

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

PRINTED: 11/18/2010
FORM APPROVED
OMB NO. 0938-0391

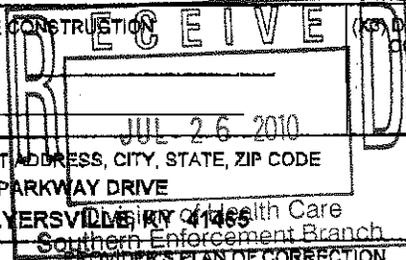
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185221	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/08/2010
NAME OF PROVIDER OR SUPPLIER SALYERSVILLE HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 571 PARKWAY DRIVE SALYERSVILLE, KY 41465		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>**Amended--</p> <p>An abbreviated standard survey (KY14931) was conducted on July 6-8, 2010. No deficient practice was identified.</p>	F 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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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F 000	INITIAL COMMENTS	F 000		
F 226 SS=D	<p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to operationalize policies/procedures for identification, investigation, and reporting of possible abuse/neglect for one (1) of three (3) sampled residents. An incident of possible resident abuse/neglect was reported to Administrative staff on May 28, 2010; however, Administrative staff failed to initiate an investigation of the incident, failed to protect residents from further possible abuse/neglect, and failed to report the allegation to the appropriate state agencies as required.</p> <p>The findings include:</p> <p>A review of the medical record for resident #1 revealed the resident was admitted to the facility on January 14, 2010. The resident had diagnoses including Tracheostomy Placement, Gastrostomy Tube Placement, Post Respiratory Failure, Coronary Artery Disease, and Heart Failure. A review of the admission nursing assessment for resident #1 dated January 14,</p>	F 226	<p>1. All residents have potential to be affected.</p> <p>2. RDCS/Administrator/Educator on nurse interviewed employees regarding any knowledge of abuse/neglect with no findings (7/7/2010-7/26/2010). Social Services interviewed residents regarding any abuse/neglect issues and asked if they knew difference between nurse/nurse aid with no findings (7/7/2010-7/8/2010). A Resident Council meeting was held on 7/7/2010 discussion included what is abuse/neglect and who to report to.</p>	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>A Sharon Welch</i>	TITLE Administrator	(X6) DATE 7/26/10
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Received Time Jul. 26. 2010 5:09PM No. 1602

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F 226	<p>Continued From page 1</p> <p>2010, revealed the resident was also admitted to the facility with an indwelling Foley catheter.</p> <p>An interview was conducted on July 6, 2010, at 2:45 p.m., with Registered Nurse (RN) #1, who cared for resident #1 on May 28, 2010. RN #1 revealed Certified Nursing Assistant (CNA) #1 reported on May 28, 2010, at approximately 2:15 p.m., that resident #1's urinary output had been decreased, and further reported that "rumors" were circulating throughout the facility that a CNA (CNA #2) had changed resident #1's catheter on the 11-7 shift (May 27-28, 2010). RN #1 immediately went to assess the status of resident #1's catheter, and found the catheter to be leaking, not draining properly, and explained that the resident had only 100-150 cubic centimeters (cc) output of urine since 7:00 a.m. that morning. RN #1 stated the catheter was changed and an immediate return of 400-450 cc of clear yellow urine was obtained. RN #1 reported the only abnormal finding when changing the catheter was that the balloon contained only 2 cc of water, and was required to have 5 cc inserted. RN #1 voiced immediately reporting the allegation that CNA #2 had changed resident #1's Foley catheter and that the catheter had not been draining properly/required changing to the Director of Nursing (DON) on May 28, 2010.</p> <p>An interview was conducted on July 6, 2010, at 4:45 p.m., with the DON. The DON stated he/she recalled RN #1 reporting on June 28, 2010, resident #1's catheter had been changed due to leaking; however, the DON reportedly did not recall RN #1 reporting the allegation that CNA #2 had changed resident #1's Foley catheter on the 11-7 shift prior. The DON went on to explain he/she had become aware of the "rumor" among</p>	F 226	<p>3.RDCS re educated DON one on one 7/7/2010.RDCS re educated I.D.T (Social Services, Activities, Dietary Manager, Reimbursement Coordinator, Unit Managers, Administrator, Education Nurse) on 7/7/2010.E.T.D (Education Nurse) re educated staff regarding abuse and neglect policy, who to report to and scope of practice (7/7/2010-7/26/2010).Omsbudman to schedule abuse and neglect education for residents within 30 days of 7/15/2010.</p>	

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F 226	<p>Continued From page 2</p> <p>floor staff regarding the CNA changing the resident's catheter stating, "You learn a lot smoking." The DON asked the nurse caring for resident #1 on the "night in question" about the incident and the nurse reported changing the resident's catheter with the assistance of CNA #2. The DON explained an investigation was not initiated regarding this incident and no further action was taken, stating, "You can't believe every rumor." The DON reported, "At some point I told [Administrator]." However, the DON could not provide a date when he/she became aware of the allegation, talked to the nurse, or notified the Administrator.</p> <p>An interview was conducted on July 6, 2010, at 5:00 p.m., with the Administrator. The Administrator stated he/she had become aware of the allegation on June 2, 2010, by a staff member who had heard "rumors" on the floor that CNA #2 had changed resident #1's catheter. The Administrator stated the DON had not reported the allegation to the Administrator. The Administrator asked CNA #2 and the nurse about the incident. CNA #2 reportedly denied changing resident #1's catheter, and the nurse "didn't know anything about a catheter." The Administrator stated no further action was taken, and an investigation was not initiated due to the allegation "just being a rumor." Further interview with the Administrator and DON on July 6, 2010, at 5:15 p.m., revealed the facility's policies/procedures regarding neglect were not implemented. The facility failed to initiate an investigation, failed to protect residents from further potential harm, and failed to report the allegation to the appropriate state agencies as required.</p>	F 226	<p>4.RDCS/RDO to monitor grievances 1x month x 2 to ensure abuse and neglect policy is followed.Department Managers to interview residents who they are assigned to monitor by room round schedule 1x week x4 weeks regarding, abuse/neglect and report findings to Administrator.</p> <p>5.Date of Compliance:7/26/2010.</p>	
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F 226	Continued From page 3 A review was conducted of the facility's policy/procedure regarding abuse, neglect, and misappropriation of resident property with a revision date of January 2007. The policy/procedure contained all required components, including that all alleged incidents were to be investigated and reported to the appropriate state agencies. The policy/procedure further revealed any employee being investigated for abusing, neglecting, or mistreating a resident would be relieved of their duties until the investigation was completed.	F 226		