

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

PRINTED: 11/16/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/29/2010
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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210
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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
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<p>F 000</p> <p>F 157 SS=D</p>	<p>INITIAL COMMENTS</p> <p>An annual survey and abbreviated surveys (KY #15095, KY #15097 and KY #15511) were conducted on 10/26/10 through 10/29/10 to determine the facility's compliance with Federal certification requirements. The facility was not in substantial compliance with Federal certification requirements with deficiencies cited at the highest Scope and Severity of a "D". KY #15095 was found unsubstantiated, with no deficiencies; KY #15097 was found substantiated with related deficiencies and KY #15511 was found unsubstantiated, with no deficiencies.</p> <p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in</p>	<p>F 000</p> <p>F 157</p>	<p>"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."</p> <p>F157 Notify of Changes</p> <p>Resident's (#3) physician was notified of the change in length of resident's pressure ulcer from .08cm to 1.6cm on 10/28/2010 by RN#1.</p> <p>A complete audit of all residents with pressure ulcers has been completed by RN#1 on 10/28/2010 to ensure that any changes in the condition of the resident's pressure ulcer has been addressed with proper physician notification.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Carolyn Louence

TITLE

Administrator

(X6) DATE

11/24/10

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

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F 157	<p>Continued From page 1</p> <p>resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to notify the resident's physician or family member regarding a change in status for one resident (#3), in the selected sample of 15.</p> <p>The facility failed to notify and/or consult with Resident #3's primary physician after a decline was identified related to the status of a pressure ulcer.</p> <p>Findings include:</p> <p>A review of the facility's policy/procedure, "Change In Condition of a Resident" dated January 2008, revealed, "It is the policy of the center to take appropriate action and provide 'timely' communication to the resident's physician and responsible party relating to a change in condition of a resident. The Licensed Nurse determines if there has been a change in condition of a resident. The Licensed Nurse confers with the Physician/Physician Extender to determine what actions may be necessary to meet the immediate needs of the resident."</p> <p>Record review revealed Resident #3 was admitted to the facility, on 10/01/06, with diagnoses to include Neurogenic Bladder, Spina</p>	F 157	<p>All licensed nursing staff have been re-educated on prevention and care of pressure ulcers and notification of physician with changes in resident's condition on 11/11/2010 by Staff Development Coordinator. All Certified Nursing Assistants have been re-educated on skin care management on 11/11/2010 by Staff Development Coordinator.</p> <p>The Director of Nursing Services and the Assistant Director of Nursing Services will conduct monthly audits for three months on physician notification of resident's changes in condition. Results of these audits will be brought monthly to the Performance Improvement Committee for further recommendations.</p> <p>Completion date</p>	11/12/2010

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F 157	<p>Continued From page 2</p> <p>Bifida, Paraplegia, Schizophrenia, Hypertension, and Depression.</p> <p>A review of the pressure ulcer assessments, dated 10/17/10 and 10/28/10, revealed a change (decline) in the status of the pressure ulcer located on the resident's left buttock was noted. Record review revealed no evidence the LPN had notified the RN supervisor for verification of the decline and/or notified the physician of the change in the status of the resident's condition.</p> <p>Observation during a skin assessment, conducted by LPN #1, on 10/28/10, at 10:02 AM, revealed Resident #3 had a pressure ulcer located on the left buttock, described as a Stage II and measuring 1.6 centimeters (cm) in length, 0.6 cm in width and 1 cm in depth, without undermining or tunneling.</p> <p>An interview with LPN #1, on 10/28/10 at 10:02 AM, revealed she did not request the RN verification of the measurements taken on 10/26/10, because she did not want to bother the RN. LPN#1 also stated she did not notify and/or consult with the resident's primary physician regarding the change in the condition of the pressure ulcer and potential need to alter treatment.</p> <p>An interview with RN #1, on 10/28/10 at 10:30 AM, revealed weekly assessments were scheduled by a list with the days identified, to be provided by the nurse on duty. If the nurse on duty was a LPN, an RN verified the LPN's assessment determination. If the RN agreed, she documented her initials beside the LPN signature. RN#1 stated she did not verify LPN #1's skin assessment of Resident #3, provided on</p>	F 157		

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F 157	Continued From page 3 10/26/10, because she was not made aware of the need to do so. She stated the primary physician should be notified of any change in the pressure ulcer status. She stated she would have contacted Resident #3's primary physician of the decline of the pressure ulcer status, if she had been made aware.	F 157		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to ensure the care plan interventions were followed for one resident (#3), in the selected sample of 15, related to transfers using a Hoyer lift. Findings include: A review of the facility policy titled, "Planning, Implementation and Evaluation: Careplanning," dated January 2008, revealed "Licensed Nurses, nursing assistants and the entire interdisciplinary team must ensure that all planned interventions and treatments are carried out as written in the care plan."	F 282	F282 Services by Qualified Persons/Per Care Plan C.N.A.s caring for resident (#3) have been re-advised the C.N.A. care card requires two assist with the use of mechanical lift for transfers of resident (#3) by Director of Nursing on 10/28/2010. An audit of all resident's care cards has been completed by charge nurse at each station on 10/28/2010 to ensure the care provided by C.N.A.s is provided as per the C.N.A. care card. Re-education of all Certified Nursing Assistants has been completed on following the directions on the C.N.A. care card on 11/11/2010 by Staff Development Coordinator.	

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F 282	<p>Continued From page 4</p> <p>Record review revealed Resident #3 was admitted to the facility on 10/01/06, with diagnoses to include Neurogenic Bladder, Spina Bifida, Paraplegia and Hypertension.</p> <p>A review of the annual Minimum Data Set (MDS), dated completed on 12/21/09, revealed the facility identified Resident #3 as totally dependent on two staff members for transfers.</p> <p>A review of the comprehensive care plan, dated 02/29/09, revealed interventions included the extensive/total assistance of two staff members for transfers. A review of the Certified Nurse Aide (CNA) care plan, dated 8/31/10, revealed interventions included the use of a mechanical lift for transfers, assisted by two staff members.</p> <p>An observation, on 10/28/10 at 9:25 AM, revealed CNA #1, while unassisted by another staff member, provided assistance with a transfer from the wheelchair to the bed, using the Hoyer lift.</p> <p>Interview with two CNAs (#1 and #2), on 10/28/10 at 10:42 AM and 10/28/10 at 10:48 AM respectively, revealed they were aware Resident #3 required the assistance of two staff members. In accordance with the resident's care plan. CNA#1 stated she did not obtain assistance from the second staff member because, "The resident is better with one assist transfers".</p> <p>An interview with Licensed Practical Nurse #1, on 10/28/10 at 10:55 AM, the Assistant Director of Nursing, on 10/28/10 at 11:00 AM, the Director of Nursing, on 10/29/10 at 6:40 PM and the Administrator, on 10/29/10 at 9:47 AM, revealed the CNA care plan details the interventions and the number of staff needed. The CNA was</p>	F 282	<p>The Director of Nursing Services and the Assistant Director of Nursing Services will conduct weekly checks and monthly audits for three months on C.N.A.s following the directions on the C.N.A. Care Cards. Results of these audits will be brought monthly to the Performance Improvement Committee for further recommendations.</p> <p>Completion date</p>	11/12/2010

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<p>F 282</p> <p>F 309</p> <p>SS=D</p>	<p>Continued From page 5 expected to follow the interventions per the care plan for each resident.</p> <p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being for one resident (#15), in the selected sample of 15. The facility failed to administer a laxative to Resident #15, per the facility's "bowel monitoring schedule". The resident did not have a recorded bowel movement, for four consecutive days. Findings include: Resident #15 was admitted to the facility, on 05/08/09, with diagnoses to include Depression, Vascular Dementia, Dysphagia and Late Effects Cerebrovascular Disease. A review of the annual Minimum Data Assessment (MDS), dated 05/14/10, revealed the resident had a feeding tube and received 76 to 100 percent of the resident's daily caloric need through the tube.</p>	<p>F 282</p> <p>F 309</p>	<p>F309 Provide Care/Services For Highest Well Being, Quality Care Nursing Care</p> <p>Resident (#15) was discharged to hospital on 06/22/2010. Constipation resolved prior to returning to the facility on 07/01/2010.</p> <p>A complete audit of all residents with a diagnosis of constipation has been completed by Director of Nursing on 10/28/2010 to ensure bowel movements have been recorded accurately and follow up completed per the bowel monitoring schedule.</p> <p>All licensed nurses and Certified Medication Aids have been re-educated on bowel monitoring schedule and proper documentation of monitoring bowel and bladder schedules on the ADL sheets on 11/11/2010 by Staff Development Coordinator.</p> <p>The Director of Nursing Services and the Assistant Director of Nursing Services with do weekly checks and monthly audits for three months of the bowel and bladder documentation on the ADL sheets</p>	
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F 309	Continued From page 6 A review of Resident #15's "Resident Functional Performance Record", dated June 2010, revealed the resident had no recorded bowel movement, from 06/16/10 through 06/19/10, a period of four days. A review of the nurses' notes, dated 06/20/10 at 1:00 AM, revealed the resident vomited twice and received an anti-emetic (Phenergan) for nausea. The nurse's notes, dated 06/22/10 at 1:00 AM, revealed Resident #15 vomited and an enema was administered, resulting in a small bowel movement. At 6:30 AM, the resident vomited a large amount of yellow colored liquid. A bowel assessment was completed and the family notified. A review of the nurse's notes, dated 06/22/10 at 5:50 PM, revealed the family was at the resident's bedside and requested a transfer for the resident to the emergency room or a visit to the facility by the primary physician, to assess the resident's status. An order was obtained and the resident was transported to the emergency room for evaluation and treatment, due to lethargy. A review of the hospital record, revealed an abdominal x-ray, dated 06/22/10, revealed a moderate fecal retention in the colon from the cecum to the rectum, with no evidence of a small bowel ileus or obstruction. The hospital discharge summary included the diagnosis of Acute Pancreatitis, Urinary Tract Infection and Severe Constipation. A review of the facility's form entitled, "Bowel Movement Monitoring Schedule", dated 08/11/09, revealed the Certified Medication Technician (CMT), scheduled to work from 6:00 AM until 2:00 PM was responsible for checking all bowel	F 309	and the Medication Administration Record to ensure the facilities protocol has been followed regarding bowel movements. Results of these audits will be brought monthly to the Performance Improvement Committee for further recommendations. Completion date	11/12/2010	

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F 309	<p>Continued From page 7</p> <p>movement records. If a resident had not had a bowel movement in three days, the CMT composed a list of all residents, needing a laxative and reported the information to the staff assigned to work the same day, from 2:00 PM TO 10:00 PM. The 2:00 PM to 10:00 PM shift used the list as a guide and administered the laxatives. The form further stated that if the resident had a feeding tube, the CMT was supposed to inform the charge nurse the resident required the medication.</p> <p>A review of the physician orders revealed an order dated 11/02/09, for Bisacodyl 10 milligram (mg) suppository to be administered rectally, as needed (prn), for constipation. A review of the medication administration record, dated June 2010, revealed the resident was not given any medication for constipation, on 06/19/10, as directed by the facility's "Bowel Movement Monitoring Schedule".</p> <p>An interview with CMT #1, on 10/29/10 at 2:15 PM, revealed she was assigned responsibility for review of the bowel records, on 06/19/10, but had no recall of including Resident #15's name on the laxative list or whether she informed the charge nurse of Resident #15's need for a laxative.</p> <p>An interview with the Director of Nursing, on 10/29/10 at 6:40 PM, revealed it was the responsibility of CMT working on the 6:00 AM to 2:00 PM shift to check each resident's bowel record daily. If a resident did not have a bowel movement during a three day period, a list was composed of residents in need of a laxative and the list was given to the nurse working on the 2:00 PM to 10:00 PM shift. The nurse was responsible for the administration of the laxatives.</p>	F 309			

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F 309	Continued From page 8	F 309		
F 314 SS=D	<p>The DON further stated that Resident #15 should have received a laxative on the night of 06/19/10.</p> <p>483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES</p> <p>Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</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 one resident (#3), in the selected sample of 15, received the necessary treatment and services to promote healing and prevent new pressure ulcers from developing.</p> <p>The facility failed to provide accurate and consistent assessment of the condition of the pressure ulcer(s) and the effectiveness of treatments provided. A decline was identified in the condition of the resident's pressure ulcer on 10/26/10. The assessing nurse failed to follow the facilities policy and procedure regarding consultation with her Registered Nurse (RN) supervisor and/or the physician. Findings include:</p> <p>Review of the facility's policy and procedure, "Skin Care and Pressure Ulcer Management Program," dated January 2010, revealed, "The</p>	F 314	<p>F314 Treatment/Services to Prevent/Heal Pressure Sores</p> <p>RN#1 completed follow up assessment on resident's (#3) pressure ulcer and resident's physician has been notified of the change in length of resident's pressure ulcer from .08cm to 1.6cm on 10/28/2010 by RN#1.</p> <p>A complete head to toe audit of all residents was completed 10/28/2010 by charge nurse on each station to ensure that residents without pressure ulcers have not developed a pressure ulcer and to ensure residents with pressure ulcers are receiving necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.</p> <p>All licensed nursing staff have been re-educated on prevention and care of pressure ulcers by Staff Development Coordinator on 11/11/2010. All Certified Nursing Assistants have been re-educated on skin care management on 11/11/2010 by Staff Development Coordinator.</p> <p>The Director of Nursing Services and the Assistant Director of Nursing</p>	

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F 314	Continued From page 9 team makes rounds weekly to evaluate wound treatment and other care interventions. The licensed nurse evaluates the pressure ulcer and documents pressure ulcer healing using the pressure ulcer documentation form. If a pressure ulcer fails to show progress toward healing within 2 weeks, the team reevaluates the treatment plan to determine whether to modify the current interventions." Record review revealed Resident #3 was admitted to the facility on 10/01/06, with diagnoses to include Neurogenic Bladder, Spina Bifida, Paraplegia and Hypertension. A review of the annual Minimum Data Set (MDS), dated completed on 12/21/09, revealed the facility identified Resident #3 as totally dependent on two staff members for bed mobility and transfers, incontinent of bowel with the use of a indwelling catheter. Additionally, the facility assessed the resident as dependent on one staff member for bathing and hygiene. Resident #3 had three Stage II pressure ulcers at the time of the assessment and was identified by the facility as at high risk for the development of pressure ulcers. A review of the Medication Administration Record, dated 10/01-31/10, revealed the wound was treated with Trypsin w/Castor Oil and Peruvian Balsam a topical spray and Hydrogel Sheat was applied to open areas on the resident's buttocks and Hydrogel guaze was used to pack deep ulcers and changed every three days and as needed. A review of the pressure ulcer assessment, dated 10/12/10, revealed the ulcer located on the resident's left upper buttock measured 0.6	F 314	Services will conduct monthly audits for three months on physician notification of resident's changes in condition. Results of these audits will be brought monthly to the Performance Improvement Committee for further recommendations. Completion date	11/12/2010

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ D. WING _____		(X3) DATE SURVEY COMPLETED 10/29/2010
NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 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 314	<p>Continued From page 10</p> <p>centimeters (cm) in length, 0.6 cm in width, and 0.6 cm in depth, with no undermining or tunneling. Licensed Practical Nurse (LPN) #2 documented the ulcer was at a Stage II.</p> <p>A review of the pressure ulcer assessment, dated 10/17/10, revealed the ulcer had increased in size and measured 0.8cm in length, 0.4 cm in width and 0.4 cm in depth, with no undermining or tunneling. Registered Nurse (RN) #1 documented the ulcer remained at a Stage II.</p> <p>A review of the pressure ulcer assessment, dated 10/26/10, revealed the pressure ulcer to the left upper buttock had increased in size since the last assessment on 10/17/10 and measured 1.6 cm in length, 0.6 cm in width and 0.4 cm in depth, with no undermining or tunneling. LPN #1 did not document the staging of the ulcer.</p> <p>Observation during a skin assessment conducted by LPN #1, on 10/28/10 at 10:02 AM, revealed a pressure ulcer was located on the resident's right upper buttock, which was not measured. An open area was located on the resident's right greater trochanter, which LPN#1 described as an excoriated area. Additionally, a pressure ulcer was located to the left buttock midline, which measured 1.6 centimeters (cm) in length, 0.6 cm in width and 1 cm in depth, without undermining or tunneling. LPN #1 stated the ulcer on the left buttock was at Stage II.</p> <p>An interview with LPN #1, on 10/28/10 at 10:02 AM, revealed weekly skin assessments and measurements of wounds were provided by a licensed nurse and verified by a RN. The RN initials beside the LPN signature, if in agreement with the LPN assessment. LPN#1 stated she did</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
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F 314	<p>Continued From page 11</p> <p>not request the RN verification of the measurements taken on 10/26/10, because she did not want to bother the RN. The LPN did not request the RN verification after the assessment completed at time of the interview.</p> <p>An comparison observation of a skin assessment was requested by the surveyor and conducted by RN #1, on 10/28/10, at 10:18 AM. The RN assessment revealed the resident had a Stage II to the right upper buttock, a Stage II to the right upper thigh measuring 1 cm length by 1 cm width and a Stage III to the left buttock midline, measuring 1 cm length, 1 cm in width, and 1 cm in depth, with undermining of the wound from the 12 o'clock position to the 6 o'clock position, measuring 5/10 cm.</p> <p>An interview with RN #1, on 10/28/10 at 10:30 AM, revealed weekly assessments were scheduled by a list with the days identified, to be provided by the nurse on duty. If the nurse on duty was a LPN, an RN verified the LPN's assessment determination. If the RN agreed, she documented her initials beside the LPN signature. RN#1 stated she did not verify LPN #1's skin assessment of Resident #3, provided on 10/26/10, because she was not made aware of the need to do so. Additionally, LPN #1 had not requested the assessment verification of the assessment completed on 10/28/10 at 10:02 AM.</p> <p>An interview with the Assistant Director of Nursing, on 10/28/10 at 10:50 AM, revealed the LPN was assigned pressure ulcer assessments, however, the RN was responsible for verification of the LPN assessment/determination. If the RN did not agree with the LPN assessment, the RN should</p>	F 314			

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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210		
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F 314	Continued From page 12 remeasure the ulcer.	F 314			
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure it was free of medication error rates of five percent or greater. Forty five opportunities were observed with ten medication errors, affecting four residents (#16, #17, #18, and #19), not in the selected sample of 15. The facility had a medication error rate of 22%. Findings include: A review of the facility policy for medication administration, dated 10/15/05, revealed medications were to be given at the time ordered, within 60 minutes before or after the designated time, except for the medications ordered before meals (AC) or after meals (PC), or specifically ordered by physician. 1. A review of the record revealed a physician order for Resident #16 included Metoprolol 50 milligrams (mg) table two times a day at 6:00 AM and at 6:00 PM and Theophylline Extended Release 200 mg table two times a day at 6:00 AM and at 6:00 PM. An observation during the medication pass, on 10/27/10 at 9:15 AM, revealed Certified Medication Technician (CMT) #1 administered	F 332	F332 Free of Medication Error Rates of 5% or More Residents (#16, #17, #18 and #19) are receiving their medications per physician order and per state regulations verified by Director of Nursing on 10/28/2010. A complete audit of all residents' medication and delivery times has been completed by Director of Nursing to ensure medications are given per physician orders and per state regulations on 11/11/2010. All licensed nursing staff have been re-educated on receiving and transcribing medication orders correctly and Certified Medication Aids have been re-educated on prevention of medication errors on 11/11/2010 by Staff Development Coordinator. The Director of Nursing Services and the Assistant Director of Nursing Services will conduct weekly checks and monthly audits for three months		

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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210
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F 332	<p>Continued From page 13</p> <p>Metoprolol 50 milligrams (mg) and Theophylline ER 200 mg to Resident #16.</p> <p>2. A review of the record revealed a physician order for Resident #17 included K-Dur (Potassium Chloride) Extended Release 20 Milliequivalents (Meq) tablet two times a day at 6:00 AM and at 6:00 PM, Metoprolol 25 mg tablet two times a day at 6:00 AM and at 6:00 PM, Topamax 200 mg two times a day at 6:00 AM and at 6:00 PM, Lamictal 100 mg tablet three times a day at 6:00 AM, at 12:00 PM and at 6:00 PM, Aldactone 25 mg tablet two times a day at 6:00 AM and at 6:00 PM.</p> <p>An observation during the medication pass, on 10/27/10 at 9:30 AM, revealed CMT #1 administered K-Dur 20 Meq tablet extended release, Metoprolol 25 mg tablet, Aldactone 25 mg tablet, Topamax 200 mg tablet, and Lamictal 100 mg tablet.</p> <p>An interview with CMT #1, on 10/27/10 at 2:00 PM, revealed she had one hour before or after the designated time to administer medications. CMT #1 stated she assisted with breakfast trays in the dining room, before starting the medication pass. She had a late start and should have completed the medication pass at 9:00 AM. CMT #1 stated she did not inform the nurses the medications were not given within the time frame. She stated she had difficulty administering the medications within timeframes and had discussed the issue previously with the Director of Nursing (DON).</p> <p>An interview with Licensed Practical Nurse (LPN) #1 and LPN #6, on 10/27/10 at 2:13 PM revealed they were not aware the CMT #1 had not</p>	F 332	<p>on medication passes. Results of these audits will be brought monthly to the Performance Improvement Committee for further recommendations.</p> <p>Completion date</p>	11/12/2010
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F 332	<p>Continued From page 14</p> <p>administered Resident #16's and #17's medication within the one hour before or after timeframe. The nurses stated they were not aware the CMT had difficulty meeting the established timeframe.</p> <p>3. A review of the physician order for Resident #18 revealed Metoprolol 25 mg tablet was to be administered twice a day at 8:00 AM and at 4:00 PM.</p> <p>An observation during the medication pass, on 10/28/10 at 9:30 AM, revealed CMT #2 administered the medications including Metoprolol 25 mg tablet.</p> <p>4. A review of the physician order for Resident #19 revealed Carbidopa-Levodopa 25/100 mg tablet was to be administered three times a day at 6:00 AM, at 11:00 AM and at 7:00 PM, and Namenda 10 mg tablet was ordered twice a day at 6:00 AM and at 6:00 PM.</p> <p>An observation during the medication pass, on 10/28/10 at 9:40 AM, revealed CMT #2 administered medications to Resident #19 to include Namenda 10 mg tablet and Carbidopa/Levodopa 25 mg/100 mg tablet, which were ordered to be given at 6:00 AM.</p> <p>An interview with CMT #2, on 10/28/10 at 10:20 AM, revealed she did not know when the medication times were changed and she followed the times detailed on the Medication Administration Record (MAR).</p> <p>An interview with the DON, on 10/28/10 at 10:00 AM, revealed she discovered that morning the medications were not given within the timeframe</p>	F 332			

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F 332	Continued From page 15 on the 400 hall. She stated the CMT did not inform anyone the medications were given outside the timeframe. She stated she expected the nurse or medication technician to administer the medications as ordered. If the staff were behind in administering the medications, then they should let the nurse know so the physician could be informed.	F 332			

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NAME OF PROVIDER OR SUPPLIER EDMONSON CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 813 S. MAIN ST. BROWNSVILLE, KY 42210
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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted on 10/28/10 to determine Federal compliance with Title 42, Code of Federal Regulations, 482.41 (b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency at a "D".	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."	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and staff interview, it was determined the facility failed to ensure doors protecting corridor openings were provided with positive latching devices as required by Chapter	K 018	K Life Safety Code Standard K018 Fire door located at doorway of room #207 was repaired by the Maintenance Supervisor on 10/28/2010 and it will now latch when shut. The Maintenance Supervisor inspected all fire doors in building to ensure they latched when shut on 10/28/2010. Maintenance Supervisor was re-educated on 10/28/2010 by the Administrator on monitoring the doors throughout the building	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Carolyn Louence</i>	TITLE <i>Administrator</i>	(X6) DATE <i>11/24/10</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 018	<p>Continued From page 1</p> <p>19 of NFPA 101, Life Safety Code 2000 Edition. This condition affected one smoke compartment and approximately 20 residents and staff.</p> <p>Findings Include: During the Life Safety Code Inspection conducted on 10/28/10, the door to Resident Room #207 was tested and found that it would not latch.</p> <p>Interview with the Director of Maintenance, at 2:00 PM on 10/28/10, revealed he was aware of the requirement that doors protecting corridor openings must latch. He stated that he regularly checked doors, but that the recent rains could have caused the wood doors to swell, preventing them from latching.</p> <p>Reference to: NFPA 101 Life Safety Code 2000 Edition 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door.</p>	K 018	<p>to ensure they are continuously maintained in reliable operating condition. These doors will be inspected and tested periodically by the Administrator.</p> <p>The Maintenance Supervisor will conduct monthly audits of all fire doors in the facility for three months and report findings to the Performance Improvement Committee for further recommendations.</p> <p>Completion date</p>	11/12/2010	