

12-27-'11 19:32 FROM-

T-718 P007/015 F-322
FORM APPROVED
OMB NO. 0988-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/08/2011
NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
(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 A Standard Recertification Survey was initiated on 12/08/11 and concluded on 12/08/11, and a Life Safety Code Survey was conducted 12/07/11. Deficiencies were cited with the highest Scope and Severity of a "D".	F 000		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure accommodation of needs were met as evidenced by the call system being out of reach for one (1) of twenty-four (24) residents (Resident #21). The findings include: Review of the clinical record revealed Resident #21 had diagnoses which included Pulmonary Embolism, Congestive Heart Failure, Cerebral Vascular Accident and Syncope. Review of the Admission Minimum Data Set (MDS) Assessment, dated 11/01/11, revealed the facility assessed Resident #21 as cognitively intact. The resident scored a fifteen (15) out of	F 246	F246 483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to ensure residents are provided and receive reasonable accommodations of individual needs and preferences. 1. Resident #21 remains in the facility and has not had any negative effects related to the call light placement during survey. 2. All resident call lights are being monitored shiftly by the licensed nursing staff to ensure they are within resident's reach. 3. The nurse aide coordinator provided education to all staff on the need to have resident call lights within reach. In-service date of 12-16-2011.	

RECEIVED
JAN - 3 2012
BY: _____

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

(X6) DATE

Cathy Burkhardt, RN, BSN *Adm* 1-3-12

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 60 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41088	

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F 246	<p>Continued From page 1</p> <p>fifteen (15) based on a Brief Interview of Mental Status conducted by the facility.</p> <p>Review of the Comprehensive Care Plan, dated 11/03/11, revealed the resident was at risk for falls and trauma related to mobility deficit and history of syncope. The plan of care also noted Resident #21 needed extensive assistance with routine care needs, toileting and hygiene. Interventions listed on the care plan included, "keep call bell within reach, encourage resident to ring call light and ask for assistance, and respond to call light".</p> <p>Observation, on 12/08/11 at 8:50 AM, revealed Resident #21 in the wheelchair at bedside. The call bell was wrapped around the bed rail and covered over with the bedspread and out of reach of the resident.</p> <p>Interview with the resident, on 12/08/11 at 8:50 AM, revealed the resident was unable to locate the call bell system.</p> <p>Interview with Certified Nursing Assistant (CNA) #7, on 12/08/11 at 9:00 AM, revealed the resident would not have been able to utilize the call system. Further interview revealed the resident had a soft voice and it would be difficult to hear if he/she had verbally tried to call out for assistance.</p> <p>Interview with Certified Nursing Assistants #5 and #6, on 12/08/11 at 12:05 PM, revealed they failed to ensure the call bell was within reach after assisting the resident out of bed and into the wheelchair.</p>	F 246	<p>4. As part of the facility ongoing continuous quality assurance program the Assistant Director of Nursing or charge nurse will audit 10% of all resident call light placement daily. These audits will be made part of the facility's QA program for the next six months.</p> <p>5. 12-17-2011.</p>	
F 281	483.20(k)(8)(i) SERVICES PROVIDED MEET	F 281		

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MAYSVILLE, KY 40311
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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 40366	
(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 SS=D	<p>Continuad From page 2 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 observation, interview and record review, the facility failed to ensure professional standards of quality for one (1) of twenty-four (24) residents by not following a physician's order or the resident's plan of care for oxygen to be administered at two (2) liters per nasal cannula for Resident #21. Observations, on 12/07/11, revealed the oxygen flowmeter set at three (3) liters.</p> <p>The findings include:</p> <p>Review of the clinical record revealed Resident #21 had diagnoses which included Pulmonary Embolism and Congestive Heart Failure.</p> <p>Review of the Physician's December Orders revealed oxygen to be administered at two (2) liters/minute per nasal cannula as needed for congestive heart failure.</p> <p>Review of the Comprehensive Care Plan, dated 11/03/11, revealed Resident #21 had impaired breathing patterns with shortness of breath and oxygen ordered at two (2) liters/minute as needed.</p> <p>Review of the clinical record revealed Resident #21 had returned to the facility from an outpatient emergency room visit on 12/07/11. Interview, on</p>	F 281	<p>F281 483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>Resident #21 was sent to the Emergency Room related to decreased O₂ saturations and respiratory concerns. While at the ER she was receiving 3 Liters of oxygen per minute via nasal cannula. Readmission orders had not been verified by the attending physician.</p> <p>It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation to provide or arrange services which meet professional standards of quality.</p> <ol style="list-style-type: none"> 1. Resident #21 remains in the facility. She had no ill effects from receiving 3L of oxygen. Orders were verified. Resident received 2L of oxygen. 2. All residents with oxygen orders were audited by the Director of Nursing to ensure accurate delivery is being provided on 12-09-2011. 	

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STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

185207

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY
COMPLETED

12/08/2011

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

620 PARKER ROAD
MAYSVILLE, KY 41056

MAYSVILLE NURSING AND REHABILITATION FACILITY

(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 3 12/07/11 at 3:00 PM, with Licensed Practical Nurse #2 revealed the resident returned to the facility around 1:00 PM.</p> <p>Record review of the Nurses' Notes revealed the resident had returned on 12/07/11 and had oxygen in place however no flow rate was listed.</p> <p>Observation, on 12/07/11 at 4:00 PM and 5:00 PM, revealed the resident was receiving oxygen via nasal cannula at a flow of three (3) liters/minute.</p> <p>Interview, on 12/07/11 at 4:30 PM, with the Certified Nursing Assistants (CNA) #7 and #8, assigned to care for Resident #21 revealed the nurse is responsible for ensuring the oxygen flow is correct.</p> <p>Interview with CNA #8, on 12/07/11 at 4:45 PM, revealed she can verify the settings but never adjust the settings of oxygen flow. She further stated when the concentrator is moved it occasionally changes the delivery settings.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 12/07/11 at 5:10 PM, revealed the oxygen was ordered to be at two (2) liters/minute and should be at (2) liters/minute. Observation at that time revealed LPN #1 adjusted the delivery from three (3) liters/minute to two (2) liters/minute as ordered.</p>	F 281	<p>3. The nursing staff will ensure proper delivery of oxygen at the beginning of each shift. In addition, the nursing assistants will verify proper delivery of O₂ while providing care. This information will be on the nurse aide care plan.</p> <p>4. As part of the facility's ongoing quality assurance the Assistant Director of Nursing will audit all resident's receiving oxygen weekly to ensure proper delivery is being provided. This practice will continue for the next three months and then quarterly.</p> <p>5. 12-10-2011.</p>	
F 328 SS=D	<p>483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>The facility must ensure that residents receive proper treatment and care for the following special services:</p>	F 328		

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F 328	<p>Continued From page 4</p> <p>Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Protheses.</p> <p>This REQUIREMENT is not met as evidenced by: Based on facility policy, observation, interview and record review, the facility failed to ensure residents receive proper treatment and care related to the administration of oxygen for one (1) of twenty-four (24) residents. Resident #21 was observed to have oxygen at a flow rate of three (3) liters/minute instead of two (2) liters/minute as ordered.</p> <p>The findings include:</p> <p>Review of the facility policy "Managing Respiratory Therapy", undated, revealed nasal cannula is an option used to deliver low oxygen flow, such as two (2) liters/minute. Nursing considerations included monitoring the resident on oxygen and evaluation of the resident's respiratory status.</p> <p>Review of the clinical record revealed Resident #21 had diagnoses which included Pulmonary Embolism and Congestive Heart Failure.</p> <p>Review of the Physician's December Orders</p>	F 328	<p>F328 4832.25(k) TREATMENT/CARE FOR SPECIAL NEEDS</p> <p>It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to ensure residents receive proper treatment and care for special services.</p> <p>Resident #21 was sent back to the facility from the local Emergency Department. Her visit to the ER related to decreased oxygen saturation and respiratory concerns. While at the ER she was receiving 3 Liters of oxygen per minute via nasal cannula. Readmission orders had not been verified with the resident's attending physician.</p> <ol style="list-style-type: none"> 1. Resident #21 remains in the facility. She had no ill effects from receiving 3L of oxygen. Orders were verified. Resident received 2L of oxygen. 2. All residents with oxygen orders were audited by the Director of Nursing to ensure accurate delivery is being provided on 12-09-2011. 	

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41058	
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F 328	<p>Continued From page 5</p> <p>revealed oxygen to be administered at two (2) liters/minute per nasal cannula as needed for congestive heart failure.</p> <p>Review of the Comprehensive Care Plan, dated 11/03/11, revealed Resident #21 had impaired breathing patterns with shortness of breath and oxygen ordered at two (2) liters/minute as needed.</p> <p>Review of Resident #21's clinical record revealed the resident had returned to the facility from an outpatient emergency room visit on 12/07/11. Interview on 12/07/11 at 3:00 PM, with Licensed Practical Nurse (LPN) #2 revealed the resident returned to the facility around 1:00 PM.</p> <p>Record review of Nurses' Notes revealed Resident #21 had returned on 12/07/11 and had oxygen in place, however, no flow rate was listed.</p> <p>Observation of Resident #21, on 12/07/11 at 4:00 PM and 5:00 PM, revealed the resident was receiving oxygen via nasal cannula at a flow rate of three (3) liters/minute.</p> <p>Interview, on 12/07/11 at 4:30 PM, with the Certified Nursing Assistants (CNA) #7 and #8, assigned to care for Resident #21 revealed the nurse is responsible for ensuring the oxygen flow is correct. Continued interview with CNA #7 revealed she had never been told to check the flow rate. Further interview with CNA #8 revealed the equipment may have been accidentally bumped by someone providing care to the resident and the flow rate changed without anyone's knowledge.</p>	F 328	<p>3. The nursing staff will ensure proper delivery of oxygen at the beginning of each shift. In addition, the nursing assistants will verify proper deliver of O₂ while providing care. This information will be on the nurse aide care plan.</p> <p>4. As part of the facility's ongoing quality assurance the Assistant Director of Nursing will audit all resident's receiving oxygen weekly to ensure proper delivery is being provided. This practice will continue for the next three months and then quarterly.</p> <p>5. 12-10-2011</p>	

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41068	
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F 328	Continued From page 6 Interview with CNA #8, on 12/07/11 at 4:45 PM, revealed she can verify the settings but never adjust the settings of oxygen flow. She further stated when the concentrator is moved it occasionally changes the delivery settings. Interview, on 12/07/11 at 5:10 PM, with Licensed Practical Nurse (LPN) #1, revealed the oxygen was ordered to be at two (2) liters/minute instead of three (3) liters/minute the resident was observed to be receiving and she made the correction to reflect the rate of flow as ordered.	F 328		
F 441 SS=D	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. (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	F 441	F441 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility 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. 1. The feeding pump which had the dried brown material on it has been cleaned and properly stored. 2. All feeding pumps were audited by the Assistant Director of Nursing to ensure they were cleaned and stored properly on 12-09-2011.	

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 820 PARKER ROAD MAYSVILLE, KY 41086
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F 441	<p>Continued From page 7</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility's policy and procedures it was determined the facility failed to have an effective system in place to prevent the development and transmission of disease and infection. The facility failed to ensure resident equipment such as tube feeding pumps were stored in a manner to prevent infection or contamination.</p> <p>The findings include:</p> <p>Review of the facility's policy "Infection Control Program Overview", dated 2007, revealed prevention of infection includes policies, procedures and aseptic practices are followed by personnel in performing procedures and in disinfection of equipment.</p> <p>Observation, on 12/06/11 at 10:34 AM, revealed a tube feeding pump was stored in the medication</p>	F 441	<p>3. An in-service was conducted by the Administrator and Director of Nursing with all licensed staff to discuss the facility's infection control program and specifically the cleaning and storage of medical equipment. 12-16-2011.</p> <p>4. As part of the facility's ongoing Quality Assurance program the Assistant Director of Nursing will audit all feeding pumps stored and clean weekly. This practice will continue for the next six months.</p> <p>5. 12-17-2011.</p>	
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F 441	Continued From page 8 room as clean but with further observation of tube feeding pump dried brown material was noted on the bottom side of the pump. Interview, on 12/06/11 at 10:35 AM, with Licensed Practical Nurse (LPN) #1, revealed the tube feeding pump was a clean machine because it was stored in the medication room. Further interview validated the tube feeding machine had dried brown material on the bottom side therefore making the feeding pump dirty. LPN #1 further indicated the process was not followed based on infection control procedures. Continued interview revealed, once a feeding pump is cleaned it should be placed in a bag once it has been cleaned and ready for use.	F 441			