

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

PRINTED: 11/19/2010
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 11/03/2010
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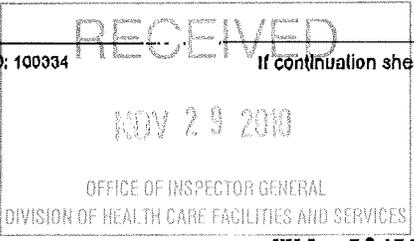
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BRANDENBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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F 000	<p>INITIAL COMMENTS</p> <p>A standard and abbreviated surveys were conducted 11/01-11/03/10 and found the facility to not meet the minimum regulatory requirements with deficiencies cited at the highest scope and severity of an "F". A Life Safety Code survey was conducted on 11/03/10 and deficiencies cited.</p> <p>Two complaint investigations conducted in conjunction with the annual survey resulted in KY #15042- Substantiated with no regulatory violations and KY #15117- Substantiated with regulatory violations cited at F323 S/S "D".</p> <p>F 253 SS=D 483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain Resident room #113 in good repair related to the large cracked areas on the ceiling, walls, and window facing with cracks extending down to an uneven floor surface. Room #109 was found to have large cracks around all four sides of the window.</p> <p>The findings include: Observation on 11/01/10 at 11:20am revealed room #113 had large cracks in the ceiling, two (2) walls, and cracks around the window facing with cracks extending down to an uneven floor surface. The cracks were one-half inch wide in places with evidence of prior attempts to fill the</p>	F 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Beth Appleby* TITLE *Administrator* (X6) DATE *11-21-10*

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



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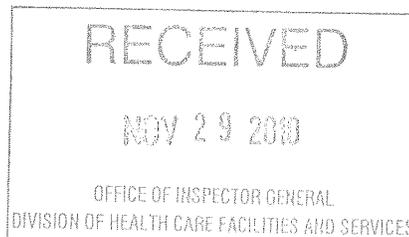
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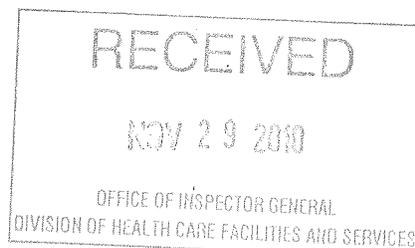
F 253	<p>Continued From page 1</p> <p>cracks with a substance that did not match the color or texture of the paint on the walls or the plaster on the ceiling.</p> <p>Observation on 11/01/10 at 11:00am revealed room #109 had large cracks around all four sides of the window facing.</p> <p>Interview on 11/01/10 at 11:20am with the Maintenance Director revealed that he attempted to fill the cracks twice annually, and added that these cracks have been a problem since he began his work at the facility six (6) years ago. He reported that after he was hired, the Army Corp of Engineers was consulted to evaluate the structure of the building. He was told that the facility is built on a couple of "sink-holes." He said the freezing in the winter and thawing promotes extension of the cracks and reopening of the cracks which have been repaired. He said, "It cracks all the time." He said the Army Corp of Engineers found the building structure to be safe.</p> <p>Interview on 11/03/10 at 3:40pm with the Maintenance Director and Administrator revealed many attempts to caulk the window had been unsuccessful. The Administrator and Maintenance Director stated many attempts at repairs had been made.</p> <p>Interview on 11/03/10 at 3:45pm with the Maintenance Director and Administrator revealed the cracks in the ceiling, walls, and window facing had been filled and treated, but the cracks had reopened. The Maintenance Director was asked if he felt the floor was level, he responded, "If you laid a ball-bearing on the floor, it would roll to the wall." When the Administrator was asked how the appearance of the walls would affect the</p>	F 253	<p>F253</p> <ol style="list-style-type: none"> 1. Resident room # 113 will have the cracks in the walls, ceiling and window facings repaired and resurfaced to match the decor of the room by - 12-18-2010, room # 109 will have the cracks around all four sides of the window repaired and resurfaced to match the decor of the room by 12-18-2010. 2. An audit of all resident rooms will be completed by the Maintenance Director by 11-22-2010 to identify any other cracks in the walls, ceiling or window facings. Any identified concerns will be corrected. 3. The Maintenance Director will be re-educated by the Administrator on 11-05-2010, related to completing monthly audits, reporting and repairing any cracks in the walls, ceiling or window facings of Resident rooms and maintaining a sanitary, orderly, and comfortable interior. 4. The Administrator will conduct weekly rounds for twelve(12) weeks to identify any cracks in the walls, ceiling or window facings to assure all are repaired and resident environment is sanitary, orderly, and comfortable. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene 	12-18-2010
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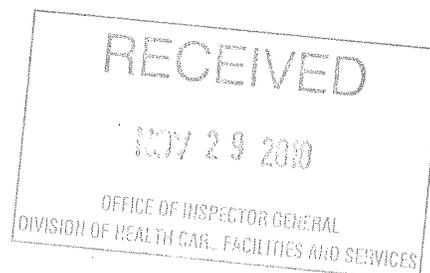
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F 253	Continued From page 2 resident with regard to providing a home-like environment, she replied, "if the cracks were repaired, and the walls were sanded and painted this room would be like any other." The Maintenance Director stated barrier sealant would not seal these cracks, and he used transparent sealant two (2) weeks ago which left a shiny appearance and could not be painted. He said that he found fire barrier compound to be most effective to fill the cracks, but noted that it was difficult to apply and could not be sanded or painted.	F 253	to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure the residents' environment was free of accident hazards as was possible and to ensure residents received adequate supervision and assistive devices to prevent accidents for one (1) of fourteen (14) sampled residents (#13). The facility failed to ensure appropriate supervision and services were provided to Resident #13 related to improper securing of the resident's wheelchair while using public transportation. The findings include:	F 323	1. Resident # 13 no longer resides in the facility. 2. An audit of all wheelchairs will be conducted by 12-10-2010 by the Maintenance Director to assure all wheelchairs are in working order including any leg rest attached. Any identified concerns will be immediately corrected. 3. All Direct care staff will be re-educated by the Director of Nursing, the Assistant Director of Nursing or the Education and Training Director by 12-18-2010, on reporting any wheelchair not in working order including leg rest. The Maintenance Director will conduct monthly audits of wheelchairs to assure all are in working order to include leg rest.	



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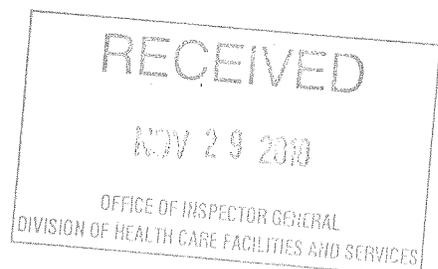
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F 323	Continued From page 3 Review of an agency referral to the Office of the Inspector General revealed Resident #13 had amputations below the knee to both legs and was unable to protect him/herself from falls during bus transportation. Resident #13 was reported to have bruising to the left side possibly as the result of improper transportation. Review of the clinical record for Resident #13 revealed the resident was admitted to the facility on 06/25/10 with diagnoses of Multiple Surgical Chest Wounds, End Stage Renal Disease, Pressure Ulcers, Diabetes, Bilateral Below the Knee Amputations, Third Degree Heart Block, and Progressive Dementia. Occupational Therapy notes dated 06/28/10 revealed the resident was weak and had normal upper extremity function. The resident's admission orders from the attending physician on 06/25/10 revealed the resident could be transferred using a wheelchair. Interview with Licensed Practical Nurse (LPN) #1 on 11/03/10 at 1:40pm revealed she got Resident #13 ready for transport to dialysis on 06/28/10. She stated the resident was seated in a facility wheelchair with leg rests in the up and locked position. She stated the leg rests would automatically lock in place when elevated. She stated there was a metal handle to unlock the leg rests. She stated the resident had bilateral below the knee amputations and the leg rests were necessary to provide the resident with support and to prevent the resident from sliding out of the wheelchair. She stated she would never have sent the resident out without locked leg rests to provide safety.	F 323	4. The Maintenance Director will audit all wheelchairs monthly for three(3) months to assure all are in working order including leg rest. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.	12-18-2010	



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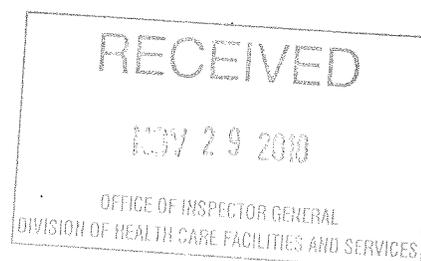
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F 323	Continued From page 4 Interview with the transport driver, on 11/03/10 at 9:40am, revealed he had difficulty with the wheelchair leg rests and they swung side to side when he made turns. He stated he stopped three (3) times to try and lock the leg rests; however, he could not figure out how to lock them. He stated he did not know how to work the wheelchair. He stated Resident #13's leg stumps would fall off the leg rests each time a turn was made. He stated the resident had a seat belt in place and did not fall out of the wheelchair at any time. Interview with the DON on 11/03/10 at 8:50am revealed she was aware of the leg rests swinging with each turn the driver made; however, she had no further information. Interview with the Administrator on 11/03/10 at 12:50pm revealed she had no information on the wheelchair, it's condition, or what happened to Resident #13.	F 323		
F 371 SS=F	483.36(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 record review, observation, and interview the facility failed to store, prepare, and	F 371	1. The (3) boxes of frozen meat patties and one(1) box of frozen biscuits were placed in a sealed air tight container on 11-03-2010. The bucket of sanitizer and rags were moved away from the food prep area on 11-04-2010 as observed by the Dietary Services Manager. The hand sanitizer dispensers in the dietary department were removed on 11-24-2010. An observation by the Dietary Services Manager on 11-08-2010, revealed that staff were washing their hands appropriately and not using hand sanitizer The water pitcher on B hall medication carts were removed and cleaned on 11-03-2010.	



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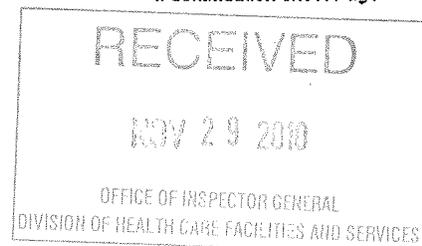
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F 371	<p>Continued From page 5</p> <p>distribute food under sanitary conditions and failed to maintain handwashing procedures in the kitchen area. Also a bucket containing sanitizer and rags was in close proximity to a food preparation area where staff were preparing food. Water pitchers used for medication pass were not clean and had stains.</p> <p>The findings include:</p> <p>Record review of Nutrition Services Freezer Storage policy revealed that frozen foods are stored in containers with tight fitting lids.</p> <p>Record review of Nutrition Services Personal Hygiene policy revealed that staff are expected to wash hands before putting on gloves to work with food and after bussing dirty dishes, and upon removing gloves, after touching anything that may contaminate hands such as dirty dishes, unsanitized equipment, work surfaces, or wash cloths.</p> <p>Observation on 11/01/10 at 9:23am found three (3) boxes of frozen meat patties and one (1) box of frozen biscuits opened and not resealed in an air-tight manner.</p> <p>Observation on 11/02/10 at 11:00am revealed the Cook and Dietary Manager utilizing hand sanitizer instead of handwashing frequently during the tray line meal service.</p> <p>Observation on 11/03/10 at 10:05am revealed a bucket with sanitizer and rags sitting on the counter of the two (2) compartment sink directly across and on the same level as the food prep area where serving bowls were being filled with pudding. The bucket with sanitizer was within</p>	F 371	<p>2. An audit of all frozen foods was completed by the Dietary Service Manager on 11-08-2010, to assure all frozen foods are stored in a sealed air tight container. Any identified concerns were immediately corrected. An observation by the Dietary Service manager on 11-04-2010, revealed that cleaning and or sanitizing agents were not stored near food prep areas. On observation by the Dietary Service Manager on 11-08-2010, revealed staff were washing their hands before putting on gloves to work with food and after bussing dirty dishes and upon removing gloves, after touching anything that may contaminate hands such as dirty dishes, unsanitized equipment, work surfaces, or wash cloths. An observation by the Assistant Director of Nursing on 11-3-2010 revealed that water pitchers on all medication carts were clean and stain free.</p> <p>3. The Dietary Services Manager re-educated all dietary employees related to washing their hands before putting on gloves to work with food and after bussing dirty dishes and upon removing gloves, after touching anything that may contaminate hands such as dirty dishes, unsanitized equipment, work surfaces, or wash cloths, on 11-23-2010. The Dietary Services Manager</p>	



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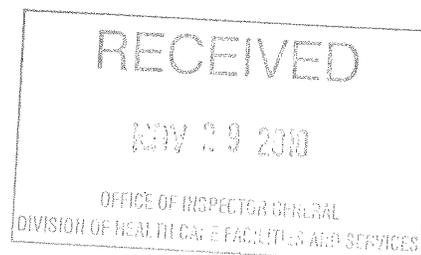
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F 371	<p>Continued From page 6 three (3) feet of food prep area.</p> <p>Interview with the Dietary Manager on 11/03/10 at 10:05am revealed that three (3) boxes of frozen meat patties and one (1) box of frozen biscuits were not resealed in an air-tight manner after some of the product had been removed. The Dietary Manager stated the air-tight packaging is not necessary as long as the box top was folded down. Upon discussing the observation of the use of hand sanitizer, the Dietary Manager explained that four (4) hand sanitizing units were installed throughout the kitchen work area for the workers convenience. She said one (1) unit was installed in the dishwashing room to enable the staff to disinfect the hands after handling dirty dishes, and before moving to the clean dishes. When asked if it is appropriate to substitute the use of hand sanitizer for handwashing with soap and water in the kitchen, she replied, "Yes." The Dietary Manager stated she did not think the bucket of sanitizer with rags directly across from the food prep area with food preparation in progress presented a risk of biological or chemical contamination, and stated, "We have never had a problem with it in the past."</p> <p>Observation on 11/03/10 at 10:45am revealed, revealed B Hall front medication cart water pitcher, which holds ice for medication pass, had discoloration on the handle, dust on the lid, and stray marks on the inside and outside of the pitcher. The B Hall back medication cart water pitcher held ice water and had a dark substance on the inside and dark sticky material on the white lid.</p> <p>Interview on 11/03/10 at 10:50am with LPN #3, revealed that the pitchers are cleaned on night</p>	F 371	<p>re-educated all dietary staff on 11-23-2010 related proper storage of sanitizer and cleaning agents and equipment. The Dietary services manager re-educated all dietary staff on 11-23-2010 related to storage of opened frozen foods sealed airtight container. The Director of Nursing will re-educated all Licensed Staff 12-18-2010 related to sending water pitchers for the medication carts to the kitchen daily for cleaning and replacing with clean pitchers.</p> <p>4. The Dietary Services Manager will conduct an audit four(4) times per week for two(2) weeks, then three(3) times per week for two(2) weeks, then weekly for eight(8) weeks, to assure staff are washing their hands before putting on gloves to work with food and after bussing dirty dishes and upon removing gloves, after touching anything that may contaminate hands such as dirty dishes, unsanitized equipment, work surfaces, or wash cloths. The Dietary Services manager will conduct an audit four (4) times per week for two(2) weeks, then three(3) times per week for two(2) weeks, then weekly for eight(8) weeks, to assure no sanitizing or cleaning agents are stored near food prep areas and that frozen foods that have been opened are stored in a container with a tight fitting lid. The Director of Nursing will audit water pitchers on all</p>	



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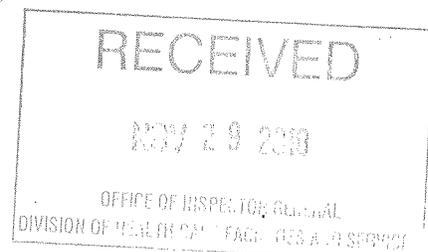
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F 371	Continued From page 7 shift, and she did not think either pitcher looked clean. Interview on 11/03/10 at 10:55am with the Assistant Director of Nursing (ADON), revealed that she didn't know if the pitchers were cleaned last night, and stated it looked like they needed to be cleaned. The ADON further stated it looked like one of the pitchers was stained on the inside, and said she would replace the pitchers immediately.	F 371	medication carts two(2) times per week for twelve(12) weeks to assure water pitchers are clean and stain free. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F431 1. The three(3) medications identified during the Survey were removed from the medication carts and discarded by the Education and Training Director on 11-3-2010. 2. An audit of all Medication carts was completed by the Director of Nursing, the Assistant Director of Nursing, the Education and Training Director or the LPN Supervisor on 11-23-2010, to assure all medications were in stored in the original package and labeled by the pharmacy. Any identified unlabeled medications will be discarded.	F371 12-18-2010



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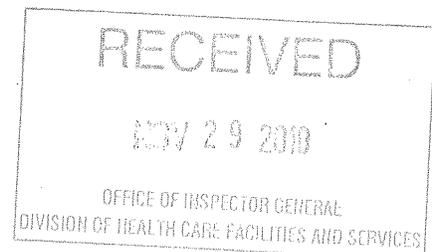
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 8</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to store medications in accordance with accepted professional principles as three (3) medications were found loose and unlabeled in the medication cart drawer.</p> <p>The findings include:</p> <p>Observation of A Hall Front medication cart on 11/03/10 at 2:00pm revealed one half of a round white tablet and one (1) Restasis ophthalmic ampule were in the medication cart drawer, unlabeled with patient name, and not stored in the original package.</p> <p>Observation of A Hall Back medication cart on 11/03/10 at 2:15pm revealed one (1) round white tablet in the medication cart drawer unlabeled with patient name and not stored in the original package.</p> <p>Interview on 11/03/10 at 2:00pm with the Director of Education and Training revealed the oral and topical medications such as Restasis should be stored in separate drawers in the medication cart. She also stated that medications should be stored in the original pharmacy package which includes</p>	F 431	<p>3. The Director of Nursing, the Assistant Director of Nursing or the Education and Training Director will re-educate all licensed staff by 12-18-2010, assuring all medications are stored in the original package and labeled by the pharmacy.</p> <p>4. The Director of Nursing, the Assistant Director of Nursing or the Education and Training Director will audit medication carts weekly for twelve(12) weeks to assure medication are stored in the original container and labeled by the pharmacy. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.</p>	12-18-2010



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F 431	Continued From page 9 resident name, and was uncertain how the two (2) tablets and Restasis ophthalmic ampule became separated from the original package. She disposed of the medications in the sharps container.	F 431			



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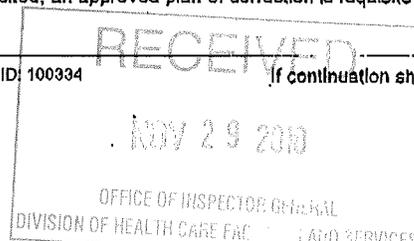
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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and concluded on 11/03/10. The facility was found not to meet the minimum requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediments to the closing of resident room doors, according to NFPA standards. The deficiency affected two (2) residents and one (1)	K 018	K018 1. Magnetic door catches that release when pulled were installed by the Maintenance Director on 11-09-2010 for rooms # 121 and # 123. 2. A one hundred (100)percent audit of all doors was completed by the Maintenance Director on 11-22-2010 to assure no doors were blocked open. Any identified concerns were immediately corrected. 3. The facility Administrator provided re-education on 11-05-2010 to the facility Maintenance Director regarding weekly rounding to include checking all doors to ensure that they are working properly and not blocked open.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Betty Appleby TITLE: Administrator (X6) DATE: 11-24-10

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



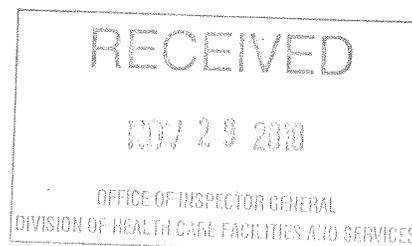
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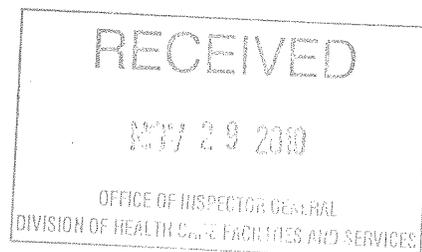
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K 018	Continued From page 1 of two (2) smoke compartments. The findings include: Observation on 11/03/10 at 11:30 AM revealed a trash can in resident rooms #121 and #123 was positioned so that it prevented the closing of the doors. The observation was confirmed with the Maintenance Director, who was present at that time. Interview on 11/03/10 at 11:30 AM, with the Maintenance Director, revealed the trash can was used to hold the door open. Reference: NFPA 101 (2000 edition) 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	4. The Administrator will conduct weekly rounds for twelve(12) weeks to assure compliance with doors not being blocked open. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.	12-18-2010
K 029 SS=F	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	K 029	K029 1. Self closing devices were installed on 11-8-2010 on janitor closets on both A Hall and B hall. 2. The Maintenance Director and the Administrator completed a one hundred(100) percent audit of all doors to ensure that all doors that project into the hallway have self closing devices. Any identified concerns were corrected.	



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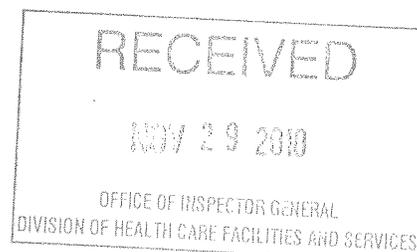
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K 029	<p>Continued From page 2</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet requirements of Protection of Hazards per NFPA Standards.</p> <p>The findings include:</p> <p>Observation on 11/03/10 at 1:13 PM revealed that the Janitors Closets in A Hall and B Hall did not have self closing devices installed on doors as required by NFPA standards. Further observation revealed that both doors projected out into the corridor over seven (7) inches. This deficiency affected all staff and fifty-four (54) residents. This was confirmed by the Maintenance Director.</p> <p>Interview on 11/03/10 at 1:13 PM with the Maintenance Director revealed he was not aware of that code in reference to the doors.</p> <p>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</p>	K 029	<p>3. The Maintenance Director was re-educated by the Administrator on 11-05-2010, related to assuring all doors that project into the hallway have a self closing device, and will be integrated into the Maintenance Director's weekly rounds.</p> <p>4. The Maintenance Director will audit all doors weekly for twelve(12) weeks to assure all doors that project into the hallway have a self closing device installed. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.</p> <p>12-18-2010</p>



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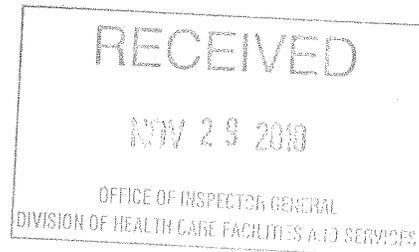
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K 029	<p>Continued From page 3</p> <p>accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following:</p> <ul style="list-style-type: none"> (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft² (9.3 m²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft² (4.6 m²), 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. <p>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.</p> <p>19.2.3.3* Any required aisle, corridor, or ramp</p>	K 029	



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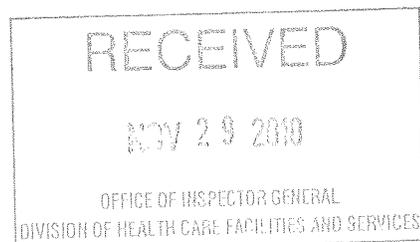
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K 029	Continued From page 4 shall be not less than 4 ft (1.2 m) in clear width where serving as means of egress from patient sleeping rooms. The aisle, corridor, or ramp shall be arranged to avoid any obstructions to the convenient removal of nonambulatory persons carried on stretchers or on mattresses serving as stretchers. Exception No. 1: Aisles, corridors, and ramps in adjunct areas not intended for the housing, treatment, or use of inpatients shall be not less than 44 in. (112 cm) in clear and unobstructed width. Exception No. 2: Exit access within a room or suite of rooms complying with the requirements of 19.2.5.	K 029		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler control valves were inspected monthly, according to NFPA standards. Sprinkler control valves must be inspected monthly to ensure proper operation of the sprinkler system. The deficiency affected two (2) smoke compartments, staff and fifty-four (54) residents.	K 062	K062 1. Sprinkler control valves were inspected by the Maintenance Director on 11-22-2010, to assure all were in proper working order. No concerns were identified. 2. Sprinkler control valves were inspected by the Maintenance Director on 11-22-2010 to assure all were in proper working order. No concerns were identified. 3. The Administrator re-educated the Maintenance Director on 11-05-2010, related to completing weekly audits of sprinkler control valves to assure sprinkler system is in proper working order.	



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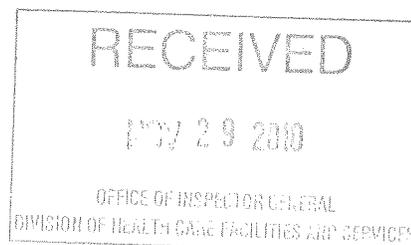
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K 062	<p>Continued From page 5</p> <p>The findings include:</p> <p>Record review of the sprinkler maintenance on 11/03/10 at 2:00 PM, revealed no documentation of the sprinkler control valves being inspected monthly. The observation was confirmed with the Director of Maintenance.</p> <p>Interview on 11/02/10 at 1:53pm, with the Director of Maintenance, revealed he does check the sprinkler control valves monthly but does not document it.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>9-3.3 Inspection.</p> <p>9-3.3.1 All valves shall be inspected weekly. Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised.</p> <p>9-3.3.2* The valve inspection shall verify that the valves are in the following condition:</p> <p>(a) In the normal open or closed position</p> <p>(b) *Properly sealed, locked, or supervised</p> <p>(c) Accessible</p> <p>(d) Provided with appropriate wrenches</p>	K 062	<p>4. The Maintenance Director will conduct weekly audits which will be reviewed by the Administrator weekly for twelve(12) weeks to assure sprinkler control valves are being inspected for proper working order. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.</p>	12-18-2010



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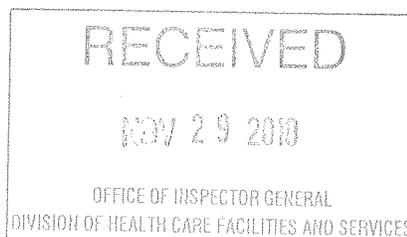
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K 062 K 072 SS=F	Continued From page 6 (e) Free from external leaks (f) Provided with appropriate identification NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency. Exits must be maintained to ensure their use in an emergency. The deficiency affected all staff and residents. The findings include: An observation on 11/03/10 at 11:11 AM, revealed two (2) clean linen carts not in use and stored in corridor in front of rooms 115 and 121 and three (3) medication carts not in use, parked in front of Nurses station in B Hall. Further observation revealed Two (2) Medication Carts stored in front of Nurses Station in A Hall. The observation was confirmed with the Maintenance Director. An interview, on 11/03/2010 at 11:11 AM, with the Maintenance Director, revealed the carts were routinely left in the halls due to lack of storage space.	K 062 K 072	K072 1. The medication carts and linen carts identified have been moved to a location that does not impede means of egress. 2. Observation by the Administrator on 11-24-2010 revealed all means of egress were without impediments. 3. All direct care staff will be re-educated on maintaining all means of egress obstacle free in case of emergency. This education will be provided by the Director of Nursing, the Assistant Director of Nursing or the Education and Training Director by 12-18-2010.	



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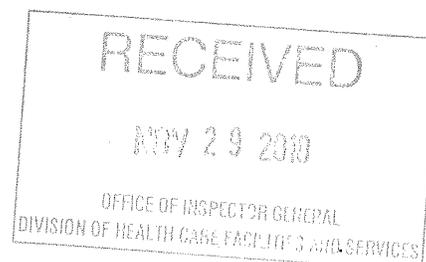
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K 072	Continued From page 7	K 072		
K 104 SS=F	<p>Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to assure the smoke barriers had no openings around duct work or piping in the attic which would allow the passage of smoke.</p> <p>The findings include:</p> <p>Observation during the Life Safety Code tour on 11/03/10, at 10:40 AM, revealed opening in one side of the smoke barrier wall, on the B Hall attic where duct work passed through the smoke barrier to the other compartment. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. This was confirmed with the Maintenance Director. The deficiency affected staff and thirty (30) residents. The facility is licensed for sixty-four (64) beds and census the day of survey was fifty-four (54).</p>	K 104	<p>4. The Administrator or the Director of Nursing will conduct audits three (3) times per week for eight (8) weeks then weekly for four(4) weeks, to assure all means of egress remain obstacle free. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.</p>	12-18-2010



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 11/03/2010
NAME OF PROVIDER OR SUPPLIER MEDCO CENTER OF BRANDENBURG			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
K 104	Continued From page 8 Interview with the Maintenance Director, on 11/03/10 at 10:40 AM, revealed he was not aware of the openings in the smoke barriers, and stated he would install metal plate at the end of the opening to satisfy code requirements. NFPA 101 2000 Edition 8.3.6 Penetrations and Miscellaneous Openings In Floors and Smoke Barriers. 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (1) The space between the penetrating item and the smoke barrier shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose. (2) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall meet one of the following conditions: a. It shall be filled with a material that is capable of maintaining the smoke resistance of the smoke barrier. b. It shall be protected by an approved device that is designed for the specific purpose.	K 104	K104 1. The identified concerns with openings in the smoke barrier wall in the attic space on Hall B were corrected and sealed with a metal plate by the Maintenance Director on 11-2-2010. 2. The Maintenance Director completed a one hundred (100) percent audit to ensure that all smoke barriers are free of openings. Any identified concerns were immediately corrected. 3. The Administrator provided re-education on 11-05-2010 to the Maintenance Director related to regulation requiring smoke barriers have no openings and smoke barriers by ducts are protected with material that is capable of maintaining the smoke resistance of the smoke barrier.	



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

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K 104	Continued From page 9 (3) Where designs take transmission of vibration into consideration, any vibration Isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke barrier. b. It shall be made by an approved device that is designed for the specific purpose.	K 104	4. The Maintenance Director will audit all smoke barriers monthly for three(3) months to assure all smoke barriers are without openings. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three(3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendation. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager, with the Medical Director participating at least Quarterly and as needed.	12-18-2010
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