

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/03/2011
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 6269 ASBURY ROAD AUGUSTA, KY 41002
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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)	(X6) COMPLETION DATE
F 000 F 364 SS=D	<p>INITIAL COMMENTS</p> <p>A Recertification Survey and an Abbreviated Survey investigating ARO#KY00016251, ARO#KY00015674, and ARO#KY15631 was initiated on 05/31/11 and concluded on 06/01/11. ARO#KY00016251 and ARO#KY00015674 were substantiated with no deficiencies cited. ARO#KY00015631 was substantiated with deficient practice cited at 483.35 Dietary Services. A Life Safety Code Survey was conducted on 06/02/11 with the highest Scope and Severity of an "F".</p> <p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide food that was palatable, attractive, and at the proper temperature. A test tray during the lunch meal on 06/01/11 revealed temperatures on two food items to be below 110 degrees. In addition, the pork chop was tough and difficult to cut and chew.</p> <p>The findings include: A test tray obtained after all trays were delivered to a unit was obtained on 06/01/11 at 12:35 PM. The Registered Dietician (RD) for the facility was</p>	F 000 F 364	<p>F 364</p> <p>The Dietary Manager reviewed 483.35 (d) (1)-(2) Nutritive Value/Appear/Palatable/Prefer Temp.</p> <p>The facility will provide food that is prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>On 06/01/2011, a test tray during the lunch meal revealed temperatures on two food items to be below 110 degrees. In addition, the pork chop was tough and difficult to chew.</p> <p>All Dietary Staff were in-serviced immediately on 06/01/2011 regarding the nutritive value, appearance, palatability, and preferable food temperatures by the Dietary Manager, the Registered Dietician, and the Administrator.</p> <p>On 06/01/2011, all residents observed to consume less than 50% of their meal and all meals on 06/01/2011, were offered a substitute meal. Nutritional intakes were observed and recorded.</p> <p>100% of residents identified with weight loss were reviewed and assessed on 06/06/2011 by the Director of Nursing and the Dietary Manager.</p> <p style="text-align: center;">RECEIVED JUL 20 2011 BY: _____</p>	07/05/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sauran Moore</i>	TITLE	(X8) DATE 7/20/2011
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her 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 364	<p>Continued From page 1</p> <p>present to take temperatures of foods on the test tray, and discovered that two (2) items on the test tray were below 110 degrees. The temperature taken for the pork chop was 108 degrees, and the temperature taken for the greens was 107.4 degrees.</p> <p>Food items from the test tray were sampled by two surveyors, and it was agreed by surveyors that the pork chop was tough to cut and eat.</p> <p>An interview with the RD on 06/01/11 at 12:40 PM revealed 120 degrees was the desired temperature for foods served to residents at point of service, and acknowledged that two of three hot items on the 06/01/11 test tray were below the desired temperature.</p> <p>The Administrator acknowledged, in an interview on 06/02/11 at 2:15 PM, that the pork chops served to residents during the 06/01/11 lunch service were tough.</p>	F 364	<p><i>F 364 continued</i></p> <p>100% of dietary staff were in-serviced and educated on 06/08/2011 by Dietary Manager on proper preparation, production, and distribution processes including steam table holding temperatures and allowable time frames, point of service temperatures, food appearance, palatability, and flavor.</p> <p>Steam table temperatures and Point of Service temperatures will be recorded by Dietary Cook/Dietary Aide for compliance of proper temperature daily, prior to each meal service. Steam table temperatures and Point of Service temperatures will be recorded by the Dietary Manager to ensure compliance with 483.35(d)(1)-(2) for ten (10) meals per week x four (4) weeks, then weekly for three (3) months.</p> <p>Dietary Manager and/or Dietary Cook will consume food on test tray three (3) to five (5) times per week, prior to meal service to ensure flavor, attractiveness, and palatability and record outcomes on a Meal Audit Form.</p>	
F 366 SS=D	<p>483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE</p> <p>Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure residents were provided appropriate substitutes for documented dislikes for one (1) of ten (10) sampled residents, (Resident #3). Resident #3 was served sweet potatoes when</p>	F 366	<p>Results of temperatures, flavor, attractiveness, and palatability will be reviewed weekly at the Standards of Care Meeting, monthly at the Menu Selection Committee and Safety Committee Meetings, and quarterly at QA meetings.</p> <p>The Standards of Care Committee includes but not limited to the following: MDS Coordinator, Director of Nursing, Quality of Life Director, Dietary Manager, Social Services Director, and Restorative Nurse Manager, and Rehabilitation Services Manager.</p>	

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F 366	<p>Continued From page 2</p> <p>they were listed as a dislike on the resident's tray ticket.</p> <p>The findings include:</p> <p>Review of the Clinical Record revealed Resident #3 was admitted to the facility on 11/22/01 with diagnoses which included Organic Brain Syndrome and Senile Dementia.</p> <p>Observation of the noon meal on 06/01/11 at 1:00 PM revealed Resident #3 was served sweet potatoes. Review of the resident's tray ticket revealed sweet potatoes were listed as a "dislike". Continued observation revealed the resident was non-verbal and unable to request a substitute.</p> <p>Interview with State Registered Nursing Assistant (SRNA) #6 on 06/01/11 at 1:05 PM revealed staff were to check the meal ticket to ensure the correct diet was served, all special instructions were followed, and substitutes were served for listed "dislikes". Continued interview revealed SRNA #6 confirmed the resident was served sweet potatoes when they were noted as a "dislike". The aide explained a two-step system for catching such errors: If overlooked in the kitchen, serving staff in the dining room should have caught the error and requested a substitute for the resident.</p> <p>Interview with Registered Nurse (RN) #3 on 06/01/11 at 1:10 PM revealed the meal ticket should have been checked in the kitchen and at point-of-service. She stated a substitute should have been provided in place of the sweet potatoes.</p>	F 366	<p><i>F364 continued</i></p> <p>The Menu Selection Committee consists of the following members: Dietary Manager, two stakeholders, two residents, and the PC and IC Resident Council President.</p> <p>The Safety Committee includes but is not limited to the following members: Plant Operations Director, Human Resources Coordinator, Director of Nursing, and Administrator.</p> <p>The Quality Assurance Committee consists of the following members: Medical Director, Administrator, Director of Nursing, Business Office Manager, Human Resources Coordinator, Social Services Director, Admissions Coordinator, MDS Coordinator, Medical Records Coordinator, Dietary Manager, Housekeeping/Laundry Manager, Plant Operations Director, Staff Development Coordinator, Quality of Life Director, Chaplain, Consulting Pharmacist, Consulting Dietician, and the Rehabilitation Services Manager.</p> <p>Monthly Resident Council Minutes will be reviewed at quarterly QA meetings to monitor for improvements with meal services regarding nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>Beginning on 06/06/2011, a new Registered Dietician will provide services to Bracken County Nursing and Rehabilitation. The Registered Dietician will assist in monthly education to dietary and nursing staff to improve meal services. 100% of new hires for dietary staff will be educated on the proper procedures in compliance with Signature HealthCARE dietary policies and procedures and 483.35(d)(1)-(2).</p>	

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F 366	Continued From page 3 Interview with the Dietary Manager on 06/03/11 at 11:10 AM revealed she maintained a Dislike Book. She stated each resident's dislikes were listed on their tray ticket. Continued interview revealed the cook went through the Dislike Book before each meal to ensure residents were served foods they liked. She further stated the aide in the dining room served as a double-check to ensure no dislikes were served.	F 366	P 366 The Dietary Manager and Administrator reviewed 483.359(d)(4) Substitutes of Similar Nutritive Value. On 06/01/2011, evaluation of Resident #3 reveals no adverse reactions from being served sweet potatoes. It is listed as a dislike on resident's tray ticket.	07/05/2011
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN Therapeutic diets must be prescribed by the attending physician. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a mechanically altered diet for two unsampled residents (Unsampled Resident #A and #B). The residents had prescribed mechanical soft diets and were served a whole slice of pizza with a hard crust. The findings include: Lunch observation on 06/01/11 at 1:10 PM revealed Unsampled Resident A and Unsampled Resident B both had dietary tickets listing "mechanically soft diet". Observation of the food items on their plates revealed both had a whole slice of pepperoni pizza with a hard crust. Interview with the Dietician on 06/01/11 at 10:30 AM revealed she wouldn't consider the pizza to be appropriate for a mechanical soft diet unless it	F 367	Resident #3 was admitted to the facility on 11/22/2001 with diagnoses which include Organic Brain Syndrome and Senile Dementia. Resident is non-verbal and unable to request a substitute. Based on observation, interview and record review it was determined the facility failed to ensure residents were provided appropriate substitutes for one (Resident #3) of ten sampled residents. Dietary Manager interviewed family members of non-verbal residents to update likes and dislikes list with regard to food preferences. Also, all verbal residents were interviewed by the Dietary Manager to update their likes/dislikes list. All likes/dislikes lists will be updated annually, along with the annual MOS assessment. 100% of annual likes/dislikes updates and admissions will be reviewed in QA for one calendar year and six months and as needed.	

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F 367	<p>Continued From page 4 was very tender. She stated she would be concerned with the meat.</p> <p>Interview with the Dietary Manager on 06/02/11 at 10:00 AM regarding a whole pizza slice being served to Unsampled Resident A and Unsampled Resident B, who are on mechanically altered diets, revealed staff made a mistake serving a whole slice of pizza to the residents. Further interview revealed staff should have cut up the pizza slices for Unsampled Resident A and Unsampled Resident B. She stated staff was nervous during the survey.</p> <p>Interview with the Administrator on 06/02/11 at 2:15 PM revealed residents on mechanically soft diets should not be served whole slices of pizza.</p>	F 367	<p>F366 continued.</p> <p>All Dietary Staff were In-serviced by the Administrator and Dietary Manager Immediately on 06/01/2011 on procedures to ensure the proper diet is served, all special instructions are followed, and substitutes are served for listed "dislikes". Dietary Aide verbalizes dislikes listed on tray card to Dietary Cook. Dietary Cook then offers a substitute of similar nutritive value to resident. Also, at point of service, Certified Nurse Aide checks tray card to ensure the proper diet is served, all special instructions are followed, and substitutes are served for listed "dislikes".</p> <p>Furthermore, beginning on 06/01/2011, dietary aide will prepare tray cards, highlighting dislikes that are listed on the resident's meal ticket in accordance with the menu items being served at that particular meal. This process is completed daily prior to each meal service.</p>	
F 425 SS=E	<p>483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH</p> <p>The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.</p> <p>A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.</p> <p>The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.</p>	F 425	<p>On 06/17/2011 and 06/20/2011, all staff were In-serviced on procedures to ensure the proper diet is served, all special instructions are followed, and substitutes are served for listed "dislikes".</p> <p>The Dietary Manager will audit the above-mentioned three step process to ensure staff are in compliance with new procedure and in compliance with 483.35(d)(4). The audit will be conducted three times weekly for one month, then monthly. Audits will be reviewed at the Menu Selection Committee Meeting monthly and quarterly at QA meetings.</p>	

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F 425	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy it was determined the facility failed to ensure multi-dose medication vials were dated upon opening to establish a product expiration date.</p> <p>The findings include:</p> <p>Observation of the medication refrigerator on 06/01/11 at 10:15 AM revealed an open vial of Tuberculin serum with no puncture date. Interview with Licensed Practical Nurse (LPN) #1 revealed any medication supplied in a vial was good for thirty (30) days after the vial was first punctured. She stated the nurse should have labelled the vial at that time to establish the expiration date. Continued interview revealed it was impossible to know when the thirty (30) days had elapsed if the vial was not labelled when punctured.</p> <p>Review of the facility's policy titled "Medication Administration-Medication Storage", dated December 2010, revealed multi-dose vials must have puncture date and nurse's initials when originally used. Continued review revealed the drug was to be used no longer than thirty (30) days after the initial puncture date.</p>	F 425	<p>F 367</p> <p>The Dietary Manager and Administrator reviewed 483.35 (e). Therapeutic diets must be prescribed by the attending physician.</p> <p>On 06/01/2011, two unsampled residents were not served a mechanically altered diet. The residents have a prescribed mechanical soft diet and were served a whole slice of pizza with a hard crust.</p> <p>Evaluation of Unsampled Resident A and Unsampled Resident B by the DON on 06/01/2011 revealed no adverse reactions from food distribution at the facility. DON notified attending physicians of Unsampled Resident A and Unsampled Resident B on 06/01/2011.</p> <p>100% of residents were audited during this meal service to ensure compliance with therapeutic diet orders.</p> <p>100% of Dietary Staff were In-serviced by the Administrator and Dietary Manager immediately on 06/01/2011 regarding the therapeutic diets ordered by the physicians for said unsampled residents. All staff were In-serviced on therapeutic diets, policies and procedures on food distribution during meal service on 06/17/2011 and 06/20/2011. Audits will be conducted by the Dietary Manager to ensure compliance with 483.35(e) for ten (10) meals per week x four (4) weeks, then weekly for three (3) months. Outcomes of audit will be reviewed weekly Standards of Care meeting, monthly at the Menu Selection Committee, monthly at the Safety Committee Meeting and quarterly at QA meetings.</p>	07/05/2011

F 425

07/05/2011

The Director of Nursing reviewed 483.60(a)(b) Pharmaceutical Services- Accurate Procedures.

The facility will provide routine and emergency drugs and biological to its residents, or obtain them under agreement described in 483.75(h) of this part. The facility will provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biological) to meet the needs of each resident. The facility will employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.

On 06/01/2011, one (1) open vial of Tuberculin serum with no puncture date was observed in the medication refrigerator. This vial was removed by the Director of Nursing on 06/01/2011 and immediately disposed of per policy.

Licensed nurses on shift were in-serviced immediately and educated by the Staff Development Nurse with return of verbalization of the procedure for Medication Administration/Medication Storage (per Signature HealthCARE policy and procedure and in compliance with 483.60(a)(b)) requiring all multi-dose vials to be dated with the date of puncture and the nurses' initials when initially opened and the fact that the vial is to be used no longer than thirty (30) days after the initial puncture date.

On 06/03/2011, the Director of Nursing audited 100% of multi-dose vials to ensure proper storage, dispensing, and administration of medications. New multi-dose Tuberculin vial ordered on Bracken County Nursing and Rehabilitation Center

06/03/2011. The Director of Nursing/Staff Development Coordinator will ensure that each delivered multi-dose vial is correctly stored and appropriately dated with initials.

Review of residents receiving Tuberculin medication since last delivery of Tuberculin on 04/22/2011 assessed for any negative outcomes or signs/symptoms of infection

F425 Continued

on 06/03/2011. No negative outcomes or signs/symptoms of infection were noted.

On 06/17/2011 and 06/20/2011, all licensed nurses were in-serviced by the Staff Development Coordinator to ensure understanding of the Medication Storage Policy and Procedure, specific to dating, initialing, and checking date prior to each use for multi-dose vials. Also, licensed nurses were educated regarding shelf-life after puncture date is thirty (30) days. Medication Administration and Storage competencies were completed these dates.

Beginning 07/03/2011, Consulting Pharmacist (Pharmamerica) will complete 100% audits of multi-dose vials with each monthly visit and communicate any concerns to the Director of Nursing. Director of Nursing or Staff Development Coordinator will complete 100% audits of multi-dose vials weekly x four (4) weeks, and monthly thereafter x 3 months, to ensure compliance with Medication Administration and Storage policies and procedures. Audits will be reviewed monthly at Safety Committee Meetings and quarterly at QA meetings.

100% of new licensed nurses will be educated regarding this policy and procedure upon hire by the Staff Development Coordinator.

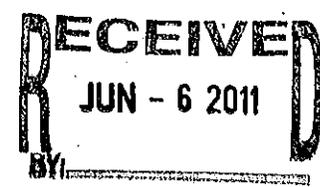
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K 000	<p>INITIAL COMMENTS</p> <p>K3 Building: 0101 K6 Plan-Approval: 1964 K7 Survey under: 2000 existing K8 SNF Type of structure: one (1) story TYPE II (111). Full automatic sprinkler system.</p> <p>A Life Safety Code survey was initiated and concluded on 06/02/2011 for compliance with Title 42, Code of Federal Regulations, 483.70, and found the facility not in compliance with NFPA 101 Life Safety Code, 2000 edition.</p>	K 000	<p>Bracken County Nursing and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during or after the survey. Facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and Facility, reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceedings. Nothing contained in this plan of correction should be considered as waiver of any potentially applicable Peer Review, Quality Assurance, or self critical examination privilege which Facility, does not waive and reserves the right to assert any administrative, civil or criminal claim, action or proceeding. Facility, offers its responses, credible allegations of compliance as part of its ongoing efforts to provide quality of care to residents.</p>	
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke barriers were maintained according to National Fire Protection Association (NFPA) standards. The deficiency affected three (3) of three (3) smoke barriers, sixty-two (62) residents, staff, and visitors.</p>	K 025	<p>K025</p> <p>The Plant Operations Manager reviewed the Life Safety Code standard K025 on 06/02/2011 regarding the construction of smoke barriers.</p> <p>On 06/9/2011, Plant Operations Manager sealed penetrations in smoke barrier due to wiring next to the nurse's station due to wiring with a material capable of limiting the transfer of smoke (Fire Caulk). The space was approximately 1 millimeter around the wire.</p>	06/03/2011

copy



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Laura N. Moore</i>	TITLE <i>LWA</i>	(X6) DATE <i>6/24/2011</i>
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K 025	<p>Continued From page 1</p> <p>The findings include:</p> <p>Observation on 06/02/2011 at 9:30 AM, with the Maintenance Director, revealed the smoke barrier located next to the nurse's station had various penetrations due to wiring that had been run through the smoke barrier. Penetrations in smoke barriers must be sealed to prevent the spread of smoke and flames. The same deficiency was noted for the smoke barrier located at resident rooms one (1) and two (2). The observation was confirmed with the Maintenance Director.</p> <p>Interview on 06/02/2011 at 9:30 AM, with the Maintenance Director, revealed he had failed to identify the penetrations in the smoke barrier before the Life Safety Code Survey.</p> <p>Reference: NFPA 101 (2000 edition) 8.2.4.4.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through smoke partitions shall be protected as follows: (1) The space between the penetrating item and the smoke partition shall meet one of the following conditions: a. It shall be filled with a material that is capable of limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose.</p>	K 025	<p>K 025 Continued</p> <p>On 06/3/2011, Plant Operations Manager sealed penetrations in the smoke barriers located at resident's rooms one (1) and two (2) due to wiring next to the nurse's station due to wiring with a material capable of limiting the transfer of smoke (Fire Caulk). The space was approximately 1 millimeter around the wire.</p> <p>On 06/03/2011, Plant Operations Manager developed an Audit Form in which three of three smoke barriers will be monitored for penetrations and compliance with K025 at least one time per month. Monthly Audit Form will be completed by the Plant Operations Manager and reviewed monthly at Safety Committee meetings and at quarterly QA meetings.</p> <p>K029</p> <p>The Plant Operations Manager reviewed the Life Safety Code NFPA 101 K029 on 06/02/2011 regarding self-closing doors.</p> <p>On 06/13/2011, Plant Operations Manager purchased and installed self closures on four (4) doors including the medical records storage room, the oxygen supply storage room, the activity storage room, and the housekeeping storage room.</p>	06/13/2011

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PRINTED: 06/16/2011
FORM APPROVED
OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5288 ASBURY ROAD AUGUSTA, KY 41002
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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)	(X6) COMPLETION DATE
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K 025	Continued From page 2 (2) Where the penetrating item uses a sleeve to penetrate the smoke partition, the sleeve shall be solidly set in the smoke partition, 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 limiting the transfer of smoke. b. It shall be protected by an approved device that is designed for the specific purpose. (3) Where designs take transmission of vibrations into consideration, any vibration isolation shall meet one of the following conditions: a. It shall be made on either side of the smoke partitions. b. It shall be made by an approved device that is designed for the specific purpose.	K 025	K 028 Continued On 06/13/2011, Plant Operations Manager will perform up to 5 checks per week on 100% of doors required to be self closing. Doors are numbered and recorded on a Door Audit Form. Findings are reviewed monthly at Safety Committee meetings and quarterly at QA meetings. K038 The Plant Operations Manager reviewed the Life Safety Code NFPA 101 K038 on 06/02/2011 regarding exlts are readily accessible at all times.	06/15/2011
K 029 SS=E	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	K 029	On 06/15/2011, Plant Operations Manager equipped door number four (4) with delayed egress hardware. On 06/15/2011, the Plant Operations Manager posted signage on exit doors numbers three (3), four (4), five (5), and six (6) to inform users of a delay in case of a fire. On 06/15/2011, the Plant Operations Manager will monitor 100% of exit doors, which are numbered, equipped with delayed egress hardware up to 5 times per week to assure they are in compliance with K038. This information will also be recorded on the Door Audit Form with findings reviewed monthly at Safety Committee meetings and quarterly at QA meetings.	

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K 029	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency affected one (1) of three (3) smoke compartments, thirty (30) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 06/02/2011 at 11:30 AM, with the Maintenance Director, revealed doors located at medical records, activities storage, and oxygen supply storage room, did not have self closers located on the doors. The total number of doors not having self closers in the area was four (4). Doors located in rooms where large quantities of combustible materials are stored must have self closers on the doors to prevent the spread of smoke and fire.</p> <p>Interview on 06/02/2011 at 11:30 AM, with the Maintenance Director, revealed he had failed to identify the doors as needing self closers.</p> <p>Reference: NFPA 101 (2000 edition) 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</p>	K 029	<p>K048</p> <p>The Plant Operations Manager reviewed the Life Safety Code NFPA 101 K048 on 06/02/2011 regarding written plan for the protection of all patients and for their evacuations in the event of an emergency.</p> <p>On 06/02/2011, the Plant Operations Manager reviewed the facility's fire safety plan which states, "If the fire is located in the kitchen area, pull the fire alarm and immediately fight the fire with appropriate fire extinguisher. If the fire is located in the hood removal system or the oven/deep fat fryer area and unsafe to fight with an extinguisher, pull handle to activate the hood suppression system then exit the building."</p> <p>On 06/24/2011, Fire Safety Plan revised to address the hood system as the primary means of extinguishment and fire extinguishers as a secondary means of fire extinguishment.</p> <p>100% of dietary staff were in-serviced regarding this policy revision by Administrator on 06/24/2011.</p> <p>100% of Staff will be in-serviced on policy revision related to the fire safety plan on 06/30/2011 by the Staff Development Coordinator.</p>	06/30/2011
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PRINTED: 06/15/2011
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5200 ASBURY ROAD AUGUSTA, KY 41002
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K 029	<p>Continued From page 4</p> <p>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>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 029	<p>K050</p> <p>The Plant Operations Manager reviewed the Life Safety Code NFPA 101 K058 on 06/02/2011 requiring fire drills to be held at unexpected times under varying conditions, at least quarterly on each shift.</p> <p>On 06/13/2011, the facility employed a full-time Plant Operations Manager. The Plant Operation Manager was oriented to the Life Safety Code and Signature HealthCARE policy and procedure which is in compliance with NFPA 101 K058. Orientation with the new Plant Operations Manager was completed on 06/16/2011.</p> <p>Plant Operations Manager conducts monthly fire drills, at least quarterly on each shift, at unexpected times under varying conditions. Fire Drills are recorded on a log, stating date, time. Another Fire Drill In-Service sheet is completed which includes:</p> <ul style="list-style-type: none"> a. The type of drill conducted; b. The date and time the drill was conducted; c. The type of situation used; d. The location of the simulated disaster area; e. The type of alarm device used (i.e., smoke/heat detector, pull station, etc.); f. The location of the alarm device used; g. The name/signature of each person attending the drill; h. The response of personnel; i. The response time; j. An analysis of the drill; k. The name and signature of the person(s) conducting the drill; and l. Any recommendations for the improvement of drills. 	06/16/2011
K 038 SS=E		K 038		

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K 038	<p>Continued From page 5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were maintained according to National Fire Protection Association (NFPA). The deficiency affected one (1) of three (3) smoke compartments, thirty (30) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 06/02/2011 at 11:02 AM, with the Maintenance Director, revealed exit door number four (4) did not have the proper signage for a door equipped with delayed egress hardware. Exit doors numbers three (3), five (5), and six (6) also did not have the proper signage for a door equipped with delayed egress hardware. Doors equipped with delayed egress hardware must maintain signage that informs users of the delay in case of a fire.</p> <p>Interview on 06/02/2011 at 11:02 AM, with the Maintenance Director, revealed he had failed to identify the doors with delayed egress as needing signage before the survey.</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors</p>	K 038	<p>K 050 Continued</p> <p>Fire Drill documents will be reviewed monthly at Safety Committee Meetings and quarterly at QA meetings.</p> <p>K062</p> <p>The Plant Operations Manager reviewed the Life Safety Code NFPA 101 K062 on 06/02/2011 requiring automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically.</p> <p>Plant Operations Manager scheduled a time with Century Fire Systems to change (1) fire sprinkler head in the oxygen supply room with paint on it and conduct inspection.</p> <p>On 6/22/2011, Century Fire Systems replaced the (1) fire sprinkler head in the oxygen supply room with paint on it and conducted an inspection of the entire system on this date.</p> <p>The sprinkler system is tested at least quarterly. The sprinkler system is tested only by Century Fire Systems. The Plant Operations Manager maintains records of system tests and inspections. The Plant Operations Manager will monitor and log any potential problems during monthly fire inspection. Results will be reviewed monthly at Safety Committee Meetings.</p>	06/22/2011
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K 038	<p>Continued From page 6</p> <p>serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the</p>	K 038		

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K 038	Continued From page 7 releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) "On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 048 SS-E	NFPA 101 LIFE SAFETY CODE STANDARD There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 This STANDARD is not met as evidenced by: Based on policy review and interview, it was determined the facility failed to ensure the facility's fire safety plan, was according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty (30) residents, staff and visitors. The findings include: Review of the facility's fire safety plan on 06/02/2011 at 9:06 AM, revealed staff are to activate the hood system if the fire is unsafe to fight with a fire extinguisher. Fire safety plans must address that the hood system is the primary means of extinguishment and fire extinguishers	K 048		

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K 048	<p>Continued From page 8 are a secondary means of fire extinguishment.</p> <p>Interview on 06/02/2011 at 9:15 AM, with the Dietary Manager, revealed if a fire was located under the hood system she would use a fire extinguisher to extinguish the fire. Further interview revealed she was never instructed that the hood system should be activated first during a fire located under the hood system and fire extinguishers were a secondary back up to the hood system.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.2.1* For health care occupancies, the proper protection of patients shall require the prompt and effective response of health care personnel. The basic response required of staff shall include the removal of all occupants directly involved with the fire emergency, transmission of an appropriate fire alarm signal to warn other building occupants and summon staff, confinement of the effects of the fire by closing doors to isolate the fire area, and the relocation of patients as detailed in the health care occupancy's fire safety plan.</p> <p>19.7.2.2 A written health care occupancy fire safety plan shall provide for the following: (1) Use of alarms</p>	K 048		

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K 048	Continued From page 9 (2) Transmission of alarm to fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire Reference: NFPA 96 (1998 edition) 7-2.1 Fire-extinguishing equipment shall include both automatic fire-extinguishing systems as primary protection and portable fire extinguishers as secondary backup.	K 048		
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted according to National Fire Protection Association (NFPA) standards. The deficiency affected three (3) of three (3) smoke barriers, sixty two (62) residents, staff, and visitors.	K 050		

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K 050	<p>Continued From page 10</p> <p>The findings include:</p> <p>Record review of the facility's fire drills on 06/02/2010 at 1:45 PM, with the Maintenance Director, revealed the facility had conducted the last two quarters for 3rd shift at 6:30 AM. The fire drills were conducted on 12/31/10 and 03/18/2011. Fire drills must be conducted at various times.</p> <p>Interview on 06/02/2010 at 1:45 PM, with the Maintenance Director, revealed he was unsure of why the fire drills were conducted at the same times.</p> <p>Reference: NFPA 101 (2000 edition) 19.7.1.2* Fire drills in health care occupancies shall include the transmission of a fire alarm signal and simulation of emergency fire conditions. Drills shall be conducted quarterly on each shift to familiarize facility personnel (nurses, interns, maintenance engineers, and administrative staff) with the signals and emergency action required under varied conditions. When drills are conducted between 9:00 p.m. (2100 hours) and 6:00 a.m. (0600 hours), a coded announcement shall be permitted to be used instead of audible alarms. Exception: Infirm or bedridden patients shall not be required to be moved during drills to safe areas or to the exterior of the building.</p>	K 050		
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K 082 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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, 9.7.6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain the fire sprinkler heads, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of three (3) smoke compartments, thirty (30) residents, staff, and visitors.</p> <p>The findings include:</p> <p>Observation on 06/02/2011 at 1:20 PM, with the Maintenance Director, revealed one (1) fire sprinkler head in the oxygen supply room had paint on the fire sprinkler head. Paint on fire sprinklers can prevent the fire sprinklers from activating in a fire situation.</p> <p>Interview on 06/02/2011 at 1:20 PM, with the Maintenance Director, revealed he had not noticed the fire sprinkler head having paint on it.</p> <p>Reference: NFPA 25 (1998 edition)</p>	K 062		

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/02/2011
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
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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
K 062	Continued From page 12 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. Exception No. 1:* Sprinklers installed in concealed spaces such as above suspended ceilings shall not require inspection. Exception No. 2: Sprinklers installed in areas that are inaccessible for safety considerations due to process operations shall be inspected during each scheduled shutdown.	K 062		