

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

PRINTED: 01/29/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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F 000	INITIAL COMMENTS A standard health survey was conducted 01/13/14 - 01/16/14 and a Life Safety Code survey was conducted on 01/14/14 with deficiencies cited at the highest scope and severity of an "E". A complaint investigation was conducted during the standard survey, investigating Complaint KY21154. The allegation of Misappropriation of Property was unsubstantiated.	F 000			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by:	F 279	1. Resident # 11 had a care plan developed for care of a Foley catheter by Director of Nursing on 1-17-14. Resident #10 had a care plan developed for the care of a Foley catheter by Assistant Director of Nursing on 1-16-14. 2. The MDS Nurse, Director of Nursing, the Assistant Director of Nursing or Charge Nurse will audit all current residents' plans of care to assure that the care plans are accurate and meet the needs of the resident. This audit will be completed by 2-28-14 and any needed additions to the care plans will be completed as identified.	3-1-14	

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

TITLE

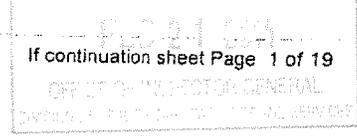
(X6) DATE

Betty Appleby

x Administrator x 2-21-14

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

DK



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F 279	<p>Continued From page 1</p> <p>Based on observation, interview, record review and policy review, it was determined the facility failed to develop a comprehensive care plan for two (2) of fifteen (15) sampled residents. Residents #10 and #11 had Foley catheters that were not reflected in the Residents' care plans.</p> <p>The findings include:</p> <p>Review of the Care Plan Policy, dated 09/08, revealed the residents comprehensive care plan should be viewed as an Interdisciplinary approach to managing the acute and chronic needs of the resident living in the facility. Efforts should always be directed towards developing care guidelines for Medical Diagnoses based on professional practice standards which can be applied broadly to any resident with the associated diagnosis.</p> <p>1. Review of the medical record for Resident #10, revealed the facility admitted the resident on 07/01/12, with a diagnosis including hemiplegia, Diabetes Mellitus, Amputation Bilateral Legs, Skin Sensation Disturbance, Respiratory Failure, Immobility Syndrome and Dementia.</p> <p>Review of Resident #10's, Minimum Data Set (MDS) Quarterly Assessment, dated 10/16/13, revealed the facility documented Resident #10 was incontinent, no catheter.</p> <p>Review of Resident #10's Comprehensive Care Plan, dated 02/04/13, revealed the resident had an alteration in elimination related to extensive assist with two (2) person physical assist and bilateral above the knee amputations. There was no documentation the resident had an indwelling catheter on the care plan.</p>	F 279	<p>3. All Licensed staff will be re-educated by the Director of Nursing, Assistant Director of Nursing or Charge Nurse related to development of the resident care plan to meet the needs of the resident. This re-education will be completed by 2-28-14 with no licensed staff working after 2-28 14 without having received this re-education.</p> <p>4. The Director of Nursing or Charge Nurse will audit five (5) resident records per week for twelve (12) to assure that care plans are developed to meet the need of the resident. The results of these observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing or Assistant Director of Nursing on a monthly basis for three(3) months and will continue on a monthly basis until the team concludes the issue is</p>	



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F 279 Continued From page 2

Observation of Resident #10, on 01/15/14 at 3:58 PM and 01/16/14 at 8:50 AM, revealed Resident #10 had a indwelling catheter bag attached to the bed frame in a dignity bag.

Interview with MDS Coordinator, on 01/15/14 at 5:20 PM, revealed she completed and updated care plans when assessments were completed. The MDS Coordinator stated the nursing staff were responsible to initiate the care plan when a resident was newly admitted with a catheter. The MDS Coordinator stated Resident #10 was admitted with an indwelling catheter in December of 2013.

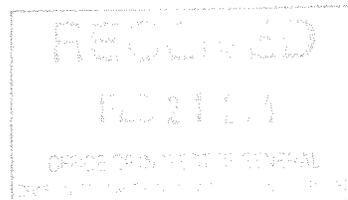
Interview with the Assistant Director of Nursing (ADON), on 01/16/14 at 5:35 PM, revealed nurses could initiate the care plan when a resident was newly admitted. The ADON stated if there was no care plan than the nursing staff would not be aware of the plan of care for the residents.

2. Review of the medical record for Resident #11, revealed the facility admitted the resident on 07/24/12, with diagnoses including Heart Failure, Diabetes Mellitus II, Hypertension, Anemia, Atherosclerosis, COPD, and Depressive Disorder.

Interview with Resident #11, on 01/16/14 at 8:10 AM, revealed he/she had been a resident there for a year; however, the facility had to insert an indwelling catheter last week for Urinary Retention.

Review of the current care plan for Resident #11, dated 06/12/13, revealed goals for alteration in bowel and bladder related to decreased mobility,

F 279 resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.



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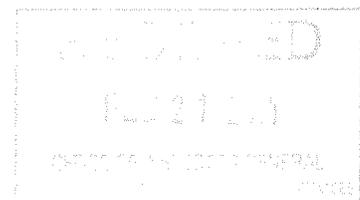
F 279	<p>Continued From page 3</p> <p>weakness, occasional incontinence, and history of diarrhea with interventions to rule out Urinary Tract Infection with changes in continence.</p> <p>Review of the current physician's orders for Resident #11, revealed on 01/15/13, the facility received an order for indwelling catheter and perineal care to be completed every shift.</p> <p>Observation of indwelling catheter care for Resident #11, on 01/16/14 at 10:00 AM, revealed CNA #2 put on her gloves, without washing her hands, and cleansed the left side of the perineum using cleansing cloths, then proceeded to the right side, cleaning downward. The CNA was observed to picked up the catheter and clean the tubing inside to out. The CNA emptied the catheter, with 450 cc's output, then removed her gloves. The CNA then picked up the dirty trash bag with her dirty hands and carried the dirty bag up the hallway without gloves. There was no hand washing observed before or after the procedure.</p> <p>Interview with CNA #2, on 01/16/14 at 10:10 AM, revealed she follows the instructions from the head set she wears which has a care plan for each resident, and catheter care was noted for Resident #11.</p> <p>Interview with LPN #3, on 01/16/14 at 10:15 AM, revealed the nurse's are required to make changes on the care plan as they receive physician's orders or any changes, such as a catheter.</p> <p>Interview with the Administrator, on 01/16/14 at 3:00 PM, revealed the Nurses should be monitoring all CNA's to ensure all catheter care</p>	F 279	
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F 279	Continued From page 4 and perineal care is completed correctly according to their training. In addition, the Administrator revealed nurses, and the Assessment Coordinator should be monitoring for care plan changes needed.	F 279	
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility standards of practice, it was determined the facility failed to ensure standards of clinical practice was applied during Perineal Care and Indwelling Catheter Care for two (2) of fifteen (15) sampled residents, (Residents #4, and #8). The facility failed to complete catheter care with correct technique for Resident #4 and failed to provide peri care with correct technique for Resident #8. The findings include: Review of the Lippincott's Textbook for Nursing Assistants, copyright 2005, regarding "Providing Catheter Care-Procedure 20-6" (used by the facility as the policy), revealed ...a. If the person is a woman: Using the other hand, separate the labia. Place your wash-cloth-covered hand at the top of the vulva and stroke downward to the anus ... Repeat, using a different part of the washcloth each time, until the area is clean. Rinse and dry the vulva and perineum thoroughly. The facility	F 281	1. On 2-4-14 the Assistant Director of Nursing (ADON) observed catheter care being provided for Resident #4 with no infection control infractions identified. C N A #1 was observed by ADON on 1-23-14 providing peri and catheter care to Resident #8 with no infection control infractions identified. C N A # 2 was observed providing peri and catheter care by ADON on 2-6-14 with no infection control infractions identified. C N A # 3 was observed providing peri and catheter care by ADON with no infractions observed on 1-30-14. LPN #3 was observed on 2-17-14 by ADON providing peri and catheter care on 2-17-14 with no infection control infractions observed. 2. The Director of Nursing and Assistant Director of Nursing observed eight (8) residents being provided peri care and four (4) residents being provided foley catheter care on 2-6-14 with no infection control infractions noted.

3-1-14



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<p>F 281</p> <p>Continued From page 5</p> <p>did not have a policy specific to when hands should be washed before and after specific procedures, or when gloves should be changed. The facility also provided the Lippincott 2005 manual female peri care as policy/procedure used for guidance. Method "A" stated place the washcloth-covered hand at the top of the vulva and stroking downward to the anus... Method "B" #20 stated to place the washcloth- covered mit at the front of the body and stroke toward the back.</p> <p>1. Review of the medical record for Resident #8 revealed the facility admitted the resident to the facility on 03/13/13 with Diagnosis including Dementia, Chronic Kidney Disease and Diabetes. Review of the admission Minimum Data Set (MDS) Assessment dated 03/25/13 and a Quarterly MDS Assessment dated 10/27/13, revealed the facility assessed the resident as incontinent of bowel and bladder and required moderate assist of one for incontinent care. Their was no indication in the medical record the resident had been treated for a Urinary Tract Infection.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed a care plan had been developed on 03/25/13 for alteration in elimination with interventions to provide incontinent care every two (2) hours, and report changes to characteristics of urine.</p> <p>Observation on 01/15/14 at 9:10 AM revealed, Certified Nursing Assistant (CNA) #3 was providing peri care for Resident #8. The CNA wiped from the vaginal area up toward the pubic area three (3) times. Licensed Practical Nurse (LPN) #3 was assisting and had observed peri care provided by the CNA.</p>	<p>F 281</p> <p>3. All Nursing personnel are being re-educated on peri care and catheter care by the Director of Nursing or Assistant Director of Nursing by 2-28-14 with no nursing staff working after 2-28-14 without having received this re-education. A return demonstration was observed while nurses and CNAs performed peri and catheter care and handwashing to ensure that they understood this process and proper technique was being used.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Charge Nurse will do five(5) observations per week for twelve (12) weeks to ensure that proper peri and catheter care technique is being followed. Additional training will be provided as necessary. The results of these observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing or Assistant Director of</p>
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F 281	<p>Continued From page 6</p> <p>Interview with CNA #3 and LPN #3 on 01/16/14 at 10:25 AM revealed the CNA did not realize she had cleaned the resident from back to front and stated it should have been from front to back. She stated the potential complications from using improper technique during peri care was at risk for Urinary Tract infections. Interview with LPN #3 at the same time revealed she did realize the CNA had done it incorrectly and waited until the surveyor left the room before asking the CNA about not using incorrect technique. CNA #3 stated she did not know when the last time she had been trained on peri care. LPN #3 stated they do most of their training on a computer program now but will do on the spot in services if necessary. She stated she did not remember if they had an on the spot training on peri care recently.</p> <p>2. Review of the medical record for Resident #4 revealed the facility admitted the resident on 08/17/12, with diagnoses including Pneumonia, History of UTI, Anemia, HTN, Hyperlipidemia, Anxiety, and Dementia with behaviors. Review of the most recent comprehensive assessment, dated 07/12/13, revealed the resident had an indwelling catheter with diagnosis of Urinary Retention.</p> <p>Review of the resident's current care plan identified an alteration in elimination with diagnosis of urinary retention and the risk for complications related to indwelling catheter use, and a history of Urinary Tract Infection, with interventions of indwelling catheter care every shift and as needed.</p>	F 281	<p>Nursing on a monthly basis for three(3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	

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F 281	<p>Continued From page 7</p> <p>Observations during indwelling catheter care, on 01/14/14 at 9:10 AM, revealed CNA #2 provided improper technique during care. The CNA was observed to put on gloves and stand the resident up to provide care, while the resident held on to a grab bar in the bathroom. CNA #2 positioned herself behind the resident in a standing position, using a cleansing cloth to clean the bowel movement (BM) by reaching under resident's perineum from catheter tubing, and wiping to the rectal area. The CNA then cleaned BM by folding the wash cloth and again wiped from the front to back twice. However, the CNA then took the cleaning cloth and reached underneath the resident's perineum and cleaned the tubing blind-sided down the catheter tubing from inside to out. The CNA failed to visualize the area of the labia, or cleanse the labia according to the procedure, nor did she change her gloves after cleaning the BM before going back to the labia, or front area.</p> <p>Interview with CNA #2, on 1/16/14 at 10:10 am, revealed she followed the instructions on the headset for each resident, which instructed her to perform catheter care for Resident #11.</p> <p>Interview with the MDS Coordinator, on 01/16/14 at 5:20 PM, revealed that procedures of how to do indwelling catheter care or perineal care is common knowledge or procedures, and CNA's should be learning this in their initial nurse aide training. They had inservices through the Silver Chair Computer program in October 2013, on catheters and perineal care.</p> <p>Interview with the Assistant Director of Nursing, on 01/16/14 at 5:00 PM revealed the CNA's received instruction on receiving care plan</p>	F 281		

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F 323 Continued From page 9
basis. Note any discrepancies, adjust water heater settings as required and retest as necessary.

Interview with the Maintenance Director, on 01/15/14 at 9:22 AM, revealed water temperatures should be between 100 to 110 degrees F.

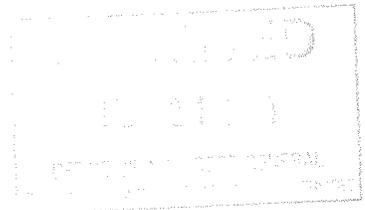
Observations made during the facility Environment Tour, on the A hall, on 01/15/14 at 9:22 AM, revealed Room 122 water temperature spiked to 115 F and then dropped to 110 F in ten (10) seconds. Room 125 water temperature spiked to 114 F and then dropped to 105 F in thirty (30) seconds. Room 133 water temperature spiked to 113 F and held. The shower room water temperature, on A hall, spiked to 113 F and dropped to 109 F in thirty (30) seconds.

Observation made during Environment Tour, on B hall, on 01/15/14 at 9:44 AM, revealed Room 103 water temperature spiked to 117 F and then dropped to 110 F in one (1) minute. Room 108 water temperature spiked to 111 F and held.

Interview with the Maintenance Director, on 01/15/14 at 9:44 AM, revealed he was taught to check one room on each hall daily. The Maintenance Director stated he was taught to always let the water spike and then drop to obtain a true reading of the water temperature. The Maintenance Director stated if water temperatures reached 120 F and dropped slowly it could possibly scald a resident.

Further interview with the Maintenance Director, on 01/15/14 at 3:06 PM, revealed if a temperature was documented high, he would then go check

F 323 4. The Administrator will review all water temperatures five (5) times per week for twelve (12) weeks to assure water temperatures are taken per the revised system and that water temperatures are within an acceptable range. The results of these audits will be reviewed by the Quality Assurance Committee consisting of the Administrator, Maintenance Director, and Director of Nursing or Assistant Director of Nursing on a monthly basis for three (3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.



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F 323	<p>Continued From page 10</p> <p>the mixing valve. The Maintenance Director stated that after the Environment Tour, he noticed the water heater temperature was on 117 F. The Maintenance Director then adjusted the valve and stated the highest the water temperatures ever spiked for him was 111 F. The Maintenance Director stated he noticed a flaw in his method of checking the water temperatures and should check front rooms, back rooms and shower rooms on each hall daily. The Maintenance Director stated the boiler was closer to the front of the halls. The Maintenance Director stated the old process of checking water temperatures was not an accurate account of water temperatures in the building because the water heater was closer to the front rooms of the halls.</p> <p>Record Reviews of the water temperature logs for the months of November, December and January revealed water temperatures were within normal limits. Record review of the water temperature logs, also revealed one (1) room on each hall was monitored daily.</p> <p>Interview with the Administrator, on 01/16/14 at 4:15 PM, revealed she was not aware the Maintenance Director was checking one (1) room on each hall daily. The Administrator stated water temperatures should be held between 100 F to 110 F. The Administrator stated water temperatures should not go above 110 F to prevent burns. The Administrator stated there had not been any incidents or injuries due to water temperatures being elevated.</p>	F 323		
F 441 SS=E	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an</p>	F 441		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/16/2014
NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108	
(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>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> <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,</p>	F 441	<p>1. The Assistant Director of Nursing observed proper infection control 3-1-14 practices including proper hand hygiene and glove changes during indwelling catheter care for Resident #4 on 2-4-14 and #10 on 1-30-14. Resident #11 was discharged from facility on 1-23-14. On 1-23-14 the Assistant Director of Nursing observed proper technique during perineal care for Resident #8.</p> <p>2. The Director of Nursing and Assistant Director of Nursing observed eight (8) residents being provided peri care and four (4) residents being provided foley catheter care on 2-6-14 with no infection control infractions noted.</p> <p>3. All Nursing personnel are being re-educated on peri care and catheter care by the Director of Nursing or Assistant Director of Nursing by 2-28-14 with no nursing staff working after 2-28-14 without having received this re-education. A return demonstration was observed while nurses and CNAs performed peri and catheter care and handwashing to ensure that they understood this process and proper technique was being used.</p>



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F 441 Continued From page 12
and review of the facility policy, it was determined the facility failed to follow proper infection control practices during catheter care and perineal care for four (4) of fifteen (15) residents (Residents #4, #8, #10, and #11). The facility failed to ensure proper hand hygiene and glove changes, during indwelling catheter care for Residents #4, #10, and #11. In addition, facility staff failed to demonstrate the correct technique during perineal care for Resident #8.

The findings include:

Review of the Lippincott's Textbook for Nursing Assistants, copyright 2005, regarding "Providing Catheter Care-Procedure 20-6" (used by the facility as the policy), revealed ...a. If the person is a woman: Using the other hand, separate the labia. Place your wash-cloth-covered hand at the top of the vulva and stroke downward to the anus ... Repeat, using a different part of the washcloth each time, until the area is clean. Rinse and dry the vulva and perineum thoroughly. The facility did not have a policy specific to when hands should be washed before and after specific procedures, or when gloves should be changed.

1. Review of the medical record for Resident #4, revealed the facility admitted the resident on 08/17/12, with diagnoses including Pneumonia, History of UTI, Anemia, HTN, Hyperlipidemia, Anxiety, and Dementia with behaviors. Review of the most recent comprehensive assessment, dated 07/12/13, revealed the resident had an indwelling catheter with diagnosis of Urinary Retention. Review of the resident's current care plan identified an alteration in elimination with diagnosis of urinary retention and risk for

F 441 4. The Director of Nursing, Assistant Director of Nursing or Charge Nurse will do five (5) observations per week for twelve (12) weeks to ensure that proper peri and catheter care technique is being followed. Additional training will be provided as necessary. The results of these observations will be reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing or Assistant Director of Nursing on a monthly basis for three(3) months and will continue on a monthly basis until the team concludes the issue is resolved. The Medical Director will attend these meetings at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.

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F 441	<p>Continued From page 13</p> <p>complications related to an indwelling catheter.</p> <p>During observation of indwelling catheter care for Resident #4, on 01/14/14 at 9:10 AM, revealed CNA #2 put on her gloves and positioned the resident in a standing position while the resident held the grab bar in the resident's bathroom. CNA #2 positioned herself behind the resident in a standing position, using a cleansing cloth to clean bowel movement by reaching under the resident's perineum from the catheter tubing, and wiped back to the rectal area. The CNA then cleaned the bowel movement (BM) by folding the wash cloth and again wiped front to back twice. However, the CNA then took the cleaning cloth and reached underneath the resident's perineum and cleaned the tubing blind-sided straight down the catheter tubing from inside to out. The CNA failed to visualize the area of the labia or cleanse the labia according to the procedure, nor did she change her gloves after cleaning the BM before going back to the labia, or front area.</p> <p>Interview with the CNA #2, on 01/14/14 at 9:20 AM, revealed she should cleanse front to back, and thought that's what she did. However, the CNA stated she should have washed her hands, but she did not think about it. The CNA revealed she did not think she should have changed her gloves.</p> <p>Interview with LPN #3, on 01/16/14 at 10:15 AM, revealed Resident #4 had a catheter since admission to the facility, and stated there had been a multiple past history of Urinary Tract Infections.</p> <p>2. Review of the medical record for Resident #11 revealed the facility admitted the Resident on</p>	F 441		

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F 441	<p>Continued From page 14</p> <p>07/24/12, with diagnoses including Congestive Heart Failure, DMII, HTN, Anemia, Atherosclerosis, COPD, and Depressive Disorder.</p> <p>Interview with Resident #11, on 01/16/14 at 8:10 AM, revealed he/she had been a resident there for a year, however stated the facility had to insert an indwelling catheter last week for Urinary Retention and stated the catheter drained 1000 cc of urine at first, then 2500 cc after a short period of time. The resident had a bariatric bed in place, and stated he/she did not like to get up.</p> <p>Review of the current care plan for Resident #11, dated 06/12/13, revealed a problem with alteration in bowel and bladder related to decreased mobility, weakness, occasional incontinence, and history of diarrhea with interventions to rule out Urinary Tract Infection with changes in continence. Review of the current physician's orders revealed Foley catheter and perineal care to be completed every shift.</p> <p>Observation of indwelling catheter care for Resident #11, on 01/16/14 at 10:00 AM, after permission obtained from the resident, revealed CNA #2 to put on her gloves, without washing her hands, and cleansed the left side of the perineum using cleansing cloths, then proceded to the right side, cleaning downward. The CNA was observed to picked up the catheter and cleaned the tubing inside to out. The CNA emptied the catheter, with 450 cc'c output, then removed her gloves and cleaned the door knob to the bathroom with the cleansing cloth. The CNA then picked up the dirty trash bag with her dirty hands and carried the dirty bag up the hallway without gloves. There was no hand washing observed before or</p>	F 441			

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NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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F 441

Continued From page 15 after the procedure.

F 441

Interview with CNA #2, on 01/16/14 at 10:10 AM, revealed she should wash her hands before and after each procedure, and realized she did not do it. She stated she usually takes the dirty trash bags to the utility room with her bare hands before washing them.

Interview with LPN #3, on 01/16/14 at 10:15 AM, revealed the CNA's were responsible for completing the Perineal area and indwelling catheter care; then they are responsible for documenting in the Accu- Nurse System four (4) times per day and the nurses monitor 3-4 times per day for percentages. The LPN revealed the CNA's have to have 100% by the end of the day. Further interview with the LPN revealed the nurse's do orientation check offs and the CNA's have three (3) days training with another aide. She further stated the CNA's need to be re-educated on the proper technique. The LPN revealed that although CNA #2 had received her Silver Chair Training in October 2013, she would need to be re-educated. In addition, the LPN revealed that Resident #11 recently received an indwelling catheter for Urinary Retention, and stated the resident is non-compliant with most care, and is Diabetic, which makes him/her prone to Urinary Tract Infections.

3. Review of the facility Infection Control Course, dated from 07/01/12 through 01/15/14, revealed staff should wash their hands before and after an invasive procedure and when ever gloves were soiled.

Review of the medical record for Resident #10, revealed the facility admitted Resident #10 on

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F 441	<p>Continued From page 16</p> <p>07/01/12, with a diagnosis including hemiplegia, Diabetes Mellitus, Amputation Bilateral Legs, Skin Sensation Disturbance, Respiratory Failure, Immobility Syndrome and Dementia.</p> <p>Observation of Catheter Care for Resident #10, on 01/16/14 at 9:18 AM, revealed Certified Nursing Assistant (CNA) # 1, washed her hands, donned gloves and cleaned Resident #10's peri area from front to back. CNA #1 then with the same gloves placed clean linen under Resident #10's coccyx. CNA #1 then asked Resident #10 to grab his/her hand to pull the resident onto his/her side to ensure the linen was not bunched under Resident #10's coccyx (with the same gloves that provided peri care). CNA #1 then drained Resident #10's catheter bag, removed gloves and washed her hands.</p> <p>Interview with CNA #1, on 01/16/14 at 9:35 AM, revealed she was not aware she should remove her gloves. CNA #1 stated that she was sure she had received training on when to remove gloves and wash hands, but could not remember when the last training occurred. CNA #1 stated she should have removed her gloves to prevent the spread of infection.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/16/14 at 10:16 AM, revealed she had observed peri care at times and found that some of the staff were not changing their gloves at appropriate times, especially when going from dirty to clean. LPN #1 stated that when she observed this she would educate the CNA on the spot. LPN #1 stated this does not happen often. LPN #1 stated she had not notice an increase in urinary bladder infections.</p>	F 441		

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F 441	<p>Continued From page 17</p> <p>4. Review of the medical record for Resident #8 revealed the facility admitted the resident on 03/13/13 with Diagnosis including Dementia, Chronic Kidney Disease and Diabetes. Review of the admission Minimum Data Set (MDS) Assessment dated 03/25/13 and a Quarterly MDS Assessment dated 10/27/13, revealed the facility assessed the resident as incontinent of bowel and bladder and required moderate assist of one (1) for incontinent care. There was no indication in the medical record the resident had been treated for a Urinary Tract Infection.</p> <p>Observation on 01/15/14 at 9:10 AM revealed, Certified Nursing Assistant (CNA) #3 was providing peri care for Resident #8. The CNA wiped from the vaginal area up toward the pubic area three (3) times. Licensed Practical Nurse (LPN) #3 was assisting and had observed peri care provided by the CNA.</p> <p>Interview with CNA #3 and LPN #3 on 01/16/14 at 10:25 AM revealed the CNA did not realize she had cleaned the resident from back to front and stated it should have been from front to back. She stated the potential complications from using improper technique during peri care was for Urinary Tract infections. Interview with LPN #3 at the same time revealed she realized the CNA had done it incorrectly and waited until the surveyor left the room before asking the CNA about not using incorrect technique. CNA #3 stated she did not know when the last time she had been trained on peri care. LPN #3 stated they do most of their training on a computer program now, but will do on the spot in services if necessary. She stated she did not remember if they had an on the spot training on peri care recently.</p>	F 441		

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F 441	<p>Continued From page 18</p> <p>Interview with the Administrator, on 01/16/14 at 3:00 PM, revealed the Nurses should be monitoring all CNA's to ensure all catheter care and perineal care is completed correctly according to their training. The Administrator revealed with the size of the home, there was no Staff Development Coordinator in the facility now. However, the Administrator stated the new Assistant Director of Nursing would be taking some of those responsibilities, and would be monitoring the in-services.</p> <p>Interview with the Director of Nursing (DON), on 01/16/14 at 4:15 PM, revealed she monitors staff providing care and reminds nurses to watch Perineal Care and Catheter Care. The DON also revealed they use an in-service program called Silver Chair, which teaches indwelling catheter care and perineal care. The DON also stated both she and the Assistant Director of Nursing should be monitoring the staff ongoing; however, revealed she had only been in the position a few months.</p> <p>Further interview with the DON, on 01/16/14 at 4:15 PM, revealed the facility did not complete skills competencies for staff, and no longer had a Staff Development Coordinator; she stated the Silver Chair Training on the computer had replaced this. However, the DON stated that spontaneous in-services can be done.</p> <p>Interview with the ADON, on 01/16/14 at 5:00 PM, revealed the facility used the Lippincott Manual for all procedures, and stated the Nursing Assistants wore headsets, which give them Care Plan interventions, such as indwelling Catheter Care and Perineal Care.</p>	F 441		

109 F. 040/000

02/10/2014 11:17:23

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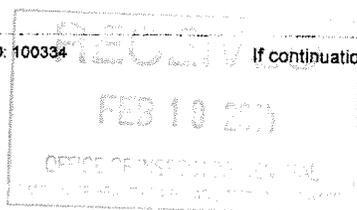
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic dry system.</p> <p>GENERATOR: Type II generator. Fuel source is propane.</p> <p>A standard Life Safety Code survey was conducted on 01/14/14. Brandenburg Nursing and Rehab was found not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for fifty seven (57) beds with a census of fifty four (54) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Betty Appleby</i>	TITLE <i>x Administrator</i>	(X6) DATE <i>2-10-14</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.

RW

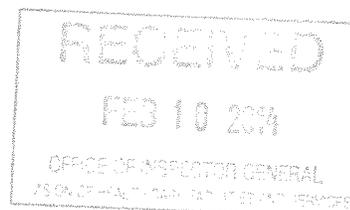


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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire). Deficiencies were cited with the highest deficiency identified at "D" level.	K 000		
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty four (34) residents, staff and visitors. The facility is certified for fifty seven (57) beds with a census of fifty four (54) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke. The findings include: Observation, on 01/14/14 at 1:35 PM, with the	K 027	1. A new cross corridor door meeting specifications detailed in 483.70(Life Safety from Fire) to replace the A Hall door identified with a gap has been ordered and will be installed by 2-28-14. 2. The Maintenance Director was inserviced by the Administrator on 1-20-14 on NFPA 101-- 7.2.1.14 regarding the requirement that doors located in a smoke barrier will resist the passage of smoke in accordance with NFPA standards. 3. The Administrator will do monitoring for twelve(12) weeks by monthly walk-throughs with the Maintenance Director of the center to ensure that there are no gaps or splits in cross corridor doors that would cause them to not resist the passage of smoke when closed.	3-1-14



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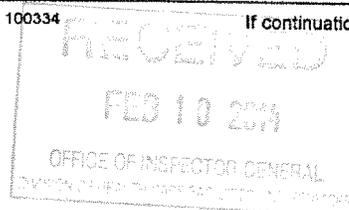
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NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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K 027	<p>Continued From page 2</p> <p>Maintenance Director revealed the cross corridor doors located in A Hall had a gap larger than an eighth of an inch and would not resist the passage of smoke when closed. This was due to the wood doors having a split where the screws for the hinges were located.</p> <p>Interview, on 01/14/14 at 1:35 PM, with the Maintenance Director revealed he was not aware the doors had too large of a gap to resist smoke. Further interview with the Maintenance Director revealed he was not aware of the split in the doors on the hinge side. Further interview revealed he was not aware of a policy for doors located in smoke partitions.</p> <p>Interview, on 01/14/14 at 2:29 PM, with the Administrator revealed she was not aware the doors had too large of a gap to resist smoke. Further interview with the Administrator revealed she was not aware of a policy for doors located in smoke partitions.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on</p>	K 027	<p>4. The results of the weekly walk-throughs will be documented by Maintenance Director and reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Maintenance Director, Dietary Manager on a monthly basis until the team concludes the issue is resolved. The Medical Director will be involved in this meeting at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	
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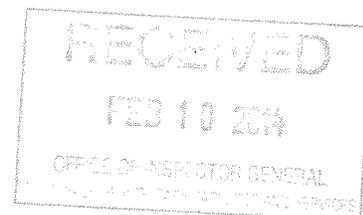
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 01/24/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 01/14/2014
NAME OF PROVIDER OR SUPPLIER BRANDENBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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K 027	Continued From page 3 the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors. Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027			
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in	K 029	1. A self-closing device was installed on the storage room closet located in the Dining Room on 1-15-14 to keep the door closed. 2. The Maintenance Director was inserviced by the Administrator on 1-20-14 on the requirement - NFPA 101-19.3.2.1 - Protection from Hazards-Hazardous Areas requiring that doors to Hazardous areas shall be self-closing or automatic closing.	3-1-14	



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K 029 Continued From page 4
accordance with NFPA Standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for fifty seven (57) beds with a census of fifty four (54) on the day of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.

The findings include:

Observation, on 01/14/14 at 1:44 PM, with the Maintenance Director revealed the door to a hazardous room located in the Dining Room did not have a self-closing device installed to keep the door closed.

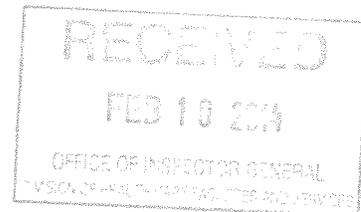
Interview, on 01/14/14 at 1:44 PM, with the Maintenance Director revealed he was not aware of the requirements for protection from hazards.

Interview, on 01/14/14 at 2:29 PM, with the Administrator revealed she was not aware the door did not have a self-closing device installed. Further interview revealed she was not aware of a policy for self-closers being installed on hazardous rooms.

Reference:
NFPA 101 (2000 Edition).
19.3.2 Protection from Hazards.
19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler

K 029 3. The Administrator will do monitoring for three months by monthly walk-throughs with the Maintenance Director of the center to ensure that there are no doors to hazardous areas within the center that do not have self-closing or automatic closing devices.

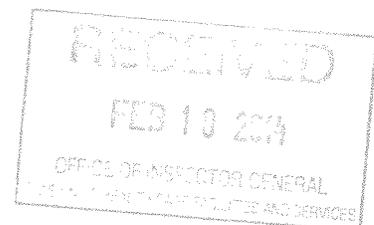
4. The results of the monthly walk-throughs will be documented by Maintenance Director and reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Maintenance Director, Dietary Manager on a monthly basis until the team concludes the issue is resolved. The Medical Director will be involved in this meeting at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.



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K 029	Continued From page 5 option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 143 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and	K 143		

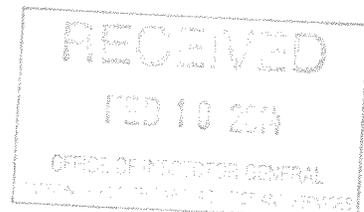


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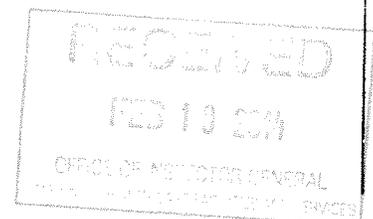
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K 143	Continued From page 6 (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the room being used to transfer liquid oxygen was rated per NFPA requirements. The deficiency had the potential to affect one (1) of four (4) smoke compartments, thirty four (34) residents, staff and visitors. The facility is certified for fifty seven (57) beds with a census of fifty four (54) on the day of the survey. The facility failed to ensure the oxygen transferring room had a fire rated door and frame that had a 1 hour fire resistive rating. The findings include: Observation, on 01/14/14 at 1:29 PM with the Maintenance Director, revealed the oxygen trans-filling room did not have a fire rated door and frame installed. The door frame is steel but there was no visible fire rating attached to the door or the frame. Interview, on 01/14/14 at 1:29 PM with the Maintenance Director, revealed he was unaware the door and the frame were required to have a one hour fire resistive rating.	K 143	1. A fire-rated door and frame with a one(1) hour fire resistive rating has been ordered for the oxygen trans-filling room in accordance with NFPA 99 and the Compressed Gas Association 8.6.2.5.2. The new fire rated door will be installed by 2-28-14. 2. The Maintenance Director was inserviced by the Administrator on 1-20-14 on NFPA 99-- 8.6.2.5.2 regarding requirements for Transferring Oxygen. 3. The Administrator will do monitoring for twelve(12) weeks by monthly walk-throughs with the Maintenance Director of the center to ensure that doors to oxygen trans-filling room remain operational and that requirements outlined under NFPA 99 8-6.2.5.2 are met.	3-1-14



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K 211	Continued From page 8 Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor: o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that Alcohol Based Hand Rub (ABHR) dispensers were not installed over or adjacent to an ignition source in accordance with NFPA standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, thirty two (32) residents, staff and visitors. The facility has fifty seven (57) certified beds with a census of fifty four (54) on the day of the survey. The findings include: Observation, on 01/14/14 at 1:40 PM, with the Maintenance Director revealed an Alcohol Based	K 211	1. The identified Alcohol Based Hand Rub (ABHR) dispensers that were installed over or adjacent to the light switch located in the Housekeeping Office, Business Office, and the Director of Nursing Office were removed and relocated by Maintenance Director on 1-16-14. 2. The Maintenance Director and the Environmental Services Director were inserviced by the Administrator on 1-20-14 regarding NFPA 101 Alcohol Based Hand Rub (ABHR) regulations according to 19.3.2.7. 3. The Administrator will do monitoring for three(3) months by monthly walk-throughs with the Maintenance Director of the center to ensure that no ABHR are installed over or adjacent to an ignition source.	3-1-14

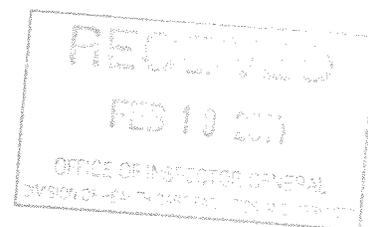


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K 211	<p>Continued From page 9</p> <p>Hand Rub Dispenser was installed over or adjacent to the light switch located in the Housekeeping Office, Business Office, and the Director of Nursing Office.</p> <p>Interview, on 01/14/14 at 1:40 PM, with the Maintenance Director revealed he was not aware the alcohol based hand rub dispensers had been mounted over an ignition source.</p> <p>Interview, on 01/14/14 at 2:29 PM, with the Administrator revealed she was not aware of the Alcohol based hand rub dispensers being installed over an ignition source. Further interview revealed she was not aware of a policy for the installation of alcohol based hand rubs.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:</p> <ul style="list-style-type: none"> o The corridor is at least 6 feet wide o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) o The dispensers have a minimum spacing of 4 ft from each other o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. o Dispensers are not installed over or adjacent to an ignition source. o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623 	K 211	<p>4. The results of the monthly walk-throughs will be documented by Maintenance Director and reviewed by the Quality Assurance Committee consisting of the Administrator, Director of Nursing, Maintenance Director, Environmental Services Supervisor, and Dietary Manager on a monthly basis until the team concludes the issue is resolved. The Medical Director will be involved in this meeting at least quarterly. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>		



FROM: