

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

PRINTED: 05/16/2013
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2013
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NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210
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F 000	INITIAL COMMENTS A recertification survey was conducted 04/30/13 through 05/02/13 to determine the facility's compliance with Federal requirements. The facility failed to meet the minimum requirements for recertification with the highest scope and severity of an "F".	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.	
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, record review, and review of the facility's policy/procedure, it was determined the facility failed to identify and appropriately assess a physical restraint for one resident (#1), in the sample selection of fifteen (15) residents. Findings include: A review of the Restrictive Device Management Program, revised 11/10, revealed a physical restraint was defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy revealed the licensed nurse would complete the device evaluation to determine the medical necessity for	F 221	F 221 Right to be Free From Physical Restraints The Licensed nurse completed a restraint assessment for resident #1 on 05/03/2013 to identify the device was a physical restraint and no adverse effects were identified. Current residents with assistive devices were reviewed by a licensed nurse utilizing the restrictive device evaluation on 5/10/13. No other physical restraints were identified. Director of Nursing Services re-educated licensed nurses on the restrictive device management program to include the difference	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Carolyn Lawrence TITLE: Administrator (X6) DATE: 05242013

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 221	<p>Continued From page 1</p> <p>the device. The next step was to determine if the device was an assistive device and would be used as an enabler, reminder, or would be restrictive. Evaluating was an extremely important step, because once residents device needs were identified, appropriate interventions would be implemented.</p> <p>An observation, on 05/02/13 at 10:00 AM, revealed Resident #1 made attempts to lean over in the wheelchair; however, the resident's shoulder harness restricted the movement. When the harness was removed, the resident was able to lean forward and back in the wheelchair per self. The resident did not have good control of his/her upper body. The resident was transferred to the bed, where he/she was able to sit up per self and crawl on the mattress; however, the resident did not have good control of his/her upper body.</p> <p>A record review revealed Resident #1 was admitted to the facility on 11/09/11 with diagnoses to include Infantile Cerebral Palsy, Epilepsy, and Unspecified Intellectual Disabilities.</p> <p>A review of the Device Evaluation, dated 01/28/13, revealed the harness was to prevent the resident from leaning forward and falling from the wheelchair. The evaluation did not include the seat belt, and did not indicate the harness was a restrictive device.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/01/13, revealed the facility assessed the resident as severely cognitively impaired and had no restraints.</p>	F 221	<p>between restrictive and assistive devices for positioning on 5/09/13.</p> <p>Director of Nursing Services, Assistant Director of Nursing Services or charge nurse will complete three chart audits a week times four weeks and then three chart audits a month times two months to ensure residents have been identified and appropriately assessed for physical restraints. Director of Nursing Services or Assistant Director of Nursing Services will report results to the Performance Improvement Committee monthly for three months for further recommendations.</p> <p>Completion date:</p>	05/30/13	

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F 221	Continued From page 2 A review of the Physician's Orders, dated May 2013, revealed an order for a shoulder harness for upper body positioning and seat belt for trunk stabilizing. Release every two hours for 10-15 minutes and as needed. An interview with the interim Assistant Director of Nursing (ADON), on 05/02/13 at 2:10 PM, revealed she completed the device evaluation for Resident #1. She revealed the purpose of the harness was to prevent the resident from falling forward. She revealed the harness "probably" should have been assessed as a restrictive device. She revealed a restraint would be anything a resident could not get out of without assistance. An interview with the Interim Director of Nursing (DON), on 05/02/13 at 2:30 PM, revealed if Resident #1 did not have the harness, he/she would fall out of the wheelchair. She revealed the resident does not attempt to get out of the wheelchair; therefore, it was not considered a restraint. She did not agree the device restricted the resident's movement.	F 221			
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure effective housekeeping and maintenance services	F 253	F 253 Housekeeping and Maintenance Services Maintenance Director replaced the caulk at the base of commodes in rooms #304, #307 and #308 on 5/24/13. Room #205 had cracked plaster near baseboard in bathroom repaired and painted by Maintenance Director on 5/24/13.		

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F 253	<p>Continued From page 3</p> <p>necessary to maintain a sanitary and orderly environment related to cracked plaster on the walls, excessive caulking around the toilet bases that was stained and dark colored, and torn wallpaper in resident's rooms.</p> <p>Findings include:</p> <p>An interview with the Maintenance Supervisor, on 05/02/13 at 2:25 PM, revealed there was no specific policy for maintenance of the resident rooms but the process was that the staff, who identified a concern, were to fill out a maintenance request form and place in the box, located on each unit. The Maintenance Supervisor stated he checks for correspondence each day.</p> <p>An observation with the Maintenance Supervisor of resident rooms, on 05/01/13 at 2:25 PM, revealed:</p> <p>A. On the 300 Wing, toilets were observed with raised, excess caulk around the toilet bases that was brown and orange in color and malodorous, in Rooms #304, #307 and #308;</p> <p>B. On the 200 Wing, Rooms #205 had cracked plaster near the wall baseboard of the bathroom and Room #206 had peeling wallpaper border all along the ceiling;</p> <p>C. On the 500 Wing, Room #501 had an area of cracked plaster on the bathroom wall.</p> <p>D. In the East/West shower room, curtain brackets were missing for the privacy curtain, causing the curtain to drag on the floor.</p>	F 253	<p>Room #206 had wallpaper boarder re-glued along the ceiling and room #501 had cracked plaster on wall in bathroom repaired and painted by Maintenance Director on 5/24/13. The missing curtain brackets on the privacy curtains in East/West shower rooms were replaced by Maintenance Director on 5/24/13.</p> <p>Maintenance Director and resident Ambassadors completed review of facility on 5/24/13 for housekeeping and maintenance services needed to maintain a sanitary, orderly and comfortable environment utilizing the environmental standard overall tool. Areas identified were addressed by housekeeping or Maintenance Director on 5/24/13.</p> <p>Maintenance Director was re-educated by Regional Project Manager on environmental rounds to be conducted monthly utilizing a rounding tool on 5/06/13. Staff were re-educated by Administrator on housekeeping and maintenance services needed to maintain a sanitary, orderly and comfortable environment to include completing work orders for repairs as necessary on 5/09/13.</p> <p>Maintenance Director and resident Ambassadors will conduct environmental audits weekly times</p>	
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F 253	Continued From page 4 An interview with the Maintenance Supervisor, on 05/02/13 at 3:00 PM, revealed he was unaware of the problems and there was no designated time for a routine walk through of the rooms to assess for any maintenance concerns. The Maintenance Supervisor stated the staff were usually good about letting him know when something needs attention.	F 253	four weeks and monthly times two months to ensure a sanitary, orderly and comfortable environment. The Maintenance Director will report results monthly for three months to the Performance Improvement Committee for further recommendations.		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment and services to prevent urinary tract infections for two residents (#8, #2), in the selected sample of fifteen (15) residents. Findings include: A review of the Personal Hygiene and Bed Making policy/procedure, undated, revealed to wash the labia majora. Use nondominant hand to	F 315	Completion Date: F 315 No Catheter, Prevent UTI, Restore Bladder Resident #2 and #8 were provided peri care and catheter care per protocol by a licensed nurse on 5/03/13. A Licensed nurse assessed resident #2 and #8 for signs and symptoms of UTI using the McGreer's criteria on 5/03/13, no signs of UTI were noted. Nurse Aide # 3 and # 5 was re-educated by Director of Nursing Services on 5/03/13 on peri-care/catheter care. Licensed Nurses assessed current residents with incontinence and indwelling catheters utilizing the McGreer's criteria for signs and	05/30/2013	

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F 315	<p>Continued From page 5</p> <p>gently retract labia from thigh; with dominant hand, wash carefully in skinfolds. Wipe in the direction from perineum to rectum. Repeat on opposite side using a separate section of washcloth.</p> <p>1. An observation of incontinent care for Resident #8, on 05/01/13 at 9:45 AM, revealed State Registered Nurse Aide (SRNA) #3 obtained a basin of warm water with several washcloths. She rinsed one washcloth in the water and applied a foaming cleanser to cleanse the resident's perineal area. She rinsed the washcloth in the water basin and used the same washcloth to cleanse the perineal area for a second time. Then she rinsed the same washcloth in the soiled water basin and used it to rinse the resident's perineal area for a third time. A new washcloth was obtained, rinsed in the soiled water basin, and used to cleanse the resident's buttocks.</p> <p>An interview with SRNA #3, on 05/01/13 at 10:00 AM, revealed she was supposed to use a new washcloth after each use. She revealed she should have changed the water in the basin when soiled.</p> <p>An interview with the Interim Director of Nursing (DON), on 05/02/13 at 10:30 AM, revealed staff should not use the same washcloth to complete perineal care. After used, a new washcloth should be obtained. Clean washcloths should not be rinsed in soiled water, she expected staff to change the water after it was soiled.</p> <p>2. An observation of urinary catheter care for</p>	F 315	<p>symptoms of urinary tract infection (UTI) on 5/23/13. No UTI's were noted</p> <p>Licensed nurses and CNA's were re-educated and competency testing provided on 05/09/13 by the Staff Development Coordinator and Director of Nursing Services to include appropriate procedures on perineal/incontinent care, and catheter care.</p> <p>The Director of Nursing, Assistant Director of Nursing or Charge Nurse will observe five residents per week for one month and three residents per week for one month then five per month for one month that are incontinent of bladder or have an indwelling catheter receive appropriate treatment and services to prevent urinary tract infections. The Director of Nursing will report the findings to the Performance Improvement Committee for three months, for further recommendations.</p> <p>Completion Date:</p>	05/30/2013	

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F 315	<p>Continued From page 6</p> <p>Resident #2, on 05/01/13 at 10:25 AM, revealed State Registered Nurse Aide (SRNA) #5 obtained a basin of warm water and several washcloths. She wet one washcloth and applied peri wash and proceeded to clean around the suprapubic catheter area. She then laid the soiled washcloth on the bedside table because she failed to gather the supplies such as plastic bags needed to successfully complete catheter care. She then proceeded to wet another washcloth to rinse the area and laid that washcloth on top of the other washcloth already on the bedside table. Then she took the first soiled washcloth from underneath the second soiled washcloth on the bedside table and proceeded to clean the anal area and laid the soiled washcloth on the bedside table again.</p> <p>An interview with SRNA #5, on 05/01/13 at 10:40 AM, revealed she would usually gather all of the supplies needed to perform catheter care including trash bags but she had been unable to track down a housekeeper to get a roll of plastic bags. She further revealed she did not have two basins of water and did not empty and change the dirty water during catheter care.</p> <p>Additionally, SRNA #5 revealed she understood the problem with laying the soiled washcloths on the bedside table and even though the resident is nothing by mouth (NPO) related to feeding tube, the nurses use the table to set up supplies for the tube feeding.</p> <p>An interview with the Director of Nursing (DON), on 05/02/13 at 2:03 PM, revealed she would expect the SRNA doing the catheter care would change out the dirty water during catheter care</p>	F 315			

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F 315	Continued From page 7 and have plastic bags to place soiled linens in. She further stated she would not expect the SRNA to lay soiled linens on a bedside table for any reason.	F 315			
F 323 SS=D	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, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate assistance devices to prevent accidents for one residents (#4), in the selected sample of fifteen (15) residents. Resident #4 had an order to drink hot beverages from a cup with a spouted lid as a safety precaution; however, observations were made of the resident drinking from a regular coffee cup. A review of the policy for Assistive Devices, dated 07/08, revealed the facility would provide assistive devices as needed to maintain or improve resident's ability to eat independently. Observations on 05/01/13 at 12:15 PM and 05/02/13 at 12:00 PM, revealed Resident #4 was in the dining room eating lunch, drinking coffee	F 323 F 323 Free of Accident Hazards/Supervision/Devices Licensed nurse provided spouted lid cup to resident #4 on 5/03/13. Licensed nurse completed skin assessment on 5/03/13, no impairments noted. Current residents were reviewed by a licensed nurse to ensure adaptive equipment to be utilized during meals was in place and current on adaptive list posted in dining room and lounge area on 5/03/13. Director of Nursing Services and Staff Development Coordinator re-educated staff on where to locate information on residents with adaptive equipment to include spouted lid cups and following tray cards on 5/09/13. Director of Nursing Services, Assistant Director of Nursing Services and Staff Development Coordinator will conduct meal audits to assure appropriate assistive devices to prevent accidents three times a week times four weeks and three times a month, times two additional months			

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F 323	<p>Continued From page 8</p> <p>from a regular coffee cup. There was no spouted lid on the cup.</p> <p>A record review revealed Resident #4 was originally admitted to the facility on 05/06/09 with diagnoses to include Senile Dementia, Impulse Control Disorder, Anxiety, and Psychosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/13, revealed the facility assessed the resident's cognition as severely impaired and was dependent with setup assistance for eating.</p> <p>A review of the Physician's Orders, dated 03/29/13, revealed an order for a spouted lid cup when drinking hot liquids to enable the resident to drink liquids independently until Occupational Therapy (OT) could evaluate. A review of the OT Evaluation, dated 04/04/13, revealed the resident was referred to their services by nursing as the resident demonstrated frequent spills related to decreased cognition. The resident was at risk to spill coffee or other hot beverages when drinking from a regular cup. The evaluation indicated for the resident to drink from a cup with a spouted lid and handle for all hot beverages to increase safety. A review of the resident's tray card, dated 05/02/13, revealed a 2 handle spout cup as adaptive equipment.</p> <p>An interview with State Registered Nurse Aide (SRNA) #4, on 05/02/13 at 1:15 PM, revealed the fluids were given to the residents in the dining room before the food trays were passed. She gave Resident #4 coffee today in the dining room for lunch; however, did not ensure the resident received a spouted lid cup. She did not know</p>	F 323	<p>Director of Nursing Services or Assistant Director of Nursing Services will report findings to the Performance Improvement Committee for the next three months for further recommendations.</p> <p>Completion Date:</p>	05/30/2013
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F 323	Continued From page 9 which residents received a special cup. An interview with the Restorative Aide, on 05/02/13 at 1:50 PM, revealed she usually passed fluids to the residents in the dining room before lunch was served. She verified she passed fluids at lunch, on 05/01/13 and 05/02/13. She revealed coffee was usually passed by her, but other staff in the dining room help as well. She revealed Resident #4 should have received a cup with a spouted lid. She verified there was a list of residents that required adaptive equipment posted inside the dining room cabinet, available for staff if needed. A review of the Physician's Order Listing (located inside the cabinet of the dining room), dated 04/02/13, revealed Resident #4 should have a cup with a spouted lid while drinking hot liquids. An interview with the Interim Director of Nursing (DON), on 05/02/13 at 2:30 PM, revealed there was a list put inside the cabinet door in the dining room, of residents with their required adaptive equipment. She expected if a staff member was unsure of what a resident needed, they should have checked the list.	F 323		
F 371 SS=E	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	F 371	F 371 Food Procure, Store/Prepare/Serve - Sanitary On 04/30/2013 Nutrition Services Aide re-heated Chopped Salisbury Steak to temperature above 135 degrees prior to serving.	

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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy, it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Observations of the kitchen revealed ground Salisbury Steak, served at a temperature of 110 degrees Fahrenheit (F.) A review of the census and condition, dated 04/30/13, revealed there were 72 residents in the building with eight of those residents being tube fed and not utilizing the kitchen facilities. Findings include: A review of the policy "Food Preparation," dated July 2008, revealed the Nutrition Services Director (NSD) and the cook were responsible for food preparation techniques, to ensure that food items are exposed to temperatures greater than 41 degrees F and or less than 135 degrees F, or per the state regulation. 1. An observation of the kitchen service area, on 04/30/13 at 11:50 AM, revealed the steamer vat to contain chopped Salisbury Steak, prepared for the noon meal. The thermometer was tested and was calibrated at 28 degrees in ice water and the temperature was tested as 110 degrees F. The meat was served on one resident's tray and set on the meal cart to be served. An interview with the NSD, on 04/30/13 at 11:55 AM, revealed the reason for serving the beef was	F 371	Audits completed on 05/01/2013 and 05/02/2013 by Nutrition Services Director to ensure all food was correct temperature. Nutrition Services Director was re-educated on F 371 to include storage, preparation, distribution, and serving food under sanitary conditions to include appropriate serving temperature by Administrator on 04/30/13. Nutrition Services Director re-educated Nutrition Services staff on storage, preparation, distribution, and serving food under sanitary conditions to include the appropriate serving temperature on 04/30/13. Nutrition Services Director will conduct three random audits weekly times three weeks and three random audits monthly for an additional two months to ensure food is being stored, prepared, distributed, and served under sanitary conditions to include appropriate temperature. Nutrition Services Director will report findings to the Performance Improvement Committee monthly times three months for further recommendations. Completion Date:	05/30/2013

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/02/2013
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F 371	Continued From page 11 that it was difficult to keep ground meat at the proper temperature due to the texture of the meat being so crumbly and stated the meat should have been at least 135 degrees F.	F 371		
F 372 SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage properly, related to lids on the dumpsters that could not be closed. Findings include: An observation of the two dumpsters, on 05/01/13 at 2:25 PM, revealed both of the dumpsters had been dented, during the trash pick up service, to where there was no way to fasten down the lids and four of the 12 lids remained open approximately 18-24 inches on both sides. An interview with the Maintenance Director, on 05/01/13 at 2:55 PM, revealed the city was responsible to maintain the containers and it was difficult to get them to fix the problem. An interview with the Administrator, on 05/01/13 at 3:00 PM, revealed she had been recently made aware of the problem and it would be fixed.	F 372	F 372 Dispose Garbage and Refuse Properly Administrator reviewed facility dumpsters on 5/04/13. Repairs needed noted. Administrator met with Mayor Jerry Meredith on 05/21/2013. An agreement was made to repair dumpsters so lids close properly on 05/21/2013. Administrator re-educated staff on the proper closing of dumpster lids and reporting inability to close to administration on 5/09/13. Dumpsters will be audited monthly by Administrator for three months to ensure they close properly. Administrator will report findings monthly to the Performance Improvement Committee for further recommendations. Completion Date:	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		05/30/2013

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F 441	<p>Continued From page 12</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 441	<p>F 441 Infection Control, Prevent Spread, Linens</p> <p>Licensed nursing staff assessed resident #4 and #8 for signs and symptoms of infection using McGreer's criteria on 5/03/13. No signs of infection noted. Nurse aide's #1, #2, and #3 were re-educated on hand hygiene to include glove usage by Director of Nursing Services on 05/03/2013.</p> <p>Current residents with incontinence and indwelling catheters were re-assessed by licensed nursing staff utilizing the McGreer's criteria to assess for UTI's related to improper hand washing and glove use on 5/23/13.</p> <p>Licensed nursing staff re-educated nurse aides and competency testing provided on hand hygiene including glove usage on 5/09/13.</p> <p>Licensed Nurses will observe nurse aides provide direct care for hand washing and glove usage to prevent the spread of infections three times a week times four weeks</p>	

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F 441	Continued From page 13 by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure staff washed their hands and changed their gloves when indicated during resident care. Findings include: A review of the Hand Hygiene policy/procedure, revised 03/01/08, revealed to remove gloves after caring for resident and decontaminate hands using an alcohol based hand rub or wash hands with antimicrobial soap and water after removing gloves. 1. An observation of incontinent care for Resident #4, on 04/30/13 at 2:50 PM, revealed State Registered Nurse Aide (SRNA) #2 provided perineal care for the resident, then obtained a urinal from the resident's drawer wearing soiled gloves. SRNA #1 and #2 changed the resident's soiled brief and cleansed the resident's buttocks. They pulled the resident's pants up and assisted the resident to the wheelchair, both wearing soiled gloves. SRNA #2 continued to make the resident's bed and obtain objects from the resident's drawer and closet, while wearing soiled gloves from incontinent care. An interview with SRNA #1 and SRNA #2, on 04/30/13 at 3:20 PM and 3:25 PM, respectively, revealed they should have removed their soiled gloves and washed their hands immediately after providing incontinent care. 2. An observation of incontinent care for Resident #8, on 05/01/13 at 9:45 AM, revealed SRNA #3	F 441	and then three times a month for two additional months. The Director of Nursing will report findings monthly times three months to the Performance Improvement Committee for further recommendations. Completion Date:	05/30/2013	

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F 441	<p>Continued From page 14</p> <p>provided incontinent care and applied barrier cream to the resident's buttocks. She removed the glove on her left hand; however, did not remove the right hand glove. She put a new brief on and repositioned the resident in bed, wearing the one soiled glove.</p> <p>An interview with SRNA #3, on 05/01/13 at 10:00 AM, revealed she should have removed both gloves after applying the barrier cream, as they were both soiled. She should have washed her hands after removing the gloves.</p> <p>An interview with the interim Director of Nursing (DON), on 05/02/13 at 10:30 AM, revealed she expected staff to change gloves and wash hands between procedures, even if on the same resident. She revealed staff should remove gloves and wash their hands before touching any other objects in the resident's room.</p>	F 441			

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N 000	INITIAL COMMENTS A re-licensure survey was conducted 04/30/13 through 05/02/13 to determine the facility's compliance with State licensure requirements. The facility failed to meet the minimum requirements for re-licensure with deficiencies cited.	N 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
N 103	902 KAR 20:300-5(1) Section 5. Resident Behavior & Fac. Practice (1) Restraints. The resident shall have the right to be free from any physical restraints imposed or psychoactive drug administered 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, record review, and review of the facility's policy/procedure, it was determined the facility failed to identify and appropriately assess a physical restraint for one resident (#1), in the sample selection of fifteen (15) residents. Findings include: A review of the Restrictive Device Management Program, revised 11/10, revealed a physical restraint was defined as any manual method or physical or mechanical device, material, or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to one's body. The policy revealed the licensed nurse would complete the device evaluation to determine the medical necessity for the device. The next step was to determine if the device was an assistive device and would be	N 103	N103 Resident Behavior and Facility Practice: Restraints The Licensed nurse completed a restraint assessment for resident #1 on 05/03/2013 to identify the device was a physical restraint and no adverse effects were identified. Current residents with assistive devices were reviewed by a licensed nurse utilizing the restrictive device evaluation on 5/10/13. No other physical restraints were identified. Director of Nursing Services re-educated licensed nurses on the restrictive device management program to include the difference between restrictive and assistive devices for positioning on 5/09/13.	

Carolyn Yancey

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE
Administrator

(X6) DATE
05242013

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N 103	Continued From page 1 used as an enabler, reminder, or would be restrictive. Evaluating was an extremely important step, because once residents device needs were identified, appropriate interventions would be implemented. An observation, on 05/02/13 at 10:00 AM, revealed Resident #1 made attempts to lean over in the wheelchair; however, the resident's shoulder harness restricted the movement. When the harness was removed, the resident was able to lean forward and back in the wheelchair per self. The resident did not have good control of his/her upper body. The resident was transferred to the bed, where he/she was able to sit up per self and crawl on the mattress; however, the resident did not have good control of his/her upper body. A record review revealed Resident #1 was admitted to the facility on 11/09/11 with diagnoses to include Infantile Cerebral Palsy, Epilepsy, and Unspecified Intellectual Disabilities. A review of the Device Evaluation, dated 01/28/13, revealed the harness was to prevent the resident from leaning forward and falling from the wheelchair. The evaluation did not include the seat belt, and did not indicate the harness was a restrictive device. A review of the quarterly Minimum Data Set (MDS) assessment, dated 02/01/13, revealed the facility assessed the resident as severely cognitively impaired and had no restraints. A review of the Physician's Orders, dated May 2013, revealed an order for a shoulder harness for upper body positioning and seat belt for trunk stabilizing. Release every two hours for 10-15	N 103	Director of Nursing Services, Assistant Director of Nursing Services or charge nurse will complete three chart audits a week times four weeks and then three chart audits a month times two months to ensure residents have been identified and appropriately assessed for physical restraints. Director of Nursing Services or Assistant Director of Nursing Services will report results to the Performance Improvement Committee monthly for three months for further recommendations. Completion date:	05/30/13

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N 103	Continued From page 2 minutes and as needed. An interview with the interim Assistant Director of Nursing (ADON), on 05/02/13 at 2:10 PM, revealed she completed the device evaluation for Resident #1. She revealed the purpose of the harness was to prevent the resident from falling forward. She revealed the harness "probably" should have been assessed as a restrictive device. She revealed a restraint would be anything a resident could not get out of without assistance. An interview with the Interlm Director of Nursing (DON), on 05/02/13 at 2:30 PM, revealed if Resident #1 did not have the harness, he/she would fall out of the wheelchair. She revealed the resident does not attempt to get out of the wheelchair; therefore, it was not considered a restraint. She did not agree the device restricted the resident's movement.	N 103		
N 134	902 KAR 20:300-6(7)(a)2. Section 6. Quality Of Life (7) Environment. (a) The facility shall provide: 2. Housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior; This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure effective housekeeping and maintenance services necessary to maintain a sanitary and orderly environment related to cracked plaster on the walls, excessive caulking around the toilet bases that was stained and dark colored, and torn	N 134	N134 Quality of Life: Environment Maintenance Director replaced the caulk at the base of commodes in rooms #304, #307 and #308 on 5/24/13. Room #205 had cracked plaster near baseboard in bathroom repaired and painted by Maintenance Director on 5/24/13. Room #206 had wallpaper boarder re-glued along the ceiling and room #501 had cracked plaster on wall in bathroom repaired and painted by Maintenance Director on 5/24/13. The missing curtain brackets on the privacy curtains in	

Office of Inspector General

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N 134	<p>Continued From page 3</p> <p>wallpaper in resident's rooms.</p> <p>Findings include:</p> <p>An interview with the Maintenance Supervisor, on 05/02/13 at 2:25 PM, revealed there was no specific policy for maintenance of the resident rooms but the process was that the staff, who identified a concern, were to fill out a maintenance request form and place in the box, located on each unit. The Maintenance Supervisor stated he checks for correspondence each day.</p> <p>An observation with the Maintenance Supervisor of resident rooms, on 05/01/13 at 2:25 PM, revealed:</p> <p>A. On the 300 Wing, toilets were observed with raised, excess caulk around the toilet bases that was brown and orange in color and malodorous, in Rooms #304, #307 and #308;</p> <p>B. On the 200 Wing, Rooms #205 had cracked plaster near the wall baseboard of the bathroom and Room #206 had peeling wallpaper border all along the ceiling;</p> <p>C. On the 500 Wing, Room #501 had an area of cracked plaster on the bathroom wall.</p> <p>D. In the East/West shower room, curtain brackets were missing for the privacy curtain, causing the curtain to drag on the floor.</p> <p>An interview with the Maintenance Supervisor, on 05/02/13 at 3:00 PM, revealed he was unaware of the problems and there was no designated time for a routine walk through of the rooms to assess for any maintenance concerns. The Maintenance</p>	N 134	<p>East/West shower rooms were replaced by Maintenance Director on 5/24/13.</p> <p>Maintenance Director and resident Ambassadors completed review of facility on 5/24/13 for housekeeping and maintenance services needed to maintain a sanitary, orderly and comfortable environment utilizing the environmental standard overall tool. Areas identified were addressed by housekeeping or Maintenance Director on 5/24/13.</p> <p>Maintenance Director was re-educated by Regional Project Manager on environmental rounds to be conducted monthly utilizing a rounding tool on 5/06/13. Staff were re-educated by Administrator on housekeeping and maintenance services needed to maintain a sanitary, orderly and comfortable environment to include completing work orders for repairs as necessary on 5/09/13.</p> <p>Maintenance Director and resident Ambassadors will conduct environmental audits weekly times four weeks and monthly times two months to ensure a sanitary, orderly and comfortable environment. The Maintenance Director will report results monthly for three months to the Performance Improvement</p>	

Office of Inspector General

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N 134	Continued From page 4 Supervisor stated the staff were usually good about letting him know when something needs attention.	N 134	Committee for further recommendations. Completion Date:	05/30/2013
N 144	902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life (7) Environment. (b) Infection control and communicable diseases. 2. The facility shall establish an infection control program which: a. Investigates, controls and prevents infections in the facility; This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure staff washed their hands and changed their gloves when indicated during resident care. Findings include: A review of the Hand Hygiene policy/procedure, revised 03/01/08, revealed to remove gloves after caring for resident and decontaminate hands using an alcohol based hand rub or wash hands with antimicrobial soap and water after removing gloves. 1. An observation of incontinent care for Resident #4, on 04/30/13 at 2:50 PM, revealed State Registered Nurse Aide (SRNA) #2 provided perineal care for the resident, then obtained a urinal from the resident's drawer wearing soiled gloves. SRNA #1 and #2 changed the resident's soiled brief and cleansed the resident's buttocks. They pulled the resident's pants up and assisted the resident to the wheelchair, both wearing	N 144	N144 Quality of Life: Environment/ Infection Control Licensed nursing staff assessed resident #4 and #8 for signs and symptoms of infection using McGreer's criteria on 5/03/13. No signs of infection noted. Nurse aide's #1, #2, and #3 were re-educated on hand hygiene to include glove usage by Director of Nursing Services on 05/03/2013. Current residents with incontinence and indwelling catheters were re-assessed by licensed nursing staff utilizing the McGreer's criteria to assess for UTI's related to improper hand washing and glove use on 5/23/13. Licensed nursing staff re-educated nurse aides and competency testing provided on hand hygiene including glove usage on 5/09/13. Licensed Nurses will observe nurse aides provide direct care for hand washing and glove usage to prevent the spread of infections three times a week times four weeks	

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N 144	Continued From page 5 soiled gloves. SRNA #2 continued to make the resident's bed and obtain objects from the resident's drawer and closet, while wearing soiled gloves from incontinent care. An interview with SRNA #1 and SRNA #2, on 04/30/13 at 3:20 PM and 3:25 PM, respectively, revealed they should have removed their soiled gloves and washed their hands immediately after providing incontinent care. 2. An observation of incontinent care for Resident #8, on 05/01/13 at 9:45 AM, revealed SRNA #3 provided Incontinent care and applied barrier cream to the resident's buttocks. She removed the glove on her left hand; however, did not remove the right hand glove. She put a new brief on and repositioned the resident in bed, wearing the one soiled glove. An interview with SRNA #3, on 05/01/13 at 10:00 AM, revealed she should have removed both gloves after applying the barrier cream, as they were both soiled. She should have washed her hands after removing the gloves. An interview with the interim Director of Nursing (DON), on 05/02/13 at 10:30 AM, revealed she expected staff to change gloves and wash hands between procedures, even if on the same resident. She revealed staff should remove gloves and wash their hands before touching any other objects in the resident's room.	N 144	and then three times a month for two additional months. The Director of Nursing will report findings monthly times three months to the Performance Improvement Committee for further recommendations. Completion Date:	05/30/2013
N 214	902 KAR 20:300-8(4)(c) Section 8. Quality of Care (4) Urinary incontinence. Based on the resident's comprehensive assessment, the facility shall ensure that:	N 214	N 214 Quality of Care: Urinary Incontinence/Catheter Care Resident #2 and #8 were provided peri care and catheter care per protocol by	

Office of Inspector General

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N 214	<p>Continued From page 6</p> <p>(c) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This requirement is not met as evidenced by: Based on observation, interview, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment and services to prevent urinary tract infections for two residents (#8, #2), in the selected sample of fifteen (15) residents.</p> <p>Findings include:</p> <p>A review of the Personal Hygiene and Bed Making policy/procedure, undated, revealed to wash the labia majora. Use nondominant hand to gently retract labia from thigh; with dominant hand, wash carefully in skinfolds. Wipe in the direction from perineum to rectum. Repeat on opposite side using a separate section of washcloth.</p> <p>1. An observation of incontinent care for Resident #8, on 05/01/13 at 9:45 AM, revealed State Registered Nurse Aide (SRNA) #3 obtained a basin of warm water with several washcloths. She rinsed one washcloth in the water and applied a foaming cleanser to cleanse the resident's perineal area. She rinsed the washcloth in the water basin and used the same washcloth to cleanse the perineal area for a second time. Then she rinsed the same washcloth in the soiled water basin and used it to rinse the resident's perineal area for a third time. A new washcloth was obtained, rinsed in the soiled water basin, and used to cleanse the resident's buttocks.</p> <p>An interview with SRNA #3, on 05/01/13 at 10:00 AM, revealed she was supposed to use a new</p>	N 214	<p>a licensed nurse on 5/03/13. A Licensed nurse assessed resident #2 and #8 for signs and symptoms of UTI using the McGreer's criteria on 5/03/13, no signs of UTI were noted. Nurse Aide # 3 and # 5 was re-educated by Director of Nursing Services on 5/03/13 on peri-care/catheter care.</p> <p>Licensed Nurses assessed current residents with incontinence and indwelling catheters utilizing the McGreer's criteria for signs and symptoms of urinary tract infection (UTI) on 5/23/13. No UTI's were noted.</p> <p>Licensed nurses and CNA's were re-educated and competency testing provided on 05/09/13 by the Staff Development Coordinator and Director of Nursing Services to include appropriate procedures on perineal/incontinent care, and catheter care.</p> <p>The Director of Nursing, Assistant Director of Nursing or Charge Nurse will observe five residents per week for one month and three residents per week for one month then five per month for one month that are incontinent of bladder or have an indwelling catheter receive appropriate treatment and services to prevent urinary tract infections. The Director</p>	

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NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
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N 214	<p>Continued From page 7</p> <p>washcloth after each use. She revealed she should have changed the water in the basin when soiled.</p> <p>An interview with the interim Director of Nursing (DON), on 05/02/13 at 10:30 AM, revealed staff should not use the same washcloth to complete perineal care. After used, a new washcloth should be obtained. Clean washcloths should not be rinsed in soiled water, she expected staff to change the water after it was soiled.</p> <p>2. An observation of urinary catheter care for Resident #2, on 05/01/13 at 10:25 AM, revealed State Registered Nurse Aide (SRNA) #5 obtained a basin of warm water and several washcloths. She wet one washcloth and applied peri wash and proceeded to clean around the suprapubic catheter area. She then laid the soiled washcloth on the bedside table because she failed to gather the supplies such as plastic bags needed to successfully complete catheter care. She then proceeded to wet another washcloth to rinse the area and laid that washcloth on top of the other washcloth already on the bedside table. Then she took the first soiled washcloth from underneath the second soiled washcloth on the bedside table and proceeded to clean the anal area and laid the soiled washcloth on the bedside table again.</p> <p>An interview with SRNA #5, on 05/01/13 at 10:40 AM, revealed she would usually gather all of the supplies needed to perform catheter care including trash bags but she had been unable to track down a housekeeper to get a roll of plastic bags. She further revealed she did not have two basins of water and did not empty and change the dirty water during catheter care.</p>	N 214	<p>of Nursing will report the findings to the Performance Improvement Committee for three months, for further recommendations.</p> <p>Completion Date:</p>	05/30/2013

Office of Inspector General

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N 214	Continued From page 8 Additionally, SRNA #5 revealed she understood the problem with laying the soiled washcloths on the bedside table and even though the resident is nothing by mouth (NPO) related to feeding tube, the nurses use the table to set up supplies for the tube feeding. An interview with the Director of Nursing (DON), on 05/02/13 at 2:03 PM, revealed she would expect the SRNA doing the catheter care would change out the dirty water during catheter care and have plastic bags to place soiled linens in. She further stated she would not expect the SRNA to lay soiled linens on a bedside table for any reason.	N 214		
N 220	902 KAR 20:300-8(7)(b) Section 8. Quality of Care (7) Accidents. The facility shall ensure that: (b) Each resident receives adequate supervision and assistive devices to prevent accidents. This requirement is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy/procedure, it was determined the facility failed to ensure each resident received adequate assistance devices to prevent accidents for one residents (#4), in the selected sample of fifteen (15) residents. Resident #4 had an order to drink hot beverages from a cup with a spouted lid as a safety precaution; however, observations were made of the resident drinking from a regular coffee cup. A review of the policy for Assistive Devices, dated	N 220	N 220 Quality of Care: Accidents Licensed nurse provided spouted lid cup to resident #4 on 5/03/13. Licensed nurse completed skin assessment on 5/03/13, no impairments noted. Current residents were reviewed by a licensed nurse to ensure adaptive equipment to be utilized during meals was in place and current on adaptive list posted in dining room and lounge area on 5/03/13. Director of Nursing Services and Staff Development Coordinator re-educated staff on where to locate information on residents with adaptive equipment to include spouted lid cups and following tray cards on 5/09/13.	

Office of Inspector General

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N 220	<p>Continued From page 9</p> <p>07/08, revealed the facility would provide assistive devices as needed to maintain or improve resident's ability to eat independently.</p> <p>Observations on 05/01/13 at 12:15 PM and 05/02/13 at 12:00 PM, revealed Resident #4 was in the dining room eating lunch, drinking coffee from a regular coffee cup. There was no spouted lid on the cup.</p> <p>A record review revealed Resident #4 was originally admitted to the facility on 05/06/09 with diagnoses to include Senile Dementia, Impulse Control Disorder, Anxiety, and Psychosis.</p> <p>A review of the quarterly Minimum Data Set (MDS) assessment, dated 03/27/13, revealed the facility assessed the resident's cognition as severely impaired and was dependent with setup assistance for eating.</p> <p>A review of the Physician's Orders, dated 03/29/13, revealed an order for a spouted lid cup when drinking hot liquids to enable the resident to drink liquids independently until Occupational Therapy (OT) could evaluate. A review of the OT Evaluation, dated 04/04/13, revealed the resident was referred to their services by nursing as the resident demonstrated frequent spills related to decreased cognition. The resident was at risk to spill coffee or other hot beverages when drinking from a regular cup. The evaluation indicated for the resident to drink from a cup with a spouted lid and handle for all hot beverages to increase safety. A review of the resident's tray card, dated 05/02/13, revealed a 2 handle spout cup as adaptive equipment.</p> <p>An interview with State Registered Nurse Aide (SRNA) #4, on 05/02/13 at 1:15 PM, revealed the</p>	N 220	<p>Director of Nursing Services, Assistant Director of Nursing Services and Staff Development Coordinator will conduct meal audits to assure appropriate assistive devices to prevent accidents three times a week times four weeks and three times a month times two additional months.</p> <p>Director of Nursing Services or Assistant Director of Nursing Services will report findings to the Performance Improvement Committee for the next three months for further recommendations.</p> <p>Completion Date:</p>	05/30/2013	

Office of Inspector General

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N 220	<p>Continued From page 10</p> <p>fluids were given to the residents in the dining room before the food trays were passed. She gave Resident #4 coffee today in the dining room for lunch; however, did not ensure the resident received a spouted lid cup. She did not know which residents received a special cup.</p> <p>An interview with the Restorative Aide, on 05/02/13 at 1:50 PM, revealed she usually passed fluids to the residents in the dining room before lunch was served. She verified she passed fluids at lunch, on 05/01/13 and 05/02/13. She revealed coffee was usually passed by her, but other staff in the dining room help as well. She revealed Resident #4 should have received a cup with a spouted lid. She verified there was a list of residents that required adaptive equipment posted inside the dining room cabinet, available for staff if needed.</p> <p>A review of the Physician's Order Listing (located inside the cabinet of the dining room), dated 04/02/13, revealed Resident #4 should have a cup with a spouted lid while drinking hot liquids.</p> <p>An interview with the Interim Director of Nursing (DON), on 05/02/13 at 2:30 PM, revealed there was a list put inside the cabinet door in the dining room, of residents with their required adaptive equipment. She expected if a staff member was unsure of what a resident needed, they should have checked the list.</p>	N 220		
N 283	<p>902 KAR 20:300-10(8)(b) Section 10. Dietary Services</p> <p>(8) Sanitary conditions. The facility shall: (b) Store, prepare, distribute, and serve food under sanitary conditions; and</p>	N 283	<p>N 283 Dietary Services</p> <p>On 04/30/2013 Nutrition Services Aide re-heated Chopped Salisbury</p>	

Office of Inspector General

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N 284 N 284	Continued From page 12 902 KAR 20:300-10(8)(c) Section 10. Dietary Services (8) Sanitary conditions. The facility shall: (c) Dispose of garbage and refuse properly. This requirement is not met as evidenced by: Based on observation and interview, it was determined the facility failed to dispose of garbage properly, related to lids on the dumpsters that could not be closed. Findings include: An observation of the two dumpsters, on 05/01/13 at 2:25 PM, revealed both of the dumpsters had been dented, during the trash pick up service, to where there was no way to fasten down the lids and four of the 12 lids remained open approximately 18-24 inches on both sides. An interview with the Maintenance Director, on 05/01/13 at 2:55 PM, revealed the city was responsible to maintain the containers and it was difficult to get them to fix the problem. An interview with the Administrator, on 05/01/13 at 3:00 PM, revealed she had been recently made aware of the problem and it would be fixed.	N 284 N 284	N 284 Dietary Services: Sanitary Conditions/Dispose of Garbage and Refuse Administrator reviewed facility dumpsters on 5/04/13. Repairs needed noted. Administrator met with Mayor Jerry Meredith on 05/21/2013. An agreement was made to repair dumpsters so lids close properly on 05/21/2013. Administrator re-educated staff on the proper closing of dumpster lids and reporting inability to close to administration on 5/09/13. Dumpsters will be audited monthly by Administrator for three months to ensure they close properly. Administrator will report findings monthly to the Performance Improvement Committee for further recommendations. Completion Date:	05/30/2013

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2013
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01.</p> <p>PLAN APPROVAL: 1994</p> <p>SURVEY UNDER: 2000 Existing.</p> <p>FACILITY TYPE: SNF/NF.</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (200).</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system installed in 1994, with 56 smoke detectors and 4 heat detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system installed in 1994.</p> <p>GENERATOR: Type II generator installed in 1994. Fuel source is Diesel.</p> <p>A standard Life Safety Code survey was conducted on 04/30/13. Edmonson Center was found in non-compliance with the requirements for participation in Medicare and Medicaid. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Edmonson Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Carolyn Foreman

Administrator

05242013

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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K 000	Continued From page 1 Fire).	K 000			
K 018 SS=E	<p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors to resident rooms were in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, twenty-seven (27) residents, staff and visitors. The facility is certified for Seventy-Four (74) beds</p>	K 018	<p>K 018 Corridor Doors to Resident Rooms</p> <p>On 05/30/2013 The Maintenance Director to adjust the doors to resident room #101, #207 and #402 so the gap around the jamb is less than 1/2 inch.</p> <p>Maintenance Director will complete a 100% audit on 05/30/2013 on all resident corridor doors to verify gap around the door jamb is less than 1/2 inch.</p> <p>Regional Property Manager re-educated the Maintenance Director on the correct size of gap around resident room doors and the monthly audit tool for monitoring and repairing the doors on 5/03/13.</p> <p>Maintenance Director will conduct three audits a week for four weeks and three audits per month for an additional two months to monitor gap size around resident room corridor doors and will report results to the Safety Committee and</p>		

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K 018	<p>Continued From page 2</p> <p>with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure four (4) corridor doors to the resident rooms did not have a gap smaller than 1/2 inch around the jamb.</p> <p>The findings include:</p> <p>Observations, on 04/30/13 between 9:57 AM and 2:59 PM with the Maintenance Supervisor, revealed the corridor doors to rooms #101, #207, and #402 had a gap larger than 1/2 inch around the jamb.</p> <p>Interview, on 04/30/13 between 9:57 AM and 2:59 PM with the Maintenance Supervisor, revealed he was unaware of the acceptable gap around the doors.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or</p>	K 018	<p>Performance Improvement Committee monthly for three months for further recommendations.</p> <p>Completion date:</p>	05/30/2013	

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K 018	Continued From page 3 combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with NFPA standards.	K 018		
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observations and interview, it was determined the facility failed to maintain smoke	K 025	K 025 Smoke Barriers Above the Ceiling Maintenance Director will seal all identified smoke barriers with an approved fire stop system and will complete construction of the smoke barrier corner at room #409 and #410. Maintenance Director will audit all smoke barriers and smoke barrier penetrations for the need of sealant by 05/30/2013. Maintenance Director was re-educated by Regional Property Manager 05/03/2013 on the correct process for sealing penetrations through smoke	

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K 025	Continued From page 4 barriers that would resist the passage of smoke between smoke compartments in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure four (4) smoke barriers were sealed around pipes and wires to resist the passage of smoke. The findings include: Observations, on 04/30/13 between 11:00 AM and 11:45 AM with the Maintenance Supervisor, revealed the smoke partitions, extending above the ceiling located throughout the facility were penetrated by pipes, wires, and ductwork. Further observation revealed the barrier at rooms #410 and #409 was not complete in the corner. Interview, on 04/30/13 between 11:00 AM and 11:45 AM with the Maintenance Supervisor, revealed he was unaware of the penetrations in the smoke barriers as they have been inspected several times since the last survey. Further interview revealed he was unaware the barriers were to be maintained from exterior wall to exterior wall in the facility. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows:	K 025	barriers and smoke barrier rounds to be conducted quarterly. Maintenance Director and Administrator will audit two smoke barriers weekly times four weeks and two smoke barriers monthly times two months to verify smoke barrier penetrations remain sealed. The Maintenance Director will report results monthly for three months to the Safety Committee and Performance Improvement Committee for further recommendations. Completion Date:	5/30/13

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/01/2013
NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210	
(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 025	Continued From page 5 (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose. 8.3.6.2 Openings occurring at points where floors or smoke barriers meet the outside walls, other smoke barriers, or fire barriers of a building shall meet one of the following conditions: (1) It shall be filled with a material that is capable of maintaining the smoke resistance of the floor or smoke barrier. (2) It shall be protected by an approved device that is designed for the specific purpose.	K 025		
K 027 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated	K 027		

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K 027	<p>Continued From page 6</p> <p>protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure four (4) doors in the smoke barriers had a gap less than 1/8 inch where the doors meet.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 at 2:59 PM with the Maintenance Supervisor, revealed the cross-corridor doors located throughout the facility would not close completely when tested, leaving a gap of approximately one-half of an inch or greater between the pair of doors and would not resist the passage of smoke.</p> <p>Interview, on 04/30/13 at 2:59 PM with the Maintenance Supervisor, revealed he was unaware the doors would not close all the way</p>	K 027	<p>K 027 Cross Corridor Doors in Smoke Barrier</p> <p>On 05/24/2013 The Maintenance Director ordered the fire rated door edge for the corridor doors in smoke barriers so the gap between the doors was 1/8 inch or less.</p> <p>Maintenance Director will complete 100% audit by 05/30/2013 on all gaps in corridor doors to verify gap between the doors was 1/8 inch or less.</p> <p>Regional Property Manager re-educated the Maintenance Director on the allowable size of gaps between corridor doors and the quarterly audit tool for monitoring and repairing the doors on 5/03/13.</p> <p>Maintenance Director will conduct three audits a week for four weeks and three audits per month for an additional two months to monitor gap size between corridor doors and will report results to the Safety Committee and Performance Improvement Committee monthly for three months for further recommendations.</p> <p>Completion date:</p>	05/30/2013

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K 027	Continued From page 7 leaving a gap between the doors in the closed position. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.	K 027			
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 029	K 029 Protection from Hazards Maintenance Director and Department Managers removed storage from Staff Development Office, Therapist Office, Outpatient Therapy Office, Restorative Office and removed excess papers and boxes from rooms #310, #309 and #306 on 05/24/2013. Administrator purchased a 5 drawer file cabinet for room #302. Maintenance Director will add self closure to Health Information Manager's office door by 05/30/2013. Maintenance Director and Resident Ambassadors will complete a 100% audit of all rooms to ensure no		

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K 029	<p>Continued From page 8</p> <p>determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, twenty-seven (27) residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure ten (10) rooms were properly protected due to the storage in the rooms.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 between 9:57 AM and 2:30 PM with the Maintenance Supervisor, revealed:</p> <ol style="list-style-type: none"> 1) The staff development office did not have a door closer installed due to the storage in the room. 2) The therapist office did not have a door closer installed due to the storage in the room. 3) The outpatient therapy office did not have a door closer installed due to the storage in the room. 4) The restorative office did not have a door closer installed due to the storage in the room. 5) The health information management office did not have a door closer installed due to the storage in the room. 6) The resident room #310 had a substantial amount of combustibles stored in the room. 7) The resident room #309 had a substantial amount of combustibles stored in the room. 8) The resident room #306 had a substantial amount of combustibles stored in the room. 9) The resident room #302 had a substantial 	K 029	<p>hazardous areas without proper door closure by 05/30/2013.</p> <p>Administrator re-educated all staff on items that can create a hazardous area monitoring of resident rooms for excess paper and/or boxes on 05/09/2013.</p> <p>Administrator to provide safety reminder regarding excess items in residents rooms to residents and family members semi-annually.</p> <p>Maintenance Director and Resident Ambassadors will conduct three audits a week times four weeks and three times a month times two additional months to monitor for any hazardous areas and will report findings to the Safety Committee and Performance Improvement Committee for the next three months for further recommendations.</p> <p>Completion Date:</p>	05/30/2013

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K 029	Continued From page 9. amount of combustibles stored in the room. Interview, on 04/30/13 between 9:57 AM and 2:30 PM with the Maintenance Supervisor, revealed he was not aware the areas listed above were considered hazardous storage thus requiring a door, a self-closer, and separation. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction	K 029		

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K 029	Continued From page 10 (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029			
K 056 SS=F	If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with NFPA Standards The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure resident wardrobes across from the door	K 056	K 056 Automatic Sprinkler System Regional Property Manager to have a sprinkler system company to expand sprinkler system coverage per code to include the wardrobes in rooms #102, #103, #106, #201, #208, #504, #605, #602, #609, #608, #401, #409, #408, #308 and #305. Bids have been received and Regional Property Manager to accept bid by 05/30/2013 Maintenance Director completed 100% audit of all resident rooms in building to identify where sprinklers are not close enough to wardrobes on 05/02/2013. Regional Property Manager re-educated Administrator and Maintenance Director on 05/02/2013 on complete sprinkler coverage for all parts of a facility. Maintenance Director and Administrator will audit all facility		

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K 056	<p>Continued From page 11 had proper sprinkler coverage.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 between 9:57 AM and 2:59 PM with the Maintenance Supervisor, revealed the wardrobes located in room #102, #103, #106, #201, #208, #504, #605, #602, #609, #608, #401, #409, #408, #308, and #305 did not have proper sprinkler coverage.</p> <p>Interview, on 04/30/13 between 9:57 AM and 2:59 PM, with the Maintenance Supervisor revealed he was not aware that the areas listed did not have proper sprinkler protection.</p> <p>Reference: NFPA 13 (1999 Edition)</p> <p>5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.</p> <p>Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.</p> <p>Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.</p> <p>Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:</p>	K 056	<p>areas monthly for the next three months to audit and verify all areas of the facility have complete sprinkler coverage and report findings to the Safety Committee and the Performance Improvement Committee monthly for the next three months for further recommendations.</p> <p>Completion Date:</p>	5/30/13

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K 056	Continued From page 12 (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		
K 066 SS=D	S&C letter stating all facilities must be fully sprinkler protected by August 2013 NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking. (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4	K 066	K 066 Noncombustible Ashtrays Metal, Self-closing Containers Maintenance Director ordered four self-closing ashtrays and a metal, self-closing container to empty ashtrays in for the employee smoking area on 05/24/2013. Maintenance Director to complete 100% audit of all smoking areas to ensure approved ashtrays and emptying receptacles are used by 05/30/2013. Regional Property Manager re-educated Maintenance Director and Administrator on the approved ashtrays and emptying receptacles on 05/03/2013. Maintenance Director and Administrator will audit smoking area ashtrays and receptacles monthly for	

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K 066	<p>Continued From page 13</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the use of approved ashtrays in the designated smoking area, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure they had a self-closing metal container to dump ashtrays into at the employee smoking area.</p> <p>The findings include:</p> <p>Observation, on 04/30/13 at 2:01 PM with the Maintenance Supervisor, revealed the smoking area for the employees did not have a metal container with a self-closing lid to dispose of the cigarette butts. Further observation revealed the area did not have self-closing ashtrays.</p> <p>Interview, on 04/30/13 at 2:01 PM with the Maintenance Supervisor, revealed he was unaware of the requirements for a smoking area at the facility.</p> <p>Reference: NFPA Standard 101 (2000 Edition).</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or</p>	K 066	<p>the next three months and report findings to the Safety Committee and the Performance Improvement Committee for further recommendations.</p> <p>Completion Date:</p>	05/30/2013

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K 066	Continued From page 14 oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the International symbol for no smoking. Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	K 066		
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on observation, record review, and interview, the facility failed to ensure the kitchen hood system was in accordance with NFPA	K 069	K 069 Protection of Cooking Facilities Maintenance Director had kitchen hood inspected and NFPA documentation received on 05/07/2013.	

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K 069	<p>Continued From page 15</p> <p>standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure the kitchen hood suppression system was inspected semi-annually.</p> <p>The findings include:</p> <p>Kitchen Hood record review, on 04/30/13 at 2:01 PM with the Maintenance Supervisor, revealed there was no documentation of a kitchen hood inspection.</p> <p>Interview, on 04/30/13 at 2:01 PM with the Maintenance Supervisor, revealed he was under the impression the proper inspection was being completed. Further Interview revealed he had a quote for a new vendor to complete the kitchen hood inspections going forward.</p> <p>Reference: NFPA 96 (1998 ed.)</p> <p>8-3 Cleaning. 8-3.1* Hoods, grease removal devices, fans, ducts, and other appurtenances shall be cleaned to bare metal at frequent intervals prior to surfaces becoming heavily contaminated with grease or oily sludge. After the exhaust system is cleaned to bare metal, it shall not be coated with powder or other substance. The entire exhaust system shall be inspected by a</p>	K 069	<p>Maintenance Director witnessed inspection and documentation on 05/07/2013.</p> <p>Maintenance Director re-educated by Regional Property Manager on 05/03/2013 on annual inspection tracking and quarterly audits to verify inspections are completely within required time frame and with correct documentation.</p> <p>Maintenance Director to audit all fire suppression systems and kitchen hood monthly times three months and report results to Safety Committee and Performance Improvement Committee for further recommendations.</p> <p>Completion Date:</p>	05/30/2013

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NAME OF PROVIDER OR SUPPLIER EDMONSON CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210	
(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 069	Continued From page 16 Extinguishers, properly trained, qualified, and certified company or person acceptable to the authority having jurisdiction in accordance with Table 8-3.1. Table 8-3.1 Exhaust System Inspection Schedule Type or Volume of Cooking Frequency Systems serving solid fuel cooking operations Monthly Systems serving high-volume cooking operations Quarterly such as 24-hour cooking, charbroiling or wok cooking Systems serving moderate-volume cooking Semiannually operations Systems serving low-volume cooking operations, such as churches, day camps, seasonal businesses, or senior centers Annually	K 069		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility,	K 073	K 073 Decorations or Furnishings Highly Flammable Maintenance Director will take current flame retardant documentation and label all items that have been sprayed with fire retardant spray by 05/30/2013. Maintenance Director and Resident	

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K 073	Continued From page 17 according to NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure decorations brought into the facility were being properly fire treated. The findings include: Observation, on 04/30/13 at 3:30 PM with the Maintenance Supervisor, revealed several stuffed animals, wreaths, and artificial floral arrangements throughout the facility had no documentation of flame retardant being applied. Interview, on 04/30/13 at 3:30 PM with the Maintenance Supervisor, revealed he was aware decorations were required to be treated with a fire retardant spray but the facility relies on a contracted company to spray the items and document. The maintenance supervisor revealed after review the documentation provided he was unable to determine which items had been fire treated. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	Ambassadors will complete 100% audit of all resident items in the building to identify any additional items needing fire retardant spray by 05/30/2013. Maintenance Director and Resident Ambassadors will audit all resident rooms for excess resident flammable items by 05/30/2013. Social Services will assist resident and family members in removing excess flammable items from resident's rooms by 05/30/2013. All remaining decorations and furnishings that are highly flammable will be sprayed with fire retardant spray, tagged and logged in Flame Retardant Monitoring Book by 05/30/2013. Maintenance Director and Resident Ambassadors will conduct three audits a week times four weeks and three times a month times two additional months to monitor for any items that require fire retardant spray and will report findings to the Safety Committee and Performance Improvement Committee for the next three months for further recommendations.	
K 104 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.	K 104	Completion Date:	05/30/2013

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K 104	Continued From page 18 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire/smoke dampers were maintained in accordance with NFPA standards. The deficiency had the potential to affect four (4) of four (4) smoke compartments, all residents, staff and visitors. The facility is certified for Seventy-Four (74) beds with a census of Seventy-Two (72) on the day of the survey. The facility failed to ensure smoke dampers in the hvac system were being inspected. The findings include: Fire Damper review, on 04/30/13 at 12:25 PM with the Maintenance Supervisor, revealed no documentation for fire/smoke damper testing. Interview, on 04/30/13 at 12:25 PM with the Maintenance Supervisor, revealed that no maintenance documentation was kept on the fire/smoke dampers. He stated he has worked for the facility for (4) four years and they have been inspected while he has been there. Reference: NFPA 90A (1999 edition) 3-4.7 Maintenance. At least every 4 years, fusible links (where applicable) shall be removed; all dampers shall be operated to verify that they fully close; the latch, if provided, shall be	K 104	K 104 Fire Damper Inspection Maintenance Director contacted vendor and had fire dampers inspected on 05/10/2013. Maintenance Director to create a job in Tels (maintenance tracker) by 05/30/2013 to ensure fire damper inspections are tracked and completed every four years when due. Maintenance Director completed 100% audit on all fire dampers to verify all had been inspected on 05/10/2013. Regional Property Manager re-educated Maintenance Director on timely inspection of fire dampers on 05/06/2013. Maintenance Director to audit fire dampers for function monthly times three months and report results to Safety Committee and Performance Improvement Committee for further recommendations. Completion date:	5/30/13

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K 104	Continued From page 19 checked; and moving parts shall be lubricated as necessary.	K 104			