STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185401	A. BUILDING _____ B. WING _____	02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDMONSON CARE AND REHABILITATION CENTER	813 S. MAIN ST. BROWNSVILLE, KY 42210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Standard Health survey was initiated on 01/31/12 and concluded on 02/03/12 and the Life Safety Code survey was conducted on 01/31/12 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be imposed. An abbreviated survey was initiated on 01/31/12 and concluded on 02/03/12 to investigate KY17486. The Division of Health Care substantiated the allegation, however at the time of the investigation, the deficiency was not serious enough to warrant citing deficiencies.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Edmonson Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 224 SS=E	483.13(c) PROHIBIT MISTREATMENT/NEGLECT/MISAPPROPRIATN The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to protect two (2) of twenty-three (23) residents from abuse/neglect. A surveyor overheard CNA #7 speak loudly and in a harsh, rude manner to Resident #20. CNA #2 reported witnessing alleged abuse to Resident #11 by CNA #8. The findings include:	F 224	**F224 Prohibit Mistreatment / Neglect / Misappropriation** Licensed nursing staff assessed resident #20 and resident #11 on 02/01/2012 and 02/02/2012 to validate no adverse effects was experienced. Residents with a BIMS score of 13, 14 and 15 were interviewed by the Social Services Director and the Regional Director of Clinical Operations on 02/01/2012 and 02/02/2012 to identify any other residents that may have been affected. All other residents, with BIMS score below 13, had a head to	02/24/2012

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Carolyn Lourence | TITLE: X Administrator | (X6) DATE: X 03082012

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

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F 224	Continued From page 1 Review of the facility's policy regarding Abuse and Neglect Prohibition Program revealed all residents have the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Neglect is failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. Verbal abuse is the use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to residents or their families regardless of their age, ability to comprehend, or disability. Verbal abuse may include yelling, screaming or speaking harshly to a resident. 1. Observation of the 400 Hall, on 02/02/12 at 7:50 AM, revealed CNA #7 speaking in a loud, harsh and rude manner to Resident #20. CNA #7 was standing in the hall outside of room 410 yelling "What are you yelling about? The bed's not made yet." This surveyor rounded the corner and again heard CNA #7 yelling in a gruff manner, "That bed is not made yet..You can get back to bed then HONEY." Interview with Resident #20, on 02/02/12 at 2:00 PM, revealed he/she was trying to get help for the roommate who was cold and wanted to go to bed. The facility indicated Resident #20 was cognitively impaired. Resident #20 stated the resident in the next bed was cold and wanted to go to bed and he/she was yelling to get some help for the roommate. Resident #20 stated no one came to help. The incident was immediately reported to the Director of Nursing, who immediately removed	F 224	toe assessment completed by Director of Nursing Services, Assistant Director of Nursing Services or charge nurse by 02/10/2012 to identify any physical signs these residents may have been affected. None were affected. Staff to include Licensed Nurses, CNAs, Housekeeping, Dietary, Activities, Laundry, Maintenance, and Department heads have been re-educated on the policy and procedures regarding prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property by the charge nurse, Director of Nursing and Assistant Director of Nursing on 02/03/2012. Administrator, Director of Nursing Services and Assistant Director of Nursing Services will interview five staff members weekly for a month and ten staff members monthly for six months to validate that staff know and understand the policy and procedures regarding prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. The Administrator and Social Services Director will interview five residents a week for a month and ten residents a month for six months to verify staff has achieved and sustained	02/24/2012 02/24/2012

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F 224	Continued From page 2 the CNA from patient care and suspended her until an investigation was completed. An attempt to interview CNA #7, revealed she did not return the phone call placed to her home. 2. Review of the clinical record for Resident #11 revealed the facility admitted Resident #11 on 04/13/09 with diagnoses of Cerebral Vascular Accident (Stroke), Left Hemiplegia (left sided paralysis), Depression, Anxiety, and Weakness. A review of the quarterly Minimum Data Set (MDS), dated 12/21/11, revealed the facility identified the resident as being cognitively intact and required extensive assistance for ambulation, dressing, bathing and hygiene. The facility assessed the resident as continent of bowel and bladder. Interview with Resident #11, on 02/02/12 at 3:55 PM, revealed he/she asked CNA #8 for help to the bathroom to have a bowel movement on 01/28/12 at about 4:30 AM. Resident #11 stated CNA #8 would not take him/her to the bathroom and instead just picked him/her up and sat him/her on the bedpan. Resident #11 asked the CNA not to treat him/her that way but the CNA would not help him/her to the bathroom. It was not until day shift came to work around 6:30 AM that a CNA finally helped Resident #11 to the bathroom. Interview with CNA #2, on 02/03/12 at 4:15 PM, revealed that on the morning of 01/28/12 Resident #11 asked CNA #8 for help to the bathroom. She stated she could hear Resident #11 yelling "Please don't do this to me, please don't do this to me." When CNA #8 came from	F 224	compliance with prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. The Administrator will complete the Performance Improvement Audit tool monthly for twelve months to monitor the effectiveness of the plan of correction and to verify sustained compliance of the policy for prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. The results of these interviews and audits will be reviewed in the monthly Performance Improvement Committee Meeting for twelve months for further recommendations.	02/24/2012 02/24/2012

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F 224	Continued From page 3 Resident #11's room she asked the CNA what was going on. CNA #8 told CNA #2 that Resident #11 just wanted out of bed but she just put him/her on the bedpan. When CNA #2 again heard Resident #11 ask to get up to the bathroom she overheard CNA #8 tell Resident #11 that she didn't have time to do that and that he/she would just have to hold it until later. Interview with CNA #8, on 02/03/12 at 9:25 AM, revealed she put Resident #11 on the bedpan the morning of 01/28/12 because that's what was normally done on the night shift. She stated she never heard the resident ask to go to the bathroom.	F 224		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the	F 225	**F225 Investigate / Report Allegations / Individuals** Payroll Coordinator validated that C.N.A. #1 had a current registry check in file on 02/03/2012. Residents with a BIMS score of 13, 14 and 15 were interviewed by the Social Services Director and the Regional Director of Clinical Operations on 02/01/2012 and 02/02/2012 to identify any other residents that may have been affected. All other residents, with BIMS score below 13, had a head to toe assessment completed by Director of Nursing Services, Assistant Director of Nursing Services or charge nurse by 02/10/2012 to identify any	02/24/2012

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F 225	Continued From page 4 State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to obtain timely nurse aide registry checks for one (1) of sixteen (16) employees hired. The findings include: Review of the facility policy "Abuse and Neglect Prohibition Program", revised November 2010, relating to page 6, under "Screening" revealed: "we screen potential employees for a history of abuse, neglect or mistreating residents, which includes abuse registry checks. In addition, page 7 under F225, states the center must not employ individuals who have had a finding entered into the state nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property.	F 225	physical signs these residents may have been affected. None were affected. Payroll Coordinator and Staff. Development Coordinator were re-educated on completing registry checks prior to employment of an individual by the Administrator on 02/06/2012. Payroll Coordinator will audit new hires monthly for the next three months to validate timely register checks have been completed. The Administrator will complete the Performance Improvement Audit tool monthly for twelve months to monitor the effectiveness of the plan of correction and to verify sustained compliance of the policy for prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. Results of these audits will be reviewed in the Performance Improvement Committee Meeting monthly for twelve months for further recommendations.	02/24/2012 02/24/2012 02/24/2012 02/24/2012

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F 225	Continued From page 5 Review of the personnel files, on 02/03/12 at 8:30 AM, revealed CNA (certified nursing assistant) #1 was hired, on 05/27/11, however there was no evidence a nurse aide registry check had been completed until 06/23/11, or almost one month later. Interview with the Administrator, on 02/03/12 at 10:30 AM, revealed they should always obtain nurse aide registry checks for new employees on or before the hire date. The Administrator stated the previous staff development coordinator, who was responsible for obtaining the registry checks, had probably thought she didn't need to get the registry check, since the nurse aide had not yet been certified.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview, review of the facility Abuse and Neglect Prohibition Program, and the Final Investigative Report, it was determined the facility failed to ensure written policies and procedures were implemented regarding reporting of alleged abuse for one (1) of twenty three (23) sampled residents. CNA #2 and LPN #3 delayed reporting the alleged abuse of Resident #11 to administration. The findings include:	F 226	**F226 Develop/Implement Abuse/Neglect, Etc. Policies** Licensed nursing staff assessed resident #11 to validate no adverse effects were experienced on 02/01/2012. Residents with a BIMS score of 13, 14 and 15 were interviewed by the Social Services Director and the Regional Director of Clinical Operations on 02/01/2012 and 02/02/2012 to identify any other residents that may have been affected. All other residents, with BIMS score below 13, had a head to toe assessment completed by Director of Nursing Services, Assistant	02/24/2012

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F 226	Continued From page 6 A review of the facility's Abuse and Neglect Prohibition Program, revealed any and all allegations of abuse are reported immediately to the Administrator and /or Director of Nursing. Interview with CNA #2, on 02/02/12 at 4:15 PM, revealed she witnessed what she considered to be abuse/neglect of Resident #11. She stated, on 01/28/12 about 5:30 AM, Resident #11 wanted to get up to go to the bathroom; however, CNA #8 refused to get the resident up, instead she put Resident #11 on the bedpan. According to CNA #2, Resident #11 was begging CNA #8 to get her up but CNA #8 refused. CNA #2 reported the incident to LPN #3 when she returned to work that night around 10:00 PM. She stated she knew it should have been reported immediately and did not have an excuse as to why it was not reported until later. CNA #2 stated she just got busy and didn't do it. Interview with LPN #3, on 02/03/12 at 3:40 PM, revealed she had received training on abuse and neglect and knew any allegation of abuse or neglect should be reported immediately. LPN #3 stated on Saturday, 01/28/12 around 10:00 PM, CNA #2 reported an alleged abuse event to her concerning Resident #11. She stated she instructed CNA #2 to call the Director of Nursing. LPN #3 stated the DON was not notified of the alleged abuse until 01/31/12 when she herself reported the incident. Interview with Director of Nursing (DON) revealed all staff are trained to report any allegations of abuse immediately to the Administrator and DON. She stated she did not understand why the	F 226	Director of Nursing Services or charge nurse by 02/10/2012 to identify any physical signs these residents may have been affected. None were affected. Staff to include Licensed Nurses, CNAs, Housekeeping, Dietary, Activities, Laundry, Maintenance, and Department heads have been re-educated by charge nurse, Director of Nursing, Assistant Director of Nursing, Dietary Manager and Laundry / Housekeeping Manager on the policy and procedures regarding immediate mandatory reporting of mistreatment, neglect, abuse of residents and misappropriation of resident property by 02/03/2012. Administrator, Director of Nursing Services and Assistant Director of Nursing Services will interview five staff members weekly for a month and ten staff members monthly for six months to validate that staff know and understand the policy and procedures regarding prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property.	02/24/2012 02/24/2012

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F 226 F 281 SS=D	Continued From page 7 allegation took three days to be reported. 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 Clinical Nursing Skills & Techniques, 6th edition by Perry and Potter copyright 2006, Mosby Inc., it was determined the facility failed to meet professional standards of care for one (1) of twenty three (23) sampled residents as evidenced by the failure to completely deflate an indwelling catheter before removal for Resident #19. The findings include: Review of the Clinical Nursing Skills & Technique 6th edition, revealed if the retention catheter balloon is not fully deflated, its' removal can result in trauma and subsequent swelling of the urethral meatus, and urinary retention can occur. The equipment used for removing a catheter is: a syringe the same size as the volume of solution used to inflate the balloon and information on the balloon size can be obtained directly from the balloon inflation valve on the catheter. Review of the clinical record for Resident #19 revealed the facility admitted the resident on 08/13/11 and was re-admitted on 10/04/11 and 12/12/11 with diagnoses of Diabetes Mellitus, Addison's Disease, Colitis, Renal Failure,	F 226 F 281	The Administrator and Social Services Director will interview five residents a week for a month and ten residents a month for six months to ensure staff has achieved and sustained compliance with the policy of prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. The Administrator will complete the Performance Improvement Audit tool monthly for twelve months to monitor the effectiveness of the plan of correction and to verify sustained compliance of the policy for prohibition of mistreatment, neglect, abuse of residents and misappropriation of resident property. **F281 Services Provided Meet Professional Standards** Licensed nursing staff assessed resident #19 on 02/02/2012 for pain and trauma. No complaints of pain or trauma noted. Other residents with a Foley catheter were identified by the Director of Nursing Services on 2/16/12. No other Foley catheters have been removed and no residents were affected.	02/24/201 02/24/2012 02/24/2012

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F 281	Continued From page 8 Neurogenic Bladder and a History of Urinary Tract Infection (UTI). Resident #19 required an indwelling catheter related to his/her Neurogenic Bladder. The physician's order was written to discontinue the indwelling catheter on 02/02/12. The Admission Minimum Data Set (MDS) and the hospital Care Screening form, dated 12/19/11, from the hospital revealed a functional status for toilet use, the resident required extensive assistance with assist of two persons for physical assistance to the bath room. The facility assessed Resident #19 for an indwelling catheter and determined the resident was always incontinent of the bowels. The MDS assessed the resident as having a UTI during the last thirty (30) days. The Care Area Assessment (CAA), dated 12/23/11, revealed the resident had urinary incontinence and an indwelling catheter was placed on 12/12/11. Observation, on 02/02/12 at 10:00 AM, in Resident #19's room with LPN #1 revealed the nurse brought into the room a graduate to collect and measure urine, and three (3) twelve (12) cubic centimeter (cc) syringes. LPN #1 removed twelve (12) cc of fluid from the valve of the indwelling catheter with the first syringe, she removed another ten (10) cc of fluid from the same valve to total twenty-two (22) cc of fluid. The third syringe was not used prior to removing the catheter. The nurse quickly pulled the catheter tubing and the resident closed her eyes and said OH! The indwelling catheter was observed partially inflated after removal. LPN #1 used the third syringe to remove an additional four (4) cc of fluid.	F 281	Assistant Director of Nursing Services re-educated licensed nursing staff on 02/16/2012 on the proper process of removing a Foley catheter. New licensed nursing staff will complete Foley catheter skills capability. Director of Nursing Services, Assistant Director of Nursing Services or designee will audit 100% of Foley Catheter removals for the next six months to ensure proper technique and competency of removing Foley Catheters. Director of Nursing Services or Assistant Director of Nursing Services will review the audit results in the Performance Improvement Committee Meeting monthly for the next 6 months for further recommendations.	02/24/2012 02/24/2012 02/24/2012

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F 281	Continued From page 9 Interview, on 02/02/12 at 10:00 AM, in Resident #19's room with LPN #1 revealed the indwelling catheter had a balloon inflation of thirty (30) cc. Interview, on 02/02/12 at 10:20 AM, with LPN #1 revealed the catheter was removed partially inflated with 3-4 cc of fluid and acknowledged the resident yelled out OHI when the catheter was removed. LPN #1 stated she could not recall her last training on indwelling catheters but was aware of the resources available in a book on nursing skills at the nurses station. LPN #1 stated she could have tried the third (3rd) syringe but she thought she had removed all the fluid. LPN #1 revealed it was the facility policy and procedure to deflate the the catheter balloon completely before removing the tube. Interview, on 02/03/12 at 10:00 AM, with Resident #19 revealed he/she has had indwelling catheters before and had more pain when the indwelling catheter was removed yesterday than any other time. Review of the nurses notes for Resident #19 revealed the indwelling catheter was removed on 02/02/12 with 3-4 millimeters (ml) or cc remaining in the bulb or balloon. Interview, on 02/03/12 at 4:26 PM, with the Director of Nursing (DON) revealed she would have to check the facility policy for removing indwelling catheters. The DON stated the facility provided annual training and a skills check off to all facility nursing staff before care was provided to residents and the facility nursing staff were competent to perform care to the residents. The DON stated that no indwelling catheter should be	F 281		

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EDMONSON CARE AND REHABILITATION CENTER	813 S. MAIN ST. BROWNSVILLE, KY 42210

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 10 removed partially inflated.	F 281		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to clean the ice machine vents of dust and to store drinking glasses in a sanitary manner to prevent contact with dust particles from the ice machine. The findings include: Review of the facility's Ice Machine Policy, dated July 2008, revealed the following: 2. The Nutrition Services Director will ensure that the ice machine will be disconnected, cleaned, and sanitized a minimum of twice a year as needed. Observation of the ice machine, on 01/31/12 at 9:00 AM, during the initial tour of the kitchen revealed the side vents to be covered with a build up of dirt and dust. In addition, there were two crates of drinking glasses stored directly under the ice machine vents.	F 371	**F 371 Food Procure, Store/Prepare/Serve - Sanitary** Nutritional Services Director immediately cleaned Ice machine and removed glassware from the area of the ice machine on 2/3/2012. Nutritional Services Director completed an audit of the department to determine if other glassware was stored in a Sanitary manner on 2/3/2012. No other ice machines are located in the facility. Cleaning schedule and tracking form was adjusted to include weekly cleaning of the ice machine and intake vent by Nutritional Services Director. Dietary staff were re-educated on 2/3/2012 to include sanitary storage of glassware and weekly cleaning schedule of ice machine by the Nutritional Services Director.	02/24/2012 02/24/2012 02/24/2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185401	A. BUILDING _____ B. WING _____	02/03/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 11 Interview with the Dietary Manager, on 02/02/12 at 2:00 PM, revealed the ice machine was cleaned periodically by Maintenance. She stated a work order should be forwarded to Maintenance to clean the vents when they become dirty. The Dietary Manager also revealed the filters are cleaned monthly, however it was not revealed when the filters had previously been changed.	F 371	The dietary manager or dietary staff will monitor the ice machine vents and glassware storage daily for one week. Weekly audits will occur for the next six months. Results will be reviewed in the performance improvement committee meeting to verify continued compliance of sanitation practice.	02/24/2012
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions 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	F 441	**F441 Infection Control, prevent spread, linens.** Residents # 7, #14 and #19 were assessed by the licensed nurse on 02/16/2012 and no signs or symptoms of infection were noted. LN#1 & LN#2 were observed performing catheter care on 2/16/2012 by Director of Nursing and no other residents were affected. 100% licensed nurses have performed a return demonstration on proper hand hygiene to verify licensed nurses are using proper hand hygiene techniques was completed by 02/23/2012 Assistant Director of Nursing re-educated licensed nurses on hand on 02/16/2012. Re-education involved 100% licensed nurses performed a return demonstration on proper hand hygiene completed by 02/23/2012.	02/24/2012 02/24/2012

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 441	Continued From page 12 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide appropriate handwashing procedures, per facility policy, before and after glove changes during supra pubic catheter care, supra pubic catheter dressing change, and indwelling catheter removal for three (3) of twenty-three (23) sampled residents (#7, #14, and #19). The findings include: Review of the facility's policy and procedure (not dated) regarding "Care of Suprapubic Catheter Competency" revealed under general guidelines... basic care includes daily cleansing of the skin around the stoma with soap and water, applying a skin barrier cream, and dressing. In addition, under dressing techniques, related to clean technique revealed...clean non-sterile gloves should be worn with normal hand hygiene procedures and the use of clean equipment prevent the introduction of micro-organisms that would cause an infection. Under the "Clean Dressing Process" revealed #12. HANDS WASHED IN BETWEEN ALL GLOVE	F 441	Director of Nursing Services or Assistant Director of Nursing Services will audit five occurrences of hand hygiene every week times four weeks, then audit ten instances every month times six months to verify continued compliance with proper hand hygiene practice. Director of Nursing Services/Assistant Director of Nursing Services or designee will review audit of hand hygiene in Performance Improvement Meeting every month for the next six months for further recommendations.	02/24/2012 02/24/2012

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F 441	Continued From page 13 CHANGES. 13. Dressing applied and gloves removed and discarded in plastic bag; and 15. Hands washed. Review of the clinical record for Resident #7 revealed a diagnosis of Right Obstructive Uropathy from Urethral Strictures requiring a suprapubic catheter. Physician orders for care of the suprapubic catheter included: Flush suprapubic catheter with 30 cc warm water every day. Use Bacitracin ointment around the suprapubic catheter twice daily, and clean with 1/2 strength peroxide and cover with a drain sponge. Observation of Resident #7's dressing change relating to the suprapubic catheter, on 02/01/12 at 08:50 AM, revealed infection control practices were not followed. The LPN (Licensed Practical Nurse) #2 was observed to put on her gloves with no handwashing and proceeded to complete the dressing change to the suprapubic catheter, however after completing the dressing change, she indicated she had forgotten to clean with the peroxide as ordered. LPN #2 removed her gloves and applied new gloves with no handwashing, and repeated the dressing change to the suprapubic site. LPN #2 then removed her gloves, and put new gloves on and proceeded to complete catheter care. There was no handwashing observed before or after the catheter care. In addition, the LPN did not clean the catheter with soap and water per facility policy. The catheter tubing was cleaned with water and a guaze, then gloves were removed again with no handwashing. New gloves were put on to flush the catheter with 30 cc warm Normal Saline, then removed with no	F 441		

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F 441	Continued From page 14 handwashing observed throughout the observation. Interview with LPN #2, on 02/01/12 at 09:30 AM, revealed she should have washed her hands between changing the gloves and between each treatment. In addition, the LPN stated she should have cleaned around the suprapubic catheter with soap and water and did not. The LPN stated she only cleaned with saline and just forgot to do so. Interview with the Director of Nursing, on 02/03/12 at 4:30 PM, revealed she would expect nurses to wash their hands and change their gloves before and after every procedure, and follow the policy and procedures for such. The DON stated there was training and on the spot inspections. Interview with the Administrator, on 02/03/12 at 5:30 PM, revealed handwashing was looked at in their Quality Assurance Committee meetings, and had noted there were previous concerns with handwashing and urinary tract infections over the past year.	F 441		

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F 441	Continued From page 15	F 441		

Review of the facility's policy titled "Precaution Guidelines", dated October 2009, revealed hand hygiene (washing hands with soap and warm water or use of hand sanitizer) is required before and after resident contact, invasive procedure, assisting resident with personal care, after handling soiled or used linens, and after removing gloves.

Review of the clinical record for Resident #19, on 02/02/12 at 7:35 AM, revealed the facility admitted the resident on 06/13/11 with diagnoses of Diabetes Mellitus, Addison's Disease, Colitis, Renal Failure, Neurogenic Bladder and a History of Urinary Tract Infection. Resident #19 required an indwelling catheter related to his/her Neurogenic Bladder. The physician orders were to change the indwelling catheter on the twenty-eighth (28) of the month and an additional order was written to discontinue the indwelling catheter on 02/02/12.

Observation, on 02/02/12 at 10:00 AM, in Resident #19's room with LPN #1 revealed during a procedure to remove an indwelling catheter, the nurse had cleaned the

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F 441	Continued From page 16 residents perineal area with gloved hands and walked over to the residents closet and opened the closet door with the dirty gloved hand. The nurse applied a pad inside the resident's underwear and pulled up both the underwear and pants. The nurse, with the same pair of gloves that provided perineal care, preceded to touch the resident's sensor alarm attached it to the resident's bed. The nurse discarded her gloves and with bare hands picked up used towels and placed them in a plastic bag and tied the bag shut. The nurse placed new gloves on without washing her hands while she measured the urine and discarded the discontinued indwelling catheter. Interview, on 02/02/12 at 10:20 AM with LPN #1 revealed she had touched the resident's closet door handle with her dirty gloved hand after she had provided perineal care. She further revealed she did not wash her hands or use hand sanitizer after taking off her dirty gloves and putting new gloves on. LPN #1 revealed she should have used hand sanitizer or washed her hands in between glove changes. LPN #1 stated the facility policy was to wash your hands before and after any resident contact and care and the facility provided computer education and had performed a skills check off but she was not sure when she last completed those. Interview, on 02/02/12 at 2:35 PM, with LPN #1 revealed the risk of touching the resident's closet door with dirty gloves could transfer infection to other residents and facility staff. She further stated she should have taken her dirty gloves off first before touching the closet door.	F 441		
F 502	483.75(j)(1) ADMINISTRATION	F 502		

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F 502 SS=D	Continued From page 17 The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure laboratory services were provided in a timely manner for one (1) of twenty three (23) residents. Resident #20 had a urinalysis ordered for 11/24/2011 which was not completed until 11/28/11. The findings include: The facility did not provide any policies on laboratory services. Review of the clinical record for Resident #20's revealed the facility admitted Resident #20 on 08/15/08 with diagnoses of Anemia, Repression, Osteoporosis, Alzheimer's, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, Hypothyroidism and Disorder of the Kidney and Ureter. The physician's orders revealed a urinalysis was was to be obtained on 11/24/11. The urine sample was not collected by the lab until 11/28/11. An antibiotic was not ordered for the urinary tract infection until 11/29/11, five days after the original order. Interview with LPN #4, on 02/03/12 at 10:00 AM, revealed the original physician's order was obtained on 11/24/11 to do a urinalysis on	F 502	**F 502 Administration** Licensed nurse assessed resident #20 on 02/03/2012 to validate no adverse affects resulted. Physician was contacted at the time the original urinalysis was ordered and he ordered that the urinalysis be obtained on the following Monday. Other labs were audited by the charge nurses on 2/3/2012 and 2/4/2012 to validate that labs were collected and sent to lab as ordered by the physicians. Assistant Director of Nursing services re-educated licensed nurses on 02/16/2012 on policy and procedure for lab services and timely follow up on lab orders. Labs will be logged on a lab tracking form for review and follow up. Director of Nursing Services or Assistant Director of Nursing Services will audit 5 lab orders and 5 lab results every week for 6 months. Director of Nursing Services or Assistant Director of Nursing Services will review audit of lab tracking in Performance Improvement Meeting every month for the next six months for further recommendations.	02/24/2012 02/24/2012 02/24/2012 02/24/2012

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F 502	Continued From page 18 Resident #20. The urine sample was obtained and put in the refrigerator for the lab technician to pick up the following morning. The lab technician failed to pick up the specimen on 11/25/11. The urine specimen was not obtained and picked up by the lab until 11/28/11 (the next working day of the lab). She stated the lab technician should have picked up the specimen on 11/25/11. Interview with the Director of Nursing (DON), on 02/03/12 at 4:30 PM, revealed the lab failed to pick up the urine specimen as ordered on 11/24/11 and it was repeated per MD order on 11/28/11. She stated the lab did not work on the weekend; however, labs could be taken to the hospital on holidays and weekends if needed. She had no explanation as to why a specimen was not sent to the hospital instead of waiting three more days to have the lab complete the urinalysis. The DON stated a resident with a urinary tract infection could get worse symptoms with a delay in lab tests and a delay in getting medication to treat the infection.	F 502		

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	185401	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1994 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: One (1) story, Type III Unprotected. SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system. GENERATOR: Type II generator. Fuel source is diesel. A standard Life Safety Code survey was conducted on 01/31/12. Edmonson Care and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for seventy-four (74) beds and the census was sixty-nine (69) on the day of the survey. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, **Edmonson Care & Rehabilitation Center** does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Carolyn Lawrence
TITLE: X Administrator
(X6) DATE: 030812

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

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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at D level.	K 000		
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, per NFPA Standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for seventy-four (74) beds and the census was sixty-nine (69) on the day of the survey. The findings include: Observation, on 01/31/11 at 11:40 AM, with the Maintenance Director revealed the door to the Dry Storage Room located in the Kitchen, did not	K 029	**K 029 NFPA 101 Life Safety Code Standard** Door to Dry Storage Room was equipped with a self closing device by 03/01/2012 by the Maintenance Director. The Maintenance Director conducted an audit on 02/01/2012 of other doors to dry storage rooms with no other doors identified without the self closing device. The Maintenance Director was re-educated by the Administrator on 02/01/2012 on the use of self closing doors in relation to dry storage areas. The Maintenance Director will conduct an audit of the self closures for six months to validate function. The results will be brought to the Performance Improvement Committee for further recommendations for six months.	03/03/2012 03/03/2012 03/03/2012 03/03/2012

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K 029	Continued From page 2 have a self closing device installed on the door. Interview, on 01/31/11 at 11:40 AM, with the Maintenance Director revealed he was not aware the Dry Storage Room was considered a hazardous storage area and the door was required to be equipped with a self closing device. 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 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 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	K 029		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185401	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	01/31/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EDMONSON CARE AND REHABILITATION CENTER	813 S. MAIN ST. BROWNSVILLE, KY 42210

(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 029	Continued From page 3 (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 062 NFPA 101 Life Safety Code Standard** The portable "K" type fire extinguisher located next to the exhaust hood in the kitchen had required signage displayed by Maintenance Director on 02/16/2012.	03/03/2012
K 062 SS=D	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 observation and interview, it was determined the facility failed to ensure fire extinguishers had the proper signage according to NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for seventy-four (74) beds, and the census was sixty-nine (69) on the day of the survey. The findings include: Observation, on 01/31/12 at 11:45 AM, with the Maintenance Director revealed the portable "K" type fire extinguisher located next to the exhaust hood in the kitchen, did not have the required signage on display. Interview, on 01/31/12 at 11:45 AM, with the	K 062	An audit was conducted by the Maintenance Director of other "K" type extinguishers in the facility and there were none noted. The Maintenance Director received re-education to place the appropriate signage with "K" type fire extinguishers by Administrator on 02/01/2012. The audit conducted by the Maintenance Director will be discussed in the next Performance Improvement Committee Meeting for further recommendations then monthly for 6 months.	03/03/2012 03/03/2012 03/03/2012

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K 062	Continued From page 4 Maintenance Director revealed he was unaware of the requirement that a sign was to be displayed near the "K" type fire extinguisher that stated the fire protection system shall be activated prior to using the fire extinguisher. Reference: NFPA 10 (1998 edition) 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher.	K 062		

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