STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

(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	Continued From page 26 services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to ensure necessary treatment and services were provided to prevent development of new pressure sores for one (1) of nineteen (19) sampled residents. Resident #1 has a history of pressure sores and remains at risk for development of new pressure sores. Inspection of the resident's skin on 02/24/11 revealed the facility had failed to apply the preventive barrier cream to the resident's reddened areas. The findings include: Observation of a skin assessment for Resident #1, on 02/24/11 at 7:35am (after permission was given by the resident), revealed two small raised, red, blister-like areas on the left buttock and one on the right buttock. When the brief was removed, the resident was noted to be incontinent of bladder. Observation revealed no barrier cream on the resident's buttocks. CNA #2 (certified nursing assistant) cleansed the resident's skin with tap water; however, when she went to apply the barrier cream, she could not find any in the resident's room. The nurse who was helping the CNA had to leave the room to obtain the barrier cream. Interview with CNA#2 at the time of the observation revealed the night shift staff had applied the brief and she did not know if they had applied the barrier cream.	F 314	3. All nursing staff will be re-educated by the Education and Training Director by 4/5/11 on the policies and procedures related to the use of barrier cream after incontinent episodes, as well as location of barrier cream in supply. 4. Observations of incontinence care to assure that moisture barrier is applied will be completed 5 times per week on each shift for 2 weeks then 5 times per week on random shifts for 10 weeks by the Education and Training Director. The Quality Assurance Committee will review the observations monthly for 3 months and according to recommendations thereafter to ensure continued compliance. If at any time concerns identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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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 314	Continued From page 27 Interview with the nurse who was present during the skin observation revealed the barrier cream should be applied after each incontinent episode and the CNAs can keep the barrier cream in the resident's room for accessibility. Review of the clinical record revealed the resident has a history of non-healing wounds on the right leg that required Apligraf placement on 11/29/10 to help promote healing. The resident was assessed to be high risk for pressure sore development related to decreased mobility, incontinence, and dependence on staff for all toileting needs. The care plan addressed the risk with the barrier cream to be applied after each incontinent episodes.	F 314		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to ensure the residents' environment remained as free from accident hazards as possible. Observation during the facility tour revealed the facility failed to ensure scissors were secured and not accessible to residents. Scissors were also left unattended on a treatment cart outside the	F 323	F323- Free of Accident Hazards 1. Scissors were removed and secured by the Registered Nurse when brought to her attention on 2/23/11. The key to the room marked "Biohazard" has been removed from the sign outside the room by the Administrator on 3/18/11. 2. A complete walkthrough of the facility was completed by the Administrator by 3/18/11to ensure that the environment was free of accident hazards as is possible. No concerns were identified. 3. All staff will be re-educated by the Education and Training Director by 4/5/11 on policies and procedures related to providing a safe environment for the residents.	4/5/11

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 323	Continued From page 28 room of Resident #10. The Biohazard room on the "B" hall was not secured. The key for the door was left stored outside the door on a sign. The findings include: Observation on 02/21/11 at 6:15pm revealed a pair of scissors left unattended on top of the medication cart next to the nurse's station at the entrance to the A wing. Observation on 02/21/11 at 6:20pm revealed RN #2 stood next to the medication cart with the scissors on top fo the cart. No action was taken to secure the scissors. RN #2 walked away from the cart while the scissors remained on top. Further observation at 6:20pm revealed an unsampled resident then stood by the medication cart, which had the scissors on top. The resident voiced confusion to this surveyor as to where he/she now lived. Observation on 02/23/11 at 8:00am outside the room of Resident #10 revealed a pair of scissors on top of the treatment cart unattended and accessible to the residents. Interview on 02/24/11 at 7:40am with LPN #3 revealed there are confused ambulatory residents within the facility that wander the hallway in the vicinity of the medication cart where the scissors where observed. Interview on 02/24/11 at 9:40am with the Director of Nurses (DON) revealed scissors are a potential harm to residents and they should not have been left out. The policy provided by the facility on	F 323	4. An audit will be completed 3 times a week for 4 weeks and weekly for 8 weeks by the Administrator, Director of Nursing or Assistant Director of Nursing to assure the environment is free of accident hazards as is possible. Identified issues/concerns will be addressed immediately. The Quality Assurance Committee will review audit results monthly for 3 months and make further recommendations for continuing audits thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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

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 323	Continued From page 29 Biohazardous/Infectious Waste (Revised January 2006) revealed the biohazard symbol is to be placed on any door in which disposed infectious waste is stored. Observation on 02/22/11 at 9:10 am revealed an unidentified staff member exiting a door to a room marked "Biohazard". The door was also labeled with the biohazard symbol. The staff member placed a key on top of a sign outside the room that was height accessible for ambulatory residents. Interview on 02/22/11 at 12pm with LPN #1 revealed the items stored in the room mark "BioHazard" are "biohazard stuff". It was revealed specimens, urine and blood, are stored in the room. Observation on 02/22/11 at 9:10am revealed a refrigerator located in the Biohazard room. The refrigerator did not have a lock, and the nurse indicated blood and urine specimens are placed there, accessible to residents that enter the room. Interview on 02/24/11 at 7:40am with LPN #3 revealed the key to the Biohazard room is kept outside the door within open sight. It was further revealed there are residents with confusion, ambulatory, within the facility that could potentially access the key. Interview on 02/24/11 at 10:50am with the Administrator revealed both scissors and the biohazard room have the potential to harm residents.	F 323		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must -	F 371	F371- Food Procure, Store/Prepare/Serve - Sanitary 1. The clean glasses were removed from under the handwashing sink on	4/5/11

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DIVISION OF HEALTH CARE CONTROL AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 371	Continued From page 30 (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 review of facility policy, it was determined that the facility failed to store, prepare, distribute and serve food under sanitary conditions. Staff was noted to serve food without sanitizing their hands after leaving the tray line area, clean glasses were stored inappropriately under the hand washing sink, and multiple pitchers observed to be sticky and dirty during the initial tour. The findings include: Review of the facility policy regarding Personal Hygiene revealed: 1. Wash hands properly and as often as needed: a. stand well away from the sink turn on the water to a gentle stream, ...Note: Wash hands prior to putting on gloves and after taking off gloves. 2. Wash hands after the following activities ... * Before and after handling raw food, *When returning to work area, * touching anything that may contaminate hands, such as dirty dishes, unsanitized equipment, work surfaces, or wash clothes, and *Before donning gloves for working with food. Observation of the kitchen area during the initial tour on 02/21/11 at 6:30pm revealed a crate of	F 371	2/25/11 by the Dietary Manager. The pitchers were removed and cleaned by the Dietary Manager on 2/25/11. Staff was observed by the Dietary Manager on 2/25/11 to follow appropriate hand washing procedures. 2. A complete sanitation audit of the kitchen will be completed by the Dietary Manager by 4/5/11 to identify other areas affected by this practice. Any identified issues will be addressed immediately. 3. All dietary staff will be re-educated by 4/5/11 by the Dietary Manager on policies and procedures related to storing, preparing and distributing food under sanitary conditions, to include proper handwashing. 4. The Nutrition Service Manager will perform a "Quick Kitchen Sanitation Rounds" 5 times a week for 4 weeks, 3 times a week for 4 weeks and weekly for 4 weeks. The Administrator will perform "Quick Kitchen Sanitation Rounds" weekly for 12 weeks to ensure continued compliance. The results of the audits will be presented to the Quality Assurance Committee for review and further recommendations. If at anytime concerns are identified the Quality Assurance Committee will review and make further recommendations. The Quality Assurance Committee will consist of, at	

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F 371	Continued From page 31 clean drinking glasses stored under the hand washing sink. Hand washing was observed at the sink with potential for dropping or splashing water onto the clean glasses. A trash can was observed to be sitting next to the crate of clean drinking glasses. Observation during the initial tour also revealed multiple juice and water pitchers (approximately 6-8) stored in the refrigerator with a brownish sticky substance on the top of each lid. The tape used to label and date the juices on the top were noted to have a black sticky substance where the old tape for labeling had been. Observation of the noon tray line on 02/22/11 revealed the cook conducting the tray line service left the steam table multiple times to obtain items for the tray service, and returned without changing her gloves or washing her hands. Observation at 11:40am revealed the cook left the steam table and moved the food cart with her gloved hands, then returned to the steam table without changing her gloves or sanitizing her hands. At 12:05pm the cook was observed to touch the barbecue beef as it was put on the bun. At 12:20pm, the cook touched the side of the food plate, and again at 12:30pm. At 12:31pm the cook left the steam table and carried an empty barbecue beef pan to the dishwasher room, cleaned the pan in the three compartment sink with gloves on, then removed the gloves, walked to the hand washing sink and obtained paper towels and dried her hands; however, did not wash her hands, then put on new gloves and returned to the steam table. At 12:45pm, the part time dietary supervisor, who was training the cook, reached over the steam	F 371	a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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F 371	Continued From page 32 table and dipped out a serving of corn without the use of gloves or hand washing. Interview with the Nutritional Service Supervisor on 02/23/11 at 9:15am revealed the drinking glasses should not have been under the hand washing sink. The Supervisor also stated the pitchers should be cleaned after each use. The sticky tape on the lids were from old tape used to date the juices. In addition, the Supervisor stated the policy regarding infection control states hands should be sanitized if items are touched with hands during food service and gloves worn. The Supervisor also stated the Cook had only been there for four (4) days and had been in serviced on infection control on hire.	F 371		
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	F 441	F441- Infection Control 1. The hot water boiler was repaired by an outside vendor on 2/24/11 and was reading 106 degrees. The gray discoloration/ build-up to the hand/arm grip attached to the shower wall was cleaned by the Housekeeping Supervisor on 3/18/11. The bar of soap in B Hall shower room was removed by the Assistant Director of Nursing on 2/25/11. The two geri-chairs with tears on both arm rest will be repaired by 4/5/11. The boxes in the room next to handicap bathroom on A Hall were removed on 2/25/11 by the Maintenance Director. Resident #3's wheelchair with cracked arms will be repaired by 4/5/11. A new door has been ordered for the A Hall shower room. The large container	4/5/11

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F 441	Continued From page 33 isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (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 maintain an Infection Control Program to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease. Water temperatures in halls of the building ranged between 48 - 96 degrees Fahrenheit (F). Bathing and grooming supplies were in shared areas and unlabeled. Shower rooms were dirty. Geri and wheel chairs had torn surfaces that could not be sanitized. The findings include: Review of facility Infection Control Policy (Prevention and Control Programs Revised November 2009) revealed infection control will include cleaning and disinfection. It further revealed precautions will be in place to prevent	F 441	in the unlocked shower closet was removed and open items discarded on 2/25/11 by the Assistant Director of Nursing. The sink in B Hall clean supply and storage room was cleaned on 2/24/11 and the soap dispenser was filled on 2/24/11 by the Housekeeping Supervisor. The sink in A Hall clean supply and storage room was cleaned and soap dispenser filled on 2/24/11 Housekeeping Supervisor. A paper towel dispenser was placed by sink and filled with paper towels on 2/28/11 by the Housekeeping Supervisor. 2. Water temperatures were checked multiple times during survey and on-going for the next week to ensure they were the appropriate temperature by the Maintenance Director. The water temperature was 106 degrees on 2/24/11 as noted by the Administrator. A 100% audit of all geri-chairs arms and wheelchairs arms will be completed by 4/5/11 by Maintenance Directors. Any identified issues will be corrected. A 100% audit of shower rooms and supply rooms will be completed to identify concerns related to cleanliness of the sinks, adequate soap dispensers and paper towels, no multi-resident single items in use, by 4/5/11 by Maintenance Directors. Any identified issues will be addressed immediately. An Audit of all doors to ensure they close and are in good repair and to assure boxes are not	

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F 441	Continued From page 34 transmission of infections through contact. The Sanitation Procedure on Personal Hygiene (Revised July 2010) revealed hands should be washed properly in water of a temperature at approximately 100 to 110 degrees F. Observed of water temperatures on 02/22/11, between 8:42am and 9:30am, revealed a range of hot water temperatures between 48 and 96 degrees F. Refer to F253 Observation on 02/21/11 at 7:45pm revealed an open used bar of soap in the B hall shower room. It was further noted that the shower had a gray discoloration/build-up to the hand/arm grip attached to the shower wall. Observed on 02/21/11 at 7:50pm in the A hall revealed two (2) Geri-chairs with tears on both arm rest and worn areas, which made sanitizing surfaces difficult. One chair was labeled with the name of Resident #13. Interview on 02/24/11 at 7:10am with the Maintenance Supervisor revealed he is responsible for the maintenance of the wheelchairs. It was further revealed wheelchairs are inspected weekly on Monday by maintenance. Therapy also looks at the chairs. It is the stated practice that split or cracked arms of the chairs are replaced. Interview on 02/24/11 at 7:11am with the Director of Nursing revealed it should be the responsibility of all staff to check the status of the wheelchairs. Observation on 02/21/11 at 9:53pm and on 02/24/11 at 9:00am revealed the room next to the	F 441	stored on the floor by the Maintenance Directors by 4/5/11. All shower rooms will be audited to assure all grab bars are free from discoloration and/or build-up by the Housekeeping Supervisor by 4/5/11. 3. The Maintenance Supervisor was re-educated by the Administrator on 2/25/11 on the policy and procedures related to water temperatures, monthly wheelchair and gerichair maintenance, storing items off of the floor and environmental rounds to identify environmental concerns. Housekeeping staff will be re-educated related to the cleaning schedule and restocking duties by the Housekeeping Supervisor by 4/5/11. All staff will be re-educated by the Education and Training Director on Infection Control policies and procedures. 4. Water temperatures will be checked daily to ensure continued compliance. Any temperatures above or below the acceptable range of 100 – 110 degrees will be addressed immediately. Monthly checks of the wheelchairs and Geri chairs will be completed by the Maintenance Supervisor for 12 weeks to ensure continued compliance. The shower and supply rooms will be audited by the Director of Nursing, Assistant Director of Nursing or Unit Manager 3 times a week for 12 weeks to ensure continued compliance.	

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F 441	Continued From page 35 handicap bathroom on the A hall had numerous boxes stored on the floor. Observed on 02/22/11 at 11:50am in the dining room were two (2) resident wheel chairs with cracked arms. One chair belonged to Resident #3 and the other was an unsampled resident. Observation on 02/22/11 at 12:12pm revealed the door to the A hall shower room would not close completely, had numerous scratches on the surface and the door frame was soiled with a black/brown/rust colored substance. Observation of the A hall shower room on 02/24/11 at 8:30am revealed a large container placed in the unlocked shower closet containing the following opened items: two deodorants, body scrub, protection cream, hair de-tangler, moisturizing lotion, body wash and after shave lotion. The items had no resident identification labels. In addition, a hair brush was noted in the same container. Interview on 02/24/11 at 8:30am with RN #1 revealed the shower aid/CNA used the items in the large container for the residents. Interview on 02/24/11 at 8:40am with CNA #3 revealed these personal hygiene items were used with multiple residents. It was further revealed the cabinet door was to be locked. Observation of the clean supply and storage room on Hall B on 02/24/11 at 8:00am revealed the sink on the Hall B supply room had dried leaves in the basin, the interior of the sink had a white scum in the basin and on the walls of the sink, as well as white and brown scum on the faucet and handles.	F 441	Housekeeping Supervisor will complete an environmental audit weekly to identify any concerns related to cleaning schedules and stocking of supplies. The Quality Assurance Committee will review the water temperature logs and results of audits monthly for 3 months, quarterly for 3 quarters and according to committee recommendations thereafter. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 441	Continued From page 36 Observation of the hand soap dispenser at the sink in Hall B's clean supply and storage room revealed an empty hand soap dispenser. Observation of Hall A's clean supply and storage room on 02/24/11 at 8:05am revealed the interior of the sink had a white scum in the basin and on the walls of the sink, as well as white and brown scum on the faucet and handles. Observation of the Hall A clean supply and storage room revealed there were not any products available for staff use to practice hand hygiene while in the supply and storage room. Interview with Licensed Practical Nurse (LPN) #1 on 02/24/22 at 8:07am revealed she/he was not sure who was responsible for cleaning the supply rooms, although the Medical Records Director does the ordering and stocking of the supply rooms on Hall A and B. Interview with the Medical Records Director on 02/24/11 at 8:20am revealed responsibility for ordering and stocking the supplies, but not for the cleaning. She/he reported housekeeping is to mop and clean in the supply room. Interview with the Director of Housekeeping on 02/24/11 at 8:25am revealed the hand soap dispenser in the Hall B supply and storage room is the old style that was changed out approximately three (3) to six (6) months ago. He reported it is the responsibility of the housekeeping department to ensure the storage and supply rooms are kept clean and this is not acceptable. He reported the lack of hand hygiene supplies did pose a concern for a breech in infection control. He reported it is the responsibility of the housekeeping department to	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING _____ B. WING _____	02/24/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 441	Continued From page 37 stock the soap dispensers. He did report it is sometimes difficult to get into the supply and storage rooms on both halls as it requires a nurse to accompany housekeeping while staff is cleaning as these are locked supply rooms. Interview with the Director of Nursing (DON) 02/24/11 at 8:28am revealed the lack of housekeeping provided to the clean supply and storage room does pose a breach of infection control since there is no hand hygiene products available for staff use. She reported the sinks are an area of contamination. She reported the sinks are in need of a cleaning and they appear to have been this way for a while.	F 441		
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide a clean, sanitary and comfortable environment for the residents. The findings include: During the environmental tour of the facility on 02/22/11 through 02/23/11, the following items were observed to be in need of repair: -The door to the A hall shower room had multiple	F 465	F465- Environment 1. The door to the A Hall Shower room will be prepared by 4/5/11, the wall next to the water fountain outside A Hall shower room will be repaired by 4/5/11, the water fountain will be repaired by 4/5/11, the faucet in room 2 will be replaced by 4/5/11, the chair in room 11 was removed and replaced on 2/25/11, A Hall registers were cleaned on 3/1/11, the register in room 7B will be painted by 4/5/11, the floor around the toilet and the tiles in room 4 will be repaired by 4/5/11, the tank in the handicap bathroom on A Hall will be repaired by 4/5/11, the rust colored stain in the bottom of the sink was cleaned on 2/25/11, the metal dispenser for plastic bags in room 34 was re-mounted to the	4/5/11

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F 465	Continued From page 38 scratches, discoloration and the door would not fully close. -The wall next to the water fountain outside the A shower room had scratches and scuff marks through to the sheetrock. -The metal side of the water fountain nearest the A hall shower room door was loose. -The sink in Room 2 has a whole worn through the faucet at the base. -A brownish/red stain was noted on the upholstered chair seat in Room 11. -The A hall registers were dusty. -The register in room 7B was rusty and in need of paint. -In Room 4, the floor around the toilet was black above the caulking. There were dark discolored tiles near and around the base of the toilet. -The handicap bathroom on the A hall had a black discoloration around the base of the tank. The floor at the base of the toilet was wet. -Room 15 has a rust colored stain in the bottom of the sink. -The metal dispenser for plastic bags in Room 34 was hanging halfway off the wall. -In Room 30, a sheet was stuffed under the window. Interview with the resident in the room revealed the sheet was placed under the window to keep the cold out.	F 465	wall on 3/18/11, the window in room 30 will be re-sealed and the toilet in room 23 will be recaulked by 4/5/11. 2. Rounds will be made throughout the facility by Maintenance Directors and/or Housekeeping Supervisor to identify other concerns with shower room doors, chipped walls, water fountains in need of repair, worn faucet, stained furniture in residents rooms, dusty registers, registers in need of paint, stained caulking around toilets and or base of the toilet, leaks from the toilets, rust in sinks, loose bag dispenser in residents rooms, unsealed windows. Any concerns will be corrected by the Maintenance Directors and/or Housekeeping Supervisor by 4-5-11. 3. The Maintenance Director will be re-educated by the Administrator by 4/5/11 on conducting environmental rounds and repairs. Housekeeping staff will be re-educated on completing a cleaning schedule by the Housekeeping Supervisor by 4/5/11. 4. Environmental rounds will be completed weekly for 12 weeks by the Maintenance Director and Housekeeping Supervisor to identify areas in need of repair. The Administrator will conduct weekly environmental rounds with the Maintenance Director and Housekeeping Supervisor for 12 weeks to ensure items are being repaired or	

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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 465	Continued From page 39 -In Room 23B, there was discolored caulking around the toilet. Interview on 02/24/11 at 10:50am with the Administrator revealed he conducts administrative rounds daily, Monday through Friday, to inspect the building for cleanliness and need for repairs. It was revealed, as problems are noted, they are discussed with housekeeping or maintenance. However, the facility recently had a change in the Maintenance department with problems identified but not corrected.	F 465	cleaned in a timely manner. Monitoring of the results of the environmental rounds will be completed by the Quality Assurance Committee on a monthly basis for 3 months and according to recommendations by the committee thereafter to ensure continued compliance. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure every nurse aide received at least 12 hours of continuing education for three (3) of ten (10)	F 497	F497- Nurse Aide Performance Review 1. It was validated that all CNA's have received 12 education hours from hire date to annual by the Education and Training Director by 4/5/11. 2. A 100% audit of all nurse aide training records will be completed by the Education and Training Director by 4/5/11 to ensure all nurse aides have received the appropriate educational hours. Any staff members identified will be given the required education by 4/5/11.	4/5/11

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F 497	Continued From page 40 records reviewed. The findings include: Review of the nurse aide education log revealed three (3) of the ten (10) records reviewed had only tne (10) hours of continuing education for a 12-month time period. Interview with the Educational Director on 02/24/11 at 11:30am revealed until recently she was unaware the nurse aides had to obtain twelve (12) hours of continuing education in a 12 month period. She revealed she had recently gone to training for this position and was provided that information at the training. She stated she has now developed a tracking log to track those hours and placed them on a spreadsheet so she could see when a nurse aide needs more educational hours. She indicated the nurse aides could receive education through online programs and mandatory in-services. She indicated she had not tracked the nurse aides' educational hours prior to the training, and that is why the three (3) aides did not have the required twelve (12) hours of continuing education.	F 497	3. The Education and Training Director will be re-educated by the Director of Nursing by 4/5/11 on the Nurse Aide continuing education requirements. A tracking log has been developed to track CNA continuing education hours to ensure continued compliance. 4. The Quality Assurance Committee will review the CNA education tracking log monthly for 3 months to ensure tracking is in place and current. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly. F514- Records	4/5/11
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and	F 514	1. Resident #1 had a bowel movement on 3/8/11. Residents' #8, #10, #11 and #12 all had a bowel movement on 3/5/11 and it was accurately documented in the computerized system as noted by the Director of Nursing on 3/17/11. Resident #1 was given a shower and documentation was completed as visualized by the Director of Nursing on 2/24/11.	

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DIVISION OF HEALTH STANDARDS

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F 514	Continued From page 41 services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to maintain clinical records that were complete and accurately documented in regard to bowel and shower records. The facility failed to consistently document bowel movements for five (5) residents out of nineteen (19) sampled. (Residents # 1, #8, #10, #1, and #12. In addition, the facility failed to document consistency on when a resident received a shower or bath. The findings include: Review of Resident #1's bowel records for the months of December 2010, January 2011 and February 2011 revealed the resident went 3-9 days without a documented bowel movement. Review of Residents #8, 10, 11, and 12 bowel records revealed the facility failed to document bowel movements for over 3 days. Refer to F309. Review of bath/shower records for Resident #1 revealed no documented shower or bath for 6 days. In addition, review of four unsampled residents revealed inconsistent documentation with some residents missing up to 6 days without a shower, and documentation of residents refusing a shower when a shower was documented as given. Interview with the Regional Nurse Consultant on	F 514	2. Starting on 3/23/11 all resident's bowel eliminations will be in the computer monitoring system as well as on the bowel elimination log. A comparison of the bowel elimination log to the computer monitoring system will be conducted by the Director of Nursing , Assistant Director of Nursing or Educational Training Director to assure all bowel eliminations are accurately documented. Any not documented will be immediately corrected. We will re-implement previous paper monitoring of bowel eliminations to validate documentation of bowel movements in the computerized monitoring system. We will continue paper log system for sixty days. 100% audit of shower records was completed by the Director of Nursing 3/10/11 to assure all showers have been documented in the computerized monitoring system.. 3. Certified Nursing Assistants will be re-educated by the Education and Training Director by 4/5/11 on imputing bowel elimination and showers into the computerized system. 4. The Director of Nursing/ Assistant Director of Nursing/ or Unit Manager will validate five days a week for 8 weeks that computerized documentation of showers and bowel movements are accurate based on shower notes and bowel elimination logs. Any	

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F 514	Continued From page 42 02/23/11 at 7:30am revealed there were problems noted with documentation of showers in November and December 2010 because the shower aides were not communicating which residents received a shower and which did not. The consultant revealed she visited the facility more frequently in the last few months and indicated there was a problem with documentation.	F 514	discrepancies will be immediately corrected and offending employee will be re-educated. Based on the analysis of the use of the bowel elimination log and shower notes the Quality Assurance Committee will determine further need to continue double documentation. After the eight weeks analysis, unless further recommended by the Quality Assurance Committee, the center will conduct random weekly audits of the bowel elimination log and shower notes to computerized documentation system for 4 weeks. If at any time concerns are identified they will be brought to the Quality Assurance Committee for further recommendations as needed. The Quality Assurance committee will review all audits monthly for 3 months for further recommendations as needed. The Quality Assurance Committee will consist of, at a minimum, the Administrator, Director of Nursing, Assistant Director of Nursing, Social Services Director, Dietary Service Manager, and Medical Director at least quarterly.	

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	186224	A. BUILDING _____ B. WING _____	R 04/07/2011

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{F 000}	INITIAL COMMENTS The annual standard survey for recertification was conducted on 02/21-24/11 in conjunction with an abbreviated complaint survey KY15746, KY15688, and KY15459. The facility was found to not meet the minimum regulatory requirements and a statement of deficiencies was issued with the highest S/S at a "G" level. The LSC Survey was conducted on 02/24/11. KY #15459 regarding quality of care was unsubstantiated. KY# 15688 was substantiated for Quality of Care and Physical Environment and a statement of deficiencies was issued. KY#15746 regarding Neglect was substantiated and a statement of deficiencies was issued. A revisit was conducted on 04/06-04/07/11 and the facility was found not to be in regulatory compliance. Regulatory violation F441 "E" was determined to exist and a new statement of deficiencies were issued.	{F 000}	**THE SUBMISSION OF THE PLAN OF CORRECTION DOES NOT CONSTITUTE AN ADMISSION BY THE PROVIDER OF ANY FACT OR CONCLUSION SET FORTH IN THE STATEMENT OF DEFICIENCY. THIS PLAN OF CORRECTION IS BEING SUBMITTED BECAUSE IT IS REQUIRED BY LAW.**	
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	F 441	F 441 – INFECTION CONTROL 1. Proper indwelling catheter care was provided to resident #7 as observed by the Director of Nursing on 4/8/11. Correct technique for wound care on resident #6 was provided as observed by the Director of Nursing on 4/8/11. All urinals, bedpans, and potty hats in bathrooms 22/23, 3/4, 5/6, 7/8, 9/10 and 17/18 were discarded and new, labeled and bagged urinals, bedpans and potty hats were stored appropriately in those bathrooms on 4/7/11. The dirty and sticky bedside table in room 20B was	4/8/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: NHA — (X6) DATE: 4/29/11

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 441	Continued From page 1 (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 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 that the facility remained in non-compliance with the regulatory requirement relating to maintaining an Infection Control Program designed to provide a safe, sanitary and comfortable environment to prevent the development and transmission of disease and infection. The facility failed to provide proper indwelling catheter care for one (1) of eleven (11) sampled residents (Resident #7), and failed to provide correct technique for wound care for one (1) of eleven (11) residents (Resident #6).	F 441	cleaned by housekeeping on 4/8/11. The dirty casters on the bedside table in room 7B were cleaned on 4/8/11 and the used bloody cap from an angiocatheter was removed from the floor and the floor was cleaned on 4/6/11. The identified dietary staff used correct hand washing technique per facility policy as observed by the Administrator on 4/8/11. 2. Indwelling catheter care was observed on all residents with an indwelling catheter on 4/7/11 and 4/8/11 by the Director of Nursing with no concerns identified. Wound care was observed on all residents with open wounds by the Director of Nursing on 4-8-11 to identify any concerns with infection control practices related to wound care; no concerns were identified. Urinals, bedpans and potty hats in all resident bathrooms were discarded and new, labeled and bagged urinals, bedpans and potty hats were stored appropriately in appropriate bathrooms on 4/7/11. All bedside tables, including casters, were cleaned by the housekeeping staff by 4/8/11. A 100% audit of all resident rooms was completed on 4/8/11 to ensure rooms were clean. Identified concerns were immediately corrected. An observation of meal tray line service was conducted by the Administrator on 4-8-11 to identify any concerns with	

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F 441	Continued From page 2 In addition, during tour on 04/06/11, there were multiple connecting bathrooms on both Hall A and B containing urinals, bedpans, and potty hats that were not bagged or labeled (Bathrooms 22/23, 3/4, 5/6, 7/8, 9/10, 17/18). Also, observation of Room 20B on Hall A revealed the bedside table to be dirty and sticky. Room 7B on Hall B had dirty coasters on the bedside table and a used bloody cap from an angiocatheter was observed lying on the floor. Observation of the dietary tray line on 04/06/11 at 11:15am revealed two (2) of three (3) dietary staff failed to use correct handwashing technique per facility policy; this was observed for five (5) handwashing observations. The findings include: 1. Observation on tour of the B Hall on 04/06/11 at 8:30am revealed the connecting bathrooms in Room 22/23 had a strong urine odor with an unlabeled urinal on the back of the commode. The bathroom in Room 34 on the B Hall was observed to have a urinal on the back of the commode containing urine; however, it had no label. 2. Observation during tour of the facility on 04/06/11 at 10:30am revealed a urinal, bedpan, and potty hat was stored on the shared bathroom floor of Rooms 7 and 8. These items did not have a name to identify which resident they belonged and were not bagged. Observation of the shared bathroom for Rooms 5 and 6 revealed 3 urinals on top of the toilet tank	F 441	hand washing; no concerns were identified. 3. All nursing staff were re-educated on proper indwelling catheter care by the Education and Training Director on 4/8/11. No other nursing staff worked after 4/8/11 without having completed this education. All licensed nursing staff were re-educated on the correct infection control practices related to wound care by the Education and Training Director or Area Director of Clinical Services on 4/8/11. No other licensed staff worked after 4/8/11 without having completed this education. All housekeeping staff were re-educated on proper cleaning of resident room floors and bedside tables, including casters by the Housekeeping Supervisor on 4/8/11. No other housekeeping staff worked after 4/8/11 without having completed this education. All dietary staff were re-educated on the correct hand washing technique by the Education and Training Director on 4/8/11. No other dietary staff worked after 4/8/11 without having completed this education. All Nursing staff were re-educated by the Education and Training Director by 4-8-11 related to labeling, storage and bagging of urinals, bed pans and potty hats. 4. The Education and Training Director, the Director of Nursing or the Assistant	

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MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 441	Continued From page 3 not labeled or bagged. In addition, a bedpan was on the floor. Observation of the shared bathroom for Rooms 17 and 18 revealed a bedpan stored on the toilet tank with no label and the item was not bagged. A potty hat was stored on the floor without a label and was not bagged. In addition, two (2) soiled washcloths and a soiled disposable wipe were observed to be on top of the toilet tank. Interview with the Director of Nursing on 04/07/11 at 1:30pm revealed the facility did not have a policy for labeling of urinals, bedpans, etc., however stated all bedpans, urinals, and potty hats should be labeled and bagged for each resident. 3. Review of the facility's hand hygiene policy and procedure regarding handwashing revealed: .....7. rinse hands thoroughly to remove residual soap. 8. Dry hands with paper towel, 9. Turn faucet's off with the paper towel, and 10. discard used towels in waste container. Observation of the dietary staff on 04/06/11 at 11:10am revealed the dietary manager washed her hands prior to assisting with tray line; however, turned off the faucet with her wet clean hands, then obtained the paper towel to dry her hands. Observation revealed this procedure was repeated at 11:30am; however, the dietary manager again turned off the faucet with her wet clean hands before obtaining a paper towel. The dietary assistant was observed to go to the handwashing sink at 11:15am after leaving the tray line area. The dietary assistant washed her hands, and was observed to turn off the water	F 441	Director of Nursing will perform observations of indwelling catheter care five (5) times per shift five (5) days a week for two (2) weeks followed by five (5) times per week on random shifts for ten (10) weeks. The Education and Training Director, the Director of Nursing or the Assistant Director of Nursing will perform observations of wound care five (5) times weekly for twelve (12) weeks. The Administrator, the Education and Training Director or the Director of Nursing will observe hand washing in the kitchen five (5) days a week for two (2) weeks followed by weekly for ten (10) weeks. The housekeeping supervisor will complete weekly rounds to identify concerns with cleanliness of residents rooms including bedside tables and floors weekly for twelve (12) weeks. The Administrator will complete environmental rounds to assure bed pans, urinals and potty hats are labeled, bagged and stored appropriately three (3) times per week for twelve (12) weeks. Results of these audits will be presented to the Quality Assurance Committee monthly for three (3) months. If at any time concerns are identified, the Quality Assurance Committee will meet to make further recommendations as needed. The Quality Assurance Committee will consist of at a minimum, the	

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185224	A. BUILDING _____ B. WING _____	R 04/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	1561 NEWTON AVE. BOWLING GREEN, KY 42104

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F 441	Continued From page 4 faucet with her wet clean hands before obtaining a paper towel. The dietary assistant was observed again completing the same handwashing procedures at 11:20am and 11:35am, thus contaminating her hands. Interview with the Dietary Assistant on 04/06/11 at 11:46am revealed she didn't realize she was washing her hands incorrectly, and stated she had received training since the survey regarding handwashing. Interview with the Dietary Manager on 04/06/11 at 11:45am revealed she forgot about using the paper towel to turn off the water faucet, and stated she should have used a paper towel. The Dietary Manger stated they had received training since the last survey on infection control and correct handwashing; the manager stated she did not realize they were doing it incorrectly. 4. Observation of indwelling catheter care for Resident #7 on 04/06/11 at 3:35pm revealed the catheter had leaked onto the resident's clothing and had a strong urine odor. Observation of RN (registered nurse) #1 performing catheter care revealed the nurse cleaned the urethral meatus (area where the catheter entered to the bladder) with back and forward motion instead of front to back. The nurse was observed to clean the meatus and labia five (5) times using the same wash cloth and back and forward motion. The nurse then dried the area using the same back and forward motions. The nurse did not clean the full length of the catheter, nor the tubing leading to the drainage bag. Interview with the nurse at the time of the observation on 04/06/11 revealed she was	F 441	Administrator, the Director of Nursing, the Assistant Director of Nursing, the Social Services Director, the Dietary Service Manager, with the Medical Director attending at least quarterly.	

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F 441	Continued From page 5 unaware she had used back and forward motions instead of front to back techniques. She stated she had been at the facility since January 2011 and could not recall if she had received any training on proper catheter care. The facility could not provide a specific policy regarding indwelling catheter care. The procedure and treatment modalities provided by the facility stated to clean the area with soap and water daily. In addition, observation of Resident #7's wound care (after the catheter care observation) on 04/06/11 at 3:45pm revealed RN#1 used the same back and forward motion when cleaning the resident's wound. 5. Observation of wound care for Resident #6 on 04/07/11 at 9:45am revealed the resident was soiled with feces. RN#2 cleaned the resident with applied gloves and several soapy washcloths. When the nurse had completed incontinent care, she touched the top sheet with the same gloves she had cleaned the feces. In addition, the nurse touched the indwelling catheter bag and tubing. She then removed the soiled gloves and washed her hands. The nurse applied clean gloves then removed the soiled dressing that had feces on the edges. The soiled dressing and washcloths with feces were placed in a plastic garbage bag on top of the resident's bedside table. The clean wound supplies were sitting beside the soiled washcloths and old dressing. During the wound treatment observation, another staff attempted to enter the room. The CNA (certified nursing assistant) placed the soiled top sheet over the resident's wound area that had already been cleaned by RN#2. The top sheet that had been	F 441		

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	185224	A. BUILDING _____ B. WING _____	R 04/07/2011

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F 441	Continued From page 6 touched by RN#2's soiled gloves was placed over the resident several times during the wound treatment in an effort to provide privacy for the resident. Once the nurse had completed the wound treatment, the CNA again placed the soiled top sheet over the resident. The nurse then told the CNA to get a clean top sheet. However, the CNA placed the clean top sheet on top of the bedside table where the soiled washcloths and old dressings had been. The table had not been disinfected. After surveyor intervention, the top sheet was removed, table disinfected, and a clean top sheet placed over the resident. Interview with RN#2 on 04/07/11 at 10:15am revealed the nurse was unaware she had touched the resident's top sheet with the same gloved hands that had cleaned feces. Interview with the Director of Nursing on 04/07/11 at 1:50pm revealed it was standard practice technique to clean from back to front during catheter care. In addition, it was standard practice that you didn't go from dirty to clean during wound care. The DON stated the facility did not have a specific policy for catheter care or wound care.	F 441		

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	185224	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/24/2011**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEDCO CENTER OF BOWLING GREEN	**1561 NEWTON AVE.** **BOWLING GREEN, KY 42104**

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K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 02/24/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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.