medication cart, which included the resident's diagnoses and prescribed medications.</p> <p>Interview on March 2, 2010, at 3:00 p.m., revealed CMT #1 was aware of the requirement to ensure residents' private information was kept confidential; however, CMT #1 stated the CMT just failed to cover the MAR during the medication pass.</p> <p>Review of the facility's policy revealed privacy of the resident's confidential information should be ensured during medication pass.</p> <p>2. On March 1, 2010, at 5:40 p.m., a Quality of Life Assessment Family Interview was being conducted in resident #3's room, with the resident's responsible party (RP). During the conversation, a Licensed Practical Nurse (LPN) proceeded to enter the resident's room without knocking, and administer resident #3's medications without affording the responsible party/surveyor an opportunity to excuse themselves from the resident's room prior to administering the resident's medications. During a subsequent interview with resident #3's responsible party on March 2, 2010, at 12:35 p.m., the RP stated the RP had felt uncomfortable on March 1, 2010, when the LPN entered resident #3's room while the RP was engaged in a private conversation with the surveyor regarding care resident #3 was receiving at the facility.</p>	F 164		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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 164	Continued From page 4 An interview was conducted on March 1, 2010, at 6:00 p.m., with the LPN who had failed to knock on the door prior to entering resident #3's room. The LPN stated his/her hands were filled with medications to be administered and, therefore, the LPN was unable to knock on the door.	F 164		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined that the facility failed to implement procedures to prohibit abuse, neglect, or misappropriation of resident property. The facility failed to conduct a timely criminal background screening for one (1) employee. The findings include: A review of the facility's Background Investigation Policy (not dated) revealed the facility was required to conduct criminal conviction investigation checks on all persons making application for employment with the facility. A review on March 3, 2010, of five randomly selected employee files revealed the facility had not conducted a timely criminal records check for one employee. Employee #1 was hired by the facility on November 24, 2009; however, a criminal background screening was not conducted for employee #1 until February 16,	F 226	226 *No resident was found to have been affected by def practice. *All residents had the ability to be affected by the def. practice. *All persons being hired at the facility will have a Criminal Background Check completed during orientation. They will not be able to work with residents until this is completed. *The QA team will audit personnel files on a quarterly basis to ensure compliance.	3-23-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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 226	Continued From page 5 2010. An interview was conducted on March 3, 2010, at 1:30 p.m., with the Personnel Manager (PM) who was responsible for ensuring the criminal background screenings were conducted. The PM stated an audit of employee files conducted by the facility in February 2010 revealed that a request for a background screening check had been submitted for employee #1 in November 2009; however, the PM stated that the background check was never received by the facility. The PM stated the facility had failed to realize the screening had not been conducted for employee #1 until the audit in February 2010.	F 226		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide residents who required thickened liquids with reasonable accommodations of readily accessible fluids. The findings include: 1. A review of resident #10's medical record revealed the resident was admitted to the facility	F 246	#246 *Resident #10 & resident #13 were assessed and found not to have been affected by def. practice. *All residents who receive thickened liquids were identified to be affected by def. practice. *Thickened liquids will be passed during ice passes at 9:00 am, 3:00pm, 9:00pm and 3:00 am. They already receive liquids at 10:00am, 2:00 pm and 8:00pm. This will give the residents who receive thickened liquids, liquids 7 times a day in a 24-hour period. The nourishment room keeps thickened liquids on hand when the dietary department is closed.	3-23-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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>on January 23, 2003. Resident #10 had diagnoses including Diabetes Mellitus, Dysphagia, and Aphasia. A review of physician's orders dated March 2010 for resident #10 revealed the resident was to receive nectar-thickened liquids.</p> <p>An observation of resident #10 on March 1, 2010, at 3:30 p.m., during the medication administration pass, revealed the resident to be hitting an empty drinking cup against the bed rails, and loudly attempting to verbalize. The Licensed Practical Nurse (LPN) administering medications stated that resident #10 was "thirsty and wanting something to drink." The LPN stated that he/she had requested resident #10 receive a pitcher of thickened liquids during the hydration passes due to the resident's frequent indications of being thirsty; however, the LPN could not recall an exact date or to whom the LPN had voiced the request, but stated that to his/her (the LPN's) knowledge, resident #10 had not been provided the increased fluids. The LPN requested a CNA provide resident #10 with a glass of fluids. Observation revealed the CNA went to the kitchen and returned to resident #10's room with a glass of thickened fluids for resident #10. The CNA placed the glass of fluids on the resident's bedside table at 3:35 p.m., and exited the resident's room. Resident #10 was observed to immediately consume three-fourths of the glass of fluids, and the entire glass of fluids by 3:40 p.m. Resident #10 was observed to drink the fluids independently without difficulty.</p> <p>An interview was conducted on March 1, 2010, at 4:00 p.m., with the CNA who had provided the glass of fluids to resident #10. The CNA stated hydration passes were conducted at 2:00 p.m.</p>	F 246	*The QA team will audit the thickened liquids pass monthly to ensure that all residents on thickened liquids receive adequate hydration.	
-------	--	-------	--	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 7</p> <p>and 8:00 p.m. daily on the second shift. The CNA stated resident #10 received one cup (eight ounces) of fluids during the hydration passes; however, no additional fluids were available to the resident to obtain independently if desired. The CNA stated that resident #10 was able to consume fluids independently when provided. The CNA stated that no additional fluids were available in the resident's room, stating if the resident became thirsty a staff member would be required to go to the kitchen and obtain the resident a glass of fluids.</p> <p>2. Observation and an interview were conducted on March 3, 2010, at 12:45 p.m., with resident #13, who was alert, oriented, and independently ambulatory. A review of resident #13's physician's orders dated March 2010 revealed the resident was to receive honey-thickened liquids.</p> <p>Resident #13 stated during the interview on March 3, 2010, that the resident required the honey-thickened liquids due to swallowing difficulties. Resident #13 stated that the resident received thickened liquids with meals, and received a cup of fluids during the "snack passes," but was not provided thickened water/fluids at bedside. Resident #13 stated he/she did at times become thirsty between the meals/snacks and would have to ask staff to obtain fluids for the resident, or ambulate to the kitchen to receive fluids. Additionally, resident #13 stated he/she had on occasion ambulated to the bathroom during the night and obtained a drink of unthickened water from the sink, due to being thirsty. However, resident #13 stated he/she would have drunk thickened water if it had been available in the room.</p>	F 246		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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 8</p> <p>An observation was conducted on March 2, 2010, at 10:30 a.m., of a CNA passing water pitchers to residents. The observation revealed residents who required thickened liquids were not provided pitchers/fluids. An interview was conducted on March 2, 2010, at 10:35 a.m., with the CNA who had passed the water pitchers. The CNA stated that residents who required thickened liquids were provided a cup of fluids during the hydration passes conducted at 10:00 a.m. and 2:00 p.m. on the day shift. The CNA stated if a resident desired more fluids between hydration passes, staff would have to obtain a cup of additional fluids for the resident from the kitchen.</p> <p>An interview was conducted on March 3, 2010, at 9:30 a.m., with the Dietary Manager (DM). The DM stated that residents who required thickened liquids, including residents who were able to independently consume fluids, were provided a cup of fluids prepared by the kitchen during the hydration passes, but were not provided routine fluids to be kept at bedside for the resident to consume at any time if desired.</p> <p>A review of the facility's "Fluids at Bedside" policy/procedure (undated) revealed it was the policy of the facility to provide water at bedside to residents and to encourage residents to consume water in their rooms. The policy further stated that water would be provided to each resident at the bedside, unless contraindicated by physician's order.</p>	F 246		
F 276 SS=D	<p>483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS</p> <p>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than</p>	F 276	<p>276</p> <p>*Resident #4 was assessed and no harm occurred as a result of the def. practice.</p>	3.23.10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
---	--

(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 276	<p>Continued From page 9 once every 3 months.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure a resident was assessed, using the Quarterly Review Minimum Data Set (MDS) instrument, not less frequently than once every three (3) months. The facility failed to complete a Quarterly MDS utilizing the Resident Assessment Instrument (RAI) for resident #4 that was due in February 2010.</p> <p>The findings include:</p> <p>Review of the medical record revealed resident #4 was admitted to the facility on April 16, 2000, with diagnoses of Alzheimer's Disease, Senile Dementia, and Psychosis. Review of the Quarterly MDS dated November 22, 2009, revealed the facility assessed resident #3 as being severely impaired in daily decision-making.</p> <p>Further review of the medical record revealed the Quarterly MDS dated November 22, 2009, was the last assessment completed for resident #3; therefore, the facility failed to complete a Quarterly MDS assessment in the three-month timeframe.</p> <p>Interview on March 2, 2010, at 2:30 p.m., with the MDS Coordinator revealed a list was made each month to include the MDS resident assessments that were required to be completed for that month. The MDS Coordinator stated resident #4 had a hospital stay and returned to the facility on January 28, 2010. The MDS Coordinator stated</p>	F 276	<p>*All nursing residents have the potential to be affected by the def. practice due to all residents requiring MDS's.</p> <p>*The MDS coordinator will do audits on MDS's 2 times a month to ensure that no assessments are missed. The coordinator will give verification of these audits each month to the DON.</p> <p>*The DON will conduct QA audits each quarterly to ensure that MDS's are conducted in a timely manner.</p>	
-------	--	-------	---	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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 276	Continued From page 10 the Coordinator considered if a Significant Change in Status (SCS) assessment would be needed as the resident required a right above-the-knee amputation during that hospitalization; however, it was determined that the SCS assessment was not warranted. The MDS Coordinator stated the Quarterly MDS was due on February 24, 2010, and the Coordinator just overlooked doing the assessment.	F 276		
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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide services that met professional standards of quality for two (2) of twenty (20) sampled residents. Resident #9 has physician's orders to receive vanilla health shakes at meals; however, the facility failed to provide the specified flavor of shakes. Additionally, the facility failed to administer medication to resident #12 as ordered by the resident's physician. The findings include: 1. A review of resident #9's physician orders dated March 2010 revealed that resident #9 was to be provided "Sugar Free Health Shakes (vanilla) w/meals three times a day." Observations of resident #9 on March 1, 2010, at 5:10 p.m., during the evening meal and on March 2, 2010, at 11:55 a.m., during the noon meal,	F 281	F281 *Residents #9 and #12 were assessed and no harm was caused by def practice. A clarification order was written for resident #9 stating that he is to receive "sugar free health shakes". The Dietary Manager has updated his tray card preferences. The nursing staff was in-serviced by the pharmacist on med pass procedure and the importance of following medication orders. *All residents with physician orders have the potential to be affected by def. practice. *All physician's orders are to be reviewed by DON for Accuracy. *The QA team will audit physicians orders quarterly to ensure accuracy.	3-23-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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)
F 281	<p>Continued From page 11</p> <p>revealed the resident had been served strawberry health shakes for both meals. A review of resident #9's dietary tray card revealed the resident was to receive a health shake with meals, but the dietary tray card did not specifically specify "vanilla" as ordered by the resident's physician.</p> <p>An interview was conducted on March 2, 2010, at 12:15 p.m., with resident #9. Resident #9 stated that he/she preferred to have vanilla health shakes, but was attempting to drink the strawberry-flavored shakes.</p> <p>An interview was conducted on March 3, 2010, at 9:30 a.m., with the Dietary Manager (DM). The DM stated he/she had been aware that resident #9 was to receive vanilla health shakes, but there were no vanilla health shakes available in the facility. The DM stated that he/she had failed to order sugar-free vanilla-flavored health shakes during the last ordering period.</p> <p>2. An observation of the medication administration on March 2, 2010, at 4:10 p.m., for resident #12 revealed the resident was administered two capsules of Renagel 400 milligrams. The resident was administered the medication with additional medications and a cup of fluids.</p> <p>A review of physician's orders for resident #12 dated March 2010 revealed that resident #12 was to receive Renagel 800 milligrams by mouth three times daily with meals. However, resident #12 did not receive a meal on March 2, 2010, until after 5:15 p.m. (more than one hour after the medication had been administered).</p>	F 281	

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 281	Continued From page 12 A review of resident #12's Medication Administration Record (MAR) revealed resident #12's Renagel was administered daily at 6:30 a.m., 12:00 p.m., and 4:30 p.m. An interview was conducted on March 2, 2010, at 4:20 p.m., with the facility's consulting Registered Pharmacist. The pharmacist stated that Renagel was to be administered in conjunction with meals, and did not allow for an acceptable time period before or after meals. An interview was conducted on March 2, 2010, at 5:00 p.m., with the Registered Nurse (RN) who had administered resident #12's Renagel. The RN stated she was aware the MAR instructed that the Renagel be administered with meals; however, the RN stated she had assumed the medication could be administered an hour before or after the meal.	F 281		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the residents' environment was free from accident hazards. The facility failed to ensure potentially hazardous items were properly	F 323	323 *No residents were found to have been affected by the def practice. *Any resident that uses the shower rooms have the potential to be affected by the def. practice. *Both shower rooms had automatic door locks installed that activate each time door is opened/closed. The doors are unlocked by a numerical code. The housekeeping dept will ensure that both shower rooms are free from hazards each day.	3-23-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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)
F 323	<p>Continued From page 13</p> <p>stored/secured. Clorox bleach, Crew Clinging toilet bowl cleaner, Virex disinfectant spray, razors, personal hygiene products, ointments, Fleet enemas, and other potentially hazardous items were observed in the men's and women's shower rooms in unsecured cabinets.</p> <p>The findings include:</p> <p>Observation on March 2, 2010, at 9:00 a.m., of the women's shower room revealed an unsecured wall cabinet that contained:</p> <ul style="list-style-type: none"> -13 cans of Fresh Scent Shaving Cream; -six partially used 7.5-ounce spray bottles of Derma Rite Bye Bye Apricot odor eliminator; -two unused Fleet enemas; -two 8.5-ounce tubes of Tena Wash Cream; -one unopened 4-ounce bottle of mouthwash; -one partially used Aloe Vista skin conditioner/protectant; -two containers of partially used Barkeepers Friend stainless steel cleaner; -one tube of protective barrier cream; and -three containers of Derma Rite deodorant/antiperspirant spray. <p>Further observation of the floor cabinet in the women's shower room revealed that this cabinet contained:</p> <ul style="list-style-type: none"> -two partially used 8-ounce spray bottles of One Step Germicidal; -one men's leather belt; -one full bottle of mouthwash; -14 8.5-ounce tubes of Tena Wash Cream; and -two containers of Derma Rite deodorant/antiperspirant spray. <p>Observation of the men's shower room revealed an unsecured wall cabinet that contained:</p>	F 323	<p>*The maintenance dept will conduct QA audits on the automatic locks on a weekly basis to ensure working order. The Hskg supervisor will conduct weekly QA audits to ensure that shower rooms are free of potential hazards.</p>

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
---	--

(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 323	<p>Continued From page 14</p> <ul style="list-style-type: none"> -three containers of prescribed ointments with three separate residents' names and directions attached and a label stating 'for external use only' on each container; -one partially used 7.5-ounce spray bottle of Derma Rite Bye Bye Apricot odor eliminator; -a working cellular phone; -one 8-ounce wound cleanser spray; and -an unopened twin pack of sodium phosphate enemas. <p>Further observation of the floor cabinet in the men's shower room revealed:</p> <ul style="list-style-type: none"> -one partially used one-gallon container of Clorox bleach, -one partially used quart container of Crew Clinging toilet bowl cleaner; and -35 disposable razors. <p>Further observation revealed a partially used spray bottle of Virex hanging on the shower curtain rod in the women's shower room.</p> <p>Interview on March 2, 2010, at 10:45 a.m., with the Director of Nursing (DON) revealed the items found in the resident bathrooms should be locked in a secured area and not accessible to residents. The DON stated no one was assigned to check the shower rooms for potentially hazardous items.</p> <p>Review of the facility's list of residents who exhibited behaviors of wandering/elopement risk revealed eight residents currently exhibited wandering behavior.</p> <p>Review of the facility's Census and Condition Record dated March 2, 2010, revealed 40 residents who resided at the facility had been diagnosed with Dementia, and six of these</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	---	--	---

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
---	--

(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 323	<p>Continued From page 15 residents were independent in ambulation.</p> <p>Review of the Material Safety Data Sheet revealed the recommended first aid measures, precautions, and health hazard data for the following hazardous products:</p> <p>Clorox Bleach-- Eye Contact: May cause eye irritation/burns. Skin: May cause skin irritation/burns. Ingestion: Call a physician.</p> <p>One-Step Germicidal Cleaner-- Eye Contact: Immediately flush eyes with running water for at least 15 minutes, keeping eyelids open. Seek medical attention immediately. Skin: Wash with plenty of soap and water. Seek medical attention if irritation develops. Ingestion: Seek medical attention. Give 3-4 glasses of milk. Do not induce vomiting. Never give anything by mouth to an unconscious person.</p> <p>Virex-- Eyes: Corrosive. May cause permanent damage including blindness. Skin: Corrosive. May cause permanent damage. Ingestion: Corrosive. May cause burns to mouth, throat, and stomach. Inhalation: May cause irritation and corrosive effects to the nose, throat, and respiratory tract.</p> <p>Crew Clinging Toilet Bowl Cleaner-- Eyes: Corrosive. May cause permanent damage. Skin: Corrosive. May cause chemical burns. Ingestion: Corrosive. May be harmful if swallowed. Inhalation: May cause irritation of the respiratory</p>	F 323		
-------	---	-------	--	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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 323	Continued From page 16 tract.	F 323		
F 329 SS=D	<p>483.25(f) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS</p> <p>Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.</p> <p>Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 329	<p>329</p> <p>*Resident #8 had Restoril 15 milligrams restored to her drug regimen.</p> <p>*All residents who had a gradual close reduction are at risk to be affected by the def. practice</p> <p>*Each resident receiving a GDR will be assessed before the reduction and daily during the reduction by the D.O.N., looking for any adverse reactions to the medication reduction. If it found that the resident is not adjusting to the GDR then the physician will be notified.</p> <p>*The QA team will audit residents receiving GDR on a quarterly basis to ensure that no residents have adverse effects from GDR.</p>	3.23.10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 329	<p>Continued From page 17</p> <p>Based on observation, interview, and record review, it was determined the facility failed to effectively monitor the gradual dose reduction for one (1) of fifteen (15) sampled residents. Resident #8 had a physician's order for Restoril 15 milligrams (mg) to be administered to the resident every night. The facility initiated a gradual dose reduction on January 28, 2010, as recommended by the consultant pharmacist. However, there was no evidence the facility monitored the effectiveness of the reduction in the Restoril for resident #8. Resident #8 complained of not being able to sleep at night since the dose reduction of the Restoril.</p> <p>The findings include:</p> <p>Observation of resident #8 at 1:50 p.m. on March 1, 2010, revealed the resident was alert and oriented to time, person, and place. Further observations of resident #8 at 3:10 p.m. on March 1, 2010, and at 8:45 a.m. on March 2, 2010, revealed the resident was lying in bed covered with a blanket, sleeping. Resident #8 stated in interview at 10:00 a.m. on March 2, 2010, that the resident had to nap during the day because the resident was unable to sleep since the "sleeping pill" had been decreased.</p> <p>A review of the medical record for resident #8 revealed the resident was admitted to the facility on July 30, 2009, with diagnoses that included Hypertension, Coronary Artery Disease, Diabetes Mellitus, Insomnia, and Anxiety.</p> <p>A review of a Quarterly Minimum Data Set (MDS) assessment for resident #8 dated February 4, 2010, revealed the resident had been assessed to have modified independence in cognitive skills</p>	F 329		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010	
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 329	<p>Continued From page 18 for daily decision-making with some difficulty in new situations only.</p> <p>A review of the current physician's orders revealed resident #8 had an order for Restoril 15 mg to be administered to the resident every other night for insomnia. Review of a physician's telephone order dated January 28, 2010, revealed the physician's order for the resident's Restoril 15 had been changed from 15 mg every night to 15 mg every other night at the recommendation of the consultant pharmacist.</p> <p>A review of the consultant pharmacist's drug regimen review dated January 25, 2010, revealed the consultant pharmacist recommended a gradual dose reduction for resident #8's Restoril 15 mg from 15 mg every night to 15 mg every other night. However, a review of a drug regimen review dated October 23, 2009, revealed the consultant pharmacist had recommended the Restoril 15 mg be evaluated, and the physician declined the recommendation at that time.</p> <p>An interview was conducted with resident #8 at 1:50 p.m. on March 1, 2010. The resident stated that the facility changed "my sleeping pill to one every other night, and I had been taking the sleeping pill every night since I came here." The resident further stated that the resident was having problems going to sleep at night on the night that the "sleeping pill" was not given. The resident further stated that staff did not come and speak with the resident prior to reducing the Restoril. In addition, the resident stated that staff told the resident that the physician was the person that reduced the Restoril, and resident #8 stated that staff did not speak to the resident regarding the Restoril reduction any time after the</p>	F 329		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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 329	Continued From page 19 order was changed. An interview was conducted with the Director of Nursing (DON) at 9:30 a.m. on March 3, 2010. The DON stated that she/he had spoken with resident #8 regarding the dose reduction in the Restoril. However, the DON stated there was no documented evidence that resident #8 had been informed of the reduction prior to the implementation of the dose reduction or that the effects of the dose reduction had been monitored for resident #8.	F 329		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain the kitchen in a sanitary manner. The dishwasher failed to maintain the required minimum 180 degrees Fahrenheit final rinse temperature. In addition, the confectioner oven, and the range top grease trap were in need of cleaning. The findings include:	F 371	371 *No resident was found to have been affected by the def practice. *All residents receiving dietary services have the potential to be affected by the def practice. *The thermostat was replaced on the dishwasher. The confection oven and the range top grease trap were cleaned. They are to be cleaned on schedule. *The QA team will do monthly audits to ensure that the dietary department to maintain an acceptable level of sanitation.	3-23-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(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)
F 371	<p>Continued From page 20</p> <p>1. An initial tour was conducted of the kitchen at 12:55 a.m. on March 1, 2010. Dietary staff was observed in the dish room scraping and washing pots, pans, and dishes. Observation of the final rinse temperature on the dishwasher was 164 degrees Fahrenheit. The surveyor observed ten dishwashing cycles, and the temperatures during the ten cycles were observed to range from 164 to 167 degrees Fahrenheit.</p> <p>Interview with dietary staff at 1:05 p.m. on March 1, 2010, revealed that staff had not observed that the dishwasher final rinse temperature was below the required 180 degrees Fahrenheit. Staff stated that staff had noticed the water in the dishwasher and the sprayer (to scrap dishes) was real hot at times and at other times the water was not very hot.</p> <p>A review of the current dishwasher temperature log revealed the final rinse temperature for the dishwasher was 185 degrees Fahrenheit for the lunch dishwashing on March 1, 2010.</p> <p>2. The confectioner oven was found to be in need of a thorough cleaning. There were spills and burned areas observed in the confectioner oven on March 1, 2010 during the initial tour.</p> <p>Interview with dietary staff at 9:20 a.m. on March 3, 2010, revealed the equipment should be thoroughly cleaned every two weeks and spills were to be cleaned daily.</p> <p>A review of the current dietary cleaning schedule revealed the oven, range top, and grease trap were documented to have been cleaned on February 5, 2010.</p>	F 371	
			(X5) COMPLETION DATE

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 371	<p>Continued From page 21</p> <p>3. The range top grease trap was observed to contain areas of burned black substances and was in need of a thorough cleaning during the initial tour on March 1, 2010.</p> <p>Interview with dietary staff at 9:20 a.m. on March 3, 2010, revealed the equipment should be thoroughly cleaned every two weeks and spills were to be cleaned daily.</p> <p>A review of the current dietary cleaning schedule revealed the oven, range top, and grease trap were documented to have been cleaned on February 5, 2010.</p>	F 371		
F 431 SS=D	<p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>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.</p> <p>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.</p> <p>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.</p>	F 431	<p>431</p> <p>*No residents were found to have been affected by the def practice.</p> <p>*All residents receiving medications were found to have been at risk by the def practice.</p> <p>*All opened and undated medications were discarded. The nursing staff was in-serviced on dating, all medications when opened discarding medication as indicated per label.</p> <p>*The QA team will conduct monthly audits of medications to ensure proper labeling and disposal when indicated.</p>	3-26-10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 22</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 observation and interview, the facility failed to label/discard drugs and biologicals in accordance with currently accepted professional principles.</p> <p>The findings include:</p> <ol style="list-style-type: none"> 1. Observation of the medication room on March 3, 2010, at 4:00 p.m., revealed a cabinet in the medication room contained four bottles of opened Magnesium Citrate (MC). Two of the bottles of MC were dated as to when opened with one bottle noted to have been opened on January 23, 2010, and one bottle being opened on February 25, 2010. Another bottle of MC was opened with approximately three-fourths of the contents gone, but the label contained no date as to when the medication was opened. One bottle of MC contained a prescription label for an unsampled resident and had been dated as opened on March 1, 2010. All the bottles of MC contained instructions on the label to "discard unused portions within 24 hours of opening." Additionally, the prescription label on the one bottle of MC repeated the instruction to "discard open bottle 	F 431		

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 431	<p>Continued From page 23 within 24 hours."</p> <p>2. Observation of the medication room refrigerator on March 3, 2010, at 4:15 p.m., revealed one bottle of opened Novolog insulin labeled for resident #18, and one bottle of opened Lantus insulin for an unsampled resident; however, the bottles of insulin failed to contain a date as to when the bottles had been opened.</p> <p>3. Observation of the Hall 1 medication cart on March 3, 2010, at 4:30 p.m., revealed the cart contained two bottles of opened MC; however, the bottles failed to contain a date as to when the medication was initially opened. Both bottles of MC contained instructions on the label to "discard unused portions within 24 hours of opening."</p> <p>An interview was conducted on March 3, 2010, at 5:00 p.m., with the Director of Nursing (DON). The DON stated that all opened bottles of medications were required to contain a date on the bottle as to when the container was opened, and that the DON was aware that MC was to be discarded within 24 hours of being opened. The DON stated the consulting pharmacist routinely monitored for expired medications, and the Medication Technician (MT) was also responsible for ensuring expired medications were not available for resident use.</p> <p>An interview was conducted on March 3, 2010, at 4:45 p.m., with the MT. The MT stated that he/she had not been aware that MC was to be discarded within 24 hours of opening the medication. The MT stated he/she had failed to see the instruction for discarding the MC within 24 hours on the medication labels.</p>	F 431	
F 465	483.70(h)	F 465	

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 465 SS=E	<p>Continued From page 24</p> <p>SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide effective housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>The findings include:</p> <p>Observation of the facility during the environmental tour on March 1, 2010 and March 2, 2010, revealed the following items were in need of repair:</p> <ul style="list-style-type: none"> -Drywall was observed to be marred at the head of resident beds in rooms 101, 201, 202, 207, 208, 302, 304, 403, 406, and 408. -Marred drywall was observed in the resident's bathroom in rooms 302, 303, 307, and 404. -Soiled privacy curtains were observed in resident rooms 401 and 402. -Baseboard was observed to be missing behind the entry door to resident room 207. -Entry doors to resident room 303, 304, and 404 were observed to be marred with splintered edges. -A buildup of mineral deposits was observed on the hot/cold knobs of the sinks in resident bathrooms in rooms 207, 208, 302, 308, 404, and 408. -A light bulb was observed to be out in the 	F 465	<p>465</p> <p>*No residents were found to have been affected by def practice.</p> <p>*All residents living in the facility have the potential to be effected by def. practice.</p> <p>*The Maintenance and Housekeeping supervisors have conducted audits on all rooms to inspect for any environmental defects. The defects will be repaired in a timely manner. The Dietary manager defrosted the refrigerator in the nourishment room.</p> <p>*The QA team will conduct an audit on a monthly basis to ensure that the facilities environment is free from defect.</p>	323.10
---------------	---	-------	---	--------

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 465	<p>Continued From page 25</p> <p>bathroom in resident room 404.</p> <p>-The light covering in resident room 201 was observed to be chipped and the top covering was loose.</p> <p>-The emergency call plate was observed to be loose and would pull out from the wall when attempting to activate the emergency call bell in the bathroom of resident room 408.</p> <p>-A large hole was observed in the bathroom door of resident room 101.</p> <p>-A resident's chest of drawers in room 102 was observed to be missing two knobs.</p> <p>-A towel bar was observed to be missing in the resident bathroom in room 207, and the towel bar in resident bathroom 307 was observed to be loose.</p> <p>-The faucet in the men's shower room was loose.</p> <p>-The bathroom door facing in resident room 202 was observed to be marred and was scarred with large black markings.</p> <p>-The refrigerator in the nourishment room was observed to have a large buildup of frost.</p> <p>An interview on March 3, 2010, at 2:30 p.m., with the Dietary Manager (DM) revealed the DM was not sure who was responsible for defrosting the refrigerator in the nourishment room.</p> <p>Interview on March 3, 2010, at 3:00 p.m., with the Housekeeping Supervisor (HS) revealed the privacy curtains were washed as needed. The HS stated the Maintenance Supervisor had recently passed away and the HS was covering that department. The HS stated rounds were conducted every day and repairs were made as needed; however, the HS was not aware of the needed repairs identified by the surveyors.</p> <p>F 514 483.75(l)(1) RES SS=D RECORDS-COMPLETE/ACCURATE/ACCESSIB</p>	F 465		
F 514		F 514	514 *Resident #9 was found not have been affected by def. practice.	3.23.10

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224
--	--

(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 26</p> <p>LE</p> <p>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.</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 observation, interview, and record review, it was determined that the facility failed to maintain an accurate clinical record for one (1) of twenty (20) sampled residents. On October 5, 2009, resident #9 began to receive a regular consistency diet after signing an informed consent despite an assessed need for a pureed consistency diet. However, current documentation in the resident's chart including the plan of care, most recent assessments, and physician's orders revealed the resident was still receiving the pureed consistency diet.</p> <p>The findings include:</p> <p>A review of resident #9's physician's orders dated March 2010, most recent Quarterly Minimum Data Set (MDS) assessment documentation dated December 17, 2009, current comprehensive care plan, and most recent dietary progress note dated December 17, 2009,</p>	F 514	<p>*All residents are at risk to be affected by def. practices.</p> <p>*Resident #9 Physicians order was corrected to reflect correct diet consistency.</p> <p>*The QA team will conduct monthly audits to ensure that the physician's orders are correct/accurate.</p>	
-------	--	-------	---	--

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

PRINTED: 04/07/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 27</p> <p>revealed resident #9 had been diagnosed to have dysphagia and was receiving a pureed diet.</p> <p>Observations of resident #9 on March 1, 2010, at 5:10 p.m., during the evening meal, and on March 2, 2010, at 11:55 a.m., during the noon meal, revealed resident #9 was served and consumed a regular consistency diet. A review of resident #9's dietary card tray on March 2, 2010, revealed resident #9 was to receive a regular consistency diet.</p> <p>An interview was conducted on March 3, 2010, at 10:00 a.m., with the Director of Nursing (DON). The DON stated, and a review of a Refusal of Treatment Form, revealed that resident #9 had signed a waiver to decline a pureed diet and had been receiving a regular consistency diet since October 5, 2009. However, the DON stated that no one in the facility had realized that resident #9's physician's orders had been incorrect since November 2009, and the resident's medical record including dietary progress notes, current assessments, and care plan indicated the resident was receiving a pureed diet.</p>	F 514		

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 050	Continued From page 1 third shift as follows: Four fire drills on the second shift from February 2009 to November 2009 were conducted between 2:09 p.m. and 2:58 p.m., and four third shift fire drills from January 2009 to October 2009, were conducted between 10:15 p.m. and 10:29 p.m. The Housekeeping Supervisor was not aware fire drills should be conducted at unexpected times and under varying conditions.	K 050			
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to ensure the building fire alarm system was maintained as required by NFPA standards. The findings include: During the Life Safety Code tour conducted on March 3, 2010, at 2:30 p.m., with the Housekeeping Supervisor, a record review revealed the last sensitivity report was completed in October 2007. A sensitivity report entails the testing of components associated with the fire alarm system; i.e., smoke detectors and heat detectors. Sensitivity testing is required every two years unless the facility meets the stipulations of testing as outlined below. An interview with the Supervisor revealed the facility's Maintenance Director was no longer with the facility and the facility depended on the fire alarm contractors to perform the required maintenance on the fire	K 054	K054 *No residents were found to affected to def practice. *All residents have the potential to be affected by the def. practice. *A sensitivity test was completed as required by NFPA standards. *The facilities QA team will monitor the fire alarm systems log to ensure that a sensitivity test is completed every two years as required by NFPA standards.	3/2/10	

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 90B PO BOX 1718 INEZ, KY 41224		
(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
K 054	<p>Continued From page 2 alarm system.</p> <p>Reference: NFPA 72 (1999 Edition).</p> <p>7-3.2.1*</p> <p>Detector sensitivity shall be checked within 1 year after installation and every alternate year thereafter. After the second required calibration test, if sensitivity tests indicate that the detector has remained within its listed and marked sensitivity range (or 4 percent obscuration light gray smoke, if not marked), the length of time between calibration tests shall be permitted to be extended to a maximum of 5 years. If the frequency is extended, records of detector-caused nuisance alarms and subsequent trends of these alarms shall be maintained. In zones or in areas where nuisance alarms show any increase over the previous year, calibration tests shall be performed.</p> <p>To ensure that each smoke detector is within its listed and marked sensitivity range, it shall be tested using any of the following methods:</p> <ol style="list-style-type: none"> (1) Calibrated test method (2) Manufacturer's calibrated sensitivity test instrument (3) Listed control equipment arranged for the purpose (4) Smoke detector/control unit arrangement whereby the detector causes a signal at the control unit where its sensitivity is outside its listed sensitivity range (5) Other calibrated sensitivity test methods approved by the authority having jurisdiction <p>Detectors found to have a sensitivity outside the listed and marked sensitivity range shall be cleaned and recalibrated or be replaced.</p> <p>Exception No. 1: Detectors listed as field adjustable shall be permitted to be either adjusted</p>	K 054		

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/03/2010
NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 908 PO BOX 1718 INEZ, KY 41224		
(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 054	Continued From page 3 within the listed and marked sensitivity range and cleaned and recalibrated, or they shall be replaced. Exception No. 2: This requirement shall not apply to single station detectors referenced in 7-3.3 and Table 7-2.2. The detector sensitivity shall not be tested or measured using any device that administers an unmeasured concentration of smoke or other aerosol into the detector. 7-3.2.2 Test frequency of interfaced equipment shall be the same as specified by the applicable NFPA standards for the equipment being supervised. 7-3.2.3 For restorable fixed-temperature, spot-type heat detectors, two or more detectors shall be tested on each initiating circuit annually. Different detectors shall be tested each year, with records kept by the building owner specifying which detectors have been tested. Within 5 years, each detector shall have been tested.	K 054			
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on interview and record review, the facility failed to maintain the sprinkler system by NFPA standards. The findings include:	K 062	K062 *No residents were found to be affected by the def. practice. *All residents had the potential to be affected by the def. practice. *A interior pipe inspection was performed on the facility sprinkler system. *The facility's QA team will audit the fire log inspections to ensure that a interior pipe inspection is performed every five years as required by NFPA standards	3/28/10	

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 90B PO BOX 1718 INEZ, KY 41224
--	--

(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 062	<p>Continued From page 4</p> <p>During the Life Safety Code tour on March 3, 2010, at 2:25 p.m., with the Housekeeping Supervisor, a record review revealed the last interior pipe inspection performed on the facility's sprinkler system was conducted on March 30, 2004. Interior pipe inspections are required every five years. The record review revealed a quick opening device (accelerator) was not operational. An accelerator ensures the sprinkler system operates in a timely manner. An interview with the Supervisor revealed the facility's Maintenance Director was no longer with the facility and the facility depended on the sprinkler contractors to perform the required maintenance on the sprinkler system.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>1-8* Records. Records of inspections, tests, and maintenance of the system and its components shall be made available to the authority having jurisdiction upon request. Typical records include, but are not limited to, valve inspections; flow, drain, and pump tests; and trip tests of dry pipe, deluge, and preaction valves.</p> <p>1-8.1 Records shall indicate the procedure performed (e.g., inspection, test, or maintenance), the organization that performed the work, the results, and the date.</p> <p>10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed,</p>	K 062		
-------	--	-------	--	--

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

PRINTED: 03/17/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185379	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/03/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER MARTIN COUNTY HEALTH CARE FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE ROUTE 008 PO BOX 1718 INEZ, KY 41224
--	--

(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 062	<p>Continued From page 5</p> <p>the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.</p> <p>10-2.3* Flushing Procedure.</p> <p>If an obstruction investigation carried out in accordance with 10-2.1 indicates the presence of sufficient material to obstruct sprinklers, a complete flushing program shall be conducted. The work shall be done by qualified personnel.</p>	K 062		
-------	--	-------	--	--