

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

PRINTED: 01/25/2012  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  01/13/2012
NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108	
(X4) ID PREFIX TAG  F 000	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG  F 000	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 SS=D	<p><b>INITIAL COMMENTS</b></p> <p>A standard Health survey was conducted 01/10-01/13/12 and a Life Safety Code survey was conducted on 01/10/12 with the highest scope and severity of an "D". The facility had the opportunity to correct the deficiencies before remedies would be imposed.</p> <p><b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b></p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's Care Plan policy, it was determined the facility failed to follow interventions for care planning on two (2) of the fifteen (15) sampled residents. Resident #5 and #11 were care planned to have chair alarms in place when up. However, observations during the survey revealed neither resident had the chair alarms in place.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Plans of Care, dated 01/2012, revealed the care plan must be reviewed and revised according to the Resident Assessment Instrument (RAI) process, and services provided or arranged must be consistent with each resident's written plan of care.</p> <p>1. Review of the most recent Nursing Care Plan</p>	F 282	<p>1. Resident #5 and Resident #11 experienced no change related to safety device. The Medical Director was notified by the Director of Nursing (D.O.N.) of findings with no new order.</p> <p>2. To identify residents at risk a one time audit of all residents with MD orders for safety devices will be completed by the DON. Unit Manager (U.M.) to ensure that all safety devices are appropriate, are applied per the physicians order, on the care plan and on the certified nurse aide assignment sheet by 2/9/2012.</p> <p>3. Education and Training Director (E.T.D) to re-educate staff regarding policy and procedure for safety device usage and monitoring by 2/13/2012. E.T.D to re educate nursing staff regarding use of C.N.A. care plans by 2/15/2012. Director of Nursing will complete audit of all resident safety device orders to ensure appropriately placed on Treatment Administration Record (TAR) by 2/10/2012.</p>	2-22-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*Beth Campbell*

*Admin.*

*2-14-12*

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 282	<p>Continued From page 1</p> <p>for Resident #5, dated 12/22/11, revealed the facility identified the resident at risk for fall and/or injury related to toe touch weight bearing status, pain, osteoarthritis, osteoporosis, decreased range of motion to left leg, cardiovascular diagnosis, bladder incontinence, dementia, cardiovascular medications, narcotics, and a previous fall with a fracture. The facility developed a care plan intervention for a chair alarm. Review of the Nursing Assistant Assignment Worksheet, dated 01/11/12, revealed Resident #5 was to have a chair alarm in place. Review of the Physicians orders, dated 12/01/11, revealed a physician's order for a chair alarm; however, review of orders, dated 01/01/12, revealed no order for a chair alarm. Review of the most recent Treatment Administration Record (TAR), dated 01/2012, revealed no entry to monitor for a chair alarm</p> <p>Observations, on 01/10/12 at 12:00 PM and 12:25 PM, revealed the resident was sitting up in the wheelchair in the dining room eating lunch without a chair alarm in place. The alarm cord was hanging free on the back of the wheelchair with no alarm box in place to connect the cord.</p> <p>Observations, on 01/10/12 at 2:20 PM, 3:30 PM, 4:15 PM, and 01/11/12 at 2:00 PM, and 4:30 PM, revealed the resident sitting up in the wheelchair in the resident's room with the alarm cord hanging free on the back of the wheelchair and no alarm box in place to connect the cord. An alarm box was noted attached to the bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 01/12/12 at 4:15 PM, revealed she did get the resident out of bed for lunch but did not recall</p>	F 282	<p>DON, Unit Manager and Department Managers to audit at least 15 residents 5 times a week for 30 days then 3 x week x 30 days to ensure that any safety devices ordered by the physician is on the TAR, on the C.N.A sheet and is on the resident. Audits to begin 2/15/2012.</p> <p>4. Quality Assurance team (Administrator, DON, ADON, Life Enrichment Director, Social Service Director, Dietary Manager and Reimbursement Coordinator) to review audit finding and revise plan monthly based on audit findings and resident interviews until team concludes the issue is resolved. This will be ongoing.</p> <p>5. Date of compliance-2/22/2012</p>	



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F 282	<p>Continued From page 2</p> <p>the resident requiring a chair alarm. However, the CNA later stated that she did recall the resident was supposed to have one but not for sure since the CNA assignment sheets had been changed daily during the survey. The CNA revealed a potential for the resident to fall if he/she attempted to get up without assistance. The CNA revealed everyone was responsible to monitor the alarms to ensure placement.</p> <p>Interview with CNA #7, on 01/12/12 at 5:30 PM, revealed she did assist Resident #5 up to the wheelchair and thought the alarm was attached and did not realize it was not in place. The CNA revealed all fall interventions can be found on the CNA assignment sheet. The CNA revealed the potential for the resident was to fall again without the alarm in place to notify staff.</p> <p>Interview with CNA #5, on 01/13/12 at 2:18 PM, revealed he assisted Resident #5 up to the wheelchair and thought the alarm was on and in place. The CNA revealed everyone was responsible to monitor for the placement of alarms.</p> <p>Interview with Licensed Practical Nurse #1, on 01/12/12 at 2:35 PM, revealed she was aware the resident had a bed alarm, after checking the treatment administration record (TAR), the LPN stated she did not see where the resident was supposed to have a chair alarm in place. When asked if the resident was care planned for an alarm, the LPN revealed she did not know and got her information regarding interventions from the TAR only. After checking the care plan, the LPN revealed an order should have been obtained to ensure the intervention was placed on</p>	F 282			



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F 282	<p>Continued From page 3</p> <p>the TAR for nursing staff to monitor. The LPN revealed she checked the care plan only to update any changes, not to view the interventions. The LPN further revealed any changes made to the care plan usually end up on the TAR, so this was the only resource used for monitoring interventions. The LPN revealed a potential for the Resident to attempt to transfer self and get injured or fall without the use of the alarm. The LPN revealed the current system of utilizing the TAR only was not working to ensure all interventions were in place. Continued interview, on 01/13/12 at 12:25 PM, revealed everyone was responsible to make sure the care plan was being followed, but without referring back to the care plan there was no way to ensure care plans are being followed.</p> <p>Interview with Registered Nurse #1, on 01/12/12 at 3:05 PM, revealed the facility had not provided training on the following the care plan. The RN further revealed she had been told by the Director of Nursing (DON), the nurses use the CNA assignment sheet to round on the residents, which would indicate any alarms that were to be in place.</p> <p>Interview with RN #3, on 01/12/12 at 3:25 PM, revealed she had never been told to use the CNA assignment sheet to round on the residents. The RN further revealed she utilized the TAR to find out what interventions are to be in place. The RN revealed she did not look at the care plan when providing care and was trained to use the TAR.</p> <p>Interview with LPN #2, on 01/12/12 at 5:15 PM, revealed she had never been told to use the CNA assignment sheet to round or monitor</p>	F 282			



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F 282	<p>Continued From page 4</p> <p>intervention. The LPN revealed she utilized the TAR and MD orders to monitor for alarm placement and functioning.</p> <p>Interview with LPN #1, on 01/13/12 at 12:25 PM, revealed she has never been told to use the CNA assignment sheet to round and had never been asked by the unit manager if a round had been completed.</p> <p>Interview with the Unit Manager, on 01/13/12 at 2:40 PM, revealed the Unit Manager rounds on the nurses once a shift utilizing the CNA assignment sheets to ensure safety rounds were completed and remind them to do so if not yet done. When asked if the nursing staff was aware they should be using the CNA assignment sheet to round, the Unit Manager stated all nurses are told in orientation to round with the CNA assignment sheet to ensure all fall interventions are in place. However, the Unit Manager later revealed the TAR was the only system in place to ensure alarms were in place and stated the nurses were not required to look at the care plan.</p> <p>Interview with the DON, on 01/13/12 at 2:35 PM, revealed all nursing staff should be checking to ensure all alarms are in place. The staff are told to round and look to make sure alarms are in place. The DON revealed nurses have access to the CNA assignment sheets and the care plans, and they should be utilized. However, the DON revealed she did not monitor to ensure care plans are followed. The DON revealed she had been notified by a therapist that Resident #5 did not have the chair alarm in place, but she did not go back to ensure an alarm was placed after being notified. The DON revealed a potential for</p>	F 282		



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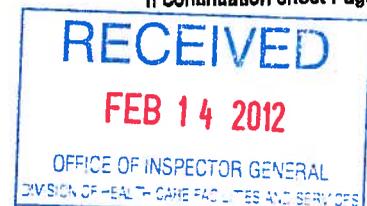
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F 282	<p>Continued From page 5</p> <p>Resident #5 to get up without assistance and sustain an injury.</p> <p>2. Observation, on 01/11/12 at 7:50 AM, revealed Resident #11 sat his/her wheelchair at the dining room table. The white alarm cable laid over the right wheelchair arm and the end was not connected to anything. The white cable end hung freely. There was no alarm box on the wheelchair.</p> <p>Observation, on 01/11/12 at 8:20 AM, enroute from dining room to resident's room revealed Resident #11's wheelchair alarm remained unattached to an alarm box and nonfunctional. The Activities Director (AD) removed him/her from the dining room via the wheelchair and pushed him/her down A Hall. The AD stopped twice in the corridor while she entered resident rooms and left the resident unattended, without a functional alarm. The AD obtained assistance from the Assistant Activities Director for wheelchair to bed transfer. The alarm did not sound when the resident was removed from the wheelchair.</p> <p>Interview, with the Activities Director (AD), on 01/11/12 at 8:25 AM, reported the wheelchair alarm did not sound and the cable was not attached to an alarm box. Resident #11 had the wheelchair alarm for the resident's safety and to prevent falls. The resident utilized the bed alarm and a wheelchair alarm.</p> <p>Interview with the Certified Nurse Assltant (CNA) #9, on 01/11/12 at 8:30 AM, reported the wheelchair alarm that did not sound was on when she went to the dining room. She assisted Resident 11 out of the bed and prepared her/him</p>	F 282		



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F 282	<p>Continued From page 6 for breakfast. Resident #11 had the wheelchair alarm for the resident's safety and to prevent falls. In addition, utilized a bed alarm. She further reported she didn't know what had happened to the alarm.</p> <p>Observation of CNA #9, while in the resident's room, on 01/11/12 at 8:32 AM, revealed she moved items around on the counter top near the sink and behind the basket, hidden by articles on the counter top revealed an alarm box. The CNA identified the alarm box as the wheelchair alarm.</p> <p>3. Review of the Nursing Care Plan, dated 12/12/11, for Resident #11 revealed the facility assessed the resident at risk for fall or injury related to the use of cardiovascular medications. The resident had also fallen at the facility on 04/12/11 and 07/21/11. The care plan intervention developed by the facility included the use of a chair alarm. Review of the Nursing Assistant Assignment Worksheet dated 01/12/12 revealed the resident was to have a chair alarm in use. Review of the physician orders dated 01/01/12 revealed no order for a chair alarm. Review of the treatment administration record (TAR) dated 01/01/12 revealed no entry for a chair alarm to be monitored.</p> <p>Interview with Certified Nursing Assistant (CNA) #11, on 01/13/12 at 11:50 AM, revealed the aides are responsible to ensure the alarms are connected and to check the alarms every time a resident is assisted into the chair. The aide stated the CNA Care Plan stated which residents would</p>	F 282			



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F 282	<p>Continued From page 7</p> <p>have a chair alarm. The facility policy was to use a chair alarm only in certain situations, such as a risk of falls. The nurses are responsible to follow up and check that the chair alarm was in place.</p> <p>Interview with CNA #10, on 01/13/12 at 11:58 AM, revealed the aides are responsible to make sure the chair alarms are working and they should be checked each time a resident gets into the chair. She stated the residents who have chair alarms are listed on the daily CNA Assignment Worksheet. The charge nurse or weekend manager was responsible for checking if the chair alarms are in place and the weekend manager checked the alarms every weekend.</p> <p>On 01/13/12 at 12:25 PM, Interview with CNA #9 revealed the aides are responsible to check chair alarms whenever a resident has gotten up or down and when doing rounds every two hours. The nurse is responsible to check the alarms have been checked by the CNA. She stated the facility policy on the use of chair alarms was for a resident at risk for falls or that the resident might get up on their own. The CNA Worksheet specified which residents had chair alarms.</p> <p>Interview with Registered Nurse (RN) #2, on 01/12/12 at 3:22 PM, revealed Resident #11 had been using a chair alarm for over six months. The use of chair alarms was re-assessed quarterly by the Unit Manager and Director of Nursing (DON).</p> <p>Interview, on 01/13/12 at 12:20 PM, with RN # 3 revealed everyone was responsible for checking if the chair alarms were in place and working, and the nurse was responsible to sign off on the TAR the alarm was in place. The aides have the CNA</p>	F 282		



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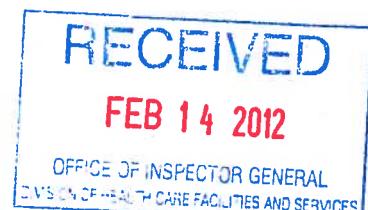
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F 282	Continued From page 8 Worksheet which was updated daily that specified which residents had a chair alarm in use. Interview continued at 1:10 PM that revealed the CNA Worksheet was updated daily in care plan meetings. The nurse reported not carrying a copy of the CNA Worksheet but it was available at the nurse's station. She only checked the TAR for use of chair alarms, and a physician order was needed for an item listed on the TAR. The nurse also stated she was not told to round with the CNA Worksheet.  On 01/13/12 at 1:50 PM, interview with the Activity Director (AD) revealed residents are reviewed in a daily clinical meeting following the care plan meeting. The daily clinical meeting, which only occurs Monday thru Friday, discusses any changes to residents care and the use of chair alarms and was responsible for updating the care plan and CNA Worksheet. She stated all shifts get the same worksheet. No one person was responsible for implementing the interventions determined in the daily clinical meeting, but that it was a team effort. The chair alarms are checked each shift.  Interview, on 01/13/12 at 2:45 PM, with the Director of Nurses (DON) revealed aides and nurses should be checking the CNA Worksheet for residents with chair alarms. The aides get a new CNA Worksheet every shift. Nurses should check alarms every time they pass medications. The DON stated chair alarms should be listed on the TAR so they can be checked off. She stated if the resident did not have the chair alarm in place it may have the potential for the resident to get up without assistance and be at risk for a fall.	F 282		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		



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F 441 SS=D	Continued From page 9 SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which 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.	F 441	1. Resident #5 and Resident A were identified and DON immediately started inservicing related to infection control policy that included use of personal protective equipment, handwashing and ensuring that meal trays were served in a sanitary environment. The Medical Director was notified of findings related to survey process that included all issues related to infection control by the DON with no new orders.  2. The DON and the Education Training Director will observe CNAs providing direct care to at least 25 residents at least one time to identify any issues with following the infection control policy. This will include all residents in isolation, and residents being offered hand hygiene at meal times. Results will be documented on an audit form. This will be completed by 2/15/2012.  3. The ETD will re educate staff regarding infection control policy, this includes hand washing, isolation practices, use of personal protective equipment and ensuring residents are offered the opportunity to wash hands and face prior to meals. This will be completed by 2/15/2012.	2-22-12



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F 441	Continued From page 10  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy on Infection Control, and the CDC Guidelines for Isolation Precautions, it was determined the facility failed to ensure the nursing staff followed their policy on isolation precautions for one (1) of the fifteen (15) sampled residents. In addition, the facility failed to ensure meal trays were passed in clean environment and handwashing was provided for one (1) of one (1) Unsampled Resident, Unsampled Resident A.  The findings include:  Review of the facility's policy titled Infection Prevention, dated November 2011, revealed Contact Precautions, in addition to standard precautions, should be used for specified residents known or suspected to be infected with epidemiologically important microorganisms that can be transmitted by direct contact with the residents or indirect contact with environmental surfaces or resident-care items in the resident environment. Contact Precautions include the use of a gown when entering the room. Remove the gown before leaving the resident environment. Ensure clothing does not contact potentially contaminated environmental surfaces after removal of the gown. Wear gloves when entering the room and remove before leaving the room and use appropriate hand hygiene immediately. Ensure that hands do not touch potentially contaminated environmental surfaces or items in the room after glove removal.	F 441	Director of Nursing (DON), ADON and or the ETD will make rounds to observe infection control practices during ADL care that include use of personal protective equipment, handwashing and ensuring meals are served in a sanitary environment each shift 5 times a week for 30 days beginning 2/17/2012. Then 3 times a week for 30 days. This will be documented on an audit form and reviewed at least weekly by Administrator to ensure any issues are immediately addressed. Administrator is to ensure that audits are completed and addressed.  Social Services Director to interview 5 residents weekly x 30d to ensure staff are offering hand hygiene prior to meals, handwashing is performed by staff and meals are served in a sanitary environment beginning 2/17/2012. This will be documented on an audit form each time interview is completed and reviewed at least weekly by the DON and the Administrator to ensure that any issue is immediately addressed.  Administrator to ensure that audits are completed and addressed. 4. Quality Assurance team (Administrator, DON, ADON, Life Enrichment Director, Social Services Director, Dietary Manager and	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2012
NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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F 441	Continued From page 11  Review of the CDC Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, dated 2007, revealed direct contact transmission occurs when microorganisms are transferred from one infected person to another person without a contaminated intermediate object or person. Indirect contact transmission involves the transfer of an infectious agent through a contaminated intermediate object or person. Examples included patient care devices, hands, clothing, uniforms, laboratory coats or isolation gowns used as personal protective equipment (PPE), which may become contaminated with potential pathogens after care of a patient with an infectious agent (e.g., MRSA, VRE, C. difficile).  Review of Resident #5's clinical record revealed the facility admitted the resident on 12/30/11 with a physicians order for contact isolation. Review of the physician's progress note revealed the resident was diagnosed with clostridium difficile (C. difficile).  1. Observation of the B Hall tray pass, on 01/11/12 at 7:32 AM, revealed CNA #2 donned gloves, no isolation gown, and entered the room of Resident #5 with the breakfast tray. The CNA raised the head of the bed, assisted the resident in proper positioning, and adjusted the resident's blanket. While leaning into the resident's bed, the CNA's clothing came in contact with the resident's bed linens during positioning. After leaving the room, the CNA continued to pass meal trays to the other residents on the hall.	F 441	Reimbursement Coordinator)to review audit finding and revise plan monthly based on audit findings and resident interviews until team concludes the issue is resolved.This will be on going. 5.Date of Compliance 2/22/2012		



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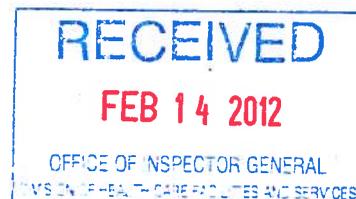
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2012
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F 441	<p>Continued From page 12</p> <p>Interview with CNA #2, on 01/12/11 at 4:15 PM, revealed she used a gown and gloves when bathing or providing incontinence care to the resident, however, she stated she did not use PPE when passing the meals trays. The CNA revealed she had received training by the facility, but did not remember when this occurred. The CNA revealed that everyone was responsible to follow isolation guidelines to prevent spreading infection.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/12/12 at 2:35 PM, revealed she did not utilize an isolation gown when passing medications or passing meal trays. The LPN revealed there was a potential for indirect contact, and the infection could be passed on to other residents.</p> <p>Interview with Registered Nurse (RN) #1, on 01/12/12 at 3:05 PM, revealed she provided education to the facility staff. The RN revealed an in-service on infection control guidelines was provided to the facility staff.</p> <p>Review of the training records, dated 07/12/11, revealed an in-service titled wound treatment and infection control which had five (5) nurses in attendance and no curriculum outline attached. Review of the in-service records revealed the infection control course on 11/02/11 discussed blood borne pathogens.</p> <p>Continued Interview with RN #1 revealed no other in-service on infection control was provided prior to survey. The RN revealed she did randomly monitor for isolation procedures when walking the halls, however she revealed this system was not</p>	F 441			



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NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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F 441	<p>Continued From page 13 working and there was a potential to spread infection.</p> <p>Interview with the Director of Nursing (DON), on 01/13/12 at 2:35 PM, revealed her expectation of the staff was, if they come in contact with the resident, or do a dressing change they should wear a gown. However, if they are going in to do something quickly such as pass medications, they do not need to wear a gown. The DON revealed the isolation policy stated to put on a gown and gloves when entering the room and does not differentiate between tasks. The DON revealed there was a potential for the bacteria to be somewhere else in the room and there was a risk for indirect contact thus resulting in the spread of the infection. The DON revealed she did briefly discuss contact precautions when the resident was admitted, however she revealed she did not monitor for contact precautions constantly.</p> <p>2. Observation, of meals service, on 01/11/12 at 7:32 AM, revealed Certified Nurse Assistant (CNA) #9 served Unsampld Resident A his/her breakfast tray. She sat the breakfast tray on the left side of the over-the-bed table with a urinal, that which contained yellow liquid. She provided the meal tray in front of the resident without removal of the urinal and did not provide the resident with the opportunity for hand hygiene.</p> <p>Interview, with CNA #9, on 01/13/12 at 2:00 PM, revealed she did not see the urinal on the</p>	F 441			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185353	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  01/13/2012
NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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F 441	Continued From page 14 over-the-bed table and was trained to provide hand hygiene prior to meal service. She reported she should remove and empty the urinal prior to the meal service.  Interview, with the Director of Nursing, on 01/13/12 at 3:20 PM revealed the staff was trained and instructed to provide hand hygiene to the residents as they were readied for the meal service. She reported some of the male residents want to keep their urinal on their tables; however, the staff was trained to empty any urinals and place elsewhere while the resident's meal was served.	F 441			



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NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG	STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1964</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 2004.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system, upgraded in 2007.</p> <p>GENERATOR: Type II generator. Fuel source is propane gas.</p> <p>A standard Life Safety Code survey was conducted on 01/10/12. Medco Center of Brandenburg was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for fifty-seven (57) beds and the census was fifty-four (54) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Beth Appleby</i>	TITLE <i>Admin</i>	(X6) DATE <i>2-14-12</i>
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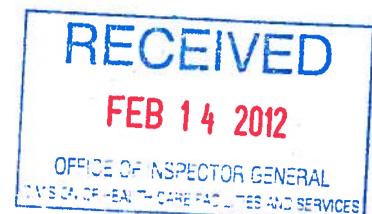
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

FEB 14 2012

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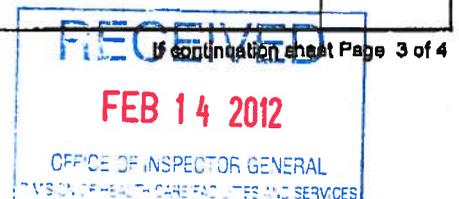
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188353	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  01/10/2012
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K 000	Continued From page 1	K 000			
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure hazardous areas were maintained according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of four (4) smoke compartments, residents, staff, and visitors. The facility is licensed for fifty-seven (57) beds and the census was fifty-four (54) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 01/10/12 at 9:45 AM, with the Maintenance Director revealed the ceiling in the Boiler Room had an approximately three (3) foot long crack in the ceiling and would not resist the</p>	K 029	<ol style="list-style-type: none"> <li>1. The identified crack in the boiler room ceiling was repaired on 1-10-12 by the Maintenance Director</li> <li>2. Maintenance Director completed a 100% audit on 1-16-12 to ensure that there were no cracks in the ceilings of any hazardous areas of the building. No other cracks in ceilings in the facility were found.</li> <li>3. The Administrator provided education to Maintenance Director on 1-16-12 related to regulation requiring ensuring hazardous areas are maintained according to NFPA standards.</li> <li>4. The Maintenance Director will audit all hazardous areas once a week for 12 weeks to assure that there are no cracks in walls or ceilings and any cracks found will be repaired immediately. All findings and repairs will be reported to Administrator. Results of all audits will be reviewed by the Quality Assurance Committee monthly for three (3) months. If at anytime concerns are identified, the Quality Assurance Committee will convene to review and make further recommendations. The Quality Assurance Committee will consist of at a minimum the Administrator, the Director of Nursing, the Maintenance Director and the Dietary Service Manager and</li> </ol>	2-22-12	



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NAME OF PROVIDER OR SUPPLIER  MEDCO CENTER OF BRANDENBURG			STREET ADDRESS, CITY, STATE, ZIP CODE 814 OLD EKRON RD BRANDENBURG, KY 40108		
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K 029	Continued From page 2 passage of smoke in the event of an emergency.  Interview, on 01/10/12 at 9:45 AM, with the Maintenance Director revealed he was unaware of the crack in the ceiling and indicated that the crack must have recently occurred.  Reference: NFPA 101 (2000 edition)  19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies	K 029	Reimbursement Coordinator) to review audit finding and revise plan monthly based on audit findings and resident interviews until team concludes the issue is resolved. This will be ongoing.  5. Date of compliance-2/22/2012.		



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K 029	Continued From page 3 and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory- or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

