

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

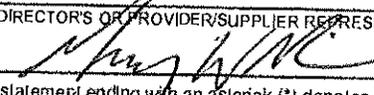
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
--	--	--	---

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 000	INITIAL COMMENTS An Abbreviated Survey investigalling KY#00019708 was conducted 01/28/13 through 02/08/13. KY#00019708 was subslantiated with deficiencies cited.	F 000	<i>Georgetown Health Care and Rehabilitation, a Signature Healthcare Facility does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey finding through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should consider as a waiver of any potentially applicable peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.</i>	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening condillons or clinical compicallons); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.	F 157		

RECEIVED
MAR 14 2013
BY:

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE ADMINISTRATOR	(X6) DATE 3/4/13
--	------------------------	---------------------

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

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 000 INITIAL COMMENTS

An Abbreviated Survey investigating KY#00019708 was conducted 01/28/13 through 02/08/13. KY#00019708 was substantiated with deficiencies cited.

F 157 483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)
SS=D

A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).

The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.

The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.

F 000

F 157

F157 483.10(b)(11) Notify of changes (Injury/Decline/Room, Etc.)

Corrective Action for Residents Affected:

1. Resident #1 is no longer a resident of the facility.

Identification of Residents with potential to be affected:

1. The director of nursing (DON) reviewed 100% of resident #1's chart on 1-2-13 for any identified change in condition and identified no other deficient practice.

2. The facility DON, Assistant Director of Nursing (ADON), Clinical Nurse Consultant and Unit Nurse Manager reviewed the 24 hour report and resident charts on 2-11-13 for identified change in condition that should have been reported to the physician. No other deficient practice was identified.

3-15-13

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

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

3/4/13

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

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 157	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified of changes in condition for one (1) of four (4) sampled residents (Resident #1). On 12/30/12 at 6:00 AM, a nurse noted she was unable to obtain Resident #1's blood pressure and had to palpate in order to obtain the blood pressure; additionally, the resident was noted to be pale, weak, and unable to take his/her medications at that time; however the Physician was not notified. The findings include: Review of the facility's policy titled, "Change in Condition (Action and Notification)", revised 04/08, revealed it was the intent of the facility to assess and document changes in a resident's health, mental, or psychosocial status in an efficient and effective manner, to relay assessment information to the Physician and to document actions. Further review revealed a resident's Physician was to be notified of a significant change in a resident's physical, mental, or psychosocial status. 1. Record review revealed the facility admitted Resident #1 on 07/26/12, with diagnoses which included Intracranial Hemorrhage, Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), and Hypertension (HTN). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/12/12, revealed Resident #3 required extensive assistance with	F 157	Measures or systems changes to prevent reoccurrence: 1. The clinical staff were educated by the DON, ADON and staff development coordinator on 2-11-13 regarding Resident Rights to a timely notification to the physician of a significant change in condition and or a deterioration in health and or the need to alter treatment due to the physical, mental and psychosocial status change of the patient. 2. The staff development coordinator will educate 100% of the licensed clinical staff with a completed competency check on how to complete a head to toe assessment, by 3-15-13. Human Resource director, DON, and or Staff Development coordinator will ensure all new licensed clinical staff completes the competency check in orientation.	
-------	---	-------	---	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 157	<p>Continued From page 2</p> <p>his/her Activities of Daily Living (ADLs).</p> <p>Review of the Nurse's Note, dated 12/30/12 and timed 6:00 AM, revealed Resident #1 was "up in chair, pale and weak". The note indicated the nurse was unable to hear B/P (blood pressure) that was palpable at 110 and resident's pulse was in 60's and irregular. Further review of the record revealed no documented evidence the Physician was notified of the change in Resident #1's condition until 8:10 AM, two (2) hours and ten (10) minutes after the noted change in condition.</p> <p>Interview, on 02/05/13 at 5:38 PM, with Licensed Practical Nurse (LPN) #4 revealed she was assigned to Resident #1's care on 12/30/12. She stated Resident #1 had been "restless" during the night and staff had gotten him/her up out of bed and taken him/her to the dining room. According to the LPN, during her "diabetic rounds" at 6:00 AM on 12/30/12, she checked Resident #1's blood sugar. She stated she tried to administer his/her pills and he/she had "a lot of trouble getting them in..." his/her mouth. The LPN stated this was "just weird" for Resident #1 and she attempted to get a blood pressure (b/p) which she was unable to hear. She stated she called a nurse from another unit, who was an experienced Emergency Room (ER) nurse, to attempt to get the resident's b/p; however, they were unable to hear a b/p, and were only able to palpate a b/p of 110. LPN #4 stated she thought Resident #1 was getting dehydrated. She stated she gave report to the oncoming shift, then phoned the Physician to request intravenous fluids (IVF's). The LPN stated when she went in to start the IVF's, Resident #1 was "breathing rapidly", so she gave him/her a nebulizer treatment which was not</p>	F 157	<p>3. The licensed nurse team, supervised by the DON and or the RN supervisor, will review the charts, new orders, lab reports and all identified concerns logged on the 24 hour report for any change in condition and for the appropriate notification to the physician in the clinical team meeting, five days per week. Identified deficient practice will be reported to the DON, the administrator and the attending physician for immediate review, assessment of the resident, and correction of the deficient practice.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>1. The administrator will report the change in condition assessment audit results to the quality assurance committee (QA committee) monthly for review and assessment for 3 months and then at the discretion of the QA committee. (QA committee consists of the following: Medical Director, Administrator, DON,</p>	
-------	---	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 157 Continued From page 3
effective. She stated she called the Physician back and asked if the resident could be sent out to the ER. When asked if she should have phoned the Physician sooner, LPN #4 stated "yes". She stated she thought the resident was getting dehydrated and she should have called the Physician sooner.

Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed when she performed her investigation related to Resident #1's condition and treatment on 12/30/12, she ascertained that LPN #4's stethoscope was not working and she should have changed stethoscopes.

Interview, on 02/06/13 at 10:28 AM, with Resident #1's Primary Care Physician (PCP) revealed he "certainly" would have wanted to have been notified of the change in Resident #1's condition. He stated he was not on call that day (12/30/12); however, he would have expected the facility to contact the on call Physician.

Interview, on 02/05/13 at 1:52 PM, with the on call Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did not believe he was notified of the change in the resident's condition.

F 157 Minimum Data Set Coordinator (MDS), Social Service Director (SSD), Human Resource Director (HR), Staff Development Coordinator, Unit Nurse Manager, Business Office Manager (BOM), Dietary Manager, Rehab Services Manager (RSM), Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director (QOL), Chaplain)

F 241 SS=D 483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY

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.

F 241 F241 483.15(a) Dignity and Respect of Individuality

3-15-13

Corrective Action for Residents Affected;

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 241	Continued From page 4 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 provide care in a manner that maintains residents' dignity. Observation on the morning of 01/29/13 revealed a State Registered Nursing Assistant (SRNA) performed perineal/incontinence care without shutting the door or curtain for Unsamped Resident F and Unsamped Resident G. The findings include: Review of the facility's "Perineal Care Guideline", dated 12/10, revealed the procedure entailed washing hands, collecting equipment, explaining the procedure to the resident, and providing privacy for the resident: close the door, window blind and privacy curtain. 1. Observation, on 01/29/13 at 4:25 AM, revealed State Registered Nurse Aide (SRNA) #1 performed perineal care for Unsamped Resident F without closing the bedside curtain or closing the door. 2. Observation, on 01/29/13 at 4:30 AM revealed SRNA #1 performed incontinence care for Unsamped Resident G without closing the bedside curtain or closing the door. Interview, on 01/29/13 at 5:30 AM, with SRNA #1, revealed she should have closed Unsamped Resident F's and Unsamped Resident G's doors to the hallway; however, she did not think about it	F 241	1. On 2-8-13 the DON assessed Resident F and Resident G to ensure resident F and Resident G did not exhibit signs of psychosocial distress due to the facility providing care in an undignified manner. 2. SRNA #1 was removed from direct care on the morning of 1-29-13 and provided one on one education by the staff development coordinator and DON regarding resident rights to Include privacy, closing the door of the room, the cubical curtain and window blinds if appropriate and providing care to each resident in a dignified manner. Identification of Residents with potential to be affected: 1. On 1-29-13, 1-30-13 and 1-31-13, the nurse consultant, the DON, and social service director evaluated clinical staff for deficient practice related to dignity and violation of resident rights. No other deficient practice was identified. Measures or systems changes to prevent reoccurrence:	
-------	---	-------	---	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 241	<p>Continued From page 4</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 provide care in a manner that maintains residents' dignity. Observation on the morning of 01/29/13 revealed a State Registered Nursing Assistant (SRNA) performed perineal/incontinence care without shutting the door or curtain for Unsamped Resident F and Unsamped Resident G.</p> <p>The findings include:</p> <p>Review of the facility's "Perineal Care Guideline", dated 12/10, revealed the procedure entailed washing hands, collecting equipment, explaining the procedure to the resident, and providing privacy for the resident; close the door, window blind and privacy curtain.</p> <p>1. Observation, on 01/29/13 at 4:25 AM, revealed State Registered Nurse Aide (SRNA) #1 performed perineal care for Unsamped Resident F without closing the bedside curtain or closing the door.</p> <p>2. Observation, on 01/29/13 at 4:30 AM revealed SRNA #1 performed Incontinence care for Unsamped Resident G without closing the bedside curtain or closing the door.</p> <p>Interview, on 01/29/13 at 5:30 AM, with SRNA #1, revealed she should have closed Unsamped Resident F's and Unsamped Resident G's doors to the hallway; however, she did not think about it</p>	F 241	<p>1. On January 29, 2013 Staff development coordinator, nurse consultant, social service director, and DON initiated education with licensed and certified nursing staff to provide care in a manner that maintains residents' dignity. Education to be completed by March 15, 2013 for all departments.</p> <p>2. The Staff development coordinator, DON, ADON, Unit Nurse Manager and or Social Services Director will monitor five (5) % of the residents each day for four days per week to ensure the residents receive consistent care to include privacy, closing the door of the room, the cubical curtain and window blinds if appropriate and providing care to each resident in a dignified manner. Monitoring changes/systems to ensure no deficient practice:</p> <p>1. The Director of Nursing and or the administrator will evaluate the 5% dignity audit weekly. Results will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.</p>	
-------	---	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 241	Continued From page 5 because she was nervous.	F 241		
F 281 SS=E	<p>Interview, on 01/29/13 at 6:30 PM, with the Director of Nursing (DON), revealed staff should provide privacy when performing care.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services that were provided or arranged by the facility met professional standards of quality for one (1) of four (4) sampled residents (Resident #1); failed to ensure Physician's Orders were followed; and failed to document changes in a resident's condition.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Change in Condition (Action and Notification)", revised 04/08, revealed it was the intent of the facility to assess and document changes in a resident's health, mental, or psychosocial status in an efficient and effective manner; to relay assessment information to the Physician and to document actions. Further review revealed a resident's Physician was to be notified of a significant change in a resident's status physical,</p>	F 281	<p>F 281 483.20(k)(3)(i) Services provided meet professional standards</p> <p>Corrective Action for Residents Affected:</p> <p>1. Resident #1 is no longer a resident of the facility.</p> <p>Identification of Residents with potential to be affected:</p> <p>1. A 100% assessment of Medication Administration Records (MARS) and Treatment Administration Records (TARS) were reviewed by the Unit Nurse Manager, DON, Medical Records Director, and Staff Development Coordinator to identify additional deficient practice of not following physician orders. Audit completed on January 31, 2013.</p> <p>2. No other residents were identified.</p>	3-15-13

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 281	Continued From page 6 mental, or psychosocial status. Interview, on 02/08/13 at 3:05 PM, with the Director of Nursing (DON) revealed following Physician's Orders, and assessing and monitoring wore basic nursing standards of practice and she did not have policies related to these areas. Additionally, she stated, in regards to following Physician's Orders and assessing and monitoring, was basic "Nursing 101". Review of the clinical record revealed the facility admitted Resident #1 on 07/26/12, with diagnoses which included Intracranial Hemorrhage, Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), and Hypertension (HTN). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/12/12, revealed Resident #1 required extensive assistance with his/her Activities of Daily Living (ADLs). Review of the Physician's Orders revealed an order, dated for 12/11/12, for the resident to have a chest x-ray related to increased congestion, cough, productive cough with green sputum. Further review revealed an order dated 12/12/12 for Omnicef (an antibiotic) three hundred (300) milligram (mg) by mouth twice a day for ten (10) days related to possible Pneumonia. Review of the Medication Administration Record (MAR) revealed the resident received nine (9) days of the antibiotic. Further review of the MAR revealed no documented evidence the resident received a tenth day of antibiotic as ordered. Further review of the Physician's Orders revealed an order dated 12/26/12 to check Resident #1's	F 281	Measures or systems changes to prevent recurrence: 1. Education initiated on February 6, 2013 for licensed nursing staff on the proper procedure in following physician orders, documentation, and notification of non-compliance by the DON and Staff Development Coordinator. Education will be completed by March 15, 2013. 2. The Staff Development Coordinator, DON, ADON, and or Nurse consultant will have completed physical assessment training to include documentation of changes in a resident's condition for licensed nurses by March 15, 2013. Human Resource director, DON, and or Staff Development coordinator will ensure all new licensed clinical staff completes the assessment training in orientation. 3. Any change in condition reported by the 24 hour report, lab results, behavior concerns, and incident and accident reports will be reviewed in the clinical meeting, five days per week. The charts will be reviewed and updated with this process.	
-------	--	-------	---	--

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <p style="text-align: center;">185141</p>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED <p style="text-align: center;">G 02/08/2013</p>
--	---	--	---

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 281 Continued From page 7
 stool for clostridium difficile (c-diff), a bacterial infection that can range from mild to life-threatening and that causes watery diarrhea, three or more times a day for several days, accompanied by pain or tenderness. Review of the Elimination Report revealed Resident #1 had a large loose bowel movement (BM) and a large soft BM on 12/27/12. However, review of the Nurse's Notes revealed no documented evidence a stool for the c-diff was obtained until 12/28/12 at 3:00 PM, at which time it was sent to the lab. Review of the lab report dated 12/28/12 revealed Resident #1's stool was positive for c-diff. The Physician was notified and Flagyl (an antibiotic used to treat c-diff) was ordered.

Interview, on 02/05/13 at 2:14 PM, with State Registered Nursing Assistant (SRNA) #6 revealed Resident #1 was having diarrhea approximately one (1) week prior to being sent out to the Emergency Room (ER) on 12/30/12.

Interview, on 02/06/13 at 11:22 AM, with SRNA #7 revealed Resident #1 had been having diarrhea approximately three (3) to four (4) days prior to being sent out to the ER.

Interview, on 02/06/13 at 6:50 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #1 had been treated with antibiotics for an Upper Respiratory Infection (URI). After reviewing the MAR she stated the resident did not receive the antibiotic for ten (10) days as ordered; he/she had only received nine (9) days. She stated Resident #1 should have received ten (10) days as ordered. The LPN indicated Resident #1 had been having loose stools, after being treated for the URI. She stated the resident had the loose

F 281 4. New physician orders are reviewed in the clinical meeting, five days per week, to ensure completion and accuracy. Any noted discrepancy will be corrected at the time of identification and the attending physician will be notified when appropriate.

5. The Unit Nurse Manager, DON, ADON, Medical Records Director, and or Staff Development Coordinator will review the MAR, TAR and chart for new order accuracy two times per week. Results will be reviewed in the weekly At Risk meeting for necessary corrective action.

Monitoring changes/systems to ensure no deficient practice:

1. Identified deficient practices to follow physician orders on Mars, Tars, and or weekly audits and the appropriate resolutions will be reviewed in the clinical meeting, five days per week.

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 281 Continued From page 8 stools for several days. According to the LPN, she notified the Physician, then Resident #1 went several days without having the loose stools and they were unable to get the specimen. She stated then the loose stools started back again and the specimen was obtained.

Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed the stool specimen for c-diff should have been obtained on 12/27/12 because the Elimination Report showed Resident #1 had stools that day. Additionally, she stated it was her expectation the antibiotic order be transcribed correctly and the resident to be given the full dose ordered.

Review of the Nurse's Note, dated 12/30/12, and timed 6:00 AM revealed Resident #1 was weak, pale, and the nurse was unable to hear the resident's blood pressure (b/p). The nurse noted the resident's b/p was palpable at 110. The nurse documented Resident #1's pulse was in the 60's and "Irregularly irregular". Review revealed no documented evidence a complete set of vital signs, which would include a temperature and respirations, was obtained at 6:00 AM on 12/30/12. Review of the Medication Administration Record (MAR) revealed the nurse administered a nebulizer treatment at 8:20 AM; however, review of the MAR and Nurse's Notes revealed no documented evidence of the resident's response to the treatment. Additionally, although Resident #1's respirations were noted to be in the 30's and labored at 8:40 AM, and an order was received to transport the resident to the Emergency Room (ER), there was no documented evidence 911 was phoned until 9:17 AM, thirty-seven (37) minutes after receiving

F 281 2. Identified deficient practices will be forwarded to the Staff Development Coordinator, DON, and or ADON for immediate education and training.

3. Results of the audits will be reported by DON, ADON, and or Unit Nurse Manager to the QA committee meeting monthly for 3 months and then at the discretion of the QA committee.

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 281	Continued From page 9 the order. Interview, on 02/05/13 at 5:38 PM, with Licensed Practical Nurse (LPN) #4 revealed she was assigned to Resident #1's care on 12/30/12. She stated Resident #1 had been "restless" during the night and staff had gotten him/her up out of bed and taken him/her to the dining room. According to the LPN, during her "diabetic rounds" at 6:00 AM on 12/30/12 she checked Resident #1's blood sugar. She stated she tried to administer his/her pills and he/she had "a lot of trouble getting them to" his/her mouth. The LPN stated this was "just weird" for Resident #1 and she attempted to get a blood pressure (b/p) which she was unable to hear. She stated she called a nurse from another unit, who was an experienced Emergency Room (ER) nurse, to attempt to get the resident's b/p, however they were unable to hear a b/p, and were only able to palpate a b/p of 110. LPN #4 stated she thought Resident #1 was getting dehydrated. She stated she gave report to the oncoming shift, then phoned the Physician to request intravenous fluids (IVFs). The LPN stated when she went in to start the IVFs Resident #1 was "breathing rapidly", so she gave him/her a nebulizer treatment which was not effective. She stated she called the Physician back and asked if the resident could be sent out to the ER. When asked if she should have phoned the Physician sooner, LPN #4 stated "yes". She stated she thought the resident was getting dehydrated and she should have called the Physician sooner. Interview, on 02/08/13 at 6:50 PM, with Licensed Practical Nurse (LPN) #2 revealed if one nurse can't get a blood pressure (b/p), the he/she	F 281		
-------	---	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 281	<p>Continued From page 10</p> <p>should have another nurse try, then if they couldn't get it, try to palpate the b/p. She stated then the nurse should notify the Physician. She indicated LPN #4 should have notified the Physician at 6:00 AM on 12/30/12 of her inability to obtain the resident's b/p and of the irregular pulse.</p> <p>Interview, on 02/08/13 at 12:38 PM, with Registered Nurse (RN) #2 revealed on 12/30/12 she was given report by LPN #4. She stated LPN #4 informed her Resident #1's b/p at 6:00 AM was palpable at 110, his/her pulse was "extremely" irregular, and he/she was confused. RN #2 stated she asked LPN #4 if she had phoned the Physician and LPN #4 had told her no. She stated, when staff rolled the resident by the nurse's station to take him/her to his/her room, she observed Resident #1 to be "slumped over". RN #2 stated after report she told LPN #4 the Physician needed to be notified and LPN #4 phoned the Physician. According to the RN, when she listened to Resident #1's lungs "they were wet". The RN stated she knew Resident #1 needed to go out. She stated after LPN #4 attempted to start the IV and couldn't she informed the LPN to call the Physician and tell him the resident needed to go to the ER. RN #4 indicated an order was received to send the resident to the ER. When asked why there was a delay, she stated staff had to prepare all the necessary paperwork for the hospital and ambulance personnel. Additional interview, on 02/08/13 at 5:55 PM, with RN #2 revealed she had called 911 on 12/30/12, and the ambulance was there "within minutes".</p> <p>Interview, on 02/07/13 at 4:00 PM, with the</p>	F 281		
-------	--	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
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 281	Continued From page 11 Director of Nursing (DON) revealed when she performed her investigation related to Resident #1's condition and treatment on 12/30/12, she ascertained that LPN #4's stethoscope was not working and the LPN should have changed stethoscopes. When asked if the Physician should have been notified of the change in Resident #1's condition at 6:00 AM on 12/30/12, she stated it would have been her expectation that the nurses have changed their equipment as they could not hear with LPN #4's stethoscope. She stated LPN #4 should have documented Resident #1's response to the nebulizer treatment, how he/she tolerated it, and his/her pulse oximetry reading after the treatment. Interview, on 02/06/13 at 10:28 AM, with Resident #1's Primary Care Physician (PCP) revealed he "certainly" would have wanted to have been notified of the change in Resident #1's condition. He stated he was not on call that day (12/30/12), however would have expected the facility to contact the on call Physician. Interview, on 02/05/13 at 1:52 PM, with the on call Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did not believe he was notified of the change in the resident's condition.	F 281			
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS 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.	F 441	F441 483.65 Infection Control, Prevent Spread, Linens Corrective Action for Residents Affected:	3-15-13	

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 441	Continued From page 12 (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. (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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policies it was determined the facility failed to establish and maintain an Infection Control Program designed to provide a safe,	F 441	1. Residents A,B,C,D,E,F,G,H were assessed by the wound nurse on 2-11-13 for any signs and symptoms of disease and or transmission of disease and or infection. 2. SRNA #1 was immediately pulled from the floor on 1-29-13 at approximately 5:30 am from her assignment when the deficient practice was identified. 3. The nurse consultant educated SRNA#1 on infection control, hand washing and proper storage of linens, on 1-29-13. 4. SRNA#1 was educated by the nurse consultant regarding peri-care for male and female residents, on 1-29-13, to include understanding and demonstration. Identification of Residents with potential to be affected:	
-------	--	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 441	Continued From page 13 sanitary and comfortable environment and to help prevent the development and transmission of disease and infections for eight (8) Unsampled Residents (Unsampled Residents A, B, C, D, E, F, G and H). Observation on 01/29/13 from 04:10 AM until 04:40 AM revealed a State Registered Nursing Assistant (SRNA) either checked residents for incontinence or performed incontinence care on eight (8) Unsampled Residents and failed to wash her hands prior to or after incontinence care for these residents with the exception of sanitizing her hands after perineal-care/incontinence care for Unsampled Resident E. In addition, the SRNA used improper infection control technique to perform perineal care/incontinence care for Unsampled Resident E, and Unsampled Resident A. Also, the SRNA touched objects with soiled hands after performing perineal care/incontinence care for these Unsampled Residents and contaminated the clean wash cloths by storing clean wash cloths on the soiled utility cart while performing care. The findings include: Review of the facility's "Handwashing Guideline, dated 12/2010, revealed the appropriate time for staff to wash hands was before and after caring for each resident 1. Observation on 01/29/13 at 4:10 AM revealed SRNA #1 cleansed Unsampled Resident A's buttocks with a wet wash cloth, then without	F 441	1. On 1-29-13 through 1-31-13 the nurse consultant, DON, and Staff Development coordinator initiated observations of the licensed and certified nursing staff which did not reveal any other deficient practices with peri-care, hand washing, changing of gloves and improper storage of linen. Measures or systems changes to prevent reoccurrence: 1. On 1-29-13 the Staff Development coordinator initiated education on peri-care training and competencies for SRNA staff. Training to be completed by March 15, 2013. 2. Human Resource director, DON, and or Staff Development coordinator will ensure all new certified and licensed clinical staff completes the peri-care competency check in orientation.	
-------	---	-------	--	--

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

PRINTED: 02/22/2013
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 02/08/2013
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 441	<p>Continued From page 14</p> <p>changing gloves or washing hands proceeded to cleanse the resident's genitals. With the same soiled gloves, the SRNA proceeded to adjust the resident's pillow and pull up the covers. She then proceeded to walk out of the room holding the bags containing the soiled "Attends" (adult briefs) and soiled wash cloths without washing her hands and placed the soiled bags in the soiled linen cart in the hallway, then removed her soiled gloves. SRNA #1 did not wash her hands after placing the soiled bags in the soiled linen cart and was observed to go to the general bathroom and roll the mechanical lift to the hallway.</p> <p>2. Observation on 01/29/13 at 4:20 PM revealed SRNA #1 then proceeded to Unsampled Resident B's Room where she picked up a wash cloth out of the floor and placed it on the bedside table and proceeded to leave the room without washing her hands.</p> <p>3. Observation on 01/29/13 at 4:22 AM revealed SRNA #1 went into Unsampled Resident C's room, donned new gloves, checked the resident's attends for incontinence, removed her gloves, and left the room without washing her hands and went to the clean linen cart and obtained wash cloths.</p> <p>4. Observation on 01/29/13 at 4:25 AM, revealed SRNA #1 performed perineal care for Unsampled Resident F and removed the soiled gloves. She then exited the room without washing her hands and obtained extra wash cloths from the base of the dirty linen cart where she was storing the clean wash cloths. She then cleansed the resident's buttocks and bagged the soiled wash</p>	F 441	<p>3. The Staff Development coordinator, ADON, and or DON will complete an audit of the Infection control program to consist of 10% of the residents per week to include all three shifts. The audit will consist of observing and evaluating the SRNAs for peri-care, hand washing, changing of gloves and proper linen storage for three months.</p> <p>4. Deficient practices identified will be forwarded to the DON and administrator for appropriate corrective action and further education if necessary. The 10% weekly audits will be reviewed in the weekly AI Risk meeting.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>1. Findings of the weekly audits will be reviewed in the QA meeting monthly for 3 months and then at the discretion of the QA committee.</p>		

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

PRINTED: 02/22/2013
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 02/08/2013
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 441	<p>Continued From page 15</p> <p>cloths and soiled attends and exited the room without washing her hands and also failed to wash her hands after exiting the room.</p> <p>5. Observation on 01/29/13 at 4:30 AM revealed SRNA #1 went to the linen storage room and obtained wash cloths. She performed incontinence care for Unsamped Resident G and exited the room wearing the soiled gloves. She then removed her soiled gloves and without washing her hands obtained clean wash cloths and towels from the clean linen cart. SRNA #1 then finished performing incontinence care for Unsamped Resident G, placed the soiled attends and soiled wash cloths in plastic bags and exited the room without washing her hands. She placed the bags in the soiled laundry hamper, removed her gloves, and failed to wash her hands. SRNA #1 then obtained clean wash cloths from the clean linen cart and rolled the dirty linen hamper down the hall holding the clean wash cloths next to the dirty linen cart.</p> <p>6. Observation, on 01/29/13 at 4:35 AM, revealed SRNA #1 checked Unsamped Resident H's attends for incontinence, removed her gloves, and left the room without washing her hands.</p> <p>7. Observation, on 01/29/13 at 4:37 AM, revealed SRNA #1 checked Unsamped Resident D for incontinence, removed her gloves and exited the room without washing her hands.</p> <p>8. Observation on 01/29/13 at 4:40 AM revealed SRNA #1 performed perineal-care on Unsamped Resident E by cleansing the outside of the vagina; however, she did not cleanse the labial folds. She then assisted the resident to turn, and</p>	F 441			

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

PRINTED: 02/22/2013
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 02/08/2013
--	--	--	---

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 441 Continued From page 16
cleansed the resident's buttocks. With the same soiled gloves, SRNA #1 used the remote control to raise the head of the bed, and then pulled the covers up. She then removed her gloves and walked out of the room, sanitizing her hands in the hall.

Interview on 01/29/13 at 5:30 AM with SRNA #1, revealed she had worked at the facility for five (5) years and the nurses had watched her perform perineal care. She stated, she should have washed her hands before and after incontinence care and prior to touching objects in the residents' rooms and hallway. She further stated, she did not realize she was storing clean wash cloths on the soiled hampers in the hallway. Continued interview revealed she did not realize she needed to remove gloves and wash hands after cleansing Unsamped Resident A's buttocks and prior to cleansing the genitals. She stated she had not cleansed Unsamped Resident #E's labial folds while performing perineal care. Further interview revealed she should not have picked a wash cloth up of the floor and placed it on the bedside table because the wash cloth would be contaminated after being on the floor.

Interview on 01/29/13 at 6:30 PM with the Director of Nursing, revealed handwashing should be performed before and after perineal/incontinence care and handwashing should be performed any time gloves were removed. She further stated staff should remove soiled gloves and wash hands prior to handling objects in the residents' rooms such as remote controls. Further interview revealed staff should not store clean linens on the dirty hampers and should not pick up linens out of the floor and

F 441

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

PRINTED: 02/22/2013
FORM APPROVED
OMB NO. 0938-0391

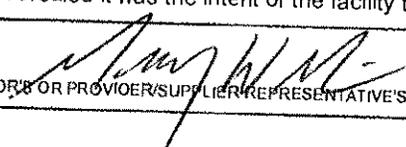
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185141	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN			STREET ADDRESS, CITY, STATE, 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 441	Continued From page 17 place on the resident's bedside table. She stated the facility was in the process of performing skills check offs and would need to include perineal care in this process. Further interview revealed the nurses should be observing for infection control issues when doing rounds.	F 441			

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 000	INITIAL COMMENTS A Complaint Survey investigating KY#00019708 was conducted 01/28/13 through 02/08/13. KY#00019708 was substantiated with deficiencies cited.	N 000	Georgetown Health Core and Rehabilitation, a Signature Healthcare Facility does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves all rights to contest the survey finding through Informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all right to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should consider as a waiver of any potentially applicable peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality care to residents.	
N 018	902 KAR 20:300-3(2)(i)1.b. Section 3. Resident Rights (2) Notice of rights and services. (i) Notification of changes. 1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is: b. A significant change in the resident's physical, mental, or psychosocial status; This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified of changes in condition for one (1) of four (4) sampled residents (Resident #1). On 12/30/12 at 6:00 AM, a nurse noted she was unable to obtain Resident #1's blood pressure and had to palpate in order to obtain the blood pressure; additionally, the resident was noted to be pale, weak, and unable to take his/her medications at that time; however the Physician was not notified. The findings include: Review of the facility's policy titled, "Change in Condition (Action and Notification)", revised 04/08, revealed it was the intent of the facility to	N 018		

RECEIVED
MAR - 4 2013

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



TITLE
ADMINISTRATOR

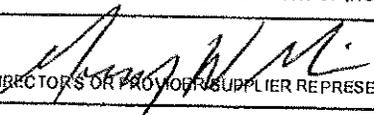
(X6) DATE
3/4/13

6899 OVN011

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 000	INITIAL COMMENTS A Complaint Survey investigating KY#00019708 was conducted 01/28/13 through 02/08/13. KY#00019708 was substantiated with deficiencies cited.	N 000		
N 018	902 KAR 20:300-3(2)(i)1.b. Section 3. Resident Rights (2) Notice of rights and services. (i) Notification of changes. 1. Except in a medical emergency or when a resident is incompetent, a facility shall consult with the resident immediately and notify the resident's physician, and if known, the resident's legal representative or interested family member within twenty-four (24) hours when there is: b. A significant change in the resident's physical, mental, or psychosocial status; This requirement is not met as evidenced by: Based on interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Physician was notified of changes in condition for one (1) of four (4) sampled residents (Resident #1). On 12/30/12 at 6:00 AM, a nurse noted she was unable to obtain Resident #1's blood pressure and had to palpate in order to obtain the blood pressure; additionally, the resident was noted to be pale, weak, and unable to take his/her medications at that time; however the Physician was not notified. The findings include: Review of the facility's policy titled, "Change in Condition (Action and Notification)", revised 04/08, revealed it was the intent of the facility to	N 018	N 018 902 KAR 20:300-3(2)(i)1.b. Section 3. Resident Rights Corrective Action for Residents Affected: 1. Resident #1 is no longer a resident of the facility. Identification of Residents with potential to be affected: 1. The director of nursing (DON) reviewed 100% of resident #1's chart on 1-2-13 for any identified change in condition and identified no other deficient practice. 2. The facility DON, Assistant Director of Nursing (ADON), Clinical Nurse Consultant and Unit Nurse Manager reviewed the 24 hour report and resident charts on 2-11-13 for identified change in condition that should have been reported to the physician. No other deficient practice was identified.	3-15-13

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



TITLE
ADMINISTRATOR

(X6) DATE
3/4/13
If continuation sheet 1 of 16

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 018	Continued From page 1 assess and document changes in a resident's health, mental, or psychosocial status in an efficient and effective manner, to relay assessment information to the Physician and to document actions. Further review revealed a resident's Physician was to be notified of a significant change in a resident's physical, mental, or psychosocial status. 1. Record review revealed the facility admitted Resident #1 on 07/26/12, with diagnoses which included Intracranial Hemorrhage, Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), and Hypertension (HTN). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 10/12/12, revealed Resident #3 required extensive assistance with his/her Activities of Daily Living (ADLs). Review of the Nurse's Note, dated 12/30/12 and timed 6:00 AM, revealed Resident #1 was "up in chair, pale and weak". The note indicated the nurse was unable to hear B/P (blood pressure) that was palpable at 110 and resident's pulse was in 60's and irregular. Further review of the record revealed no documented evidence the Phystician was notified of the change in Resident #1's condition until 8:10 AM, two (2) hours and ten (10) minutes after the noted change in condition. Interview, on 02/05/13 at 5:38 PM, with Licensed Practical Nurse (LPN) #4 revealed she was assigned to Resident #1's care on 12/30/12. She stated Resident #1 had been "restless" during the night and staff had gotten him/her up out of bed and taken him/her to the dining room. According to the LPN, during her "diabetic rounds" at 6:00 AM on 12/30/12, she checked Resident #1's blood sugar. She stated she tried to administer his/her pills and he/she had "a lot of trouble	N 018	Measures or systems changes to prevent recurrence: 1. The clinical staff were educated by the DON, ADON and staff development coordinator on 2-11-13 regarding Resident Rights to a timely notification to the physician of a significant change in condition and or a deterioration in health and or the need to alter treatment due to the physical, mental and psychosocial status change of the patient. 2. The staff development coordinator will educate 100% of the licensed clinical staff with a completed competency check on how to complete a head to toe assessment, by 3-15-13. Human Resource director, DON, and or Staff Development coordinator will ensure all new licensed clinical staff completes the competency check in orientation.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 018	Continued From page 2 getting them to..." his/her mouth. The LPN stated this was "just weird" for Resident #1 and she attempted to get a blood pressure (b/p) which she was unable to hear. She stated she called a nurse from another unit, who was an experienced Emergency Room (ER) nurse, to attempt to get the resident's b/p; however, they were unable to hear a b/p, and were only able to palpate a b/p of 110. LPN #4 stated she thought Resident #1 was getting dehydrated. She stated she gave report to the oncoming shift, then phoned the Physician to request intravenous fluids (IVF's). The LPN stated when she went in to start the IVF's, Resident #1 was "breathing rapidly", so she gave him/her a nebulizer treatment which was not effective. She stated she called the Physician back and asked if the resident could be sent out to the ER. When asked if she should have phoned the Physician sooner, LPN #4 stated "yes". She stated she thought the resident was getting dehydrated and she should have called the Physician sooner. Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed when she performed her investigation related to Resident #1's condition and treatment on 12/30/12, she ascertained that LPN #4's stethoscope was not working and she should have changed stethoscopes. Interview, on 02/06/13 at 10:28 AM, with Resident #1's Primary Care Physician (PCP) revealed he "certainly" would have wanted to have been notified of the change in Resident #1's condition. He stated he was not on call that day (12/30/12); however, he would have expected the facility to contact the on call Physician. Interview, on 02/05/13 at 1:52 PM, with the on call	N 018	3. The licensed nurse team, supervised by the DON and or the RN supervisor, will review the charts, new orders, lab reports and all identified concerns logged on the 24 hour report for any change in condition and for the appropriate notification to the physician in the clinical team meeting, five days per week. Identified deficient practice will be reported to the DON, the administrator and the attending physician for immediate review, assessment of the resident, and correction of the deficient practice. Monitoring changes/systems to ensure no deficient practice: 1. The administrator will report the change in condition assessment audit results to the quality assurance committee (QA committee) monthly for review and assessment for 3 months and then at the discretion of the QA committee. (QA committee consists of the following: Medical Director, Administrator, DON,	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 018	Continued From page 2 getting them to..." his/her mouth. The LPN stated this was "just weird" for Resident #1 and she attempted to get a blood pressure (b/p) which she was unable to hear. She stated she called a nurse from another unit, who was an experienced Emergency Room (ER) nurse, to attempt to get the resident's b/p; however, they were unable to hear a b/p, and were only able to palpate a b/p of 110. LPN #4 stated she thought Resident #1 was getting dehydrated. She stated she gave report to the oncoming shift, then phoned the Physician to request intravenous fluids (IVF's). The LPN stated when she went in to start the IVF's, Resident #1 was "breathing rapidly", so she gave him/her a nebulizer treatment which was not effective. She stated she called the Physician back and asked if the resident could be sent out to the ER. When asked if she should have phoned the Physician sooner, LPN #4 stated "yes". She stated she thought the resident was getting dehydrated and she should have called the Physician sooner. Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed when she performed her investigation related to Resident #1's condition and treatment on 12/30/12, she ascertained that LPN #4's stethoscope was not working and she should have changed stethoscopes. Interview, on 02/06/13 at 10:28 AM, with Resident #1's Primary Care Physician (PCP) revealed he "certainly" would have wanted to have been notified of the change in Resident #1's condition. He stated he was not on call that day (12/30/12); however, he would have expected the facility to contact the on call Physician. Interview, on 02/05/13 at 1:52 PM, with the on call	N 018	Minimum Data Set Coordinator (MDS), Social Service Director (SSD), Human Resource Director (HR), Staff Development Coordinator, Unit Nurse Manager, Business Office Manager (BOM), Dietary Manager, Rehab Services Manager (RSM), Medical Records, Maintenance Director, Housekeeping Director, Quality of Life Director (QOL), Chaplain)	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 018	Continued From page 3 Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did not believe he was notified of the change in the resident's condition.	N 018		
N 113	902 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall 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. 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 provide care in a manner that maintains residents' dignity. Observation on the morning of 01/29/13 revealed a State Registered Nursing Assistant (SRNA) performed perineal/incontinence care without shutting the door or curtain for Unsampled Resident F and Unsampled Resident G. The findings include: Review of the facility's "Perineal Care Guideline", dated 12/10, revealed the procedure entailed washing hands, collecting equipment, explaining the procedure to the resident, and providing privacy for the resident: close the door, window blind and privacy curtain. 1. Observation, on 01/29/13 at 4:25 AM, revealed State Registered Nurse Aide (SRNA) #1 performed perineal care for Unsampled Resident F without closing the bedside curtain or closing the door.	N 113	N 113 902 KAR 20:300-6(1) Section 6. Quality of Life Corrective Action for Residents Affected: 1. On 2-8-13 the DON assessed Resident F and Resident G to ensure resident F and Resident G did not exhibit signs of psychosocial distress due to the facility providing care in an undignified manner. 2. SRNA #1 was removed from direct care on the morning of 1-29-13 and provided one on one education by the staff development coordinator and DON regarding resident rights to Include privacy, closing the door of the room, the cubical curtain and window blinds if appropriate and providing care to each resident in a dignified manner.	3-15-13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	{X1} PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	{X2} MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	{X3} DATE SURVEY COMPLETED C 02/08/2013
--	--	--	---

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} COMPLETE DATE
N 018	Continued From page 3 Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did not believe he was notified of the change in the resident's condition.	N 018		
N 113	902 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall 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. 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 provide care in a manner that maintains residents' dignity. Observation on the morning of 01/29/13 revealed a State Registered Nursing Assistant (SRNA) performed perineal/incontinence care without shutting the door or curtain for Unsampled Resident F and Unsampled Resident G. The findings include: Review of the facility's "Perineal Care Guideline", dated 12/10, revealed the procedure entailed washing hands, collecting equipment, explaining the procedure to the resident, and providing privacy for the resident: close the door, window blind and privacy curtain. 1. Observation, on 01/29/13 at 4:25 AM, revealed State Registered Nurse Aide (SRNA) #1 performed perineal care for Unsampled Resident F without closing the bedside curtain or closing the door.	N 113	Identification of Residents with potential to be affected: 1. On 1-29-13, 1-30-13 and 1-31-13, the nurse consultant, the DON, and social service director evaluated clinical staff for deficient practice related to dignity and violation of resident rights. No other deficient practice was identified. Measures or systems changes to prevent reoccurrence: 1. On January 29, 2013 Staff development coordinator, nurse consultant, social service director, and DON initiated education with licensed and certified nursing staff to provide care in a manner that maintains residents' dignity. Education to be completed by March 15, 2013 for all departments.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 018	Continued From page 3 Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did not believe he was notified of the change in the resident's condition.	N 018		
N 113	002 KAR 20:300-6(1) Section 6. Quality Of Life (1) Dignity. The facility shall 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. 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 provide care in a manner that maintains residents' dignity. Observation on the morning of 01/29/13 revealed a State Registered Nursing Assistant (SRNA) performed perineal/incontinence care without shutting the door or curtain for Unsamped Resident F and Unsamped Resident G. The findings include: Review of the facility's "Perineal Care Guideline", dated 12/10, revealed the procedure entailed washing hands, collecting equipment, explaining the procedure to the resident, and providing privacy for the resident: close the door, window blind and privacy curtain. 1. Observation, on 01/29/13 at 4:25 AM, revealed State Registered Nurse Aide (SRNA) #1 performed perineal care for Unsamped Resident F without closing the bedside curtain or closing the door.	N 113	2. The Staff development coordinator, DON, ADON, Unit Nurse Manager and or Social Services Director will monitor five (5) % of the residents each day for four days per week to ensure the residents receive consistent care to include privacy, closing the door of the room, the cubical curtain and window blinds if appropriate and providing care to each resident in a dignified manner.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		{X1} PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	{X2} MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	{X3} DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
{X4} IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	{X5} COMPLETE DATE
N 113	Continued From page 4 2. Observation, on 01/29/13 at 4:30 AM revealed SRNA #1 performed incontinence care for Unsamped Resident G without closing the bedside curtain or closing the door. Interview, on 01/29/13 at 5:30 AM, with SRNA #1, revealed she should have closed Unsamped Resident F's and Unsamped Resident G's doors to the hallway; however, she did not think about it because she was nervous. Interview, on 01/29/13 at 6:30 PM, with the Director of Nursing (DON), revealed staff should provide privacy when performing care.	N 113	Monitoring changes/systems to ensure no deficient practice: 1. The Director of Nursing and or the administrator will evaluate the 5% dignity audit weekly. Results will be reviewed in the Quality Assurance meeting monthly for 3 months and then at the discretion of the QA committee.	
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 policies it was determined the facility failed to 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 infections for eight (8) Unsamped Residents (Unsamped Residents A, B, C, D, E, F, G and H). Observation on 01/29/13 from 04:10 AM until 04:40 AM revealed a State Registered Nursing Assistant (SRNA) either checked residents for	N 144	N 144 902 KAR 20:300-6(7)(b)2.a. Section 6. Quality of Life Corrective Action for Residents Affected: 1. Resident #1 is no longer a resident of the facility. Identification of Residents with potential to be affected:	3-15-13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	<p>Continued From page 5</p> <p>incontinence or performed incontinence care on eight (8) Unsampled Residents and failed to wash her hands prior to or after incontinence care for these residents with the exception of sanitizing her hands after perineal-care/incontinence care for Unsampled Resident E.</p> <p>In addition, the SRNA used improper infection control technique to perform perineal care/incontinence care for Unsampled Resident E, and Unsampled Resident A.</p> <p>Also, the SRNA touched objects with soiled hands after performing perineal care/incontinence care for these Unsampled Residents and contaminated the clean wash cloths by storing clean wash cloths on the soiled utility cart while performing care.</p> <p>The findings include:</p> <p>Review of the facility's "Handwashing Guideline, dated 12/2010, revealed the appropriate time for staff to wash hands was before and after caring for each resident</p> <p>1. Observation on 01/29/13 at 4:10 AM revealed SRNA #1 cleansed Unsampled Resident A's buttocks with a wet wash cloth, then without changing gloves or washing hands proceeded to cleanse the resident's genitals. With the same soiled gloves, the SRNA proceeded to adjust the resident's pillow and pull up the covers. She then proceeded to walk out of the room folding the bags containing the soiled "Attends" (adult briefs) and soiled wash cloths without washing her hands and placed the soiled bags in the soiled linen cart in the hallway, then removed her soiled gloves. SRNA #1 did not wash her hands after placing the soiled bags in the soiled linen</p>	N 144	<p>1. A 100% assessment of Medication Administration Records (MARS) and Treatment Administration Records (TARS) were reviewed by the Unit Nurse Manager, DON, Medical Records Director, and Staff Development Coordinator to identify additional deficient practice of not following physician orders. Audit completed on January 31, 2013.</p> <p>2. No other residents were identified.</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. Education initiated on February 6, 2013 for licensed nursing staff on the proper procedure in following physician orders, documentation, and notification of non-compliance by the DON and Staff Development Coordinator. Education will be completed by March 15, 2013.</p>	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 144	Continued From page 6 cart and was observed to go to the general bathroom and roll the mechanical lift to the hallway. 2. Observation on 01/29/13 at 4:20 PM revealed SRNA #1 then proceeded to Unsampld Resident B's Room where she picked up a wash cloth out of the floor and placed it on the bedside table and proceeded to leave the room without washing her hands. 3. Observation on 01/29/13 at 4:22 AM revealed SRNA #1 went into Unsampld Resident C's room, donned new gloves, checked the resident's attends for incontinence, removed her gloves, and left the room without washing her hands and went to the clean linen cart and obtained wash cloths. 4. Observation on 01/29/13 at 4:25 AM, revealed SRNA #1 performed perineal care for Unsampld Resident F and removed the soiled gloves. She then exited the room without washing her hands and obtained extra wash cloths from the base of the dirty linen cart where she was storing the clean wash cloths. She then cleansed the resident's buttocks and bagged the soiled wash cloths and soiled attends and exited the room without washing her hands and also failed to wash he hands after exiting the room. 5. Observation on 01/29/13 at 4:30 AM revealed SRNA #1 went to the linen storage room and obtained wash cloths. She performed incontinence care for Unsampld Resident G and exited the room wearing the soiled gloves. She then removed her soiled gloves and without washing her hands obtained clean wash cloths and towels from the clean linen cart. SRNA #1 then finished performing incontinence care for	N 144	2. The Staff Development Coordinator, DON, ADON, and or Nurse consultant will have completed physical assessment training to include documentation of changes in a resident's condition for licensed nurses by March 15, 2013. Human Resource director, DON, and or Staff Development coordinator will ensure all new licensed clinical staff completes the assessment training in orlentation. 3. Any change in condition reported by the 24 hour report, lab results, behavior concerns, and incident and accident reports will be reviewed in the clinical meeting, five days per week. The charts will be reviewed and updated with this process. 4. New physican orders are reviewed in the clinical meeting, five days per week, to ensure completion and accuracy. Any noted discrepancy will be corrected at the time of identification and the attending physician will be notified when appropriate.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 144	Continued From page 7 Unsamped Resident G, placed the soiled attends and soiled wash cloths in plastic bags and exited the room without washing her hands. She placed the bags in the soiled laundry hamper, removed her gloves, and failed to wash her hands. SRNA #1 then obtained clean wash cloths from the clean linen cart and rolled the dirty linen hamper down the hall holding the clean wash cloths next to the dirty linen cart. 6. Observation, on 01/29/13 at 4:35 AM, revealed SRNA #1 checked Unsamped Resident H's attends for incontinence, removed her gloves, and left the room without washing her hands. 7. Observation, on 01/29/13 at 4:37 AM, revealed SRNA #1 checked Unsamped Resident D for incontinence, removed her gloves and exited the room without washing her hands. 8. Observation on 01/29/13 at 4:40 AM revealed SRNA #1 performed perineal-care on Unsamped Resident E by cleansing the outside of the vagina; however, she did not cleanse the labial folds. She then assisted the resident to turn, and cleansed the resident's buttocks. With the same soiled gloves, SRNA #1 used the remote control to raise the head of the bed, and then pulled the covers up. She then removed her gloves and walked out of the room, sanitizing her hands in the hall. Interview on 01/29/13 at 5:30 AM with SRNA #1, revealed she had worked at the facility for five (5) years and the nurses had watched her perform perineal care. She stated, she should have washed her hands before and after incontinence care and prior to touching objects in the residents' rooms and hallway. She further stated, she did not realize she was storing clean wash cloths on	N 144	5. The Unit Nurse Manager, DON, ADON, Medical Records Director, and or Staff Development Coordinator will review the MAR, TAR and chart for new order accuracy two times per week. Results will be reviewed in the weekly At Risk meeting for necessary corrective action. Monitoring changes/systems to ensure no deficient practice: 1. Identified deficient practices to follow physician orders on Mars, Tars, and or weekly audits and the appropriate resolutions will be reviewed in the clinical meeting, five days per week. 2. Identified deficient practices will be forwarded to the Staff Development Coordinator, DON, and or ADON for immediate education and training. 3. Results of the audits will be reported by DON, ADON, and or Unit Nurse Manager to the QA committee meeting monthly for 3 months and then at the discretion of the QA committee.	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) IO 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) COMPLETE DATE
N 144	Continued From page 8 the soiled hampers in the hallway. Continued interview revealed she did not realize she needed to remove gloves and wash hands after cleansing Unsamped Resident A's buttocks and prior to cleansing the genitals. She stated she had not cleansed Unsamped Resident #E's labial folds while performing perineal care. Further interview revealed she should not have picked a wash cloth up of the floor and placed it on the bedside table because the wash cloth would be contaminated after being on the floor. Interview on 01/29/13 at 6:30 PM with the Director of Nursing, revealed handwashing should be performed before and after perineal/incontinence care and handwashing should be performed any time gloves were removed. She further stated staff should remove soiled gloves and wash hands prior to handling objects in the residents' rooms such as remote controls. Further interview revealed staff should not store clean linens on the dirty hampers and should not pick up linens out of the floor and place on the resident's bedside table. She stated the facility was in the process of performing skills check offs and would need to include perineal care in this process. Further interview revealed the nurses should be observing for infection control issues when doing rounds.	N 144		
N 193	902 KAR 20:300-7(4)(c)1. Section 7. Resident Assessment (4) Comprehensive care plans. (c) The services provided or arranged by the facility shall: 1. Meet professional standards of quality; and This requirement is not met as evidenced by:	N 193	N 193 902 KAR 20:300-7(4)(c)1. Section 7. Resident Assessment Corrective Action for Residents Affected:	3-15-13

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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)	(X6) COMPLETE DATE
N 193	Continued From page 9 Based on interview, record review and review of the facility's policy, it was determined the facility failed to ensure services that were provided or arranged by the facility met professional standards of quality for one (1) of four (4) sampled residents (Resident #1); failed to ensure Physician's Orders were followed; and failed to document changes in a resident's condition. The findings include: Review of the facility's policy titled, "Change in Condition (Action and Notification)", revised 04/08, revealed it was the intent of the facility to assess and document changes in a resident's health, mental, or psychosocial status in an efficient and effective manner; to relay assessment information to the Physician and to document actions. Further review revealed a resident's Physician was to be notified of a significant change in a resident's status physical, mental, or psychosocial status. Interview, on 02/08/13 at 3:05 PM, with the Director of Nursing (DON) revealed following Physician's Orders, and assessing and monitoring were basic nursing standards of practice and she did not have policies related to these areas. Additionally, she stated, in regards to following Physician's Orders and assessing and monitoring, was basic "Nursing 101". Review of the clinical record revealed the facility admitted Resident #1 on 07/28/12, with diagnoses which included Intracranial Hemorrhage, Diabetes Mellitus (DM), Chronic Obstructive Pulmonary Disease (COPD), and Hypertension (HTN). Review of the Quarterly Minimum Data Set (MDS) Assessment, dated	N 193	1. Residents A,B,C,D,E,F,G,H were assessed by the wound nurse on 2-11-13 for any signs and symptoms of disease and or transmission of disease and or infection. 2. SRNA #1 was immediately pulled from the floor on 1-29-13 at approximately 5:30 am from her assignment when the deficient practice was identified. 3. The nurse consultant educated SRNA#1 on infection control, hand washing and proper storage of linens, on 1-29-13. 4. SRNA#1 was educated by the nurse consultant regarding per-care for male and female residents, on 1-29-13, to include understanding and demonstration. Identification of Residents with potential to be affected:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 193i	<p>Continued From page 10</p> <p>10/12/12, revealed Resident #1 required extensive assistance with his/her Activities of Daily Living (ADLs).</p> <p>Review of the Physician's Orders revealed an order, dated for 12/11/12, for the resident to have a chest x-ray related to increased congestion, cough, productive cough with green sputum. Further review revealed an order dated 12/12/12 for Omnicef (an antibiotic) three hundred (300) milligram (mg) by mouth twice a day for ten (10) days related to possible Pneumonia. Review of the Medication Administration Record (MAR) revealed the resident received nine (9) days of the antibiotic. Further review of the MAR revealed no documented evidence the resident received a tenth day of antibiotic as ordered.</p> <p>Further review of the Physician's Orders revealed an order dated 12/26/12 to check Resident #1's stool for clostridium difficile (c-diff), a bacterial infection that can range from mild to life-threatening and that causes watery diarrhea, three or more times a day for several days, accompanied by pain or tenderness. Review of the Elimination Report revealed Resident #1 had a large loose bowel movement (BM) and a large soft BM on 12/27/12. However, review of the Nurse's Notes revealed no documented evidence a stool for the c-diff was obtained until 12/28/12 at 3:00 PM, at which time it was sent to the lab. Review of the lab report dated 12/28/12 revealed Resident #1's stool was positive for c-diff. The Physician was notified and Flagyl (an antibiotic used to treat c-diff) was ordered.</p> <p>Interview, on 02/05/13 at 2:14 PM, with State Registered Nursing Assistant (SRNA) #6 revealed Resident #1 was having diarrhea approximately one (1) week prior to being sent out to the</p>	N 193	<p>1. On 1-29-13 through 1-31-13 the nurse consultant, DON, and Staff Development coordinator initiated observations of the licensed and certified nursing staff which did not reveal any other deficient practices with peri-care, hand washing, changing of gloves and improper storage of linen.</p> <p>Measures or systems changes to prevent reoccurrence:</p> <p>1. On 1-29-13 the Staff Development coordinator initiated education on peri-care training and competencies for SRNA staff. Training to be completed by March 15, 2013.</p> <p>2. Human Resource director, DON, and or Staff Development coordinator will ensure all new certified and licensed clinical staff completes the peri-care competency check in orientation.</p>	

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 193	<p>Continued From page 11</p> <p>Emergency Room (ER) on 12/30/12.</p> <p>Interview, on 02/06/13 at 11:22 AM, with SRNA #7 revealed Resident #1 had been having diarrhea approximately three (3) to four (4) days prior to being sent out to the ER.</p> <p>Interview, on 02/06/13 at 6:50 PM, with Licensed Practical Nurse (LPN) #2 revealed Resident #1 had been treated with antibiotics for an Upper Respiratory Infection (URI). After reviewing the MAR she stated the resident did not receive the antibiotic for ten (10) days as ordered; he/she had only received nine (9) days. She stated Resident #1 should have received ten (10) days as ordered. The LPN indicated Resident #1 had been having loose stools, after being treated for the URI. She stated the resident had the loose stools for several days. According to the LPN, she notified the Physician, then Resident #1 went several days without having the loose stools and they were unable to get the specimen. She stated when the loose stools started back again and the specimen was obtained.</p> <p>Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed the stool specimen for c-diff should have been obtained on 12/27/12 because the Elimination Report showed Resident #1 had stools that day. Additionally, she stated it was her expectation the antibiotic order be transcribed correctly and the resident to be given the full dose ordered.</p> <p>Review of the Nurse's Note, dated 12/30/12, and timed 6:00 AM revealed Resident #1 was weak, pale, and the nurse was unable to hear the resident's blood pressure (b/p). The nurse noted the resident's b/p was palpable at 110. The nurse documented Resident #1's pulse was in the 60's</p>	N 193	<p>3. The Staff Development coordinator, ADON, and or DON will complete an audit of the infection control program to consist of 10% of the residents per week to include all three shifts. The audit will consist of observing and evaluating the SRNAs for peri-care, hand washing, changing of gloves and proper linen storage for three months.</p> <p>4. Deficient practices identified will be forwarded to the DON and administrator for appropriate corrective action and further education if necessary. The 10% weekly audits will be reviewed in the weekly At Risk meeting.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>1. Findings of the weekly audits will be reviewed in the QA meeting monthly for 3 months and then at the discretion of the QA committee.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324		
(X4) IO PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	IO PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 193	Continued From page 12 and "irregularly irregular". Review revealed no documented evidence a complete set of vital signs, which would include a temperature and respirations, was obtained at 6:00 AM on 12/30/12. Review of the Medication Administration Record (MAR) revealed the nurse administered a nebulizer treatment at 8:20 AM; however, review of the MAR and Nurse's Notes revealed no documented evidence of the resident's response to the treatment. Additionally, although Resident #1's respirations were noted to be in the 30's and labored at 8:40 AM, and an order was received to transport the resident to the Emergency Room (ER), there was no documented evidence 911 was phoned until 9:17 AM, thirty-seven (37) minutes after receiving the order. Interview, on 02/05/13 at 5:38 PM, with Licensed Practical Nurse (LPN) #4 revealed she was assigned to Resident #1's care on 12/30/12. She stated Resident #1 had been "restless" during the night and staff had gotten him/her up out of bed and taken him/her to the dining room. According to the LPN, during her "diabetic rounds" at 6:00 AM on 12/30/12 she checked Resident #1's blood sugar. She stated she tried to administer his/her pills and he/she had "a lot of trouble getting them to" his/her mouth. The LPN stated this was "just weird" for Resident #1 and she attempted to get a blood pressure (b/p) which she was unable to hear. She stated she called a nurse from another unit, who was an experienced Emergency Room (ER) nurse, to attempt to get the resident's b/p, however they were unable to hear a b/p, and were only able to palpate a b/p of 110. LPN #4 stated she thought Resident #1 was getting dehydrated. She stated she gave report to the oncoming shift, then phoned the Physician to request intravenous fluids (IVFs). The LPN	N 193		

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
--	--	--	---

NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF GEORGETOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 102 POCAHONTAS TRAIL GEORGETOWN, KY 40324
--	---

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

N 193 Continued From page 13

stated when she went in to start the IVs Resident #1 was "breathing rapidly", so she gave him/her a nebulizer treatment which was not effective. She stated she called the Physician back and asked if the resident could be sent out to the ER. When asked if she should have phoned the Physician sooner, LPN #4 stated "yes". She stated she thought the resident was getting dehydrated and she should have called the Physician sooner.

Interview, on 02/06/13 at 6:50 PM, with Licensed Practical Nurse (LPN) #2 revealed if one nurse can't get a blood pressure (b/p), the he/she should have another nurse try, then if they couldn't get it, try to palpate the b/p. She stated then the nurse should notify the Physician. She indicated LPN #4 should have notified the Physician at 6:00 AM on 12/30/12 of her inability to obtain the resident's b/p and of the irregular pulse.

Interview, on 02/08/13 at 12:38 PM, with Registered Nurse (RN) #2 revealed on 12/30/12 she was given report by LPN #4. She stated LPN #4 informed her Resident #1's b/p at 6:00 AM was palpable at 110, his/her pulse was "extremely" irregular, and he/she was confused. RN #2 stated she asked LPN #4 if she had phoned the Physician and LPN #4 had told her no. She stated, when staff rolled the resident by the nurse's station to take him/her to his/her room, she observed Resident #1 to be "slumped over". RN #2 stated after report she told LPN #4 the Physician needed to be notified and LPN #4 phoned the Physician. According to the RN, when she listened to Resident #1's lungs "they were wet". The RN stated she knew Resident #1 needed to go out. She stated after LPN #4 attempted to start the IV and couldn't she

N 193

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
--	--	--	---

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) COMPLETE DATE
--------------------	--	---------------	---	--------------------

N 193 | Continued From page 14

informed the LPN to call the Physician and tell him the resident needed to go to the ER. RN #4 indicated an order was received to send the resident to the ER. When asked why there was a delay, she stated staff had to prepare all the necessary paperwork for the hospital and ambulance personnel. Additional Interview, on 02/08/13 at 5:55 PM, with RN #2 revealed she had called 911 on 12/30/12, and the ambulance was there "withn minutes".

Interview, on 02/07/13 at 4:00 PM, with the Director of Nursing (DON) revealed when she performed her investigation related to Resident #1's condition and treatment on 12/30/12, she ascertained that LPN #4's stethoscope was not working and the LPN should have changed stethoscopes. When asked if the Physician should have been notified of the change in Resident #1's condition at 6:00 AM on 12/30/12, she stated it would have been her expectation that the nurses have changed their equipment as they could not hear with LPN #4's stethoscope. She stated LPN #4 should have documented Resident #1's response to the nebulzer treatment, how he/she tolerated it, and his/her pulse oximetry reading after the treatment.

Interview, on 02/06/13 at 10:28 AM, with Resident #1's Primary Care Physician (PCP) revealed he "certainly" would have wanted to have been notified of the change in Resident #1's condition. He stated he was not on call that day (12/30/12), however would have expected the facility to contact the on call Physician.

Interview, on 02/05/13 at 1:52 PM, with the on call Physician revealed he could not recall if he was notified of Resident #1's change in condition at 6:00 AM on 12/30/12. However, he stated he did

N 193

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2013
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) COMPLETE DATE
N 193	Continued From page 15 not believe he was notified of the change in the resident's condition.	N 193		