

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

PRINTED: 04/09/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/09/2014
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 03/27/14.

{F 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.

Acceptable

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2014
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5238 ASBURY ROAD AUGUSTA, KY 41002
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F 000	INITIAL COMMENTS A Recertification Survey was initiated on 03/04/14 and concluded on 03/06/13 with deficient practice cited at the highest Scope and Severity of an "E."	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to promote care for residents in a manner and in an environment that maintained or enhanced each resident's dignity or respect for one (1) eleven (11) sampled residents (Resident #7) and one (1) unsampled resident (Unsampled Resident B). Resident #7 was observed to have been in states of undress during the survey, exposed to passersby in the hallway; and also was observed to have been wearing a pair of socks clearly labelled with another resident's name. Additionally, Unsampled Resident B was observed lying on the bed as State Registered Nurse Aide (SRNA) #2 asked an unidentified SRNA to get her a "bib" for Unsampled Resident B, and SRNA #2 told Unsampled Resident B the other SRNA was "going to get" him/her "a bib".	F 241	F241 1. The Director of Nursing has reviewed 483.15 (a), dignity and respect of individuality. The facility will promote care for each resident in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his/her individuality. On 3/4/14, the socks that Resident #7 was wearing that were clearly labeled with another resident's name were immediately removed by CNA #1 and Resident #7's own personal socks were applied. On 3/4/14, the Social Services Director and a CNA obtained permission from Resident #7 to assess his drawers and closet for any items or articles of clothing that may be unlabeled or had incorrect label. Any such found items were removed from room and/or labeled appropriately. The	3/24/14

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Donna Chubb</i>	TITLE DON	(X6) DATE 4/4/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that her safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5280 ASBURY ROAD AUGUSTA, KY 41002	

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F 241	<p>Continued From page 1</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Federal Resident/Patient Rights", revised November 2013, revealed every resident had the right to a dignified existence. Continued review revealed in accordance with the Omnibus Budget Reconciliation Act (OBRA), the facility would protect and promote the rights of each resident. Further review of the policy revealed residents had the right to personal privacy which included accomodation and personal care.</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 09/23/13, with diagnoses which included Muscle Weakness, Hypertension and Congestive Heart Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/25/14 revealed the facility assessed Resident #7 to have had a Brief Interview for Mental Status (BIMS) score of thirteen which indicated the resident was cognitively intact. Review of Resident #7's Comprehensive Care Plan revealed the resident had been care planned for activities of daily living (ADL) deficit and interventions noted he/she needed total care with dressing. Further review of the care plan revealed Resident #7 "preferred to stay unclothed from the waist down".</p> <p>1. Observation, on 03/04/14 at 4:00 PM, revealed Resident #7 to have been sitting on the edge of his/her bed dressed in a sweat shirt, boxer shorts, and gray non-skid socks which were labeled with another resident's name who also resided in the facility.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 03/04/14 at approximately 4:07 PM,</p>	F 241	<p>stakeholders on duty on 3/5/14 and 3/6/14 were educated by the Staff Development Coordinator regarding dignity, respect, and privacy policy. The DON met with Resident #7 on 3/6/14 to review alternate methods of clothing and pulling of curtain to eliminate exposure of his body and to increase compliance and comfort in being clothed. Resident #7 participated in choices and interventions. The DON met with Resident B on 3/7/14 regarding the use of clothing protectors. Resident B referred to the clothing protector as a "bib". The Staff Development Coordinator initiated a written inservice to all stakeholders on 3/7/14 regarding dignity, respect, and privacy.</p> <p>2. On 3/10/14, 100% of all resident's closets and drawers were assessed by housekeeping personnel for identification and removal of any items or articles of clothing that were not labeled properly, or located in incorrect area, to ensure dignity and respect of all residents.</p>	
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3209 ASBURY ROAD AUGUSTA, KY 41002		
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F 241	<p>Continued From page 2</p> <p>revealed Resident #7 had wanted to wear the sweat shirt and boxer shorts. CNA #1 stated Resident #7 could not dress on his/her own; and required assistance with all ADLs, except eating. She reported Resident #7 should not have had on another resident's socks; and stated she would change the socks immediately. She stated the facility had measures to ensure Resident #7 wore his/her own clothing and did not have to wear other residents' clothing. She indicated staff could have checked with housekeeping and/or laundry staff to make sure Resident #7 received his/her clothing.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 03/05/14 at 6:33 PM, revealed Resident #7 should not have had another resident's socks on. She reported staff should have sent the other resident's socks back to laundry and ensured Resident #7 had his/her own clothing. She stated ensuring Resident #7 had his/her own clothing was important because of concern for the resident's dignity.</p> <p>Interview with the Social Service Director (SSD) on 03/06/14 at 11:26 AM, revealed staff should have checked Resident #7's drawer to make sure he/she had his/her own socks on. She added Resident #7 had a dresser drawer full of his/her own socks. She stated staff should have checked with laundry to see if the facility had extra pairs of socks for residents who needed them. The SSD stated staff should have notified her so she could have talked to the family and have had them pick up socks for Resident #7. According to the SSD, having to wear socks labeled with another resident's name was a dignity issue and should not have happened.</p>	F 241	<p>On 3/26/14, the Staff Development Coordinator completed an audit of 100% of all nursing staff during meal services to ensure dignity and respect was provided, specifically to offering of clothing protectors prior to meals. On 3/10/14, the SDC/designee completed audits of 100% of residents in rooms and out of rooms to ensure dignity, respect, and privacy was maintained, specifically to clothing, and body exposure.</p> <p>3. On 3/7/14, the Staff Development Coordinator inserviced all stakeholders on dignity, respect, and privacy, as well as ensuring that all staff are aware of labeling procedures of resident's personal items and which dresser drawers/closets belong to which resident in each semi-private room.</p> <p>4. The DON/designee will monitor meal service delivery for 5 meals a week x 2 weeks to ensure staff compliance with dignity and respect policy, in relation to appropriate terminology of offering of clothing</p>	

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5209 ASBURY ROAD AUGUSTA, KY 41002		
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F 241	<p>Continued From page 3</p> <p>Interview with the Director of Nursing (DON) on 03/06/14 at 8:26 PM, revealed her expectations were for Resident #7 to have had on his/her socks, since he had socks in his/her drawer.</p> <p>2. Continued observation on 03/05/14 at approximately 9:15 AM, revealed the door to Resident #7's room had been open and the resident was lying on the bed on his/her side with his/her eyes closed. Observation revealed Resident #7 to have had a white sheet, folded in half on top of him/her and the resident's unclothed leg and buttock were exposed.</p> <p>Observation of Resident #7 on 03/06/14 at approximately 12:35 PM, revealed the resident lying on the bed with a large red blanket on top of him/her. Continued observation revealed when Resident #7 raised his/her leg, passersby were able to visualize the resident was unclothed under the blanket.</p> <p>Interview with CNA #4 on 03/05/14 at 3:27 PM, revealed she was assigned to care for Resident #7. She reported the resident had a red blanket with a top sheet to ensure his/her privacy. She indicated when she observed Resident #7 was exposed, she closed the door or privacy curtain, corrected the top sheet/blanket and re-opened the door or privacy curtain when she had ensured he/she was fully covered. She stated she would not leave the curtain pulled when Resident #7 was exposed, because she had not been told to keep it pulled.</p> <p>Interview with LPN #1 on 03/05/14 at 6:38 PM, revealed Resident #7 preferred being unclothed. She reported staff encouraged the resident to use the lap blanket while lying on the bed. LPN #1</p>	F 241	<p>protectors. Meal delivery will continue to be monitored by the DON/designee at least weekly thereafter x 3 months to ensure continued compliance. The DON/designee will audit each resident 2 days a week x 2 weeks and monthly x 2 months to ensure compliance with dignity and respect, in relation to properly labeled clothing, and that each resident will not have body exposure to others. The results of these audits will be forwarded to the daily clinical meeting by the Staff Development Coordinator. All results will be reported to the quarterly Quality Assurance Committee for review and addressed immediately.</p>	

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002		
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F 241	<p>Continued From page 4</p> <p>stated she tried to keep the resident's curtain closed; however he/she often liked to look out into the hallway. She stated Resident #7 could not open the curtain, he/she required staff's assistance for this. LPN #1 revealed staff should have checked Resident #7's room every hour to ensure he/she was covered and not exposed.</p> <p>Interview with the SSD on 03/06/14 at 11:26 AM, revealed if staff had noticed Resident #7 was exposed, they should have covered him/her. She stated if the resident chose not to cover up; then staff should have pulled the privacy curtain. The SSD reported staff should have monitored Resident #7 to see if he/she had been uncovered.</p> <p>Interview with the DON on 03/06/14 at approximately 8:45 PM, revealed staff should have been providing frequent checks of Resident #7's room to ensure he/she was fully covered. She stated the privacy curtain should have been pulled to ensure Resident #7 was not exposed to others passing by his/her room. According to the DON, leaving the resident exposed was a dignity issue.</p> <p>3. Observation on 03/05/14 at 12:14 PM, revealed Unsampld Resident B was lying on the bed while CNA#2 was standing at his/her room door. CNA #2 told an unidentified CNA to get her a "bib" for Unsampld Resident B, then informed Unsampld Resident B the other CNA was getting him/her "a bib".</p> <p>Interview, on 03/05/14 at 12:14 PM, with CNA #2 revealed she should have told the other CNA to get a clothing protector for Unsampld Resident B; and should not have used "bib" when she talked to the resident. Further interview revealed</p>	F 241		

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F 241	Continued From page 5 bibs were for babies not adults; and this had been a dignity issue for the resident. Interview, on 03/05/14 at 3:30 PM, with the DON revealed CNA #2 should not have called the clothing protector a bib. She stated a bib was childlike and a clothing protector was for the protection of clothing. She indicated this had been a dignity issue.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide housekeeping services necessary to maintain a sanitary, orderly, and comfortable interior. Observations during the survey revealed a black substance observed in the shower room along the caulking between the wall and floor, as well as, on the wall of the shower between some brickwork. Additionally, observation revealed a brown waxy buildup was observed along walls in the facility, under radiators, and around closed doorways and door jambs. The findings include: Observation of the facility environment during a tour on 03/05/14 at 9:15 AM, revealed a black substance in the seam and on the caulking between the walls and floor of the shower in the	F 253	F 253 Environmental - Resident Shower Room: Dirt buildup in shower area between some tile work and along the seam/caulking between the walls and floor. 1. Removed all dirt areas from wall area by removing caulking also using a concrete cleaner on the wall 2. Removed all old caulking from between wall and floor. Installed all new base tiles along walls in shower area. Used concrete cleaner in grout then sealed. 3. In-service was giving to all staff on wiping the shower down after each use. 4. Ceramic tile was put in place	3/21/14

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5239 ASBURY ROAD AUGUSTA, KY 41002		
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F 253	Continued From page 6 shower room. Observation revealed the black substance had also been observed between some of the brickwork in the shower. Continued observation revealed a buildup of a brown substance observed along the walls and with a heavier buildup behind the doors in the residents' dining room. Additionally, observation revealed the buildup had been observed: around and beneath closed doors; beneath radiators; in the central hall; and along walls in several resident rooms. Observation on 03/06/14 at 10:50 AM, revealed the black substance in the resident shower room remained even though the room had been cleaned by housekeeping services. Continued observation revealed the brown buildup remained beneath radiators and along walls throughout the facility. Interview with the Housekeeping Director and Maintenance Director on 03/06/14 at 12:30 PM, revealed the substance in the shower room between some brickwork and along the seam/caulking between the walls and floor appeared to have been dirt which had built up over time. The Housekeeping Director stated the area should have been cleaned better. Additionally, interview with the Housekeeping Director and Maintenance Director revealed the areas of brown discoloration along walls, beneath radiators, and around door jams were caused by a buildup of wax, with some dirty buildup along door jams. They stated the dining room was deep cleaned every three weeks, which included stripping wax from the floor; cleaning the floor; and re-applying wax. They indicated the areas around radiators and door jams appeared not to have been stripped and cleaned; however should	F 253	For better outcome of cleaning the shower. F 253 Environmental – Brown discoloration along walls, beneath radiators, and around door jams caused by buildup of wax. 1. Created an updated cleaning schedule for the building. Building now broken into 8 zones. Floor cleaning will take place in each zone once per month. Housekeeping Director will maintain sign off sheets showing areas completed. 2. Have requested, to the Corporate Office, the purchase of a new floor stripping machine designed to clean in corners and edges. 3. Plant Operations Director and Housekeeping Director will in-service all housekeeping staff on proper floor cleaning procedures. 4. All new housekeeping staff will be given an orientation on floor cleaning procedures. 5. Plant Operations Director and Housekeeping Director will conduct floor audits once per month to ensure that floor care is maintained.	3/12/14	

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F 253	Continued From page 7 have been.	F 253			
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review and review of the Resident Assessment Instrument (RAI) User Manual Version 3.0, it was determined the facility failed to complete a significant change on the Minimum Data Set (MDS) for one (1) of eleven (11) sampled residents (Resident #3). The facility failed to complete a significant change MDS when Resident #3 showed a decline in his/her health status in more than one (1) area. The findings include: Interview with the MDS Coordinator on 03/06/14 at 8:45 AM, revealed the facility referred to the standard RAI Manual for guidance on "Significant	F 274	F274 1. The Director of Nursing and MDS Coordinator reviewed 483.20(b)(2)(ii), comprehensive assessment after a significant change. The facility will conduct a comprehensive assessment of a resident within 14 days after it is determined that there has been a significant change in the resident's physical or mental condition. On 3/6/14, the DON educated the MDS Coordinator to initiate a comprehensive significant change assessment immediately on Resident #3. The MDS Coordinator immediately assessed Resident #3 and initiated the Significant Change assessment. Resident #3 was assessed on 3/6/14 to ensure all needs are being met and care plan reviewed for accuracy reflective of resident's current status.	3/26/14	

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F 274

Continued From page 8
Change" in residents.

Review of the RAI User Manual Version 3.0, dated April 2012, revealed a "Significant Change" was a decline or improvement in a resident's status that: would not normally have resolved itself without intervention by staff; by implementation of standard disease-related clinical interventions; and if more than one area of the resident's health status had been impacted. Continued review revealed residents with a decline in two (2) or more of the following areas: Activities of Daily Living (ADL); incontinence pattern changes or placement of an indwelling catheter; and emergence of a new Pressure Ulcer at Stage II or higher, or worsening in Pressure Ulcer status, required completion of a Significant Change MDS Assessment.

Observation of Resident #3 on 03/05/14 3:35 PM, revealed the resident sitting in his/her wheelchair participating in an activity in the dining area. He/She had been observed to have had a catheter privacy bag on his/her wheelchair.

Review of Resident #3's record, revealed the facility admitted the resident on 06/22/12, with diagnoses which included Anxiety Disorder, Schizophrenia, Depressive Disorder, Urinary Obstruction, Edema and Muscle Weakness. Review of Resident #3's Annual MDS Assessment dated 06/06/13, revealed the facility had assessed Resident #3 to have been able to ambulate with supervision, such as, oversight, encouragement or cueing with assist of one (1) staff in his/her room and with no assist in hallways. Review of the Quarterly MDS Assessment dated 09/04/13 and 01/28/14, revealed Resident #3 had experienced a decline

F 274

- On 3/26/14, the MDS Coordinator completed an audit/assessment of 100% of all residents for review of the need for a significant change assessment, to ensure compliance with initiating a comprehensive significant change assessment on any resident with more than one area of major decline or improvement of health status. The MDS Coordinator utilized the Casper reports and previous MDS assessments for comparison to audit for any need for significant change assessments, as well as completing current resident assessments.
- On 3/6/14, the DON educated the MDS Coordinator regarding the RAI manual and process for assessing and completing comprehensive significant change assessments. On 3/11/14, a regional clinical

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002		
(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 274	<p>Continued From page 9</p> <p>in his/her ability to walk. Review of the Quarterly MDS Assessments revealed the facility had assessed Resident #3 to no longer have the activity of ambulation occur.</p> <p>Additionally, review of the Annual MDS Assessment revealed Resident #3 had been continent of urine and had not required an indwelling catheter. However, review of the Quarterly MDS Assessments revealed the facility had assessed Resident #3 to have had an indwelling catheter.</p> <p>Further review of the MDS Assessments revealed on the Annual MDS and Quarterly MDS dated 09/04/13 the facility had assessed Resident #3 to have been at risk for a Pressure Ulcer and to have had no Pressure Ulcers at the time of the assessments. However, review of the Quarterly MDS Assessment dated 01/28/14, revealed the facility had assessed Resident #3 to have had a Stage III Pressure Ulcer at that time.</p> <p>Review of the Physician verbal telephone order dated 12/08/13, revealed Resident #3 had been diagnosed with urinary retention and a Foley Catheter (F/C) had been ordered to bedside drainage (BSD) as needed.</p> <p>Review of the Nurse's Notes dated 01/09/14 at 2:00 PM revealed a Stage III (3) pressure ulcer had been observed on Resident #3's right lower buttock.</p> <p>Interview with the MDS Coordinator on 03/06/14 at 8:45 AM, revealed she had completed the MDS Assessments for Resident #3. She stated in order for a resident to have had a Significant Change MDS completed a resident had to have</p>	F 274	<p>reimbursement consultant educated the MDS Coordinator regarding the RAI manual and process for initiating and completion of comprehensive significant change assessments. The MDS Coordinator will be knowledgeable of each resident's current health status, and will initiate a significant change assessment as needed.</p> <p>4. The MDS Coordinator will review the Casper report weekly x 4 weeks, then monthly x 2 months, to review for improvements or declines in resident's health status, to ensure that comprehensive significant assessments are completed timely. The MDS Coordinator will review each report with the DON for accuracy. The MDS Coordinator will compare each required MDS assessment with the prior completed MDS assessment to audit for declines or</p>	

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5209 ASBURY ROAD AUGUSTA, KY 41002	
(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 274	Continued From page 10 had a decline in two (2) or three (3) areas. The MDS Coordinator reviewed Resident #3's record and stated the resident should have had a Significant Change MDS Assessment completed. She stated a Significant Change MDS Assessment was important because it provided a more Comprehensive Assessment of the resident. Interview with the Director of Nursing (DON) on 03/06/14 at 8:26 PM, revealed Resident #3 should have had a Significant Change MDS Assessment completed. She indicated she had the MDS Coordinator initiate one (1) immediately after learning the information.	F 274	improvements in resident's health status. This comparison will be completed ongoing and with each new assessment. The MDS Coordinator will review findings with the DON weekly x 4 weeks, then monthly x 2. The results/findings of these reviews will be forwarded and reported to the quarterly Quality Assurance Committee for review and addressed immediately.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	F280 1. The Director of Nursing and MDS Coordinator have reviewed 483.20(d)(3), 483.10(k)(2) regarding residents right to participate in planning care and revisions to care plans. On 3/6/14, the MDS Coordinator reviewed and revised Resident #7's care plan to reflect interventions in place and documented to ensure Resident #7's dignity and privacy are maintained. This included interventions of pulling curtain, frequent checks to ensure body isn't exposed, and alternate clothing. The entire	3/27/14

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5369 ASBURY ROAD AUGUSTA, KY 41002		
(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 280	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review and review of the facility's policy, it was determined the facility failed to revise the Comprehensive Care Plan for one (1) of eleven (11) sampled residents (Resident #7). The facility failed to revise Resident #7's Comprehensive Care Plan with additional interventions to ensure his/her privacy and dignity were maintained.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Care Plan: Clinical", dated December 2010, revealed all residents were to have care plans which provided guidance to all staff who cared for the resident; and communicated changes in care to all direct care staff. Continued review of the policy revealed an interdisciplinary approach for identification of problems and development of solutions and goals provided individualization and coordination of resident care. Further review revealed the interdisciplinary care plan was to have been reviewed; revised and updated quarterly and more frequently if warranted by a change in a resident's condition.</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 09/23/13, with diagnoses which included Hypertension, Muscle Weakness and Congestive Heart Failure. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 02/25/14 revealed the facility assessed Resident #7 as having a Brief Interview for Mental Status (BIMS) score of thirteen which indicated no cognitive impairment.</p>	F 280	<p>comprehensive care plan was reviewed to ensure accuracy for Resident #7 in all aspects of care. No further revisions were needed at this time.</p> <ol style="list-style-type: none"> On 3/27/14, 100% of all resident's care plans were reviewed by the MDS Coordinator for accuracy, and revisions were made as indicated, to ensure each individual care plan reflected each resident's current physical and mental status with appropriate interventions documented. On 3/6/14, the DON educated the MDS Coordinator regarding the comprehensive assessment and care planning for each resident, to ensure all residents have a care plan with appropriate interventions for all aspects of each resident's care. The MDS Coordinator/DON will audit 20% of care plans weekly x 4 weeks, then monthly x 2 months to ensure comprehensive care plans are accurate and reflect appropriate interventions. Care plans will be revised immediately as needed. The 	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5239 ASBURY ROAD AUGUSTA, KY 41002	
(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 280	Continued From page 12 Review of Resident #7's Comprehensive Care Plan revealed the resident had an activities of daily living (ADL) deficit care plan which indicated he/she required total assist with dressing. Further review revealed Resident #7 preferred not being clothed from the waist down. Observation of Resident #7, on 03/05/14 at approximately 9:15 AM, and on 03/06/14 at approximately 12:35 PM, revealed Resident #7 to have been lying on his/her bed with the lower half of his/her body exposed to people passing the room in the hallway. Interview with Social Service Director (SSD) on 03/06/14 at 11:26 AM, revealed if Resident #7 chose not to have the lower half of his/her unclothed body covered, staff should ensure the privacy curtain was pulled. According to the SSD, staff should have been monitoring Resident #7 to ensure he/she was not exposed. After reviewing Resident #7's care plan the SSD stated ensuring the resident's lower body was covered had not been care planned, however should have been. Interview with the Assistant Director of Nursing (ADON) on 03/06/14 at 10:55 AM, revealed staff should have ensured Resident #7's privacy curtain was pulled when they observed his/her eyes were closed. She stated staff should have checked on the resident throughout the day. According to the ADON, she was not one-hundred percent sure this had been care planned. She indicated Resident #7's care plan should have been revised to include this intervention if it had not been care planned. Interview with the DON on 03/06/14 at	F 280	results of these audits will be forwarded and reported to the quarterly Quality Assurance Committee for review and addressed immediately.	

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASSBURY ROAD AUGUSTA, KY 41002
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 280	Continued From page 13 approximately 8:45 PM, revealed staff should have been performing frequent checks of Resident #7's room to ensure he/she was fully covered and not exposed. She stated staff should have pulled the privacy curtain to ensure he/she was not exposed. According to the DON, this intervention had not been care planned; however the care plan should have been revised to include it to ensure Resident #7's dignity and privacy were protected.	F 280		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	F441 1. The Director of Nursing reviewed 483.65(a)(b), Infection Control. The facility will prevent the spread of infection by maintaining a safe, sanitary, and comfortable environment. On 3/5/14, LPN #1 immediately replaced the indwelling catheter tubing system on Resident #3. The new tubing was properly raised and secured off of the floor. The nursing staff on duty were immediately inserviced on 3/5/14 by the Staff Development Coordinator, regarding the infection control policy and new securing device for Resident #3's indwelling catheter tubing to prevent the tubing from touching the floor. Resident #3 was	3/11/14

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5289 ASBURY ROAD AUGUSTA, KY 41002
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F 441	Continued From page 14 (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, record review and review of the facility's policy, it was determined the facility failed to maintain an infection control policy designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection for one (1) of eleven (11) sampled residents (Resident #3) as evidenced by observation of the resident's indwelling catheter tubing lying on the floor while Resident #3 had been sitting in his/her wheelchair. The findings include: Review of the facility's, "Infection Control Policies and Practices", revised August 2007, revealed the facility's infection control policies and practices were intended to facilitate maintaining a safe, sanitary and comfortable environment and help prevent and manage transmission of diseases and infections. Interview, on 03/06/14 at 9:17 PM, with the Director of Nursing (DON) revealed the facility had no standard monitoring system to ensure	F 441	assessed on 3/5/14 by LPN #1 for any signs/symptoms of infection. No negative outcomes were identified. 2. On 3/6/14, the DON/ADON audited all indwelling catheters for proper positioning and securing to ensure touched the floor while the resident was in chair or bed, to ensure compliance with the infection control policy. On 3/6/14, a securing device was provided for any resident with an indwelling catheter that may have tubing that could touch the floor. 3. On 3/11/14, the Staff Development Coordinator completed an inservice with all nursing staff to ensure understanding of the infection control policy, general and specific to indwelling catheters. The nursing staff was also educated on securing tubing to prevent infection control concerns. 4. The DON/designee will monitor any residents with indwelling catheters 5 times a week x 2 weeks, then weekly x 2 weeks, then monthly x 2 months to ensure catheter tubing is not	
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 165344	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/06/2014
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5239 ASBURY ROAD AUGUSTA, KY 41002	
(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 441	Continued From page 15 Indwelling catheter bags did not touch the facility's floor. She indicated the facility had not identified this as a problem prior to the survey. The DON stated her expectations were catheter tubing should not touch the floor. Record review revealed Resident #3 was admitted 01/14/14 with diagnoses which included Benign Prostatic Hyperplasia (BPH-enlargement of the prostate) and Urinary Retention. Review of Resident #3's March 2014 Physician Orders revealed an order for an indwelling catheter. Observation on 03/05/14 at 10:41 AM, revealed Resident #3 sitting in a wheelchair at the nurse's station. Observation revealed the indwelling catheter bag had been in a privacy bag, connected to a bar under the wheelchair; however the catheter tubing was observed lying on the floor. Interview, on 03/05/14 at 10:48 AM, with Licensed Practical Nurse (LPN) #1 revealed Resident #3's catheter tubing should never have been lying on the floor as this was unsanitary and was an infection control issue. Interview, on 03/05/14 at 3:30 PM, with the DON revealed catheter tubing should not touch the floor. She stated if this occurred the resident was at increased risk of infection. She indicated, therefore allowing indwelling catheter tubing to lie on the floor was an infection control issue.	F 441	touching the floor, ensuring compliance with the infection control program. The Dietary Manager/Designee will conduct infection control audits during food preparation, cooking and tray line weekly x 4 weeks, then monthly x 2 months, ensuring compliance with the infection control policy. The audits will include proper handwashing and handling of food. The Staff Development Coordinator/Designee will monitor meal service delivery weekly x 4 weeks, then monthly x 2 months for proper handling of food and hand hygiene, ensuring compliance to prevent the spread of infection. The Staff Development Coordinator/Designee will complete infection control audits with Certified Nursing Assistants during indwelling catheter care and perineal care, 5 times a week x 2 weeks, weekly x 2 weeks, then monthly x 2 months. The SDC/ designee will complete audits of licensed nurses during skin assessments and wound care weekly x 4 weeks, then 2 times a month x 2 months to ensure compliance with infection control. The SDC/ designee	

infections daily. The results of these audits will be forwarded by the SDC to the daily clinical meeting for review. The results will also be reported to the quarterly Quality

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED R 04/04/2014
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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5269 ASBURY ROAD AUGUSTA, KY 41002
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{K 000} INITIAL COMMENTS

Based on an offsite review of the acceptable Plan of Correction (POC), the facility was deemed to be in compliance as alleged on 04/04/14 as alleged.

{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.

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5268 ASECURY ROAD AUGUSTA, KY 41002	
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) Building: 01 Survey under: NFPA 101 (2000 Edition) Plan approval: 1964 Facility type: SNF/NF Type of structure: One story with partial basement, Type V (000) Smoke Compartment: Three (3) Fire Alarm: Complete fire alarm with smoke detectors installed in corridors, heat detectors in basement and boiler room. Sprinkler System: Complete sprinkler system (wet). Generator: Type 2 generator powered by natural gas A standard Life Safety Code survey (using 2786S Short Form) was initiated on 03/05/2014 and concluded on 03/05/2014. Bracken County Nursing and Rehabilitation Center was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was twenty-eight (28). The facility is licensed for thirty-two (32) beds. The highest Scope and Severity was an "F" level.	K 000	Bracken County Nursing and Rehabilitation Center does not believe and does not admit that any deficiencies existed before, during, or after the survey. Facility reserves the rights to contest the survey findings through informal dispute resolution, formal appeal proceedings, or any administrative or legal proceedings. The plan of correction is not meant to establish any standard of care, contract obligation or position. Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action, or proceedings. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance, or self-critical examination privilege with the facility, does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. Facility offers it's responses, credible allegations of compliance as part of its ongoing efforts to provide quality care to residents.	
K 056	NFPA 101 LIFE SAFETY CODE STANDARD	K 056		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Ann Kibben RN
TITLE
NM
(X8) DATE
4/4/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it has other safeguards providing 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 those 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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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 5259 ASSURY ROAD AUGUSTA, KY 41062
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K 056 SS=E	<p>Continued From page 1</p> <p>If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the facility was fully sprinklered according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of three (3) smoke compartments, fifteen (15) residents, staff and visitors.</p> <p>The findings include:</p> <p>Observation on 03/05/2014 at 3:00 PM, with the Maintenance Director revealed a canopy (approximately 8' x 20' constructed of metal) located over the exterior exit of the Intermediate Care (IC) Short Hall which was not protected by the facility sprinkler system. The same was found for the canopy (approximately 6' x 8' constructed of metal) for the staff smoking area. Canopies must be protected by the facility sprinkler system to ensure the facility is protected</p>	K 056	<p>K 056</p> <ol style="list-style-type: none"> 1. Sprinkler contractor, Century Fire Protection, contacted to install additional sprinkler protection in the 2 canopy areas of the facility that were currently without sprinkler protection. 2. Canopy sprinklered areas will now be included, to ensure compliance, during all quarterly sprinkler inspections and maintained by Century Fire Protection. 3. Canopy sprinklered areas will now be included, to ensure compliance, during all monthly sprinkler inspections conducted by the Plant Operations Director. 	4/4/14
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 03/05/2014	
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5239 ASBURY ROAD AUGUSTA, KY 41002		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 056	Continued From page 2 from fire. Interview on 03/05/2014 at 3:00 PM with the Maintenance Director, revealed he was unaware the canopies were required to be sprinkler protected since it was constructed of metal. Further interview revealed the facility relied on the outside sprinkler contractor to ensure all areas of the building were fully sprinklered. The findings were acknowledged by the Administrator during the exit conference. Reference: Centers for Medicare/Medicaid Survey and Certification Letter 13-55	K 056		
K 062 SS=F	NFWA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on record review and interviews it was determined the facility failed to ensure sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect thirty-two (32) residents, staff and visitors. The findings include: Record review of the facility's sprinkler inspection records on 03/05/2014 at 2:51 PM, indicated the facility last had an internal pipe inspection	K 062	1. Sprinkler contractor, Century Fire Protection was contacted to perform an onsite internal pipe inspection. 2. Will notify sprinkler contractor when the 5 year expiration date is near and have the sprinkler pipe inspection performed during that quarterly inspection.	3/21/14

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 183344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5239 ASBURY ROAD AUGUSTA, KY 41002	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 3 performed on 02/17/09. This was confirmed by the Maintenance Director. Sprinkler pipes must have an internal inspection performed every five (5) years to insure the pipes are not obstructed with foreign material which would prevent the sprinkler from operating during a fire. Interview on 03/05/2014 at 2:51 PM with the Maintenance Director, revealed he was not aware of the facility having an internal pipe inspection of the sprinkler system performed since this that date. Further interview revealed the facility relied on an outside contractor to perform and keep all inspections up to date. The findings were acknowledged by the Administrator during the exit conference. Reference: NFPA 25 (1998 edition) 10-2.2* Obstruction Prevention. Systems shall be examined internally for obstructions where conditions exist that could cause obstructed piping. If the condition has not been corrected or the condition is one that could result in obstruction of piping despite any previous flushing procedures that have been performed, the system shall be examined internally for obstructions every 5 years. This investigation shall be accomplished by examining the interior of a dry valve or preaction valve and by removing two cross main flushing connections.	K 062	3. Will maintain a copy of the inspection report both in the facility Life Safety Manual and online in the TELS maintenance log. A copy of the report will also be found on the Century Fire Protection web site.	
K 072 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10	K 072	K 072 1. Will monitor the condition of all sidewalks and continuously maintain them free of all obstructions or impediments to full instant use in the case of fire or other emergency.	3/2/14

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NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 5259 ASBURY ROAD AUGUSTA, KY 41002	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
K 072	<p>Continued From page 4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interviews, it was determined the facility failed to ensure means of egress were continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of ten (10) exits, four (4) residents, staff and visitors.</p> <p>The findings included:</p> <p>Observation on 03/05/2014 at 12:47 PM with the Maintenance Director, revealed the outside sidewalk leading from Intermediate Care (IC) Short Hall Wing had an accumulation of ice and snow. Ice and snow must be removed from sidewalks to ensure full and instant use during a fire or other emergency. The finding was confirmed with the Maintenance Director.</p> <p>Interview on 03/05/2014 at 12:47 PM with the Maintenance Director, revealed he had not cleared this area of ice and snow due to it not being used as a main exit. Further interview with the Maintenance Director, revealed he was aware of the need to keep sidewalks free and clear of ice and snow to ensure full and instant use during a fire or other emergency.</p> <p>The findings were acknowledged by the Administrator during the exit conference. Reference: NFPA 101 (2000 edition)</p> <p>7.1.10.1* Means of egress shall be continuously</p>	K 072	<p>2. Will have current contractor who is providing ice and snow removal maintain all sidewalks and parking areas free and clear during times when the Maintenance Director is not onsite.</p> <p>3. Will maintain all snow removal equipment in proper order and accessible to all staff.</p> <p>4. Will maintain an adequate supply of salt/deicer on site to pre-treat and treat outside egress areas.</p> <p>5. In-service and Safety Meeting was completed on March 21st during which time staff was reminded to ensure means of egress at all exit door locations.</p> <p>6. Plant Operations Policy and Procedure Manual will be updated to ensure means of egress are maintained during all weather conditions.</p>

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185344	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER BRACKEN COUNTY NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 5209 ASBURY ROAD AUGUSTA, KY 41002	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 072	Continued From page 5 maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072		