

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

PRINTED: 08/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ COMPLETED B. WING _____ COMPLETED	
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41659	
(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 June 14-16, 2011. Deficiencies were identified with the highest scope and severity at "G" level with an opportunity to correct.	F 000	Prestonsburg Health Care Center does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure one of sixteen sampled residents was free from physical restraints not required to treat a medical symptom (resident #4). Resident #4 was observed to be in a reclined geri-chair (chair that prevents rising) during the survey conducted on June 14-16, 2011. Observation and interview revealed that resident #4 attempted to get out of the chair without staff assistance on a daily basis. There was no evidence the facility identified the presence of a medical symptom for resident #4 that required the use of a physical restraint or utilized a systematic process of evaluation to identify the therapeutic interventions required to attain or maintain the resident's highest practicable physical, mental, or psychosocial well-being. There was no evidence the facility determined the least restrictive alternatives to avoid a decline in function or the appropriateness of the restraints for resident #4.	F 221		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *Adm* (X5) DATE: *7-19-11*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 221	<p>Continued From page 1 The findings include:</p> <p>A review of the facility's Restraint policy/procedure (dated December 2010) revealed physical restraints were to be used only when alternative methods were not sufficient to protect the resident or others from injury and were not a substitute for less restrictive forms of protective restraint. There was no evidence the Restraint policy/procedure addressed the protocol/systematic process of evaluation and care planning staff was to utilize prior to the utilization of physical restraints for residents. The policy further did not define a physical restraint and did not provide a listing of types of physical restraints or devices that could be considered a physical restraint that were utilized for facility residents.</p> <p>The Director of Nursing (DON) was interviewed on June 15, 2011, at 4:00 p.m. The DON stated a therapy evaluation/assessment should have been completed to determine the appropriate restraint device to be utilized for resident #4 and a prescreening restraint assessment should have been conducted. The DON stated restraint use was to be reviewed at least quarterly to evaluate for the effectiveness and continued use of the restraint device. The DON also stated she believed resident #4 had initially been placed in the geri-chair due to the resident's acute illness to promote comfort; however, no assessment had been conducted to evaluate the appropriateness or the continued use of the geri-chair for the resident.</p> <p>A review of the medical record revealed resident #4 was admitted to the facility on March 25, 2011.</p>	F 221	<p>F 221 483.13 (a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>Corrective Action For Resident(s) Affected:</p> <p>Resident #4 was evaluated/assessed for the need of a geri chair as a physical restraint. It was determined that a restraint was needed for Resident #4 as it is necessary for promoting the resident's quality of life. A physician's order was obtained for the geri chair as a physical restraint. Consent from the family for the restraint was obtained. Resident #4's care plan and CNA care plan were updated accordingly.</p> <p>How The Facility Will Act To Protect Residents in Similar Situation:</p> <p>The facility will evaluate/assess all residents in the facility that utilizes a geri chair as a possible restraint. Any residents that are utilizing a geri chair that is classified as a restraint will have a restraint care plan completed, a family consent and will be reassessed for restraint reduction/elimination at least quarterly and as needed.</p>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DIB111

Facility ID: 100128

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 40363		
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F 221	Continued From page 2 with diagnoses to include Hypertension, Senile Dementia, Chronic Obstructive Pulmonary Disease (COPD), Depression, Chronic Ischemic Heart Disease, Atrial Fibrillation, and Acute Pancreatitis. A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on April 1, 2011, revealed the facility assessed resident #4 to require limited assistance of one staff person for bed mobility, transfers, ambulation, and toileting. The resident was unsteady but able to move from a seated to standing position without assistance, was able to become stabilized with assistance with walking, turning around, and transfers, and did not require the use of a restraint. Further record review revealed resident #4 required hospitalization from April 7-15, 2011, and again from April 28-May 5, 2011, secondary to a diagnosis of Acute Pancreatitis. Review of the Physical Therapy Evaluation Summary with a Start of Care date of May 6, 2011, revealed resident #4 had an acute loss of overall mobility status and Activity of Daily Living (ADL) tasks, requiring minimum to moderate assistance from staff with positioning self from a lying to a sitting position on the side of the bed. The resident was also assessed to require minimum to moderate assistance of two staff persons to stand from a sitting position. According to the assessment, the resident continued to have deficits in mobility, transfers, balance/coordination, gait mobility, wheelchair propulsion and activity tolerance. There was no evidence that resident #4 was assessed for the use of a geri-chair by the Physical Therapy staff. A review of the 14-day Medicare MDS assessment completed on May 19, 2011, revealed the facility assessed resident #4 to be nonambulatory and to require extensive	F 221	Measures To Prevent Reoccurrence: When a physician's order is obtained for a geri chair an RN will evaluate and care plan the need for a restraint device. Nursing staff were inserviced on 6/16/2011 on the restraint policy focusing on geri chairs that could be considered a restraint by the DON. An RN will evaluate/assess all residents for the need of a geri chair as a physical restraint prior to the use of a geri chair. Monitoring of Corrective Action: DON will audit use of all geri chairs as restraints along with proper documentation in care plan for 3 months, then bi-weekly for 3 months, then monthly for 3 months. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed. Completion Date: 7/19/11		

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F 221	<p>Continued From page 3</p> <p>assistance from staff for bed mobility, transfers, and toileting. The assessment further revealed resident #4 did not require the use of a restraint device.</p> <p>Review of the comprehensive care plan and the Certified Nurse Aide (CNA) care plan for resident #4 revealed no evidence that a geri-chair was to be utilized for this resident. There was no evidence in the resident's medical record, Medicare MDS assessments, or comprehensive and CNA care plans that resident #4 had been assessed for the use of a geri-chair.</p> <p>Resident #4 was observed on June 14, 2011, at 1:15 p.m., sitting in a geri-chair (chair that prevents rising) in the dining/activity room of the facility with the back of the chair noted to be locked in a reclined position. The resident was unable to sit in an upright position while the chair was in the locked position. On June 14, 2011, at 2:40 p.m., resident #4 was again sitting in the reclined geri-chair, however, the back of the chair which was reclined was not in a locked position. The resident was observed to raise his/her trunk away from the upper part of the geri-chair and push the footrests with his/her legs and feet until the resident was able to sit erect in the chair and lower the footrests in an attempt to get out of the chair. Facility staff was observed to intervene, prevent the resident from getting out of the geri-chair, and place resident #4 in a locked reclined position in the chair. Resident #4 was observed on June 15, 2011, at 10:50 a.m., sitting in the locked reclined geri-chair with both legs over each side of the chair. The resident was again unable to sit in an upright position while the back of the chair was in the locked reclined</p>	F 221			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DIB111

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F 221	<p>Continued From page 4 position.</p> <p>An interview conducted with CNA #1 on June 16, 2011, at 10:30 a.m., revealed resident #4 had been using the geri-chair for several weeks. CNA #1 stated the resident had been able to ambulate prior to the hospital stays but now was too weak. CNA #1 stated resident #4 would make attempts to rise from the geri-chair and would put his/her legs over the side of the chair.</p> <p>An Interview conducted with Licensed Practical Nurse (LPN) #1 on June 15, 2011, at 10:00 a.m., who was responsible to provide direct resident care, revealed resident #4 had made attempts to get up out of the geri-chair. LPN #1 stated she did not know why the geri-chair was being used for resident #4 and Therapy Services usually recommended the type of chair to be used by the resident.</p> <p>An interview conducted with the Physical Therapy Assistant (PTA) on June 15, 2011, at 2:10 p.m., revealed resident #4 had been utilizing the geri-chair for several weeks. The PTA stated she could not recall if a wheelchair had been tried with the resident prior to using the geri-chair. The PTA stated resident #4 would place the resident's legs over the side of the lower section of the geri-chair and had made attempts to get up from the chair.</p> <p>An interview conducted with the Physical Therapist (PT) on June 15, 2011, at 5:15 p.m., revealed an assessment should have been completed by a therapist to determine the most appropriate device to utilize for resident #4 prior to the implementation of a restraining device.</p>	F 221			

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F 221	Continued From page 5 The PT stated the gert-chair had not been considered a restraint for resident #4 since the resident was unable to safely self-transfer.	F 221		
F 272 SS=G	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272	F 272 483.20(b)(1) Comprehensive Assessments Corrective Action for Resident(s) Affected: Resident #3 was assessed for risk factors including Braden scores and noncompliance issues regarding potential skin breakdown. Appropriate interventions were implemented to prevent future skin breakdown. Resident #3's care plan was updated accordingly on 6/15/11. Physician and family were notified of findings on 6/15/11. How the Facility Will Act to Prevent Resident's in Similar Situations: All residents were assessed for risk factors related to skin breakdown as well as any noncompliance issues with care by the DON/MDSC on 6/17/11. All care plans were updated accordingly with appropriate interventions to prevent skin breakdown.	

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F 272	Continued From page 6 This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, the facility failed to conduct a thorough assessment utilizing the Resident Assessment Instrument (RAI) process for one of sixteen sampled residents. The facility failed to comprehensively assess, identify risks and causative factors, and develop individualized interventions regarding the development of pressure sores for resident #3. Resident #3 was observed to be sitting in a wheelchair for extensive periods of time on June 14, 2011, June 15, 2011, and June 16, 2011. Interviews with staff revealed resident #3 was noncompliant with taking rest periods from the wheelchair, changing positions while sitting, and notifying staff of incontinence episodes so that incontinence care could be provided. However, there was no evidence the facility had assessed the resident's noncompliance with care as a risk factor for pressure sores. On June 15, 2011, resident #3 was observed to have a Stage II open area to the coccyx that had not been identified by the facility. The findings include: A review of the facility policy entitled Pressure Ulcer Management (dated December 2010) revealed that an assessment is the beginning of pressure ulcer treatment and the entire resident must be assessed by health care professionals to	F 272	Measures Taken To Prevent Reoccurrence: Nurses and nurse aides was inserviced on 6/17/11 by the Social Worker on reporting, documenting and communicating noncompliance or refusal of care. Any noncompliance or refusal of care issues or concerns will be addressed daily in clinical meeting (a daily meeting with the IDT to discuss physician orders, lab results, falls, wounds, etc) and care planned accordingly. Residents will be assessed on admission by RN/LPN and at least quarterly by the MDS nurse for risk factors of skin breakdown and appropriate interventions will be implemented to prevent skin breakdown. Nursing and CNA staff will be checked off on a head to toe skin assessment and all new nursing/CNA staff will be checked off as well as a part of orientation. Education will be ongoing for three months regarding documenting, reporting, and communicating noncompliance or refusal of care issues.	

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F 272	<p>Continued From page 7</p> <p>Include the Physical Therapist and Registered Dietitian. Based on the assessment, the policy stated an effective plan of care would be developed consistent with the resident's goals/wishes and a preventative program would be implemented to prevent the development of pressure sores.</p> <p>Resident #3 was admitted to the facility on December 6, 2010, with diagnoses of Malignant Neoplasm of the bone, Chronic Obstructive Pulmonary Disease, Urinary Tract Infection, and a Fractured Left Clavicle. The Comprehensive Minimum Data Set (MDS) assessment dated December 14, 2010, revealed the facility assessed the resident to usually make his/her self understood and to usually understand others. Further review of the assessment revealed the resident was assessed to be at risk for developing pressure ulcers and was frequently incontinent of bowel and bladder. Resident #3 was also assessed to require one staff person for physical assistance with transfers, bed mobility, toilet use, and personal hygiene. Resident #3 was not assessed to be resistant to care.</p> <p>Review of the Care Area Assessment Summary (CAAS) dated December 13, 2010, revealed resident #3 had impaired daily decision-making skills, required cues and supervision at times, and staff was to anticipate the resident's needs and assist with meeting them daily. The CAAS also revealed resident #3 was at high risk for developing pressure ulcers due to incontinence and impaired mobility, and staff was to provide peri-care to the resident after each incontinence episode. Further review of the CAAS revealed no evidence that resident #3 was assessed to be</p>	F 272	<p>Monitoring of Corrective Action:</p> <p>ADM/DON will audit skin risk assessments and care plan interventions for preventing skin breakdown weekly for 3 months, then bi-weekly for 3 months, then monthly for 3 months. All concerns will be addressed immediately. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p>Completion Date: 7/19/11</p>	

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F 272	<p>Continued From page 8</p> <p>resistive to care.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, with a completion date of May 27, 2011, revealed the facility assessed resident #3 to usually make his/her self understood and to usually understand others. The assessment revealed resident #3 was continent of bowel and bladder and required the assistance of one staff person with transfers, bed mobility, toilet use, and personal hygiene. The quarterly assessment further revealed the resident had a Stage II pressure ulcer and was at risk for developing new pressure ulcers; however, the resident was not assessed to refuse or be resistant to care.</p> <p>A review of resident #3's most recent skin assessment dated June 15, 2011, that was conducted by CNA #6 during the resident's shower revealed the resident had one Stage II pressure sore to the coccyx and had no new open areas.</p> <p>Observation of a skin assessment of resident #3 conducted by LPN #1 on June 15, 2011, at 2:40 p.m., after the resident returned from the shower, revealed an additional open area to the resident's coccyx which had not been identified by facility staff during the resident's shower. The unidentified open area measured .5 centimeters (cm) by .5 cm.</p> <p>Observations on June 14, 2011, at 3:00 p.m. and 4:00 p.m.; on June 15, 2011, at 8:45 a.m., 10:40 a.m., 12:00 p.m., 2:50 p.m., and 3:50 p.m.; on June 16, 2011, at 8:35 a.m., 9:30 a.m., 10:40 a.m., 11:35 a.m., 1:00 p.m., 2:35 p.m., and 3:45</p>	F 272			

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F 272	<p>Continued From page 9</p> <p>p.m., revealed resident #3 was sitting in a wheelchair in the same position and was not assisted to bed or to reposition in the chair.</p> <p>Interviews with CNA #1 on June 15, 2011, at 4:20 p.m., with CNA #4 on June 16, 2011, at 5:30 p.m., and with CNA #3 on June 16, 2011, at 5:35 p.m., revealed resident #3 was incontinent at times, wore incontinence briefs, and had a long history of noncompliance with incontinence care and repositioning when up in a chair. CNA #1 stated resident #3 "sits up in a wheelchair every day and refuses to change positions." CNA #4 stated resident #3 "likes to take care of herself," CNA #3 stated the resident would change the wet incontinence briefs without staff assistance, refused to allow staff assistance with removing the wet briefs, and frequently refused staff assistance with personal care.</p> <p>Interview with the Director of Nursing (DON) on June 16, 2011, at 5:40 p.m., revealed resident #3 should receive incontinence care after each incontinence episode and the DON was not aware staff had failed to provide the incontinence care. The DON was aware resident #3 sat in a wheelchair for long periods of time and refused to go back to bed. The DON stated the facility should have identified the resident's resistance to care as a causative factor for the development of pressure sores and interventions should have been developed/implemented regarding the resident's refusal of care due to the resident's risk for the development of new pressure sores and the presence of the Stage II pressure sore to the resident's coccyx area. The DON was unaware of the second open area to resident #3's coccyx until it was identified by the surveyor on June 16,</p>	F 272			

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41663		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 272	Continued From page 10 2011. The DON stated the facility's newly hired MDS nurse was still in training and the DON was responsible for the completion of all MDS assessments.	F 272			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of the facility's policies, it was determined the facility failed to conduct a comprehensive assessment for one of sixteen sampled residents after a significant change in the resident's physical condition. Resident #4 experienced a decline in physical status after being readmitted from the hospital; however, there was no evidence the facility had conducted a significant change assessment to further evaluate the changes in the resident's condition. The findings include:	F 274	F 274 483.20(b)(2)(ii) Comprehensive Assess After Significant Change Corrective Action For Resident(s) Affected: A significant change assessment was completed on Resident #4 on 6/19/11 by the MDSC. Resident #4's care plan was updated accordingly on 6/19/11. How the Facility Will Act To Protect Residents in Similar Situation: All residents' medical records were reviewed by the DON and corporate MDS nurse consultant on 6/16/11 for the past year for change in ADL status, weight loss/gain, and pressure ulcers to identify if any significant change assessments were warranted.		

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 274	<p>Continued From page 11</p> <p>A review of the facility policy related to Assessment Management (dated June 2010) revealed a significant change comprehensive assessment would be conducted for residents when a decline in two or more areas have been identified. These areas include any decline in Activity of Daily Living (ADL) physical function where a resident is newly coded as requiring extensive assistance or total dependence, changes in the resident's incontinence pattern, use of a trunk restraint or a chair that prevents rising when it has not been used before, and overall decline in the resident's condition.</p> <p>A review of the medical record revealed resident #4 was admitted to the facility on March 25, 2011, with diagnoses to include Hypertension, Senile Dementia, Chronic Obstructive Pulmonary Disease (COPD), Depression, Chronic Ischemic Heart Disease, Atrial Fibrillation, and Acute Pancreatitis. A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on April 1, 2011, revealed the facility assessed resident #4 to require limited assistance of one staff person for bed mobility, transfers, ambulation, personal hygiene, and toileting. The resident was assessed to require extensive assistance of one staff person with bathing and to be continent of bowel and bladder function. Record review revealed resident #4 required hospitalization from April 7-15, 2011, and from April 25-May 5, 2011, secondary to a diagnosis of Acute Pancreatitis and exacerbation of COPD.</p> <p>A 14-day Medicare MDS assessment completed on May 19, 2011 (after the last hospital stay).</p>	F 274	<p>Measures to Prevent Reoccurrence:</p> <p>ADL changes, new/worsening pressure ulcers, weight loss/gain will be discussed daily in clinical meeting (a daily meeting with the IDT to discuss physician orders, lab results, falls, wounds, etc) and weekly in at risk meeting to determine the need for a significant change with updated care planning. Any resident's identified with a need for a significant change assessment will have a significant change assessment and an updated care plan with the interdisciplinary team. The MDS coordinator will also complete new assessments while comparing to the prior assessment to identify changes that would warrant a significant change.</p> <p>Monitoring of Corrective Action:</p> <p>ADM/DON will audit a 10% resident sample to identify residents who need a significant change assessment and updated care plan for the next 6 months. Concerns will be addressed immediately.</p> <p>Completion date: 7/19/11</p>	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41853	
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F 274	<p>Continued From page 12</p> <p>revealed the facility assessed resident #4 to require the extensive assistance of two staff persons for bed mobility, transfers, dressing, personal hygiene, and toileting, and was nonambulatory. The assessment further revealed resident #4 was assessed to require the total assistance of staff for eating and bathing needs and to be frequently incontinent of bowel and bladder function. According to the assessments, the resident experienced a significant decline in physical function related to transfer, bed mobility, ambulation, dressing, personal hygiene, bathing, eating, toileting, and bowel/bladder function, and had sustained a weight loss on May 19, 2011. There was no evidence the facility evaluated the changes in the resident's physical condition and no evidence a significant change assessment had been conducted.</p> <p>Resident #4 was observed on June 14, 2011, at 1:15 p.m., 2:40 p.m., and 4:00 p.m., to be sitting in a reclined geri-chair. On June 15, 2011, at 12:05 p.m., resident #4 was observed in the facility dining room sitting in a reclined geri-chair. Facility staff was observed to spoon feed resident #4 during the lunch meal. The resident was again observed on June 16, 2011, at 10:20 a.m., to be sitting in the reclined geri-chair. On June 18, 2011, at 2:00 p.m., resident #4 was observed to be transferred from the chair to the bed with the assistance of two staff persons. The resident was wearing an adult brief during this observation. Observation of a skin assessment for resident #4 on June 16, 2011, at 2:00 p.m., revealed the resident had no skin breakdown. The resident required the assistance of staff with turning/repositioning during the skin assessment.</p>	F 274		

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 274	Continued From page 13 Interview with CNA #1 on June 16, 2011, at 10:30 a.m., revealed prior to the hospitalization of resident #4, the resident required limited assistance from staff with ADLs and was confined of bowel and bladder. After the resident returned to the facility from the hospital on May 5, 2011, the resident required more assistance from staff with care. An interview conducted with the DON on June 15, 2011, at 4:00 p.m., revealed the DON had been responsible for conducting the MDS assessments after the previous MDS Nurse terminated her employment at the facility in May 2011. The DON stated residents were reviewed during the daily "stand-up" meetings with the Interdisciplinary Team (IDT) to identify changes in the resident's ADL function. The DON stated a new MDS assessment should be compared with the previous MDS assessment to identify significant changes; however, the DON stated the facility failed to identify the decline in resident #4's physical status and a significant change assessment had not been conducted for the resident.	F 274			
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an	F 280	F 280 483.20(D)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP		

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
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F 280	<p>Continued From page 14</p> <p>interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, the facility failed to periodically review and revise the comprehensive care plan for one of sixteen sampled residents. Resident #4 sustained a significant change in Activity of Daily Living (ADL) function after being readmitted to the facility from a hospital. However, the facility failed to revise the comprehensive care plan to address the changes in the resident's ability to perform ADL needs.</p> <p>The findings include: A review of the facility Care Plan policy (dated December 2010) revealed the Interdisciplinary Team (IDT) was responsible to review, revise, and update the resident's care plan quarterly and more frequently if warranted by a change in the resident's condition. Resident #4 was admitted to the facility on March 25, 2011, with diagnoses to include Hypertension, Senile Dementia, Chronic Obstructive Pulmonary</p>	F 280	<p>Corrective Action for Resident(s) Affected:</p> <p>Resident #4's care plan was updated by the DON/MDSC to clinically correspond to the resident's care needs on 6/15/11.</p> <p>How the Facility Will Act To Protect Residents in Similar Situations:</p> <p>All resident's care plans were reviewed between 6/15/11 and 6/23/11 by the DON/ADON to ensure each resident's care plan corresponded to their care needs. No concerns were identified.</p> <p>Measures To Prevent Reoccurrence:</p> <p>Any changes to the resident's care needs will be reviewed and discussed daily in clinical meeting. Care plans will also be reviewed in this meeting to ensure that the care plan has been updated by the MDS nurse and corresponds to the resident's needs. Residents' care needs who are returning to the facility from an acute care setting will be reviewed and discussed in clinical meeting (a daily meeting with the IDT to discuss physician orders, lab results, falls, wounds, etc) and their care plans updated accordingly by the MDS nurse.</p>	

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: DIB111

Facility ID: 100122

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 15 Disease (COPD), Depression, Chronic Ischemic Heart Disease, Atrial Fibrillation, and Acute Pancreatitis. Resident #4 was readmitted to the facility from a hospital on May 5, 2011, with a diagnosis of Acute Pancreatitis. A review of the admission comprehensive Minimum Data Set (MDS) assessment completed on April 1, 2011, revealed the facility assessed resident #4 to require limited assistance of one staff person for bed mobility, transfers, ambulation, personal hygiene, and toileting. The resident was assessed to require extensive assistance of one staff person for bathing and to be continent of bowel and bladder function. On April 1, 2011, the comprehensive care plan reflected that resident #4 required the limited assistance of staff with bed mobility, transfer, ambulation, dressing, toileting, personal hygiene, and bathing. The resident also required supervision with eating. The resident was assessed to be continent of bowel and bladder and the facility would monitor for changes in the resident's elimination status. On April 27, 2011, the resident's care plan was updated and revealed the resident required the assistance of two staff persons for transfers. A 14-day Medicare MDS assessment completed on May 19, 2011, revealed the resident had experienced a decline in a minimum of seven areas of activities of daily living. The resident was assessed to require extensive assistance of staff for bed mobility, transfers, dressing, personal hygiene, and toileting, and to be nonambulatory. The assessment further revealed resident #4 required the total assistance of staff for eating and bathing needs and was frequently incontinent of bowel and bladder function. There was no evidence facility staff	F 280	Monitoring of Corrective Action: The ADM/DON will audit 20% of resident's care plans weekly to ensure they are specific to each resident's needs weekly for 3 months, then bi-weekly for 3 months, then monthly for 3 months. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed. Completion Date: 7/19/11.	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41853		
(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 280	<p>Continued From page 16</p> <p>updated the resident's comprehensive care plan to reflect these changes in ADL function and elimination status.</p> <p>Resident #4 was observed on June 14, 2011, at 1:15 p.m., at 2:40 p.m., and at 4:00 p.m., to be sitting in a reclined ger-chair. On June 15, 2011, at 12:05 p.m., resident #4 was observed in the facility dining room seated in a reclined geri-chair. Facility staff was observed to spoon feed resident #4 during the lunch meal.</p> <p>An Interview conducted with the DON on June 15, 2011, at 4:00 p.m., revealed the DON was responsible for the revision and updating of the care plans for this resident in May 2011. The DON stated the ADLs were discussed daily during the morning meetings with the IDT to evaluate for changes in the residents' ADL status. The DON stated the facility had not identified the significant changes in resident #4's ADLs and had not reviewed/updated the resident's plan of care. The DON further stated the ADON was responsible for conducting an assessment when a change in bowel and bladder function occurred.</p> <p>An interview conducted with the ADON on June 15, 2011, at 4:55 p.m., revealed the ADON had conducted a bowel and bladder assessment after resident #4 was readmitted from the hospital; however, the ADON stated the resident's care plan had not been reviewed and revised to reflect the decline in elimination.</p> <p>Interview with CNA #1 on June 16, 2011, at 10:30 a.m., revealed the CNAs were responsible to utilize the CNA care plan for guidance to provide direct care for the resident. Although the CNA</p>	F 280			

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 280	Continued From page 17 care plan had not been reviewed and revised, CNA #1 stated the increased care needs for resident #4 had been communicated to the GNAs by the staff nurses.	F 280		
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, record review, and interview, the facility failed to follow physician's orders for one of sixteen sampled residents. Resident #1 had physician's orders for extra meat to be served with meals; however, on June 14, 2011, at the evening meal the resident received a standard-sized portion of meat. The findings include: A review of the medical record revealed resident #1 was admitted to the facility February 12, 2008, with diagnosis that included Alzheimer's Disease, Hypertension, Schizophrenia, Depression, Bladder Neoplasm, Dysphagia, and Chronic Obstructive Pulmonary Disease. A comprehensive Minimum Data Set (MDS) assessment dated November 2, 2010, revealed the facility assessed resident #1 to be at risk for altered nutrition related to chewing/swallowing problems as well as the resident's disease process. Further review of the medical record revealed on March 24, 2011, resident #1's physician ordered a pureed, no-added-salt diet with extra meat servings for each meal the	F 281	F 281 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS Corrective Action for Resident(s) Affected: Administrator inserviced dietary staff on 6/15/11 regarding following physician orders of prescribed diet. How The Facility Will Protect Residents in Similar Situation: Residents with extra meat portions were identified on 6/15/11 by the dietary manager and monitored to ensure residents were receiving prescribed diets including extra meat portions.	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	RS COMPLETION DATE
F 281	Continued From page 18 resident was served at the facility. Observations of the evening meal on June 14, 2011, at 6:10 p.m., revealed staff served resident #1 a pureed seafood patty, pureed vegetables, pureed potatoes, and a pureed brownie. The pureed seafood patty was a single portion with no extra portion observed. An interview with the Certified Nursing Assistant (CNA) on June 14, 2011, at 6:20 p.m., revealed the CNA was supposed to check the tray card to ensure accuracy. The CNA stated the seafood patty did not appear to have an extra portion added to it. An interview with the dietary employee on June 14, 2011, at 6:25 p.m., who had prepared resident #1's tray, revealed the dietary employee had overlooked the notation on the resident's tray card regarding the extra serving of meat. The dietary employee stated, "I guess I just had too many irons in the fire and overlooked it." The dietary employee further stated, "We were short-staffed."	F 281	Measures to Prevent Reoccurrence: Dietary manager reviewed all residents' diet orders to identify residents' that were ordered to have extra meat portions. Nursing staff, including RN's or LPN's are to check tray accuracy on these residents prior to tray leaving kitchen at every meal. Monitoring of Corrective Action: Dietary manager will audit diet and tray accuracy on residents with extra meat portions weekly for 3 months, then bi-weekly for 3 months, then monthly for 3 months. Dietician will audit 20% sample weekly for tray accuracy. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed.	
F 314 SS=G	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	Completion Date: 7/19/11 F 314 483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and a review of facility policy, it was determined the facility failed to provide the necessary treatment and services to prevent new pressure sores from developing for two of sixteen sampled residents (#3 and #7). The facility failed to ensure policies related to Skin Management and Prevention, Pressure Sore Management, and Measures for Preventing Pressure Sores were implemented to prevent pressure sore management. The facility identified residents #3 and #7 as at risk for pressure sores. The facility failed to identify the development of pressure sores for residents #3 and #7. On June 16, 2011, residents #3 and #7 were identified as having unidentified pressure sores. Staff interviews revealed resident #3 was noncompliant with repositioning while sitting and was resistant with incontinence care. Resident #3 was observed sitting up in a wheelchair for extensive periods of time on June 14, 2011, June 15, 2011, and June 16, 2011. There was no evidence the facility had assessed the resident's noncompliance as a risk factor for the development of pressure sores. Additionally, interview revealed staff failed to provide incontinence care for resident #3 during two scheduled shifts as required by the comprehensive plan of care. On June 15, 2011, resident #3 was observed to have a new open area to the coccyx, which had not been identified by staff. In addition, resident #7, who was identified to be at risk for the development of pressure sores, was observed to have two unidentified open areas to the left buttock.	F 314	Corrective Action For Resident(s) Affected: A complete, full body skin assessment was completed on residents #3 and #7 and all areas noted were documented in the each resident's medical record and addressed in the residents' care plan on 6/15/11. Physician and family notified on 6/15/11 by DON. How the Facility Will Protect Residents in Similar Situations: A complete full body skin assessment was completed on every resident in the facility on 6/15/11 by the ADON and MDS nurse. All skin issues were addressed in the resident's medical record and care plan. Physician(s) and families were notified on 6/15/11.		

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 20 The findings include:</p> <p>A review of the facility's policy Skin Management and Prevention (no date noted) revealed staff would complete total body skin observations on resident shower/bath days, and notify the resident's physician and family of new skin conditions. In addition, review of the facility's policy Pressure Sore Management (dated December 2010) revealed staff was to develop an effective care plan consistent with the resident's goals and wishes. The policy stated staff was to implement a program to prevent additional new areas from developing which included weekly skin assessments, the utilization of pressure-relieving devices for residents identified at risk for the development of pressure sores, reposition residents identified at risk every two hours while seated in the chair, cleanse the resident's skin after every incontinence episode, and apply an ointment-based product to protect the skin. The policy further required staff to complete a Braden Scale pressure risk assessment for each resident upon admission, quarterly, and as needed. The policy stated the presence of one pressure sore would indicate the resident was at risk for developing additional sores, and staff was to implement a program to prevent additional new areas from occurring. Review of the facility policy entitled Measures for Preventing Pressure Sores (dated December 2003) revealed pressure sores were unavoidable if the facility properly assessed, care planned, implemented the care plan, evaluated the resident outcome, and revised the care plan as needed.</p> <p>1. Resident #3 was admitted to the facility on</p>	F 314	<p>Measures To Prevent Reoccurrence:</p> <p>Nurse Aides were inserviced on 6/17/11 by DON/ADON to check entire skin daily, document all areas noted, and report new areas to the nurse immediately. Nurses were inserviced on 6/17/11 on proper skin assessments as well as proper documenting of all skin areas. Nurse Aides who failed to report new areas on residents #3 and #7 received disciplinary action. A head to toe skin assessment competency was implemented for all nursing/CNA staff. New employees will receive this competency as a part of the orientation process. Education will be ongoing regarding documenting, reporting, and observing skin issues over the next three months.</p> <p>Monitoring of Corrective Action:</p> <p>DON/ADON will audit 20% of nurses' skin assessments and compare to each resident's skin weekly for 3 months, then bi-weekly for 3 months, then monthly for 3 months. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p>Completion Date: 7/19/11.</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 1B5304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	<p>Continued From page 21</p> <p>December 6, 2010. The Comprehensive Minimum Data Set (MDS) assessment dated December 14, 2010, revealed the resident was frequently incontinent of bowel and bladder, and required one staff person for physical assistance with transfers, bed mobility, toilet use, and personal hygiene. A review of the Pressure Sore Care Area Assessment Summary (CAAS) dated December 14, 2010, revealed resident #3 was identified as high risk for the development of pressure ulcers due to incontinence and impaired mobility. Record review revealed the last Braden Scale Risk Assessment was completed on February 24, 2011, with the resident's score documented as 18, indicating the resident was at risk for pressure sore development. The quarterly Minimum Data Set (MDS) assessment dated May 27, 2011, revealed resident #3 had a Stage II pressure ulcer to the coccyx.</p> <p>A review of resident #3's current comprehensive care plan with a review date of February 24, 2011, revealed the facility had identified that resident #3 was at risk for the development of pressure sores due to immobility and incontinence. Interventions to prevent the development of pressure sores for this resident included incontinence care after each incontinence episode, completion of the Braden Scale Risk Assessment quarterly, turning/repositioning the resident every two hours, and to conduct weekly skin assessments and report changes in the skin assessment to the nurse and physician. However, there was no evidence the Braden Scale Risk Assessment had been conducted when the quarterly MDS assessment was completed on May 27, 2011.</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	ID COMPLETION DATE
F 314	<p>Continued From page 22</p> <p>Observations on June 14, 2011, at 3:00 p.m. and 4:00 p.m., revealed resident #3 was seated in a wheelchair, was not assisted by staff with repositioning, and no incontinence care was observed to be provided. On June 15, 2011, at 8:45 a.m., 10:40 a.m., 12:00 p.m., 2:50 p.m., and 3:50 p.m., the resident was again observed seated in a wheelchair without being repositioned by staff and no incontinence care was observed to be provided.</p> <p>Interview on June 15, 2011, at 4:20 p.m., with CNA #1 revealed the CNA was assigned to provide care for resident #3 and was aware incontinence care was to be provided for resident #3 every two hours per the CNA care plan. However, the CNA stated she had not provided resident #3 with perineal care since reporting to work at 6:00 a.m., and as a result had not identified the open area to the resident's coccyx. CNA #1 stated resident #3 was incontinent at times, wore incontinence briefs, had a long-term history of noncompliance with incontinence care, and the CNA had not assessed the resident during her shift to ensure the resident was clean and dry. CNA #1 stated resident #3 had remained seated in a wheelchair since 6:00 a.m. on June 15, 2011, and had refused to go back to bed. CNA #1 stated resident #3, "sits up in the wheelchair every day, and refuses to change positions." The CNA failed to report the resident's noncompliance with care to the nurse.</p> <p>A review of a "total body skin observation" completed by CNA #6 on June 15, 2011, during the shower provided for resident #3, revealed no new open areas were identified in the resident's skin. Interview on June 15, 2011, at 4:10 p.m.,</p>	F 314		

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
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F 314	<p>Continued From page 23</p> <p>with CNA #6 revealed she had bathed resident #3 and had completed a "total body skin observation" of the resident; however, the CNA did not identify the open area to the resident's coccyx.</p> <p>Observation of a skin assessment completed by LPN #1 on June 15, 2011, at 2:40 p.m., after the shower was provided for resident #3, revealed an unidentified open area to the resident's coccyx. LPN #1 measured the new open area during the skin assessment and the pressure sore was identified to measure 0.5 cm by 0.5 cm. The open area was red in color and no drainage was observed. Interview with LPN #1 revealed the newly identified open area to resident #3's coccyx had not been reported. The LPN stated resident #3 had just returned from the shower and staff should have completed a "total body skin observation" of the resident at that time.</p> <p>Interview on June 15, 2011, at 4:10 p.m., with CNA #6 revealed the CNA had just bathed resident #3 and had completed a total body skin observation; however, the CNA did not identify the new open area to the resident's coccyx area.</p> <p>On June 16, 2011, at 8:35 a.m., 9:30 a.m., 10:40 a.m., 11:35 a.m., 1:00 p.m., 2:35 p.m., and 3:45 p.m., resident #3 was again observed seated in a wheelchair, was not assisted by staff with repositioning, and no incontinence care was observed to be provided. Interviews with CNA #3 and CNA #4 on June 16, 2011, at 5:30 p.m., revealed the CNAs had been assigned to care for resident #3 on the 6:00 p.m. to 6:00 a.m. shift beginning on June 14, 2011. CNA #4 stated resident #3 had "accidents" at times, often</p>	F 314		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 314	<p>Continued From page 24</p> <p>refused incontinence care, and the resident would frequently change his/her own brief without requesting staff assistance. CNA #4 stated the CNA had not provided perineal care to the resident during the entire shift on June 14-15, 2011, and therefore had not noted the new open area to resident #3's coccyx. CNA #3 stated resident #3 was incontinent at times, would change his/her own wet incontinence briefs, and refused staff assistance to remove wet briefs. CNA #4 had not provided incontinence care for resident #3 during the shift.</p> <p>Interview with the Director of Nursing (DON) on June 16, 2011, at 5:40 p.m., revealed resident #3 should receive incontinence care after each incontinence episode. The DON was not aware staff failed to provide the incontinence care. The DON was aware that resident #3 did sit in a wheelchair for long periods of time and refused to go back to bed. However, no care plan interventions had been developed/implemented regarding the resident's noncompliance with care. The DON was not aware resident #3 had developed a new open area until the area was identified by the surveyor on June 15, 2011. The DON also stated resident #3 should have been assessed using the Braden Scale for Pressure Sore Risk, during the completion of the May 2011 quarterly MDS assessment.</p> <p>2. Resident #7 was admitted to the facility on January 19, 2011, with diagnoses of Gastrostomy Tube Placement, Senile Dementia, Urinary Retention, Foley Catheter Placement, and Diabetes. A review of the Comprehensive Minimum Data Set (MDS) dated January 27, 2011, and the CAAS dated January 26, 2011,</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41657		
(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 314	<p>Continued From page 25</p> <p>revealed the facility assessed the resident as having an indwelling urinary catheter, bowel incontinence, and to be at high risk for the development of pressure sores. The assessment revealed resident #7 required extensive assistance from staff with bed mobility, toilet use, and bathing. A review of the CAAS revealed the care team would care plan and focus on assuring signs and symptoms of skin breakdown would be recognized and treated promptly.</p> <p>Review of resident #7's comprehensive care plan dated April 13, 2011, revealed the resident was at risk for the development of pressure ulcers due to immobility and incontinence. Staff was required to complete a weekly skin assessment, provide incontinence care after each incontinence episode, inspect the resident's skin during bathing, and notify the physician of any changes in the resident's skin condition. Review of the most recent skin assessment completed on June 13, 2011, revealed there were no open areas to the resident's skin.</p> <p>Observation during a skin assessment performed by LPN #1 on June 15, 2011, at 3:55 p.m., revealed resident #7 had two open areas to the resident's left buttock that were red in color with no drainage noted. The LPN was observed to measure the open areas and measurements revealed one open area was 1 cm by 1 cm with the other open area measuring 0.5 cm by 0.5 cm. Interview with LPN #1 during the skin assessment revealed these open areas had not been identified by facility staff.</p> <p>Interview with CNA #1 on June 15, 2011, at 4:20 p.m., revealed she was assigned to provide care</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 26 for resident #7 on the 6:00 a.m. to 6:00 p.m. shift on June 15, 2011. However, the CNA had not looked at the resident's "bottom" during the shift and had not identified the open area to the resident's buttock. Interview with CNA #2 on June 15, 2011, at 4:25 p.m., revealed she had identified redness to resident #7's buttock the last day she worked (unable to remember when), and did not report the redness to anyone. Interview with the DON on June 16, 2011, at 5:40 p.m., revealed the DON was unaware resident #7 had two open areas to the buttocks.	F 314		
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 facility policy review, it was determined the facility failed to ensure foods were stored and labeled under sanitary conditions. Multiple food items were observed to be stored in the stand-up refrigerator that exceeded the recommended "use by" dates.	F 371	F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY Corrective Action For Resident(s) Affected: The following food items were disposed of: -Two bowls of vanilla pudding, dated June 9, 2011 -A Styrofoam drink cup containing a liquid substance with no date or label.	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	<p>Continued From page 27</p> <p>The findings include:</p> <p>A review of the Storage of Food policy/procedure (dated October 2009) revealed all perishable items were required to be covered, labeled, and dated. The policy further stated all food items were to be dated when received and all dry, refrigerated, and frozen items were to be rotated using the "first in, first out" method. The policy related to Food Storage in Refrigerators (dated October 2009) revealed milk would be dated when opened and prepared foods/liquids would be labeled, dated, and stored in the refrigerator no longer than 48 to 72 hours.</p> <p>Observations conducted during the initial tour of the kitchen on June 14, 2011, at 12:45 p.m., revealed the following items were stored and available for use in the stand-up refrigerator with labels/dates which exceeded the supplier's and/or facility's recommended "use by" dates:</p> <ul style="list-style-type: none"> -Two bowls of vanilla pudding, dated June 9, 2011. -A Styrofoam drink cup containing a liquid substance with no date or label. -One box of tomatoes with molded areas, dated May 26, 2011. -Seven heads of lettuce with wilted, brown edges, dated May 26, 2011. -One package of sliced ham lying on a metal sheet pan with a light brown liquid partially covering the ham. The package was dated with a "best by" date of May 20, 2011. -Ten cans of biscuits with a "best by" date of June 12, 2011. -One box of cherry tomatoes, dated May 26, 2011. 	F 371	<ul style="list-style-type: none"> -One box of tomatoes with molded areas, dated May 26, 2011. -Seven heads of lettuce with wilted, brown edges, dated May 26, 2011. -One package of sliced ham lying on a metal sheet pan with a light brown liquid partially covering the ham. The package was dated with a "best by" date of May 20, 2011. -Ten cans of biscuits with a "best by" date of June 12, 2011. -One box of cherry tomatoes, dated May 26, 2011. -Four mini ears of corn, dated June 9, 2011. -One partially filled gallon jug of whole milk with an expiration date of June 12, 2011. -One bowl of prepared bologna salad, date June 9, 2011. <p>How the Facility Will Act to Protect Residents in Similar Situations:</p> <p>All food refrigerators and storage units were checked for expired foods/liquids, unlabeled foods/liquids, foods/liquids without dates, and food/liquids for past "best by" dates by the ADM on 6/14/11. All above identified food/liquid were disposed of on 6/14/11</p>	

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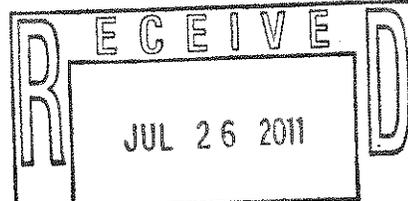
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 28 -Four mini ears of corn, dated June 9, 2011. -One partially filled gallon jug of whole milk with an expiration date of June 12, 2011. -One bowl of prepared bologna salad, dated June 9, 2011. An interview conducted with the Dietary Aide (DA) on June 14, 2011, at 12:50 a.m., revealed all dietary staff was responsible to check the refrigerator daily for expired food/drink items. The DA stated she and the other DA had returned to work on June 14, 2011, after being off on leave and had not checked the refrigerator since reporting to work. The DA stated food/drink items should not be stored or available for use after the recommended "best by" dates. An interview conducted with the Dietary Manager (DM) on June 15, 2011, at 3:45 p.m., revealed the Dietary Aides were responsible to check the refrigerator daily for expired or outdated food and drink items. The DM stated she also checked the refrigerator daily but had not checked the foods in the refrigerator on June 15, 2011, and had not discarded foods that were expired or out of date.	F 371	Measures to Prevent Reoccurrence: The administrator inserviced the dietary department on 6/14/11 regarding the food storage policy and the importance of checking the storage areas daily. All food refrigerators and storage units will be inspected daily by the dietary aide for expired foods/liquids, unlabeled and undated foods/liquids, and expired "best by" dates and will be disposed of accordingly. The dietary manger will be responsible to ensure that the dietary aides are checking the storage areas. Monitoring of Corrective Action: The Dietician will audit the storage areas for expired food weekly for 3 months, bi-weekly for 3 months, then monthly. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed. Completion date: 7/19/11.	
F 455 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to provide services to maintain a sanitary	F 465	F 465 483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT	

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NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653	
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F 465	<p>Continued From page 29</p> <p>environment. Two medication carts and the medication refrigerator were observed to be soiled during the observations of the Medication Room.</p> <p>The findings include:</p> <p>During the environmental tour on June 16, 2011, at 1:30 p.m., two medication carts were observed to be soiled with pill residue and dried sticky substance. In addition, the medication refrigerator was soiled with dried residue.</p> <p>An interview with Licensed Practical Nurse (LPN) #2 on Thursday, June 16, 2011, at 1:30 p.m., revealed the medication carts were supposed to have been cleaned on "Tuesday," but "apparently" the carts had not been cleaned.</p> <p>An interview with Registered Nurse (RN) #1 at 1:30 p.m. on June 16, 2011, revealed staff had not been given assignments to ensure the refrigerator was cleaned.</p> <p>An interview with the facility's Administrator on June 16, 2011, at 1:30 p.m., revealed it was the responsibility of the night shift staff to clean the medication carts. However, according to the Administrator, the facility did not have a "schedule" for facility staff to clean the refrigerator.</p>	F 465	<p>Corrective Action for Resident(s) Affected:</p> <p>Medication carts (3), prominent cart, and medication room refrigerators(3) were properly cleaned and disinfected on 6/16/11 by the medication nurses.</p> <p>How the Facility Will Protect Residents in Similar Situations:</p> <p>Medication room and contents was inspected and disinfected on 6/16/11 by the ADON.</p> <p>Measures To Prevent Recurrence:</p> <p>Nursing staff was inserviced on 6/17/11 by the DON/ADON on proper cleaning of medication room, carts and refrigerators as well as when carts/refrigerators are to be cleaned. Cleaning schedule checklist was implemented to assist nursing staff when to clean carts/refrigerators.</p> <p>Monitoring of Corrective Action:</p> <p>DON/ADON will audit medication and treatment carts as well as refrigerators weekly to ensure proper and timely cleaning/disinfecting of carts/refrigerators. Any concerns will be addressed immediately. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p>Completion Date: 7/19/11</p>	



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"A" FORM

STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNPs AND NPs	PROVIDER # 185304	Division of Health Care Southwest Enforcement Branch	DATE SURVEY COMPLETE 6/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY		

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F160	<p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to convey the resident's funds, and a final accounting of those funds, to the individual or probate responsible for the resident's estate within thirty days of death for two of sixteen sampled residents. Resident #14 expired on February 19, 2011, and the facility did not convey resident funds until March 29, 2011. Resident #15 expired on February 20, 2011, and the facility did not convey resident funds until March 29, 2011.</p> <p>The findings include:</p> <p>A review of the financial record for resident #14 revealed resident #14 expired on February 19, 2011, and the facility did not convey resident funds or close the resident's account until March 29, 2011.</p> <p>A review of the financial record for resident #15 revealed resident #15 expired on February 20, 2011, and the facility did not convey resident funds until March 29, 2011.</p> <p>An interview conducted with the Facility Accountant on June 15, 2011, at 3:05 p.m., revealed the Accountant had not closed the account for resident #14 because the resident's family was moving to a new address. Further interview with the Accountant revealed resident #15's account was not closed because the Accountant had overlooked the account and had not closed the account within the required 30 days after the resident was deceased.</p> <p>Corrective Action for Resident(s) Affected: Funds were remitted to the family on March 29, 2011. HR was instructed on proper policy of resident's funds.</p> <p>How the Facility will Protect other Residents in Similar Situations: All discharges/deaths of the last 30 days were reviewed on 6/16/11 by the ADM/HR(accountant) to determine any concerns. No concerns were identified.</p> <p>Measures to Prevent Recurrence: Administrator educated HR(accountant) regarding the policy on resident's funds.</p> <p>Monitoring of Corrective Action: All discharges/deaths will be discussed daily in morning meeting with the Administrator and HR(accountant) to identify a timeframe to distribute funds within the 30 days of discharge/death. Administrator will keep list of discharges/deaths dates and audit 15 days from discharge/death for closing of resident's funds. Results of the audit will be discussed in QA meeting to determine effectiveness and to determine if further education and/or interventions are needed.</p> <p>Completion Date: 7/19/11 <i>Lynn [Signature] ADM 7-19-11</i></p>

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 disolvable 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 disolvable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of

The above-cited deficiencies pose no actual harm to the residents

02/090

Event ID: DIB111

If continuation sheet 1 of 1

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

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185304	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/16/2011
NAME OF PROVIDER OR SUPPLIER PRESTONSBURG HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 147 NORTH HIGHLAND AVENUE PRESTONSBURG, KY 41653		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS A life safety code survey was initiated and concluded on June 16, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70(a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE	

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