

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

PRINTED: 08/03/2010
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 06/29/2010
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 F 226 SS=D	<p>INITIAL COMMENTS</p> <p>A Standard Recertification/Re-licensure Survey and an Abbreviated Survey investigating ARO #KY00014425 were initiated as an NHI survey on Sunday 06/27/10 and concluded on 06/29/10. The complaint was unsubstantiated with no deficiencies cited. Deficiencies were cited with the highest Scope and Severity of a "F" Safety Code Survey was completed on 06/29/10.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to follow their policy related to screening employees. Two (2) out of eight (8) employees' files revealed the facility failed to obtain Abuse Registry checks prior to employment and one (1) out of eight (8) files revealed the facility failed to obtain a criminal background check prior to employment.</p> <p>The findings include:</p> <p>1. Review of Employee #8's personnel file revealed a hire date of 11/17/08, and the abuse registry check was to obtained until 09/02/09.</p> <p>2. Review of Employee #7's personnel file revealed a hire date of 05/05/10. The abuse and criminal records checks were not obtained until 08/07/10.</p>	F 000	<p>483.13(c) F226 Development Abuse/Neglect etc Policies</p> <p>Corrective Action for Residents Affected</p> <p>(1.) Employee #7 and 8 are within compliance. Identification of Residents with potential to be affected:</p> <p>(1.) All staff records will be audited by the HR Director, to include but not limited too, abuse registry and background checks and all employee records will be in compliance by 8/1/10.</p> <p>Measures or systems changes to prevent occurrence:</p> <p>(1.) Administrative staff have been educated/trained by administrator on proper abuse/ neglect policy and procedure.</p> <p>(2.) All abuse registry and background checks of new employees will be checked and obtained by the HR director and/or administrative staff before hire. The abuse check and criminal background check will be verified for compliance by the Administrator/ D.O.N. for compliance before the employee attends day one of orientation.</p> <p>(3.) New hire check sheet will be completed on all new employees and signed by HR director and Administrator to ensure compliance with abuse/neglect policy and procedure.</p> <p>(4.) HR director will audit all new hire packets weekly for abuse checks and background checks then report findings to Administrator on weekly basis.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Administrator/HR director will review all new hire packet check sheets monthly for compliance. Findings will be reported in quarterly QA meeting for ongoing evaluation, revision, education/training and/or implementation.</p>	8/01/2010

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE Administrator DATE 8/03/2010

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

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F 226	Continued From page 1	F 226		
F 323 SS=	<p>Review of the facility's policy revealed that all new hires must be credentialed prior to employment which includes, OIG (Office of Inspector General) check, Abuse Registry Check and Sex Offender Registry.</p> <p>Interview with the Director of Nursing and Nurse Consultant on 06/29/10 at 1:46 PM revealed there should always be an Abuse and Criminal check prior to the hire date on all employees.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the environment was free from hazards. Observations and interviews revealed spring loaded clip chains across all residents' rooms doors. Interview revealed cognitively impaired residents required staff assistance to exit their rooms.</p> <p>The findings include: Observations on 06/29/10 at 3:35 PM, revealed spring loaded clip chains across all residents'</p>	F 323	<p>483.25(h) Free of Accident, Hazards/Supervision/Devices F323</p> <p>Corrective Action for Residents Affected:</p> <ol style="list-style-type: none"> (1.) Residents #2 and #3 were immediately assessed by the D.O.N. for potential for environmental hazards. (2.) Resident #2 and #3 chains across doors were removed by the Maintenance on 8/3/10. <p>Identification of residents with potential to be affected:</p> <ol style="list-style-type: none"> (1.) All residents were assessed by the D.O.N and SDC for potential hazards related to access of, entry too and exit from, individual rooms. (2.) All resident room chains will be removed by the Maintenance Director by 8/6/10. Mesh stop signs or door guards fastened by Velcro will be placed on identified rooms per resident/POA request. <p>Measures or system changes to prevent recurrence:</p> <ol style="list-style-type: none"> (1.) All resident rooms will be assessed daily during team rounding and by the house supervisor on weekends to ensure the resident environment remains free of accident hazards. (2.) All staff will be educated on environmental hazards and appropriate notification/reporting by the SDC/Safety committee by 8/1/10. (3.) Nursing staff and Housekeeping staff will monitor daily for safety hazards noting any issues on the maintenance request log sheet. (4.) Maintenance director/Assistant director will monitor maintenance request log sheet daily, report findings during morning stand up meeting and correct any deficiencies noted. 	8/06/2010

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F 323	Continued From page 2 rooms doors. Review of the clinical revealed two (2) of the three (3) residents' rooms sampled, revealed the facility had assessed the residents to be cognitively impaired in decision making skills. Further observation revealed Resident #1 was able to unhook the spring loaded clip. However, Resident #2 and Resident #3 were not able to unhook the spring loaded clip. Interview on 06/27/10 at 8:45 AM with CNA #1 (Certified Nursing Assistant) revealed the cognitive impaired residents were not able to take the chains down and leave their rooms without assistance. Interview on 06/29/10 at 3:45 PM with CNA #4 revealed a CNA would have to unhook the chain for a confused resident. Interview on 06/29/10 at 3:55 PM with CNA #2 revealed the aides had to assist the cognitive impaired residents out of their rooms, as the residents could not unhook the chains. Interview on 06/29/10 at 4:00 PM with CNA #3 revealed confused cognitive impaired residents have to be assisted to get out of their room, as they can not undo the chain. Interview on 06/27/10 at 11:10 AM with the Maintenance Director revealed he had been looking for something to replace the chains. He stated the chains had been here since had worked there.	F 323	Monitoring changes/systems to ensure no deficient practice: (1.) Administrator/Maintenance Director will review daily team rounding sheets and maintenance log sheet monthly for compliance. Findings will be reported in monthly safety meeting and forwarded to quarterly Q/A meeting for ongoing evaluation, revision, education/training and/or implementation.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or	F 371		

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F 371	<p>Continued From page 3</p> <p>considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, and interview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions as evidenced by hair not properly covered, dishes stored wet and opened items in the refrigerator not dated when opened.</p> <p>The findings include:</p> <p>Observation of the kitchen on 06/27/10, at 10:00 AM, revealed bowls stored wet, when turned upside down water ran out of the bowls.</p> <p>Interview with Dietary Aide #2, on 06/27/10, at 10:30 AM confirmed that water did run out of the stored bowls when turned upside down. She stated, "Dishes are to be air dried before put away because bacteria can grow".</p> <p>Observation of the tray line on 06/27/10, at 12:10 PM revealed Cook's #1's hair was not properly covered. Her hair covering only covered the back of her head. The Director of Nursing did bring this to her attention about half way through the tray line, this was corrected and the tray line was resumed.</p> <p>During an Interview with Cook #1 on 06/27/10, at</p>	F 371	<p>483.35(i) Food Procure, Store/Prepare/Serve, Sanitary P371</p> <p>Corrective Action for Residents Affected:</p> <p>(1.) All residents were assessed by the D.O.N. and SDC for potential injury related to storage, preparation and distribution of food under sanitary conditions.</p> <p>(2.) Identified bowls were immediately rewashed and dried, hairnet was immediately corrected, and undated food was discarded.</p> <p>Identification of Residents with potential to be affected:</p> <p>(1.) All dietary staff was immediately educated/trained by the Dietician on appropriate storage, preparation and distribution of food under sanitary conditions and infection control policy and procedure to include but not limited too, hair nets, appropriate drying of dishes before storage and dating opened items.</p> <p>(2.) Sanitary rounds were conducted by D.O.N and interim dietary manager on 6/30/10 to identify any other concerns. None were identified.</p> <p>Measures or system changes to prevent recurrence:</p> <p>(1.) Food service/infection control rounds will be done by the D.M./Designee daily for 2 weeks, then 3 times a week for 2 weeks and then weekly for 2 months then quarterly thereafter. Rounds will include but not limited too, the storage of bowls, dating of opened food, and the appropriate placement of hair nets.</p> <p>(2.) D.M./Designee will report compliance during morning stand up meeting to address needed evaluations, revisions, education/ training and/or implementation.</p>	7/02/2010

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F 371	<p>Continued From page 4</p> <p>12:45 PM she stated, "All hair should be covered at all times".</p> <p>Further observation of the kitchen on 06/28/10, at 6:00 PM revealed a container of scrambled egg mix and a container of thicken dairy milk opened but not dated.</p> <p>Interview with the Acting Dietary Manager on 06/28/10, at 4:50 PM revealed that all items were to be dated when opened. She further stated, "These should have been dated when opened, I don't know why the AM cook did not date them".</p>	F 371	<p>(3.) All dietary staff received education/training on appropriate food service delivery and infection control techniques on 7/02/10 by the dietician and D.O.N. All new staff will receive education/training on appropriate food service delivery and infection control during orientation.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Administrator/D.M./Designee will review daily food service/infection control rounding sheets monthly. Findings will be reported in monthly infection control meeting and forwarded to quarterly Q/A meeting for ongoing evaluation, revision, education/training and/or implementation</p>	
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K 000 K 038 SS=F	<p>INITIAL COMMENTS</p> <p>A Life Safety Code survey was initiated and concluded on 08-29-10. 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".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 08/29/10 at 3:19 PM revealed the facility had placed plastic chains across the residents' doors. Further observation revealed the chains were held in place on one side with a plastic breakaway lock and the other side of the chain was held in place with a spring loaded clip.</p> <p>Interview on 08/29/10 at 3:19 PM, with the Director of Housekeeping, revealed that the facility had used been using the plastic chains for the past five (5) years. The Director of Housekeeping stated the chains were requested</p>	K 000 K 038	<p>K 038 NFPA 101 Life Safety Code Standard</p> <p>Corrective action for residents affected:</p> <p>(1.) All residents were assessed for potential hazards by the D.O.N. and SDC related to exit access.</p> <p>Identification of residents with potential to be affected:</p> <p>(1.) All residents were assessed by the D.O.N. and SDC for potential hazards related to access of, entry to and exit from, individual rooms.</p> <p>(2.) All resident room chains will be removed by maintenance director by 8/6/10. Mesh stop signs and/or door guards fastened by Velcro will be placed on identified rooms per resident/POA request.</p> <p>Measures or system changes to prevent re-occurrences:</p> <p>(1.) All resident rooms will be assessed daily during team rounding to ensure the resident environment remains free of accident hazards.</p> <p>(2.) All staff will be educated/trained on environmental hazards and appropriate notification/reporting by the SDC/Safety committee by 8/1/10.</p> <p>(3.) Nursing staff and Housekeeping staff will monitor daily for safety hazards noting any issues on the maintenance request log sheet.</p> <p>(4.) Maintenance director/Assistant director will monitor maintenance request log sheet daily, report findings during morning stand up meeting and correct any deficiencies noted.</p> <p>Monitoring changes/systems to ensure no deficient practice:</p> <p>(1.) Administrator/Maintenance Director will review daily team rounding sheets and maintenance log sheet monthly for compliance. Findings will be reported in monthly safety meeting and forwarded to quarterly Q/A meeting for ongoing evaluation, revision, education/training and/or implementation.</p>	8/06/2010

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BY: _____

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nikki Kelly, MHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>8/23/2010</i>
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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 disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 038	Continued From page 1 by the residents to keep residents from wandering into their rooms. Reference: NFPA 101 (2000 edition) 19.2 MEANS OF EGRESS REQUIREMENTS 19.2.1 General. Every aisle, passageway, corridor, exit discharge, exit location, and access shall be in accordance with Chapter 7. Exception: As modified by 19.2.2 through 19.2.11.	K 038		
K 060 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined that the facility failed to ensure fire drills were conducted according to NFPA standards. The findings include: Record review on 06/29/2010 at 2:16 PM, revealed that the facility had failed to conduct any 3rd or 4th quarter fire drills for 3rd shift in calendar year 2009.	K 060	K 050 NFPA 101 Life Safety Code Standard Corrective action for residents affected: (1.) All residents were assessed for potential injury by the D.O.N. and SDC related to Fire drill discrepancy. Identification of residents with potential to be affected: (1.) Maintenance director and assistant director were educated/trained on Life Safety Code - NFPA 101 section 19.7.1.2 by the Administrator 7/20/10. Measure or system changes to prevent recurrences: (1.) Maintenance director/Assistant director will conduct required fire drills and maintain log book. Safety committee will monitor log books on monthly basis to ensure compliance. Monitoring change/system to ensure no deficient practice: (1.) Maintenance director/Assistant director will report findings from fire drill log book to monthly safety meeting and forwarded to quarterly Q/A meeting for ongoing evaluation, revision, education/training and/or implementation.	7/20/2010

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K 050	<p>Continued From page 2</p> <p>Interview on 06/29/2010 at 2:16 PM, with the Maintenance Director, revealed that he was unsure of why there were not any fire drills conducted during those quarters.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p>	K 050		