

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

PRINTED: 06/18/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  186344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/03/2010
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8289 ASBURY ROAD AUGUSTA, KY 41002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food. If direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>F441</p> <p>1. The DON has reviewed 483.65 infection control, and will maintain a safe, comfortable environment to help prevent the development and spread of disease and infections as evidenced by insufficient hand washing during meal service in dining room and during medication pass. The state registered nurses aide passing trays and the certified medication aide were removed from direct care and educated by the staff development coordinator with return demonstration of process before providing additional care on 06/03/2010.</p> <p>2. On 06/25/2010 the DON audited 100% of the staff during meal service to ensure sufficient hand washing was performed. On 06/25/2010 a 100% audit of all licensed staff and certified medication aides was completed for medication administration by the Staff Development Coordinator. All licensed staff have reviewed competency check off for medication pass and infection control review/assessment of all residents was completed on 06/03/2010 to determine any s/s of infection. No negative outcomes were found.</p>	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark D. Henderson LNA</i>	TITLE <i>Administrator</i>	(X8) DATE 6/23/2010
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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 disclosure 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 disclosure 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 441	<p>Continued From page 1</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview 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 infection as evidenced by insufficient handwashing during meal service in Dining Room and during Medication Pass observation.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>Observation of Medication Pass on 06/03/10 at 9:00 AM revealed the Certified Medication Technician (CMT) licked her thumb several times while turning pages of the Medication Administration Record (MAR) and failed to sanitize her hands before she continued to dispense medications. At 9:20 AM, she took an unsampled resident's pulse and continued to dispense medications without sanitizing her hands.</li> </ol> <p>Interview with the CMT on 06/03/10 at 1:40 PM revealed she should have washed her hands after licking her thumb and after touching the resident. She stated she did not realize that she licked her thumb.</p> <p>Interview with the Director of Nursing revealed the</p>	F 441	<p>3. On 6/14/2010, the SDC in serviced all licensed nursing staff to ensure understanding of the infection control policy, specific to handwashing. A follow up inservice for all licensed staff was conducted by the SDC on 6/18/10 to review the infection control policy with intended focus on handwashing procedures. Infection control, hand washing, and sanitation competency checks have been completed and recorded. Alcohol gel hand sanitizers have been provided to all nursing staff to become a detail of their daily uniform on 07/02/2010.</p> <p>4. The DON/designee will monitor meal service delivery for 10 meals a week for 2 weeks to ensure staff compliance with infection control program in relation to handwashing during meal service. Meal delivery will continue to be monitored by the Staff Development Coordinator at least weekly thereafter x 3 months to ensure continued compliance. Med pass will be audited by the Staff Development Coordinator with each Certified Medication Technician weekly x 4 weeks and monthly x 2 months to ensure continued compliance of infection control program. The results of these audits will be forwarded to daily clinical meeting and reported to weekly at risk meeting by the Staff Development Coordinator. All results will be reported to the quarterly QA committee for review and addressed immediately.</p>	07/03/2010

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NAME OF PROVIDER OR SUPPLIER  <b>BRACKEN COUNTY NURSING &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>6269 ASBURY ROAD AUGUSTA, KY 41002</b>
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F 441	<p>Continued From page 2</p> <p>CMT should have washed her hands after licking her thumb and after taking the resident's pulse.</p> <p>2. Observation In the Dining Room on 08/02/10 between 7:30 AM and 8:30 AM revealed Certified Nurse Assistant #4 serving and setting up breakfast trays for sixteen (16) residents. She was observed setting up trays for ten (10) residents before sanitizing her hands with alcohol gel hand sanitizer. While she was setting up breakfast trays for these residents, she was observed patting one resident's back and then opening several resident's individual milk cartons and small butter containers. Continued observation revealed CNA #4 to pick up and butter one resident's toast and then, without sanitizing, to pick up and butter another resident's toast.</p> <p>During an interview on 08/03/10 at 4:45 PM, CNA #4 was asked if she had received training on infection control procedures. The CNA, who had worked at this facility for two (2) years said she had not received training on infection control for a long time, not since her orientation. CNA #4 further stated she was aware of infection control procedures but had forgotten to sanitize her hands more at breakfast on 08/02/10 due to nervousness.</p> <p>On 08/03/10 at 6:00 PM, the Director of Nursing (DON) was interviewed about the facility infection control policy and training for staff. She stated that the facility had provided two (2) inservices since January 2010 which covered infection control. The subjects of these inservices were Urinary Tract Infections and Survey Preparedness. In these inservices staff was trained on infection control policy: if you touch</p>	F 441		

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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5268 ASBURY ROAD AUGUSTA, KY 41002		
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F 441	Continued From page 3 food, sanitize; before touching food, sanitize; after passing 3 trays, sanitize; and after touching a resident, sanitize. The DON further stated that the staff received inservices at least quarterly.	F 441			

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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and concluded on 06/02/2010. The facility was found to not meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was a "F".	K 000	Bracken County Nursing and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Facility, reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding.	
K 012 88=0	NFWA 101 LIFE SAFETY CODE STANDARD  Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1  This STANDARD is not met as evidenced by: Based on observation and interview it was BY: determined the facility failed to ensure all required areas were sprinkler protected, according to NFPA standards.  The findings include:  Observation on 06/02/10 at 12:50 PM, revealed an approximate 14 x 38 foot combustible (wood) overhang at the smoking area of the facility. The Plant Operations Manager was present during the observation.  Interview on 06/02/10 at 12:50 PM, with the Plant Operations Manager revealed he was not aware that the canopy should be sprinkler protected.  Actual NFPA Standard: NFPA 13 (1999 edition)  5-13.6.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 ft (1.2 m) in width.	K 012	Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which Facility, does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Facility, offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.  K 012 1. The plant operations manager reviewed the life safety code standard K012 on 06/02/2010 regarding sprinklers shall be installed under exterior roofs or canopies exceeding 4ft in width.  2. On 06/03/2010 Century Fire Systems was contacted by the Plant operations manager for a quote to install sprinklers for the approximate 14 X 38 foot wooden, combustible overhang canopy at the facility smoking area.	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Mark D. Henderson LHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>6/23/10</i>
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K 012	Continued From page 1 Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 012	3. On 06/14/2010 Century Fire Systems was scheduled by the plant operations manager to install a sprinkler system for the smoking area canopy on 07/08/2010.	
K 018 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	4. The entire sprinkler system will be checked weekly, tested quarterly and reported to the monthly safety committee and quarterly QA committee for follow up by the plant operations manager and addressed immediately.	07/09/2010
	This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure corridor doors were maintained to resist the passage of smoke, according to NFPA standards.  The findings include: Observation on 06/02/10 at 11:45 AM, revealed two (2) holes, in the upper right hand corner of the door of room #16. The holes penetrated the		K 018 1. The plant operations manager reviewed the NFPA 101 life safety code standard K018 on 06/02/2010 regarding doors are to be maintained to resist the passage of smoke, according to NFPA standards.  2. All doors were audited by the plant operations manager on 06/03/2010 and 16 resident room doors were determined to have two holes through each door.  3. On 06/10/2010 all holes in all 16 resident room doors are in the process of being sealed with a non flammable material, sanded and repainted to resist passage of smoke by the plant operations manager and will be completed by 06/30/2010.	
			4. All doors will be audited monthly for condition and compliance and reported to the monthly safety committee and quarterly QA committee for follow up by the plant operations manager and addressed immediately.	07/09/2010

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K 018	<p>Continued From page 2</p> <p>door all the way through. Further observation revealed holes in the same location for all residents' room doors. The Plant Operations manager confirmed the observation. Interview on 08/02/10 at 11:45 AM, with the Plant Operations Manager, revealed that he was aware of the holes. The Plant Operations Manager stated the holes had been there as long as he could remember. During further interview, the Plant Operations Manager stated that the doors at one time had magnetic hold open devices on the doors. The Plant Operations Manager further stated that when the magnetic hold open devices were removed from the door, the holes were left by the screws that held the magnetic hold open devices to the door.</p> <p>Actual NFPA Standard: NFPA 101 (2000 edition)</p> <p>19.3.6.3.1 Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke.</p>	K 018	
K 046 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p>	K 046	<p>K 046</p> <p>1. The plant operations manager reviewed the NFPA 101 life safety code standard K046 on 06/02/2010 regarding emergency lighting of at least 1½ hours duration.</p>

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K 046	Continued From page 3  This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to maintain emergency lighting to the exterior exits, according to NFPA standards. The findings include:  Observation on 06/02/10 at 1:15 PM, revealed that the exterior exit from the dining room area did not have emergency lighting. The Plant Operations Manager was present during the observation.  Interview on 06/02/10 at 1:15 PM with the Plant Operations Manager, revealed that he was unaware of the area not having emergency lighting.  Actual NFPA Standard: NFPA 101 (2000 Edition).  7.9.1.1* Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following: (1) Buildings or structures where required in Chapters 11 through 42 (2) Underground and windowless structures as addressed in Section 11.7 (3) High-rise buildings as required by other sections of this Code (4) Doors equipped with delayed egress locks (5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply	K 046	2. All exit doors were audited on 06/03/2010 by the plant operations manager for emergency lighting and the dining room exit door was determined to not have emergency lighting.  3. Emergency lighting will be installed and connected to generator backup by the plant operations manager for the dining room door exit by 07/08/2010.  4. The emergency lighting system with generator back up will be tested weekly and logged for operation and reported to the monthly safety committee and quarterly QA committee for follow up by the plant operations manager and addressed immediately.	07/09/2010

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K 046	Continued From page 4	K 046			
K 082 SS=D	<p>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to maintain the sprinkler system, according to NFPA standards. The findings include: Observation on 06/02/10 at 12:42 PM, revealed that two (2) sprinkler head escutcheon plates for the Human Resource Director's office were displaced. Further observation revealed that the ceiling tile for one of the sprinkler heads was displaced preventing the sprinkler from operating properly.</p> <p>Interview on 08/02/10 at 12:42 PM with the Plant Operations Manager, revealed that he was unaware of the displaced escutcheon plates and the ceiling tile blocking the sprinkler head.</p> <p>Actual NFPA Standard: NFPA 101 (2000 edition) 9.7.5 Maintenance and Testing.</p>	K 062	<p><b>K062</b></p> <ol style="list-style-type: none"> <li>The plant operations manager reviewed the NFPA 101 life safety code standard K046 on 06/02/2010 stating required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</li> <li>The plant operations manager contacted Century Fire Systems on 06/03/2010 for a quote to correct escutcheon plates on sprinklers in Human Resources Directors Office.</li> <li>On 06/14/2010 Century Fire Systems was scheduled to correct and repair sprinkler escutcheon plates in the Human resources director's office on 07/08/2010.</li> <li>The entire sprinkler system will be checked weekly, tested quarterly and reported to the monthly safety committee and quarterly QA committee for follow up by the plant operations manager and addressed immediately.</li> </ol>	07/09/2010	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 082	Continued From page 5 All automatic sprinkler and standpipe systems required by this Code shall be inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems.	K 082		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2  This STANDARD is not met as evidenced by: Based on observation and staff interview it was determined the facility failed to maintain electrical wiring, according to NFPA standards. The findings include: Observation on 06/02/10 at 12:35 PM, revealed an electric extension cord running from the facility to an outside sign. The Plant Operations Manager was present during the observation.  Interview on 06/02/10 at 12:35 PM, with the Plant Operations Manager, revealed the electric extension cord had been in use since January 2010. The Plant Operations Manager stated that plans had been made to run permanent wiring to the sign, but he has been too busy to get the wiring installed.  Actual NFPA Standard: NFPA 70, 9.1.2  400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following:	K 147	K147 1. The plant operations manager has reviewed the NFPA 101 life safety code K147 on 06/02/2010 regarding electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code, 9.1.2. Upon investigation by the plant operations manager on 06/02/2010 the electric extension cord running from the facility to the outside sign was removed.  2. On 06/03/2010 the plant operations manager conducted a facility audit for electrical wiring, extension cords, and equipment throughout.  3. New underground permanent fixed wiring will be installed by a licensed electrician for the outside sign on 07/08/2010.  4. The facility will be audited weekly for use of extension cords and proper compliance of life safety code K147 and reported to the monthly safety committee and quarterly QA committee for follow up by the plant operations manager and addressed immediately.	07/09/2010

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

PRINTED: 06/16/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/02/2010
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NAME OF PROVIDER OR SUPPLIER  BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
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K 147	<p>Continued From page 6</p> <ol style="list-style-type: none"> <li>1. As a substitute for the fixed wiring of a structure</li> <li>2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors</li> <li>3. Where run through doorways, windows, or similar openings</li> <li>4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8.</li> <li>5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</li> <li>6. Where installed in raceways, except as otherwise permitted in this Code</li> </ol>	K 147		