

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6289 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 Recertification Survey and an Abbreviated Survey investigating KY#00018587 was initiated on 06/26/12 and concluded on 06/29/12. KY#00018587 was unsubstantiated with no deficiencies cited. The highest Scope and Severity of an "F".	F 000		
F 164 SS-D	<p>483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.</p> <p>Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.</p> <p>The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.</p> <p>The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.</p>	F 164	<p>483.10(c), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</p> <p>The facility will ensure privacy for residents when entering residents' rooms by knocking or asking for permission to enter.</p> <ol style="list-style-type: none"> The two staff members (Chaplain/Activity Director and Maintenance Supervisor) were immediately instructed to knock before entering rooms 6, 11, 12 as well as all resident rooms and to ask for permission before entering. The DON and Administrator spoke with residents in rooms 6, 11, and 12 to ensure their personal privacy would be maintained. The Social Worker will audit 100% of residents to ensure personal privacy is maintained by the staff by knocking on doors or asking permission before entering residents' room. 	

REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/25/12
---	------------------------	----------------------

Deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 accreditation participation.

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 164	<p>Continued From page 1</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure privacy for residents as evidenced by two (2) staff members being observed from 06/26/12 to 06/27/12 to enter residents' rooms without knocking and asking for permission to enter.</p> <p>The findings include:</p> <p>Observation, on 06/26/12 revealed the Chaplain/Activities Director entered in room twelve (12) at 5:10 PM and back out and at 5:11 PM entered into room six (6) without knocking before either entry.</p> <p>Interview the Chaplain/Activities Director, on 06/29/12 at 10:00 AM, revealed it was the facility's practice to ensure privacy to the residents by allowing the residents to have private phone calls via the cordless phone, providing a private area to gather with family and friends and encouraging the use of the privacy curtains. The Chaplain/Activities Director stated if a resident's door was open, he would knock and ask permission to enter the room. He also stated on 06/26/12, when the survey team arrived it was the facility's strategy to do quick inspections of residents' rooms to ensure the safety of the residents. The Chaplain/Activities Director stated, it was the normal practice for staff members to knock on a residents' door and wait for the resident to verbally acknowledge that the resident was accepting for the staff member to come into their room.</p>	F 164	<p>3. The staff was in-serviced on 6/29/2012 by DON and Staff Development Director on personal privacy of residents and knocking before entering their room. The Staff Development Director or DON will in-service the staff again on 7/27/12 regarding personal privacy and knocking before entering a resident's room. 2. The Social Worker, DON or designee will conduct daily audits of staff entry into residents rooms for 1 weeks, then weekly for 4 weeks, then monthly for 3 months and quarterly for 2 quarters to ensure personal privacy.</p> <p>4. The Quality Assurance Team will review the results of audits monthly to ensure compliance.</p>	<p>Date Completed 8/13/12</p>

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
---	---	--	--

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 164	Continued From page 2 Observations, on 06/27/12 at 2:40 PM, revealed the Maintenance Director walked into room eleven (11) without knocking and then at 2:43 PM he walked into room six (6) without knocking. Interview with the Maintenance Director, on 06/28/12 at 10:05 AM, revealed it was normal practice to knock on a resident's door prior to entering his/her room. He continued by saying the residents were like family and it was not his intention to offend anyone.	F 164		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment, prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by:	F 280	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The facility will ensure that the Comprehensive Care Plans for all residents are revised. 1. The MDS Coordinator immediately revised the comprehensive care plans for resident # 4 and #8. 2. The MDS Coordinator and DON will audit 100% of residents comprehensive care plans to ensure revisions are current.	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 280	<p>Continued From page 3</p> <p>Based on observation, interview and record review, it was determined the facility failed to revise the Comprehensive Care Plan for two (2) of ten (10) sampled residents (Residents #4 and #8).</p> <p>The care plan for Resident #4 was not revised and included an intervention for oxygen which the resident did not use.</p> <p>The care plan for Resident #8 was not revised and included an intervention for the resident to wear Velcro tennis shoes at all times which the resident did not wear.</p> <p>The findings include:</p> <ol style="list-style-type: none"> Review of Resident #4's medical record revealed the facility admitted the resident on 03/10/11 with diagnoses which included Senile Dementia, Alteration in Consciousness, and Essential Hypertension. Review of the Comprehensive Care Plan, dated 03/01/12, revealed a problem of Risk for Cardiovascular Complication with an intervention of oxygen as ordered. Review of the Physician's orders revealed Resident #4 had not had an order for oxygen since his/her admission. <p>Observation of Resident #4 on 06/26/12 at 4:45 PM, 5:55 PM, on 06/27/12 at 8:15 AM and 2:45 PM, and again on 06/29/12 at 12:20 PM, revealed Resident # was not using oxygen.</p> <p>Interview, on 06/29/12 at 12:25 PM, with the Minimum Data Set (MDS) Coordinator revealed Resident #4's care plan for Risk for Cardiovascular Complications was pre-made and</p>	F 280	<ol style="list-style-type: none"> The DON in-serviced the MDS Coordinator on 6/29/2012 regarding appropriate revisions to comprehensive care plans being in place for all residents. The MDS Coordinator will review the comprehensive care plans daily during clinical meeting and revise as needed. The DON/Administrator will monitor 10% (ten percent) of comprehensive care plans weekly for 4 weeks then monthly for 3 months and then quarterly for 2 quarters to ensure that residents' comprehensive care plans have been revised and are current. The Quality Assurance Committee will review the finding of MDS audits monthly to ensure compliance. 	Date Completed 8/13/12

CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

185344

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

(X3) DATE SURVEY COMPLETED

C

06/28/2012

NAME OF PROVIDER OR SUPPLIER

BRACKEN COUNTY NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

5269 ASBURY ROAD
AUGUSTA, KY 41002

(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 280	<p>Continued From page 4</p> <p>the intervention for oxygen as needed should had been deleted as an intervention for Resident #4 because the resident did not have an order and did not require the use of oxygen.</p> <p>2. Review of Resident #8's medical record revealed the facility admitted the resident on 11/09/11 with diagnoses which included Diabetic Neuropathy, Legal Blindness and Osteoarthritis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 06/18/12, revealed the resident had a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident had no cognitive impairment. Further review of the record revealed the resident was assessed to be at risk for falls.</p> <p>Review of the Comprehensive Care Plan revealed a Fall Risk care plan, dated 06/18/12, which included an intervention for the resident to wear Velcro tennis shoes at all times.</p> <p>Observations, on 06/28/12 at 12:15 PM and 4:50 PM and again on 06/29/12 at 7:40 AM, 9:25 AM and 11:15 AM, revealed no evidence of Resident #8 wearing Velcro tennis shoes. Interview, on 06/29/12 at 11:15 AM, with Resident #8 revealed he/she did not wear Velcro tennis except to church on Sundays.</p> <p>Interview, on 06/29/12 at 12:15 PM, with the Minimum Data Set (MDS) Coordinator revealed Resident #8's Fall Risk care plan was pre-made and the intervention for Resident #8 to wear Velcro tennis shoes at all times should have been deleted off the care plan as the resident did not wear them at all times.</p>	F 280		

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

JA JP PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
---	--

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 280	Continued From page 5 Interview, on 06/29/12 at 3:07 PM, with the Director of Nursing (DON) revealed Resident #8 did not wear Velcro tennis shoes. She stated she had been told the resident's Fall Risk care plan was a "standard" care plan. She stated it should have been individualized for this resident.	F 280		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation of tray line service during the evening meal on 06/28/12, revealed Dietary Aide #1 left the tray line six (6) different times to obtain items from the walk-in refrigerator and to obtain a food cart, then returned to the tray line without washing her hands. The findings include: Review of facility policy entitled, Infection Control, undated revealed the facility would endeavor to prevent the spread of infection by teaching safe	F 371	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility will store, prepare, distribute, and serve food under sanitary conditions. 1. #1 dietary aide was immediately instructed to wash hands when leaving the tray line or retrieving a tray cart. The dietary cook was instructed on proper food temps at point of service. 2. The kitchen staff was observed by the administrator and dietary manager on 6/28/12 and 6/29/12 for proper hand washing techniques and food trays for proper temps at point of service. 3. The kitchen staff was in-serviced on 6/27/12 and again on 6/28/12 by Dietary Manager and SDC on proper hand washing, infection control and proper food temps at point of service. The Staff Development Director, DON, or	

CENTERS FOR MEDICARE & MEDICAID SERVICES

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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD.. AUGUSTA, KY 41002
--	--

(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 371	<p>Continued From page 6</p> <p>food handling practices to limit cross-contamination.</p> <p>1. Observation on 06/28/12, at 4:40 PM, during the evening meal service revealed Dietary Aide #1 left the tray line at 4:55 PM, 5:00 PM, 5:13 PM and 5:18 PM to enter the walk-in refrigerator to obtain food items, then returned to the tray line without washing her hands. Continued observation revealed at 5:28 PM Dietary Aide #1 left the tray line, obtained a food cart and returned to the tray line without washing her hands. Further observation revealed at 5:30 PM Dietary Aide #1 left the tray line, went to the milk cooler and obtained a carton of milk, then returned to the tray line without washing her hands.</p> <p>Interview, on 06/28/12 at 6:05 PM, with Dietary Aide #1 revealed she should have washed her hands prior to returning to the tray line after leaving it to obtain items from the walk-in refrigerator and to obtain the cart. She stated she knew to do that, she was just in a hurry and forgot.</p> <p>Interview, on 06/28/12 at 9:15 AM with Licensed Practical Nurse (LPN) #1, serving as the Interim Dietary Manager, revealed if dietary staff had to leave the tray line for any reason they were to wash their hands prior to returning to the tray line.</p> <p>Interview, on 06/29/12 at 10:28 PM, with the Registered Dietician (RD) revealed hands should be washed anytime staff leave the tray line. The RD stated she had inserviced all the kitchen staff on the importance of hand washing and infection control.</p>	F 371	<p>Dietary Manager will in-service the staff again on 7/27/12 on proper hand washing, infection control and proper food temps at point of service.</p> <p>The Dietary Manager will monitor every meal service for 5 days, then monitor 1 meal services per day for 5 days, then monitor 1 meal service a week for 4 weeks for proper hand washing techniques. The dietary manager will prepare a test tray for 2 meals a day for 3 days, then 1 meal a day weekly for 4 weeks, then 1 meal a day monthly for 3 months and then quarterly for 2 quarters for proper food temps at point of service.</p> <p>4. The Standards of Care Committee, including DON, Administrator, MDS, SDC, and Dietary Manager will review results of test tray temperatures from the Dietary Manager during weekly standards of care and during monthly Quality Assurance meetings to ensure compliance.</p>	Date Completed 8/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 371	<p>Continued From page 7</p> <p>2. Observation, on 06/26/12 at 4:40 PM, of a test tray revealed the food temperature for the green beans to be one hundred and fifteen (115) degrees Fahrenheit, the refrigerator beets temperature to be sixty (60) degrees Fahrenheit, and the Jello temperature to be fifty (50) degrees Fahrenheit.</p> <p>Interview, on 06/29/12 at 10:25 AM, with the Registered Dietician (RD) revealed the temperature for the green beans should have been one hundred and twenty (120) degrees Fahrenheit or above, and the temperatures for the beets and Jello should have been below forty-five (45) degrees Fahrenheit.</p>	F 371		
F 441 NS=D	<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</p>	F 441	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility will 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. Also, the facility will ensure that sharps containers are properly handled to prevent contamination.</p> <p>1. Resident #1 was assessed by Primary Care Physician on 6/28/2012 with no negative outcomes noted. (2) SRNA #5, #7 and #8 were immediately instructed on proper infection control procedures related to</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6289 ASBURY ROAD AUGUSTA, KY. 41002
--	---

(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 8</p> <p>Isolate the resident.</p> <p>(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.</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 the facility's policy, 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 for one (1) of ten (10) sampled residents (Resident #1) and one (1) unsampled resident (Unsampled Resident A). In addition, the facility failed to ensure a sharps container was properly handled to prevent contamination.</p> <p>The findings include: Review of the facility's "Handwashing Policy", with an effective date of December 2010, revealed staff was to wash their hands as necessary to</p>	F 441	<p>changing gloves and washing hands by the DON. The DON and SRNA#5, #7 and #8 ensured resident #1 was cleaned properly and applied protective cream according to facilities infection control policy and procedures and disinfected the bolster, bed controls, changed the sheets, pillowcases, pillow and gown.</p> <p>(3) Registered Nurse #5 immediately placed gloves on before obtaining finger sticks from other residents.</p> <p>(4) The sharps container in the medication room was removed and placed in the bio hazard waste disposal.</p> <p>2. 100% of residents were audited on 6/29/12 for signs and symptoms of Clostridium-Difficile by DON and charge nurses. No residents were found to have signs and symptoms of Clostridium-Difficile. (2) 100% of residents' charts were reviewed on 6/29/12 by the DON and SDC to identify the residents that receive finger sticks. (3) 100% of Residents rooms and the facility were audited on 6/29/12 by Administrator, DON, and SDC to locate all sharp containers.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 9 prevent the spread of infections or germs.</p> <p>1. Review of Resident #1's medical record revealed he/she had been diagnosed with Clostridium Difficile (c-diff) on 06/26/12.</p> <p>Observation, on 06/27/12 at 10:07 AM, of a skin assessment for Resident #1 revealed Licensed Practical Nurse (LPN) #1 performed the assessment with the assistance of State Registered Nursing Assistant (SRNA) #8. SRNA #8 was observed to pull a brief soiled with liquid bowel movement out from under Resident #1 touching the resident's back with the soiled area. Continued observation revealed SRNA #8 wiped Resident #1's back and anal area with a disposable wipe, disposed of the soiled brief and wipe, and pulled the new brief and pad under the resident. SRNA #8 was observed to adjust Resident #1's gown and bed covers, put a bolster behind the resident's back and a pillow under his/her feet. Further observation revealed SRNA #8 touched the bed control to raise the head of the bed. During the observations SRNA #8 was not observed changing his soiled gloves or sanitizing his hands.</p> <p>Interview, on 06/27/12 at 4:15 PM, with SRNA #8 revealed he was aware Resident #1 had a diagnosis of c-diff. He stated he should have removed his soiled gloves after disposing of the soiled brief. SRNA #8 stated he should have washed his hands and applied new gloves.</p> <p>2. Observation, on 06/27/12 at 4:30 PM, of SRNA #5 and SRNA #7 providing care for Resident #1 revealed the aides to cleanse the resident's perineal area with their gloved hands. Without</p>	F 441	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>3. The Nursing Staff was in-serviced on 6/27/12 and again on 6/29/12 by DON, SDC on proper infection control techniques related to changing gloves and hand washing. Licensed Nurses were in-serviced by DON, SDC on 6/28/12 and again on 6/29/12 regarding proper infection procedures related to finger sticks and proper disposal of sharps containers. The SDC, DON or designee will in-service the staff again on 7/27/12 regarding infection control techniques. (1) The DON or designee will observe direct patient care by the nursing staff to ensure proper infection and control procedures are maintained on residents in contact isolation. 25 % (twenty five percent) of nursing staff will be monitored daily for 5 days, then weekly for 4 weeks, then monthly for 3 months then quarterly for two quarters to ensure compliance. (2) Observation of the licensed nursing staff will be performed by the DON or designee during finger sticks daily for 5 days then weekly for 4 weeks then monthly for 3 months and then quarterly for 2 quarters to ensure proper infection control techniques are maintained.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185244	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/29/2012
--	--	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8289 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 10</p> <p>changing the soiled gloves the SRNAs applied a protective cream, adjusted Resident #1's bed covers, touched the bed control to raise the head of the bed. The SRNAs were observed to obtain clean pillowcases and apply them to a pillow and bolster on the resident's bed without changing their soiled gloves or sanitizing their hands.</p> <p>Interview, on 06/27/12 at 4:40 PM, with SRNA #5 and SRNA #7 revealed they should have washed their hands after cleansing Resident #1's perineal area and applied new gloves.</p> <p>Interview, on 06/29/12 at 3:09 PM with the Director of Nursing and the Infection Control Nurse/LPN #1 revealed staff should have removed their soiled gloves, washed their hands, and applied new gloves prior to moving to another area of the body or touching other objects.</p> <p>3. Observation, on 06/28/12 at 4:45 PM, revealed Registered Nurse (RN) #5 obtained a finger stick for a blood glucose reading on Unsampled Resident A without gloves. During an interview with RN #5, on 06/29/12 at 8:20 AM, she revealed she was aware that she should have worn gloves during the procedure and that she normally did wear them.</p> <p>Interview, on 06/29/12 at 3:09 PM, with the Director of Nursing (DON) revealed nursing staff should wear gloves when obtaining fingerstick blood sugars (FSBS).</p> <p>4. Observation of the medication room, on 06/28/12 at 10:30 AM, revealed a sharps container that had been secured with a plastic tie lock but the contents was past the fill line. RN #8</p>	F 441	<p>(3) The Central Supply Director will monitor all sharp containers weekly for 8 weeks then monthly for 10 months to ensure proper use and disposal of sharp containers according to proper infection control policy and procedures. The Central Supply Director and Licensed Nursing staff will be responsible for disposing and replacing sharps containers as needed.</p> <p>4. The Quality Assurance Team will review reports during monthly QA Meeting to ensure compliance.</p>	Date Completed 8/13/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

185344

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____

B. WING _____

OMB NO. 0938-0391

(X3) DATE SURVEY COMPLETED

C

06/29/2012

NAME OF PROVIDER OR SUPPLIER

BRACKEN COUNTY NURSING & REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

5289 ASBURY ROAD

AUGUSTA, KY 41002

(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 11</p> <p>stated the sharps container should not be filled with sharps beyond the fill line.</p> <p>Interview, on 06/29/12 at 10:15 AM, with the DON revealed nursing staff were not to overfill the sharps containers to prevent needle sticks and contamination. She stated the nurses were responsible for taking locked sharps containers to the biohazard waste barrels.</p>	F 441		

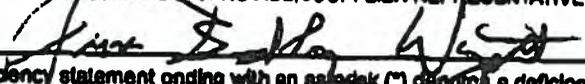
GENERALS FOR MEDICARE & MEDICAID SERVICES

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 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2012
--	--	--	--

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1984</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story with partial basement, Type II (111)</p> <p>Smoke Compartment: Three (3)</p> <p>Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in basement and boiler room.</p> <p>Sprinkler System: Complete sprinkler system (wet).</p> <p>Generator: Type 2 generator powered by natural gas</p> <p>A standard Life Safety Code survey was conducted on 06/27/12. Bracken County Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was twenty six (26). The facility is licensed for sixty two (62) beds.</p> <p>The Highest Scope and Severity deficiency was an "F" level.</p>	K 000		
K 130 SS=F	NFPA 101 MISCELLANEOUS	K 130		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 7/25/12
---	------------------------	----------------------

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days after 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.

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES NO PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 130	<p>Continued From page 1 OTHER LSC DEFICIENCY NOT ON 2786</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect three (3) of three (3) smoke compartments, thirty-two (32) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation, on 06/27/2012 at 12:02 PM, revealed the emergency generator had the battery charger wired directly to the emergency generator battery. The battery charger can not be wired directly to the emergency generator battery due to increased risk of fires. The observation was confirmed with the Maintenance Director.</p> <p>Interview, on 06/27/2012 at 12:02 PM, with the Maintenance Director revealed he was not aware the battery charger was wired directly to the emergency generator battery.</p> <p>NFPA 110 (1999 edition)</p> <p>5-12.6 The starting battery units shall be located as close as practicable to the prime mover starter to minimize voltage drop. Battery cables shall be sized to minimize voltage drop in accordance with the manufacturer's recommendations and</p>	K 130	<p>NFPA 101 MISCELLANEOUS</p> <p>The facility will ensure the emergency generator will be maintained according to National Fire Protection Association (NFPA) standards.</p> <ol style="list-style-type: none"> 1. The battery charger was disconnected by Maintenance Supervisor on 6/28/12 from the emergency generator battery and properly connected to the starter according to NFPA standards on 07/13/2012. 2. The Maintenance Supervisor will ensure that the generator is inspected annually by certified electrician to ensure proper electrical connections are maintained to reduce the risk of fire. The Maintenance Supervisor will check the generator weekly for 8 weeks to ensure proper functioning of emergency generator. The Maintenance Supervisor will log and record weekly generator checks and annual visits of generator electrical checks in maintenance binder. The Maintenance Supervisor was in-serviced by the Administrator on 6/29/12 regarding maintaining the emergency generator according to NFPA standards. 	

CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6288 ASBURY ROAD AUGUSTA, KY 41002
--	--

(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 130	Continued From page 2 accepted engineering practices. Battery charger output wiring shall be permanently connected. Connections shall not be made at the battery terminals.	K 130	3. The Quality Assurance Team will monitor Maintenance Binders weekly to ensure compliance and during monthly Quality Assurance meetings.	Date Completed 8/13/12