

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

PRINTED: 07/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/23/2011
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324	
(X4) ID PREFIX TAG F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241 SS=E	<p>INITIAL COMMENTS</p> <p>A Recertification/Abbreviated Survey Investigating ARO#KY00015513 was initiated on 08/21/11 and concluded on 08/23/11 with deficiencies cited with the highest Scope and Severity of and "F". ARO#KY00015513 was unsubstantiated with no deficiencies identified.</p> <p>483.16(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to promote the care for residents in a manner and in an environment that maintains or enhances each resident's dignity for two (2) of twelve (12) sampled residents, (Residents #2 and #7). Resident #2 was observed with an uncovered urinary bag and Resident #7 was observed uncovered while being transferred to the shower.</p> <p>The findings include: Record Review of the facility's policy, "Maintaining Dignity and Privacy in Long Term Care", dated 06/01/11, stated residents must have their dignity preserved at all times. Further review cited examples of resident dignity which included keeping urinary bags covered and keeping the resident covered when being transferred to and</p>		<p>13.15 Dignity and Respect Individuality</p> <p>Corrective Action for Residents Affected:</p> <ol style="list-style-type: none"> On 6-22-11 a foley catheter dignity bag was placed for resident #2 by the Unit Nursing Manager to ensure privacy. On 6-21-11 resident #7 was covered with a bath blanket by SRNA #1 before leaving the shower room. SRNA #1 was educated immediately by the Unit Manager to ensure that any resident that is being transported is completely covered with clothing or a bath blanket. <p>Identification of Residents with potential to be affected:</p> <ol style="list-style-type: none"> All other residents with foley catheters were assessed on 6-22-11 by the Unit Manager, Charge Nurse, MDS Nurse and Interim Director of nursing to ensure the foley catheter bags were covered. 	7/30/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Ronnie Hrusky* TITLE: Administrator DATE: 8/11/11

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

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SIGNATURE HEALTHCARE OF GEORGETOWN

102 POCAHONTAS TRAIL
GEORGETOWN, KY 40324

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 241	<p>Continued From page 1 from their room to the shower.</p> <p>1. Record review revealed the facility admitted Resident #2 on 03/16/07 with diagnoses which included Recurrent Urinary Tract Infection and Neurogenic Bladder. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 03/02/11, revealed the facility scored Resident #2 as twelve (12) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating Resident #2's cognition was intact.</p> <p>Observation on 06/21/11 at 10:05 AM revealed Resident #2's indwelling catheter bag suspended from the bed frame, on the side that faced the resident's doorway, without a privacy cover in place.</p> <p>Observation on 06/22/11 at 9:30 AM revealed Resident #2's indwelling catheter bag suspended from the bed frame, on the side that faced the resident's door and visible from the hallway, without a privacy cover in place.</p> <p>Interview with the Unit Nursing Manager, on 06/22/11 at 4:05 PM revealed urinary catheter bags should be covered in a privacy bag. She further stated she was unaware that Resident #2's bag had recently been observed without a privacy cover in place.</p> <p>An Interview with Resident #2 on 06/22/11 at 6:20 PM revealed he/she preferred to keep the catheter bag covered by a privacy bag.</p> <p>2. Record review revealed the facility admitted Resident #7 on 05/02/11 with diagnoses which included Contracture of Lower Leg Joint and</p>	F 241	<p>2. All residents that are transported to the shower room have the potential to be affected. Measures or systems changes to prevent reoccurrence:</p> <p>1. All Nursing Staff were educated by the Interim DON, Unit Managers or MDS nurse by July 29, 2011 on the dignity of residents, to include foley catheter bags, use of bath blankets, privacy, care of residents to enhance or maintain resident dignity.</p> <p>2. The housekeeping/laundry supervisor will audit the clean linen room three days a week for three months to ensure dignity bags and bath blankets are adequately stocked and readily available.</p> <p>4. The Interim DON, Charge Nurse, Unit Manager or MDS Nurse Manager will audit all foley catheters three days a week for three months to ensure compliance with foley catheter bag coverings.</p>	

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F 241	Continued From page 2 Difficulty Walking. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/09/11, revealed the facility scored Resident #7 as eleven (11) out of fifteen (15) on the Brief Interview for Mental Status (BIMS), indicating Resident #7's cognition was moderately impaired. Observation of Resident #7 in the hallway on 06/21/11 at 12:05 PM, revealed the resident being transported in a shower chair with his/her buttocks partially exposed. Interview with State Registered Nurse Aide (SRNA) #1 on 06/21/11 at 12:15 PM revealed she was unaware the Resident #7's buttocks were not covered when she was transporting the resident to the shower room. She further stated a facility employee brought a bath blanket to the shower room to use to cover Resident #7 to ensure his/her dignity was maintained when transporting the resident back to the room. Interview with SRNA #2 on 06/23/11 at 10:10 AM revealed bath blankets are not always available to use when transporting residents to the shower room via shower chair, however the resident's dignity must be maintained. She further stated that in the absence of a bath blanket she would make sure the resident's gown was tucked around their back side and a sheet placed around the resident as a covering.	F 241	Monitoring changes/systems to ensure no deficient practice: 1. Findings of the linen room audit and the dignity bag audit will be reviewed for compliance in the QA Committee meeting monthly for 3 months and then at the discretion of the QA committee. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.		
F 280 SS=E	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or	F 280	F 280 483.10 Right to Participate Planning Care-Revise CP	7/30/11	

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F 280	<p>Continued From page 3 changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy it was determined the facility failed to ensure Comprehensive Plans of Care were revised for three (3) of twelve (12) sampled residents (Resident's #3, #7, and #10). Resident #3 had a Physician Order on 06/06/11 for Thrombo Embolic Deterrent (TED) hose, which are elastic stockings used as a preventive measure to reduce the occurrence of blood clots. In addition, a nursing note on 03/27/11 at 10:20 AM revealed Resident #3 had a fall. Resident #3's Comprehensive Plan of Care was not revised to include the TED hose or the fall interventions. Resident #7's Comprehensive Plan of Care was not revised to reflect an order for TED hose, initiation of antibiotic therapy or Isolation/Contact Precautions. In addition, Resident #10's</p>	F 280	<p>Corrective Action for Residents Affected:</p> <ol style="list-style-type: none"> 1. Resident #3's comprehensive careplan was revised on 6-23-11 by the MDS Nurse to include TED hose for edema in the lower extremities and fall interventions that were put into place for the fall that occurred on 3-27-11. 2. Resident #7's comprehensive careplan was revised on 6-23-11 by the MDS Nurse to include antibiotic therapy which began on 6-16-11 and TED hose for edema in the lower extremities. Resident #7's isolation precautions were changed to universal precautions on 6-22-11. 3. Resident #10's careplan was revised on 6-23-11 by the MDS Nurse to reflect the current order for 1750 cc fluid daily, the order for TED Hose for lower extremity edema and current antibiotic therapy for C-Diff infection. The resident is not currently in isolation. 	
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F 280	<p>Continued From page 4</p> <p>Comprehensive Plan of Care did not include updates/revisions related to Physician's Orders for TED hose, initiation of antibiotic therapy or a volume adjustment to the resident's daily fluid restrictions.</p> <p>The findings include:</p> <p>Review of the facility policy titled, "Care Plan", dated 12/2010, revealed it is used to identify problems, develop solutions, and communicate changes in care to all direct care staff.</p> <p>1. Review of Resident #3's medical record revealed the facility admitted the resident on 08/29/08 with diagnoses which included Senile Dementia, Osteoporosis, Hypertension, and Anemia. Review of the Care Area Assessment (CAA) from the most recent Minimum Data Set Assessment, dated 01/20/11, identified Resident #3 was at risk for falls and a Care Plan was developed for the problem on 02/01/11 with preventative interventions.</p> <p>Review of the Medical Record revealed a nursing note on 03/27/11 at 10:20 AM which indicated Resident #3 sustained a fall when transferring self from bed to wheelchair with no apparent injury. Review of the resident's Care Plan for falls revealed no revisions to the plan of care to address fall prevention intervention(s) related to the 03/27/11 fall.</p> <p>Review of the Medical Record revealed on 06/06/11 the resident had edema (swelling) in their lower extremities. A Physician's Order was completed on 06/06/11 for TED hose as an intervention to reduce the edema. Review of the</p>	F 280	<p>Identification of Residents with potential to be affected:</p> <p>1. An audit was completed by MDS Nurse, Unit Manager or Interim DON by 7-29-11 to ensure current physician orders match the comprehensive careplan for each resident. Revisions made as needed.</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. Nursing staff were educated by the Interim DON, MDS Nurse, Unit Manager or Charge Nurse by 7-29-11 to update the careplan as the order is taken.</p> <p>2. The careplans will be brought to the daily clinical meeting by the MDS Nurse to ensure that new physician orders have been added to the careplan. Revisions will be made at that time if needed, by the MDS Nurse, unit manager, or DON.</p>		

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F 280	<p>Continued From page 5</p> <p>Treatment Administration Record (TAR) revealed the resident was to have the TED hose on in the AM and off in the PM. Review of the Comprehensive Care Plan revealed no intervention was added for the use of TED hose.</p> <p>Multiple observations of the resident on 06/22/11 revealed Resident #3 was wearing TED hose.</p> <p>Interview with the DON on 06/23/11 revealed when a resident falls the care plan should be updated with intervention(s) to help prevent a recurrence of the fall event. Further interview revealed when the order for TED hose was received, Resident #3's plan of care should have been updated to include the TED hose intervention.</p> <p>2. Review of Resident #7's medical record revealed the facility admitted the resident on 05/02/11 with diagnoses which included Contracture of Lower Leg Joint and Difficulty Walking, Heart Failure and Renal Failure. Review of the Admission Minimum Data Set (MDS) Assessment, dated 05/09/11, revealed the facility scored Resident #7 as eleven (11) out of fifteen (15) utilizing the Brief Interview for Mental Status (BIMS) evaluation tool, indicating Resident #7's cognition was moderately impaired.</p> <p>Observation on 06/21/11 at 9:30 AM revealed a sign on Resident #7's door, "Check with nurse before entering room".</p> <p>Interview with the Unit Nurse Manager, on 06/21/11 at 10:00 AM, revealed the signage on Resident #7's door, "Check with nurse before entering room", was protocol for enforcement of</p>	F 280	<p>3. A 10% audit of careplans will be completed weekly for three months by the Unit Manager or DON to ensure that the resident's comprehensive careplan reflects the current physician orders.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>1. Findings of the 10% careplan audit will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.</p>		

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F 280	<p>Continued From page 6</p> <p>Contact/Isolation Precautions. Further interview revealed Contact/Isolation Precautions were related to the resident's recent diagnosis of Clostridium Difficile (C-Diff), an infection caused by the overgrowth of bacteria commonly found in the bowel. To minimize the potential for spread of infection any activities outside of the resident's room were minimized such as visits to the dining/social recreation and therapy areas. Also, to maintain the integrity of the scale, an order for obtaining the resident's body weight every three (3) days was temporarily suspended.</p> <p>Review of the Comprehensive Care Plan for Resident #7 revealed Contact/Isolation Precautions and/or Interventions were not listed on the resident's Comprehensive Plan of Care.</p> <p>Record review revealed a Physician Order for Resident #7, dated 06/16/11, for Keflex (oral antibiotic to treat infection). Further review of the Comprehensive Care Plan revealed no evidence the care plan had been revised to include the use of the antibiotic or infection related to the use of the antibiotic.</p> <p>Further review of the Comprehensive Plan of Care revealed Resident #7 had Congestive Heart Failure, problem date of 05/13/11, and interventions which included monitor lower extremities for any pain, swelling or redness as needed. However, the Care Plan was not revised to reflect the Physician's Order, dated 05/24/11 for TED hose as an intervention to reduce swelling of the lower extremities (legs).</p> <p>Observation of Resident #7 on 06/22/11 at 2:10 PM revealed TED hose on both legs.</p>	F 280			

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F 280	<p>Continued From page 7</p> <p>Interview with the MDS Nurse Manager on 06/23/11 at 2:50 PM revealed a copy of Physician's Orders, including antibiotics and TED hose, would be given to the MDS office so revisions could be made to a resident's Care Plan. However, she could not confirm if Resident #7's orders had been received in the office which would have inflated the revisions to the Comprehensive Plan of Care.</p> <p>3. Record review revealed the facility admitted Resident #10 on 03/03/11 with diagnoses which included Respiratory Failure, Renal Failure and Chronic Kidney Disease. Review of the Admission MDS Assessment, dated 03/10/11, revealed the facility scored Resident #10 as ten (10) out of fifteen (15) using the BIMS evaluation tool; indicating Resident #10's cognition was moderately impaired.</p> <p>Review of Resident #10's Physician's Orders, dated 06/02/11, revealed an order for TED hose.</p> <p>Review of Resident #10's Physician's Orders, dated 06/07/11, revealed an order for Vancomycin (antibiotic) for treatment of a C-Diff infection and an order for Contact Isolation Precautions.</p> <p>Review of Resident #10's Physician's Orders, dated 06/13/11, revealed an order to increase Resident #10's fluids to seventeen-hundred and fifty (1750) cc daily.</p> <p>Record review of Resident #10's Comprehensive Plan of Care revealed the resident was at risk for fluid volume deficit and was on fifteen hundred (1500) cubic centimeter (cc) fluid restriction,</p>	F 280			

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F 280	Continued From page 8 dated 05/27/11. There was no evidence the plan of care was revised to reflect the Physician's Order for the increase in fluid to 1750 cc daily. Further review of the care plan revealed no reference to Resident #10's infection of C-Diff, the antibiotic therapy ordered as treatment, nor the Contact Isolation Precaution. In addition, there was no evidence the care plan was revised to include the intervention for TED hose, as ordered. Interview with the Unit Nurse Manager, on 06/23/11 at 11:30 AM, revealed a copy of the Physician's Orders was given to the MDS nurse so that appropriate revisions could be made to the resident's plan of care. However, she could not find the update listed on the Comprehensive Plan of Care for Resident #10. Interview with the Dietitian and Dietary Manager on 06/23/11 at 2:30 PM revealed Resident #10 was on seventeen-hundred and fifty (1750) cc daily fluid restriction diet per the current Physician's Order. However, they could not confirm how dietary was made aware of that specific physician order change. Interview with the Director of Nursing, on 06/23/11 at 4:00 PM revealed the resident's Comprehensive Care Plans should have been revised when physician orders were received for TED hose, a volume change for a fluid restricted diet, antibiotic therapy and the initiation of Contact/Isolation Precautions.	F 280		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323	F 323 483.25 (h) Free of Accident Hazards/Supervision/Devices	7/30/11

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F 323	<p>Continued From page 9</p> <p>environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the resident environment remained free of accident hazards. The doors of twelve (12) of twenty-one (21) resident rooms were difficult to fully close or open once closed, presenting a potential safety risk in case of emergency.</p> <p>The findings include:</p> <p>Observation on 6/21/11, during the initial tour revealed difficulty fully shutting the doors to twelve (12) resident rooms, and difficulty opening the doors once they were shut. Some doors required extensive effort from surveyors to close and open, posing a potential danger to residents, especially in case of emergency.</p> <p>Emergency interviews conducted with two direct care and one supervisory staff on 06/22/11 between 2:33 PM and 3:14 PM revealed in case of a fire or tornado, residents are removed from resident rooms and the door would be shut.</p> <p>An interview with the Environmental Services Director on 06/22/11 at 1:54 PM revealed agreement that the inability to open or close the doors to resident rooms would be a safety hazard</p>	F 323	<p>Corrective Action for Residents Affected:</p> <p>1. Repairs began immediately by the construction crew on 6-21-11 for the 12 resident doors that were identified to have difficulty opening and closing.</p> <p>Identification of Residents with potential to be affected:</p> <p>1. All resident doors were checked by the construction crew on 6-21-11 to ensure proper functioning, No other doors to resident rooms were affected.</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. All staff were educated by 7-29-11 by Regional Nurse, DON, Unit Manager, Environmental director, Administrator and/or</p>		

Cont.

**F 323 483.25 (h) Free of Accident
Hazards/Supervision/Devices**

Maintenance Director by 7/29/11 on accidents, to include that the resident environment remains as free of accident hazards as is possible and staff are to report any identified safety hazards to the Administrator, Maintenance Director and/or DON Immediately.

The Administrator and Regional Maintenance Director developed a plan to ensure a safe environment during the construction and renovation prior to the beginning of construction and the facility's staff was in serviced 3-11-11.

2. Maintenance Director will conduct weekly room round audits, weekly x 3 months to ensure a safe environment.

3. Maintenance Director will complete the "Contractor Safety Assessment" audit weekly x 4 weeks, then monthly x2.

4. All resident doors will be audited monthly for 3 months by the maintenance director and/or administrator to include bathroom doors to ensure every resident door is functioning properly.

Cont.

**F 323 483.25 (h) Free of Accident
Hazards/Supervision/Devices**

5. The Safety Committee will meet monthly for review of safety audits to include monthly maintenance rounds, weekly room rounds, incident & accidents which were a result of environmental hazards and any other identified environmental safety issues. Safety committee minutes will be available for review as appropriate.

Monitoring changes/systems to ensure no deficient practice:

1. The door audit, weekly room round audit, "Contractor Safety Assessment" audit and minutes from monthly Safety Committee minutes will be reviewed by the QA committee monthly for three months and then at the discretion of the QA committee for evaluation of any concerns to include new interventions, educational opportunities or revision of plan. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 06/23/2011
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 323 F 371 SS-F	Continued From page 10 In case of a fire or a tornado. 489.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to store, prepare, distribute and serve foods under sanitary conditions to prevent foodborne illness. The findings include: Review of facility policy in Dietary Services entitled "Storage of Foods and Supplies" revealed it is the facility policy that after products have been received, they should be immediately taken to proper, secure storage area. Pertaining to the kitchen practices cited, their procedures are as follows: 1. All perishable items stored in the refrigerator or freezer must be covered, labeled and dated. 2. Cleaning supplies are to be stored separately from food items. 3. All food items are to be dated upon receipt.	F 323 F 371	489.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY 1. All outdated and unlabeled food items were discarded immediately. Chemicals were removed and properly stored. Food items were dated and labeled upon receipt. All opened food was properly enclosed, covered, dated and labeled. A thermometer was placed in the freezer, along with a temperature log. Fans were placed in the dry storage area and thermometer placed to monitor temperature daily. Hood filters were immediately cleaned. Utensils were stored in proper direction. Mop bucket was emptied and cleaned, new mop head was placed and old mop head was discarded and dust pan was cleaned immediately. Kitchen aide #1 was immediately educated on proper hand washing technique and sanitary procedures. No residents were affected by this practice.	7/30/11	

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F 371	<p>Continued From page 11</p> <p>4. All refrigerated cooked food or other products removed from original containers must be enclosed in clean, sanitized, covered containers and dated and labeled.</p> <p>5. Check refrigerator thermometer regularly.</p> <p>Review of the facility policy in Dietary Services entitled "Cleaning Hoods and Filters" revealed it is the facility policy that hoods and filters will be thoroughly cleaned monthly.</p> <p>Review of the facility policy entitled "Infection Control" revealed it is the facility's policy that they will endeavor to prevent the spread of infection by screening staff members for infectious disease and teaching safe food handling practices to limit cross-contamination.</p> <p>Observation on 06/21/11 at 10:00 AM of a cart in the food preparation area revealed bags of bread, rolls and cookies undated as to when they were received or the expiration.</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:00 AM revealed this was his first day on the job in this facility, he was not familiar with the supplier bakery goods supplier and did not know why the food items are undated with no expiration dates.</p> <p>Observation on 06/21/11 at 10:05 AM revealed a full container of tea sitting on the counter uncovered.</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:05 AM revealed the container of tea should have been covered to protect it from contamination before distribution to residents and</p>	F 371	<p>Identification of Residents with potential to be affected:</p> <p>1. All residents have the potential to be affected by the deficient practice.</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. The DM in-serviced all dietary staff by July 29th on proper temperatures in storage areas, freezers, to check and record the temperature daily, proper hand washing/infection control, food handling to include acceptable dates, dating, labeling, food storage, proper cleaning and storage of chemicals, brooms, mops, dust pans. In addition, the DM educated the staff on the acceptable date range for keeping and disposing of perishable foods.</p> <p>2. Food storage areas are monitored daily for proper temperature, with the use of thermometers and temperature logs.</p>		

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F 371	<p>Continued From page 12</p> <p>he did not know why it was uncovered.</p> <p>Observation on 06/21/11 at 10:10 AM revealed an outdated bag of boiled eggs (dated 06/13/11) in the refrigerator. Further observation revealed a package of ham and four (4) one pound packages of butter not dated when stored.</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:10 AM revealed the bags of boiled eggs were old and should have been disposed of and the ham and butter should have been dated when put into the refrigerator. He did not know why they were not dated.</p> <p>Observation on 06/21/11 at 10:30 AM in the basement dry storage area revealed a box of onions opened and undated when received and full of swarming insects. Further observation of the dry storage area revealed a bag of sugar, open and undated when received or opened.</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:30 AM revealed he had never been in the dry storage area before and it was certainly wrong to not date food items when received or opened, to leave a bag of sugar open in storage, and to not dispose of produce that had become infested with insects. He had no answer for why these things had not been done prior to his employment at the facility.</p> <p>Observation on 06/21/11 at 10:40 AM revealed a box of health shakes in the basement freezer which were undated when received and had no expiration dates. There was also no thermometer in this freezer to monitor the temperature.</p>	F 371	<p>3. The facility contacted the HVAC Company on 6/24/11 and ordered a 3 ton unit to be installed to assist in maintaining the recommended temperature</p> <p>4. Hoods and ducts are cleaned at least monthly to prevent buildup. They are professionally cleaned every six months. Filters are cleaned weekly.</p> <p>5. The Dietary Manager, RD, Nurse Consultant, and/or Administrator will conduct the following audits:</p> <p>a. Safe food handling practices twice weekly for one month and then weekly for two months.</p> <p>b. Random audit to be done for proper dating, labeling, storage of food 2 x weekly x 3 months.</p> <p>c. Freezer temps will be done twice weekly x 2 months, then weekly x 1 month.</p>	

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F 371	<p>Continued From page 13</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:40 AM revealed the box of health shakes should have been dated when received into stock, especially since the products did not have expiration dates. Also, he could not find a thermometer in the freezer and had no explanation for why one was not kept in the freezer to monitor the temperature.</p> <p>Observation on 06/21/11 at 10:50 in the kitchen revealed the filters in the hood over the stove/cook top were very dusty.</p> <p>Interview with the Dietary Manager on 06/21/11 at 10:50 AM revealed the range hood and filters should have been cleaned but agreed they look dirty. He did not know when they were cleaned last.</p> <p>Observation in the food preparation area on 06/21/11 at 11:00 AM revealed utensils in the drawers were turned in various directions.</p> <p>Interview with the Dietary Manager on 06/21/11 at 11:00 AM revealed the utensils should all be turned in one direction with the handles easily reachable to prevent contamination, but did not know why they were not.</p> <p>Observation in the food preparation area on 06/21/11 at 11:05 PM revealed cleaning supplies stored under the kitchen sink, in the same vicinity as food preparation.</p> <p>Interview with Kitchen Aide #1 on 06/21/11 at 11:05 PM revealed someone lost the key to the closet where cleaning chemicals should be stored and they were not able to properly store them for</p>	F 371	<p>d. Random audit to be done for the receiving and dating of bread, rolls, cookies 2 x monthly x 3 months.</p> <p>e. Audit of containers in dry storage area weekly x 3 months.</p> <p>f. Utensils placement weekly x 3 months.</p> <p>g. Safe Food Handling/ Hand washing and changing gloves weekly x 3 months.</p> <p>h. Storage of mop heads/ mop bucket and dust pans weekly x 2 months.</p> <p>i. Storage of chemicals audit to be done weekly x 3 months.</p>		

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F 371	<p>Continued From page 14</p> <p>awhile. Interview with the Dietary Manager on 06/21/11 at 11:05 AM revealed cleaning products should be stored in a separate closet, away from the food preparation area.</p> <p>Observation of the kitchen cleaning closet, off the hall outside the kitchen, at 11:15 AM on 06/21/11 revealed the mop bucket had been stored there with dirty water unemptied and the dirty mop still in the bucket. Also, a long-handled dust bin was hanging on the wall with the bin still containing dirt and debris.</p> <p>Interview with Kitchen Aide #1 on 06/21/11 at 11:15 AM revealed the housekeeping staff had left these items unemptied, but an interview with the Housekeeping Manager on 06/22/11 at 10:00 AM revealed they did not use this closet or these cleaning items for housekeeping.</p> <p>Observation of the tray line service on 06/21/11 at 12:15 PM revealed the tray line server, Cook #1, left tray line to take food items out of the refrigerator and oven and returned to tray line service without washing her hands or changing gloves.</p> <p>Interview with Cook #1 revealed she did not know returning to serve on tray line after touching refrigerator or oven handles (without washing her hands) was an improper sanitation practice. In addition, the temperature of the dry storage area was observed to be seventy-nine (79) degrees and humid on 06/22/11 at 1:54 PM. Dry storage was observed to be located in the basement of the facility with no means to regulate the temperature to ensure the safety of the food.</p>	F 371	<p>Monitoring changes/systems to ensure no deficient practice:</p> <p>1. The results of the temperature logs and all dietary audits will be forwarded to the QA Committee for review for three months then there after as determined by the QA Committee. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.</p>	

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F 371	Continued From page 15 An interview with the Dietary Manager on 08/23/11 at 3:20 PM revealed the temperature and climate of the dry storage area was controlled only by an exit door being opened or closed and the use of fans. Further interview revealed the ideal temperature of the dry storage area to be seventy (70) degrees or below, and the lack of temperature and climate control was a concern for some foodstuffs in dry storage.	F 371	Measures or systems changes to prevent reoccurrence: 1. The DM will in-service staff by 7/29/11 on safe food handling, hand washing, and changing gloves at proper times to prevent cross-contamination. 2. The DM will audit staff for safe food handling practices, hand washing, and changing gloves at the correct times daily for a week then twice weekly for one month then weekly for two months. Monitoring changes/systems to ensure no deficient practice: The Administrator will present the results of the audits to the QA Committee for review and recommendations for three months and then at the discretion of the QA Committee.	7/30/11	

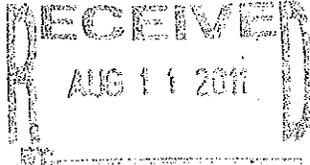
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K 000	INITIAL COMMENTS K3 Building: 0101 K6 Plan Approval: 04/13/78 K7 Survey under: 2000 existing K8 SNF Type of structure: one story Skilled Nursing Facility Type 2 unprotected construction. A Life Safety Code survey was initiated and concluded on 06/22/11, for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 Edition. The following findings demonstrate noncompliance with the highest scope/severity at "F" level.	K 000	 K 025 NFPA 101 LIFE SAFETY CODE STANDARDS: Corrective Action for Residents Affected: 1. All smoke barrier penetrations that were identified on 062211 (smoke barrier wall penetration next to dining room, the 4 penetrations from various wires at the nurses station, the 2 penetrations from missing sheetrock, and the smoke barrier not visualized in the shower room) were repaired on 06/22/11 by the Maintenance Director with fire caulk and access to smoke barrier in shower room was made.	7/30/11
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	K 025		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Annie Herushy* TITLE: Administrator (X6) DATE: 8/11/11

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

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K 025	<p>Continued From page 1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke barriers, fifty (50) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 06/22/11 at 10:07 AM, revealed the smoke barrier wall next to the dining room, had a penetration from an audiovisual cable that was not sealed. Further observation revealed, the smoke barrier located at the nurses' station had four (4) penetrations from various wires and two (2) penetrations from missing sheetrock that were not sealed. The smoke barrier located above the shower room could not be visualized due to not having any access to the smoke barrier. Penetrations in smoke barriers must be sealed with a material suitable to stop the spread of smoke and fire. Access to smoke barriers must be provided to ensure smoke barriers can be maintained. All penetrations were confirmed with the Maintenance Director at time of discovery.</p> <p>Interview on 06/22/11 at 10:07 AM, with the Maintenance Director, revealed he had not identified any penetrations in the smoke barriers. Further interview revealed the facility would provide access to the smoke barrier located above the shower room.</p> <p>Reference: NFPA 101 (2000 edition) 4.5.7 Maintenance. Whenever or wherever any device, equipment,</p>	K 025	<p>Identification of Residents with potential to be affected:</p> <ol style="list-style-type: none"> 1. All residents have the potential to be affected by smoke barrier penetrations. 2. An inspection by the Regional Maintenance personnel and Maintenance Director was conducted 6/22/11 on all of the fire walls and any penetration identified was repaired on 06/22/11 by the Maintenance Director. <p>Measures or systems changes to prevent reoccurrence:</p> <ol style="list-style-type: none"> 1. Smoke barriers will be monitored by the Maintenance Director during weekly maintenance rounds and reported to the Administrator each week. 	

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K 025	<p>Continued From page 2</p> <p>system, condition, arrangement, level of protection, or any other feature is required for compliance with the provisions of this Code, such device, equipment, system, condition, arrangement, level of protection, or other feature shall thereafter be maintained unless the Code exempts such maintenance.</p> <p>8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows:</p> <p>(1) The space between the penetrating item and the smoke partition shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that is designed for the specific purpose.</p> <p>(2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, and the space between the item and the sleeve shall meet one of the following conditions:</p> <p>a. It shall be filled with a material that is capable of limiting the transfer of smoke.</p> <p>b. It shall be protected by an approved device that</p>	K 025	<p>Monitoring changes/systems to ensure no deficient practice:</p> <ol style="list-style-type: none"> 1. Maintenance Checklist including audit for smoke penetrations will be completed weekly x 4, then monthly x 2 by the Maintenance Director and submitted to the Administrator for review. 2. Results of the weekly Maintenance Checklist audit will be forwarded to the QA Committee for review by the Administrator monthly x 3 and then at the discretion of the QA Committee. 	

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K 025	Continued From page 3 is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025	K 038 NFPA 101 LIFE SAFETY CODE STANDARDS: Corrective Action for Residents Affected: 1. On 6/22/11 all mini blinds on the exit doors (100, 200, 300	
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The findings include: Observation on 06/22/11 at 10:00 AM revealed mini blinds on the exit doors, (100, 200 and 300 Hallways). This could cause confusion of the direction of egress in the event of fire or disaster. This was confirmed by the Environmental Services Director.	K 038	halls) were removed immediately by the Environmental Services Director. Identification of Residents with potential to be affected: 1. All residents have the potential to be affected by having exit doors not being clearly recognizable. Measures or systems changes to prevent reoccurrence: 1. The Environmental Services Director was in-serviced by Regional Maintenance on the code regarding Exit Doors and Exit Access per NFPA on 6/22/11.	7/30/11

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

PRINTED: 07/08/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN, BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/22/2011
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(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 038	Continued From page 4 Interview on 06/22/11 at 10:00 AM with the Environmental Services Director revealed they did not know they could not use mini blinds on the doors and stated it was for Resident privacy. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038	Monitoring changes/systems to ensure no deficient practice: 1. Maintenance Checklist including audits for exit access, easily accessible and recognizable exits will be completed weekly x 4, then monthly x2 by the Maintenance Director and submitted to the Administrator for review. 2. Results of the weekly Maintenance Checklist audit will be forwarded to the QA Committee for review by the Administrator monthly x 3 and then at the discretion of the QA Committee. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.		
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No	K 072			

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K 072	<p>Continued From page 5</p> <p>furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure corridors were maintained, free from obstructions to the full instant in the case of fire or other emergencies. Exits must be maintained to ensure their use in an emergency. The deficiency has the potential to affect all fifty (50) residents, staff, and visitors. The facility is licensed for fifty (50) beds and the census was forty-seven (47) the day of the survey.</p> <p>The findings include:</p> <p>Observation on 06/22/11 at 9:26 AM with the Environmental Services Director, revealed clean linen carts, soiled linen carts and lifts were observed to be stored over thirty (30) minutes in the 100, 200 and 300 corridors. This observation was also confirmed with the Environmental Services Director.</p> <p>Interview with the Environmental Service Director, at the time of the observation, confirmed the carts were being stored in the corridors.</p> <p>Reference: NFPA 101 (2000 Edition) Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or</p>	K 072	<p>K-072 NFPA 101 Life Safety Code Standard</p> <p>Corrective Action for Residents Affected:</p> <p>1. No residents were affected by this practice.</p> <p>Identification of Residents with potential to be affected:</p> <p>1. All residents have the potential to be impacted by this practice</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. Nursing and Laundry staff will be educated by DON, MDS, Administrator or Regional Nurse by 8/7/11 regarding importance of maintaining continuous means of egress and storage areas for linen carts and lifts when not in use.</p>	7/30/11

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K 072	Continued From page 6 impediments to full instant use in the case of fire or other emergency.	K 072	<p>Monitoring changes/systems to ensure no deficient practice:</p> <p>DON or Nursing Supervisors/Charge Nurses will conduct audits daily for a week then three times a week for a month, then weekly for two month to ensure no impediments to egress and proper storage of lifts and linen carts.</p> <p>Results of the audits will be forwarded by the Administrator monthly x3 to the QA Committee for review and recommendations with follow up monitoring to be determined by the QA Committee. The QA committee consists of the following: Medical Director, Administrator, DON, MDS, SSD, HR, BOM, Dietary Manager, Rehab Director, Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director, and Chaplain.</p>	