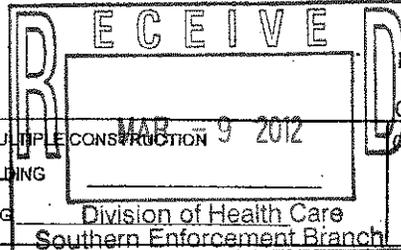


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 02/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 02/16/2012
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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR	STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717
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F 000	INITIAL COMMENTS A standard health survey was conducted on 02/13/12-02/16/12. Deficient practice was identified with the highest scope and severity at "E" level. An abbreviated standard survey (KY17783) was also conducted at this time. The complaint was substantiated with related deficient practice identified.	F 000	Plan of Correction Cumberland Valley Manner Standard Survey 2/13-16/2012	
F 241 SS=D	(All stated times were Eastern Standard Time.) 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 facility policy the facility failed to promote care for residents in a manner and environment that maintained or enhanced each resident's dignity for one of seventeen sampled residents (Resident #14) and two unsampled residents (Unsampled Residents B and C). Observation during the initial tour of the facility on 02/13/12, and during medication pass on 02/14/12, revealed staff failed to knock and obtain permission prior to entering the resident's room. Additionally, observation of meal service on 02/14/12, revealed staff stood at a resident's bedside and staff was observed to stand beside a	F 241	Preparation and execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This plan of correction is prepared and executed solely because it is required by federal and state law. F 241 Dignity 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 N 113-902 KAR 20:300-6(1) Section 6. Quality of Life.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 03/09/12
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 241	<p>Continued From page 1</p> <p>resident in the dining room while assisting the resident with the meals.</p> <p>The findings include:</p> <p>Review of the facility's Privacy and Confidentiality policy (dated 02/20/07) revealed staff should knock on a resident's door before entering the resident's room. Further review of a policy titled Required Actions to Promote Dignity and Privacy (not dated) revealed staff was to knock on the resident's door and should wait for the resident to respond before entering the resident's room. The facility failed to provide a policy that directed staff of the proper position to maintain during feeding a resident.</p> <p>1. Observation during the initial tour on 02/13/12, at 10:00 PM, revealed LPN #2 entered resident room 216 but failed to knock prior to entering the room. Observation of medication pass on 02/14/12, at 6:00 PM, revealed LPN #2 prepared six oral medications, one inhaler, and two nebulizer treatment medications for administration to Resident #14. LPN #2 entered Resident #14's room to check the resident's pulse prior to the medication administration. LPN #2 failed to knock prior to entering the resident's room. LPN #2 returned to the medication cart positioned in the hallway. LPN #2 prepared an additional medication for pain at the request of Resident #14. LPN #2 re-entered Resident #14's room to administer the oral pain medication and the nebulizer treatments. LPN #2 failed to knock prior to entering Resident #14's room.</p> <p>Interview on 02/15/12, at 5:00 PM, with LPN #2 revealed staff should knock on the resident's door</p>	F 241	<p>Criteria 1: -Medication administration staff knocks before entering the room of resident #14 as determined during med pass observations. - Staff are seated while assisting resident's #B & C to eat as determined during meal service observations.</p> <p>Criteria 2: Medication and meal service observations were conducted on 03/05/12, 03/06/12, and 03/07/12 by the DON/ADON/Staff Development nurse to determine that staff are knocking before entering resident rooms during med pass and are seated while assisting residents to eat.</p> <p>Criteria 3: Inservice education was provided for licensed and non-licensed nursing staff by the DON/ADON on 03/06/12 thru 03/15/12 which included but was not limited to: -knocking before</p>		

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F 241	<p>Continued From page 2</p> <p>prior to entering the room. LPN #2 stated staff should also inform the resident of the name of the person wanting to enter the room. LPN #2 stated he was nervous and failed to knock on the resident's door prior to entering the room.</p> <p>Interview with the Director of Nursing (DON) on 02/16/12, at 1:45 PM, revealed staff should always knock on a resident's door prior to entering the resident's room.</p> <p>2. Observation on 02/14/12, at 9:05 AM, revealed LPN #1 assisted unsampled Resident B with the breakfast meal. Further observation revealed LPN #1 stood at unsampled Resident B's bedside during the meal.</p> <p>Observation of the noon meal on 02/14/12, at 1:25 PM, revealed a Speech/Language Pathologist (SLP) assisted unsampled Resident B with the lunch meal. The SLP stood at unsampled Resident B's bedside during the meal.</p> <p>Observation of the evening meal service on 02/14/12, at 6:45 PM, in Dining Room 3 revealed CNA #1 stood beside unsampled Resident C during the supper meal.</p> <p>Observation on 02/15/12, at 9:10 AM, revealed CNA #2 stood at unsampled Resident B's bedside to feed the breakfast meal.</p> <p>Interview with CNA #1 on 02/14/12, at 6:15 PM, revealed staff had to stand during the meal to be able to reach the resident.</p> <p>Interview on 02/15/12, at 9:40 AM, with CNA #2 revealed staff could stand or sit while feeding</p>	F 241	<p>entering resident rooms during med pass; -being seated while assisting residents to eat their meals.</p> <p>Criteria 4: The CQI indicators for the monitoring of resident dignity issues, including but not limited to knocking before entering resident rooms, and being seated while assisting resident to eat, will be utilized monthly X 2 months and then quarterly thereafter under the supervision of the DON.</p> <p>Criteria 5: March 16, 2012</p>	

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F 241	Continued From page 3 residents. CNA #2 revealed it was easier to stand to reach the residents that required feeding by staff. Interview on 02/15/12, at 2:00 PM, with the SLP revealed the SLP was not aware of facility requirements for feeding residents. The SLP stated the resident's bed was in a high position and staff would have to stand to feed the resident. Interview with LPN #1 on 02/15/12, at 3:00 PM, revealed staff should be at the eye level of the resident while feeding a resident. LPN #1 stated she stood while feeding unsampled Resident B because the resident required a low air loss mattress with the pump positioned at the foot of the bed and staff must be careful when lowering the bed. LPN #1 stated the bed could be positioned lower for staff to sit while feeding the resident. Interview with the Director of Nursing (DON) on 02/16/12, at 1:45 PM, revealed staff should be at eye level in a sitting position when feeding residents.	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:	F 253	F 253 Housekeeping and Maintenance Services The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. N 134 902 KAR 20:300-6(7)(a)2. Section 6 Quality of Life. The facility shall provide housekeeping and maintenance services necessary to maintain a sanitary, orderly and comfortable interior.	

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F 253	<p>Continued From page 4</p> <p>Based on observation and interview, it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Observation on 02/14/12 and 02/15/12, revealed fall mats with torn edges, a bedside chair and shower bench with torn seat cushion, a black substance on the floor and wall tile in a shower room, broken/chipped wall tiles, soiled IV poles at a resident's bedside, and a hole in a resident's bathroom door.</p> <p>The findings include:</p> <p>During the environmental tour of the facility on 02/14/12, at 1:15 PM, and on 02/15/12, at 10:00 AM, the following items were observed to be in need of repair:</p> <ul style="list-style-type: none"> -A black substance was observed on the floor and wall tiles in the shower stall of Station 1's tub room. -The seat cushion on the shower bench in Station 1's tub room was torn. -The base and legs of the tube feeding pole in resident rooms 105, 203, and 315 were soiled with a dried brownish substance. -The seat cushion of the bedside chair was torn and the emergency call bell string was soiled with a dark brown substance in resident room 232. -The wooden arms of the bedside chair in resident room 105 were marred/scraped and had exposed splintered wood. -The light over the vanity in resident room 106 did not work. -The fall mats in resident rooms 207, 227, and 315 were torn which exposed the foam inside the fall mats. 	F 253	<p>Criteria 1:</p> <ul style="list-style-type: none"> -The black substance on the floor and wall tile in the Station 1 shower room has been cleaned. -The torn seat cushion on the Station 1 shower bench have been repaired/replaced. -The base and legs of the tube feeding pole in rooms 105, 203, and 315 have been cleaned. -The bedside chair in room #105 has been replaced. -The light over the vanity in room #106 has been repaired. -The loose/broken tile in the 200 hall shower room have been repaired. -The frayed bedside mats have been replaced/repared. -The top of the A/C unit in room #204 has been repaired. -The hole in the bathroom door of room #217 has been repaired. <p>Criteria 2: An audit was performed by the housekeeping/maintenance staff on 03/07/12 for resident rooms and care areas to identify issues requiring the attention of housekeeping or maintenance. Each</p>	

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F 253	Continued From page 5 -Tiles were broken/chipped in the first shower stall in the 200 Hall Women's Shower Room. -The top of the air conditioner vent was broken, exposing sharp edges, in resident room 204. -A hole was observed in the lower portion of the bathroom door in resident room 217. Interview on 02/16/12, at 2:00 PM, with the Maintenance/Environmental Services Supervisor (M/ESS) revealed rounds were conducted several times each day to monitor the environment and determine if there were items in need of repair. The M/ESS also stated when staff identified anything in need of repair/cleaning they were required to enter the information in a work order/log book kept at the nurses' station or call/page the maintenance staff to inform them of the identified concern. The M/ESS confirmed work orders had not been issued for the items identified.	F 253	item identified was prioritized and scheduled for completion on 03/16/12 under the supervision of the Administrator. Criteria 3: The housekeeping and maintenance staff have received inservice education by the Administrator on routine inspection of the resident rooms and care areas to determine that issues are identified and addressed in a timely manner, as provided on 03/06/12 thru 03/13/12. Criteria 4: The CQI indicator for the monitoring of housekeeping and maintenance issues will be utilized monthly X 2 months then quarterly as per the CQI calendar under the supervision of the Housekeeping and Maintenance supervisors. Criteria 5: March 22, 2012	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES. Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, the facility failed to	F 314	F 314 Pressure Ulcers Based on the Comprehensive Assessment of a resident, the facility must ensure that-	

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F 314	Continued From page 6 provide necessary treatment and services to promote healing and prevent infection during wound care for two of seventeen sampled residents (Resident #2 and Resident #13). Observation of wound care treatment on 02/15/12, revealed staff failed to change gloves and wash/sanitize hands while providing wound care for Resident #2. Additionally, staff was observed to cross over the clean dressing field with a soiled dressing while providing wound care for Resident #13. The findings include: 1. Observation on 02/15/12, at 10:00 AM, revealed Registered Nurse (RN) #1 performed wound care to two pressure wounds located on each buttock/coccyx area of Resident #2. RN #1 was observed to wash her hands, apply non-sterile gloves, and remove the soiled dressing from Resident #2's buttocks/coccyx. After removing and discarding the soiled dressing, RN #1 removed her gloves, washed her hands, and applied new non-sterile gloves. RN #1 then cleansed Resident #2's left buttock/coccyx wound with Normal Saline and gauze sponge. RN #1 discarded the soiled gauze and gloves in the trash, washed her hands, applied new clean non-sterile gloves, and cleansed the right buttock/coccyx wound with Normal Saline and gauze sponge. RN #1 discarded the soiled gauze and gloves in the trash. RN #1 washed her hands and applied a pair of sterile gloves. By using her gloved fingers, RN #1 was observed to pack wounds with the normal saline saturated roll gauze without changing gloves and washing hands in between wounds. A dry thick gauze pad was placed over	F 314	1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and 2) A resident who has an ulcer receives care and services to promote healing and to prevent additional ulcers. N 211 902 KAE 20:300-8(3)(b) Section 8. Quality of Care. Criteria 1: Residents #2 and 13 are provided wound care in accordance with clinical standards of care as determined by wound care observations. Criteria 2: Residents are provided wound care in accordance with clinical standards of care as determined during wound care observations conducted by the DON/ADON/Infection Control	

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F 314	<p>Continued From page 7</p> <p>the packing and the dressing was secured with tape. RN #1 failed to change gloves and wash her hands in between the wound packing to the two separate wounds on Resident #2's buttock/coccyx area.</p> <p>An interview conducted with RN on 02/15/12, at 10:35 AM, revealed she considered the wounds to each side of Resident #2's buttock/coccyx area to be two separate wounds but did not consider cross-contamination of bacteria from wound to wound because she never allowed the roll gauze to leave her hand. RN #1 revealed that to ensure prevention of bacterial cross-contamination she should have removed her gloves, washed her hands, and applied new sterile gloves between wound packings.</p> <p>An interview with the Director of Nursing on 02/16/12, at 2:20 PM, revealed when a nurse is providing wound care she would expect the nurse to wash their hands before and after removing the soiled dressing, and then to change their gloves and wash their hands between any wound where there is an area of skin separating the wounds.</p> <p>An interview with the Infection Control Nurse on 02/16/12, at 3:20 PM, revealed nurses are trained upon hire to wash their hands any time they remove their gloves. Further interview with the Infection Control Nurse revealed that nurses are also trained to treat any wound that is separated by an area of skin as two separate wounds.</p> <p>2. Observation of wound care on 02/16/12, at 9:30 AM, revealed LPN #1 prepared a clean field on Resident #13's rolling bedside table with the dressing supplies needed to perform the wound</p>	F 314	<p>Nurse on 03/06/12, 03/07/12, and 03/08/12.</p> <p>Criteria 3: Licensed nursing staff have received inservice education on wound care in accordance with clinical standards of care including but not limited to changing of gloves and handwashing and maintaining the clean field, as provided by the Infection Control/Wound nurse on 03/06/12 thru 03/15/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of wound care compliance with clinical standards of care will be utilized monthly X 2 months and then quarterly under the supervision of the DON.</p> <p>Criteria 5: March 16, 2012</p>		

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F 314	Continued From page 8 care. LPN #1 removed the soiled dressing from Resident #13's coccyx area. LPN #1 discarded the soiled dressing in the waste receptacle that was positioned on the floor beside the rolling bedside table. LPN #1 crossed over the clean field to discard the soiled dressings. Interview on 02/16/12, at 9:40 AM, with LPN #1 revealed crossing over the clean field with the soiled dressings could contaminate the clean dressings and cause infection to the resident. LPN #1 stated she failed to ensure proper placement of the waste receptacle to prevent crossing over the clean field. Interview on 02/16/12, at 9:45 AM, with the Infection Control Nurse revealed cross-contamination could occur if staff crossed over a clean field that contained clean dressing supplies to discard the soiled items.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the facility's policy/procedure, it was determined the facility failed to ensure appropriate treatment	F 322	F 322 N/G Treatment/Services Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. N 236 902 KAR 20:300-8(12)(b). Section 8. Quality of Care.	

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F 322	<p>Continued From page 9</p> <p>and services were provided to one of seventeen sampled residents (Resident #12) and one unsampled resident (Resident A) related to Gastrostomy tubes (G-tubes). Observations revealed staff failed to verify proper placement of the G-tube, and failed to flush the G-tube before and after a medication administration.</p> <p>The findings include:</p> <p>A review of the facility's policy "Specific Medication Administration Procedures" (HB12: Enteral Tube Medication Administration) (dated 01/14/11) revealed that in preparation of medication administration staff should check for proper tube placement of the G-tube and check gastric contents for residual feeding. Furthermore, the policy stated G-tubes should be flushed with 15-30 milliliters (ml) of water, or prescribed amount, before and after medication administration.</p> <p>1. An observation on 02/14/12, at 12:00 PM, during a medication pass for Resident #12 revealed Licensed Practical Nurse (LPN) #5 failed to verify placement of the G-tube prior to the administration of Xanax 0.25 milligrams (mg), Mirapex 0.5 mg, and 30 ml of water.</p> <p>An interview with LPN #5 immediately following the procedure revealed she was aware she did not check placement of the G-tube prior to the administration of the medication and stated she had been trained to check G-tube placement before any medication administration. LPN #5 stated she "was nervous and forgot." LPN #5 verbalized she should have verified placement of the G-tube.</p>	F 322	<p>Criteria 1: Verification of g-tube placement is completed before medication administration for resident #12, and before and after medication flushes are administered as ordered for resident #A.</p> <p>Criteria 2: An audit of residents with orders for g-tube medications was completed by the DON/ADON/ on 03/05/12, 03/06/12, and 03/07/12 to determine that these are provided after verification of g-tube placement, and with before and after water flushes as ordered.</p> <p>Criteria 3: Medication administration staff have received inservice education by the DON/ADON on 03/06/12 thru 03/15/12 on the need to verify g-tube placement before medication administration and to provide before and after medication 'flushes as ordered with g-tube medications.</p>		

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

PRINTED: 02/29/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/16/2012
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F 322	Continued From page 10 2. Observation of medication pass on 02/14/12, at 5:05 PM, revealed Licensed Practical Nurse (LPN) #2 prepared Carafate 1 Gram/10 milliliters for administration via G-tube to unsampled Resident A. LPN #2 checked placement of the G-tube and then administered the 10 milliliters of Carafate via the G-tube. Further observation revealed LPN #2 reconnected the tube feeding. LPN #2 failed to flush unsampled Resident A's G-tube prior to the medication administration and failed to flush the G-tube after the medication had been administered in accordance with facility policy. Interview with LPN #2 on 02/16/12, at 5:20 PM, revealed he failed to flush the G-tube prior to and after the medication administration. LPN #2 stated he was nervous and since the resident had an automatic flush controlled by the pump the resident would receive the flush. An interview with the Director of Nursing (DON) on 02/16/12, at 5:25 PM, revealed that nurses are trained in employee competencies upon hire to follow the facility's protocol to verify G-tube placement before medication administration and to flush G-tubes before and after medication administration.	F 322	Criteria 4: The CQI indicator for the monitoring of compliance with g-tube med pass in accordance with MD orders will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/ADON. Criteria 5: March 16, 2012.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	F 323 Accidents and Supervision The facility must ensure that the resident environment remains as free of accident hazards as is possible. N 219 KAR 20:300-8(7)(a) Section 8 Quality of Care.	

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

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F-323	Continued From page 11 This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of facility policy, Census and Condition, and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure residents' environment remained as free from accident hazards as possible. Observation during the environmental tour revealed the facility failed to ensure disinfectant spray, air freshener, shampoo, disposable razors, nail clippers, prescription lotions, and sharp manicure sticks were secured/locked and not accessible to residents. Additionally, an electrical cord/electrical plug protruded from the base of the air conditioner and extended into the pathway in resident room 208. The findings include: Review of the facility policy entitled Safety Rules for Employees (not dated) revealed employees were required to comply with all safety procedures in addition to their specific department rules to prevent injury to residents, visitors, and employees. The policy directed staff that all toxic chemicals must be properly labeled and stored in a secure/locked area. 1. Observation on 02/15/12, at 10:00 AM, of the Station 1 tub/shower room revealed a partially used gallon container of Provon Antibacterial Soap on the floor near the sink of the shower room. Further observation revealed the lid of the Provon Antibacterial Soap was missing. The	F 323	Criteria 1: The razors, prescription lotion, disinfectant spray, antimicrobial soap, shampoo, manicure sticks, nail clippers and air freshener were stored in a designated locked storage area. -The electrical plug at the base of the air conditioner in room 205 has been secured. Criteria 2: -An audit was completed on 03/05/12, 03/06/12, & 03/07/12 by the DON/ADON/Infection Control Nurse/Maintenance Staff of resident accessible bathing and storage areas to determine that there were no hygiene or cleaning products stored in a manner accessible to residents, and that plugs are secured at the base of the air conditioner units. -Locks were installed on the resident bathing and storage areas to prevent unsupervised resident access to hygiene or cleaning products.		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 323	<p>Continued From page 12</p> <p>door to the shower room was not locked/secured and easily accessible to residents.</p> <p>Observation on 02/15/12, at 11:10 AM, revealed a storage cabinet was unsecured/unlocked in the women's shower room located on the 200 Wing. The storage closet contained the following: 14 disposable razors, 2 large toenail clippers, an opened box of sharp wooden manicure sticks, a full box of 144 sharp wooden manicure sticks, 8 bottles of White Rain Shampoo/Conditioner, a partially used gallon container of Provon Antibacterial Soap, a partially used spray container of Lysol Disinfectant Spray, and 2 prescription lotions (Ammonium Lactate Lotion 12%) containing a resident's name and directions for use.</p> <p>Further observation on 02/15/12, revealed the Clean Work Room was unlocked/unsecured and was located next door to a wandering resident's room. Observation of the floor cabinet in the Clean Work Room revealed a spray can of Lysol IC foaming disinfectant and a can of Time Mist air freshener in a cabinet drawer.</p> <p>Review of the MSDS for Lysol Disinfectant Spray revealed misuse of the disinfectant could cause eye irritation and the product could be irritating to the respiratory system if inhaled.</p> <p>Further review of the MSDS information for Provon Antibacterial Soap and White Rain Shampoo/Conditioner revealed the products could cause moderate irritation to the eyes and if ingested the products could cause gastric disturbances.</p>	F 323	<p>Criteria 3:-Licensed and non-licensed nursing staff have received inservice education on the new locking devices on the resident bathing and storage areas, and the need to keep all hygiene and cleaning products stored correctly in the designated locked areas, as provided by the DON/ADON/NHA on 03/06/12 thru 03/15/12.</p> <p>-Maintenance staff have received inservice education on the need to monitor that the air conditioner plugs are secured as part of quarterly audits, as provided by the NHA on 03/06/12 thru 03/13/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of proper storage of resident hygiene and facility cleaning products will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the Maintenance Supervisor.</p> <p>Criteria 5: March 16, 2012</p>		

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

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F 323	<p>Continued From page 13</p> <p>The MSDS information for Ammonium Lactate Lotion 12% listed the following precautionary measures: avoid ingestion, inhalation, skin, and eye contact. Review of the MSDS information for Time Mist Air Freshener revealed the product contained acetone and could be irritating and could possibly cause injury to the eye. The MSDS further warned acetone could have harmful effects on the liver and kidney.</p> <p>Further review revealed the MSDS information for Lysol IC advised that the product contained denatured ethanol and ingesting could result in ethanol poisoning. The information advised staff to call the Poison Control Center immediately if the product was ingested.</p> <p>Review of the facility's Census and Condition Record dated 02/15/12, revealed 40 residents had a diagnosis of Dementia. Review of a list provided by the facility revealed 16 residents were assessed to exhibit wandering behaviors.</p> <p>Further observation revealed a resident's doorway near the shower room had a velcro stop sign door guard applied to the entry door frame to prevent wandering residents from entering the resident's room.</p> <p>Interview on 02/15/12, at 10:15 AM, with CNA #3 revealed he had given residents tub baths on the 100 Hall but had not noticed the Provon Antibacterial Soap on the floor near the sink. CNA #3 stated he was not sure why the soap was left out because residents should not have access to it.</p> <p>Interview on 02/15/12, at 11:10 AM, with CNA #4</p>	F 323		

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

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FORM APPROVED
OMB NO. 0938-0391

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F 323	<p>Continued From page 14</p> <p>revealed residents should not have access to chemicals or the items in the cabinet. CNA #4 revealed the cabinet was left unlocked at times and it was the responsibility of the person assigned to give tub baths to ensure the cabinet was locked because that CNA was the only person with the key. CNA #4 stated the items in the storage closet could harm residents if the items were swallowed.</p> <p>Interview on 02/15/12, at 11:25 AM, with the Director of Nursing (DON) revealed the CNA assigned to give tub baths was responsible to ensure the cabinet remained locked and residents should not have access to items stored in the cabinet. The DON stated CNA #10 was responsible for the tub baths but as of 02/15/12, was no longer employed by the facility. The DON stated the facility policy was that the cabinet should be locked at all times. The DON stated the items could be harmful if swallowed and prescription lotions or creams should never be stored in the cabinet.</p> <p>An interview was attempted on 02/15/12, at 1:45 PM, with CNA #10 but the CNA was unable to be contacted by phone.</p> <p>Interview on 02/16/12, at 4:30 PM, with LPN #1/the Unit Coordinator (UC) revealed the UC was unaware the shower room cabinet was not locked. The UC stated she conducted routine checks of the shower room but had not noticed the cabinet was unlocked. The UC revealed the storage closet should be locked when not in use and residents should not have access to the items stored in the closet.</p>	F 323			

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

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F 323	Continued From page 15 2. Observation during the environmental tour on 02/15/12, at 10:00 AM, revealed an electrical socket was loose and protruding from under the air conditioner in resident room 205. The air conditioner cord was connected to the electrical socket and protruding into the pathway by the resident's bed. Interview with the Maintenance Supervisor (MS) on 02/16/12, at 2:00 PM, revealed he was not aware of the electrical socket being loose. The MS stated he made rounds frequently and staff notified him of items in need of repair by writing in a log book kept at the nurses' station. The MS stated the cord protruding into the resident's pathway could cause a resident to fall.	F 323		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide foods/liquids that were palatable and at the proper temperature during the breakfast meal on 02/15/12. The findings include: A review of the Food Preparation/Cooking & Holding/Delivery policy (undated) revealed the hot	F 364	F 364 Nutritive value, Proper Temp. Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance, and food that is palatable, attractive, and at the proper temperature. N 273 902 KAR 20:300-10(4)(b) Section 10. Dietary Services Criteria 1&2: -Test trays checked on 03/07/12, 03/08/12, and 03/09/12 by the RD indicate hot breakfast items were maintained at desired temperatures. -Resident interviews conducted by the RD/DM on 03/07/12, 03/08/12, and 03/09/12 indicated no resident complaints pertaining to breakfast food item temperatures.	

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 364	Continued From page 16 foods were to be served hot and the cold foods were to be served cold when the tray reached the residents. The policy did not include specific timeframes for the resident meal trays to be distributed. Observation of the 222 Hall on 02/15/12, at 8:00 AM, revealed staff was still serving breakfast trays with seven trays remaining on the breakfast cart. The last tray was removed at 8:05 AM (25 minutes after the cart was delivered to the 222 Hall). A food temperature and palatability test was conducted of the food items from the last tray with the Director of Nursing (DON). The food temperatures revealed the eggs were 86.5 degrees Fahrenheit, the sausage was 77.9 degrees Fahrenheit, and the coffee was 99.5 degrees Fahrenheit. The palatability test revealed the eggs, sausage, and coffee tasted cold. A group interview was conducted at 3:30 PM on 02/14/12, with eight alert/oriented residents. The residents stated that breakfast was usually cold by the time the trays reached the residents. Interview with the Dietary Manager (DM) on 02/15/12, at 8:15 AM, revealed the breakfast cart for the 222 Hall came from the kitchen at 7:35 AM and arrived at the 222 Hall by 7:40 AM.	F 364	Criteria 3: -The tray cart delivery was reviewed/ revised to reduce the number of breakfast trays delivered on each cart to maintain breakfast items at desired temperatures. -Hot breakfast items are now served in insulated/covered dishes to maintain desired temperatures. -Dietary staff have received inservice education from the Dietary Manager/RD on the revised breakfast tray cart delivery system and the use of insulated/covered dishes as provided on 03/09/12 thru 03/13/12. Criteria 4: The CQI indicator for the monitoring of meal tray items within desired temperatures will be utilized monthly under the supervision of the Dietary Manager. Criteria 5: March 16, 2012	
F 365 SS=D	483.35(d)(3) FOOD IN FORM TO MEET INDIVIDUAL NEEDS Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	F 365	F 365 Food in form to meet individual needs. Each resident receives and the facility provides food prepared in a form designed to meet individual needs.	

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

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F 365	<p>Continued From page 17</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure the therapeutic diet ordered by the physician was provided for one of seventeen sampled residents (Resident #1).</p> <p>The findings include:</p> <p>A review of the facility's Mechanical Diet Policy revised 02/15/12, revealed the resident with an order for a mechanical soft diet would receive foods that were appropriately altered mechanically if required according to the menu spreadsheet.</p> <p>A review of the "Serving Meal Trays" procedure (no date) revealed the staff member delivering the food tray was to "make sure the tray is complete. Check items on tray with the dietary card. Make sure assistive devices are included."</p> <p>Review of the physician's orders dated 01/21/12, for the month of February 2012 and the dietary food card revealed Resident #1 was to receive a Mechanical Soft Diet. The resident's name and room number were identified on the dietary food card. Review of the clinical record revealed the resident's diagnoses included Esophageal Reflux and Eating Disorder. Review of the nursing care plan revealed Resident #1 has dentures but the dentures were ill fitting and the resident did not wear them.</p> <p>Observation on 02/14/12, at 1:30 PM, of the noon meal revealed Resident #1's lunch food tray contained cubed beef, mashed potatoes,</p>	F 365	<p>N 274 902 KAR 20:300-10(4)(c) Section 10 Dietary Services</p> <p>Criteria 1: Resident #1 is provided meat consistency with meals in accordance with MD orders and menu designation.</p> <p>Criteria 2: Residents are provided meat consistency with meals in accordance with MD orders and menu designation.</p> <p>Criteria 3: -The facility Policy/Procedure for meat consistency was revised to determine meats are provided in accordance with MD orders and menu designation. -Dietary staff have received inservice education on the revised P&P for meat consistency as provided by the RD/DM on 03/09/12 thru 03/13/12.</p> <p>Criteria 4: The CQI indicator for the monitoring of meal items in accordance with MD orders and menu designation will be utilized monthly under the supervision of the Dietary Manager.</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 365	Continued From page 18 vegetable medley, baked beans, a banana, 4-ounce container of yogurt, and a container of sherbet. Resident #1 reported to a Certified Medical Technician (CMT) who was in the room caring for Resident #1's roommate, "I can't chew this meat." The CMT left the room and brought in Licensed Practical Nurse (LPN) #5. LPN #5 observed Resident #1's lunch food tray and dietary food card and stated, "They brought you the wrong one. Your meat is supposed to be chopped." Then LPN #5 stated she would notify the kitchen to bring Resident #1 a new tray with the correct meat. Interview on 02/15/12, at 4:20 PM, with the Director of Nursing (DON) revealed the staff member that delivers the resident's tray is expected to check the resident's dietary food card to ensure the meal is the correct one ordered. If the meal that is delivered to the resident is incorrect then a new tray with the correct diet is ordered from Dietary. Further interview with the DON revealed all direct care staff was trained in orientation related to different food consistencies. Interview on 02/15/12, at 4:40 PM, with the Dietary Manager (DM) revealed the resident's physician-ordered meal cards are printed out every morning. The DM stated it was the dietary staff member on the tray line who called out to the dietary staff (who dipped the food) the resident's name, diet, dislikes, and the correct diet. The dietary staff member dipping out the food onto the food trays was then expected to dip out the correct food to be served to the resident.	F 365	Criteria 5: March 16, 2012.		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY	F 371			

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

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F 371	<p>Continued From page 19</p> <p>The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to store and serve food under sanitary conditions during tray line observation on 02/14/12 and 02/15/12. Bowls were observed to be stored wet, and a staff member failed to change gloves while serving food after going to other areas of the kitchen. The same staff member returned to the steam table with the same gloves and continued serving food and picking up the bread with the same gloved hand.</p> <p>The findings include:</p> <p>1. A review of the Dish Washing Policy/Procedures (not dated) revealed cleaned dishes must be allowed to air dry before storage.</p> <p>Observation of the noon meal on 02/14/12, at 11:40 AM, revealed the staff member serving the hot foods from the steam table picked up three bowls from a tray where the bowls had been stored. When the staff person picked up the bowls water dripped from the bowls. Observation of more bowls stored on trays outside of the dish</p>	F.371	<p>F 371 Food Procure, Store/Prepare/Serve – Sanitary The facility must store, prepare, distribute, and serve food under sanitary conditions.</p> <p>N 283 902 KAR 20:300-10(8)(b). Section 10. Dietary Services. The facility shall store, prepare, distribute and serve food under sanitary conditions.</p> <p>Criteria 1: -The dinex bowls have been washed and air dried as per dietary sanitation standards of practice. - Dietary staff perform hand sanitation and glove/utensil use in accordance with dietary-infection control standards of practice.</p> <p>Criteria 2: -Dinex bowls are washed and air dried as per dietary sanitation standards of practice. - Dietary staff perform hand sanitation and glove/utensil use in accordance with dietary infection control standards of practice.</p>		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/16/2012
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
(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 371	<p>Continued From page 20</p> <p>room revealed several of the bowls had been stored wet.</p> <p>Interview with the Registered Dietitian (RD) on 02/14/12, at 11:40 AM, revealed she had not realized the bowls had been stored wet.</p> <p>Interview with the Dietary Manager (DM) on 02/16/12, at 12:50 PM, revealed staff should have allowed more drying time for the bowls.</p> <p>2. A review of the Dietary Food Handling Policy/Procedures (not dated) revealed foods should be prepared and served with clean tongs, scoops, forks, spoons, spatulas, or other suitable implements so as to avoid manual contact of prepared foods with hands.</p> <p>Observation of the evening meal on 02/15/12, at 5:15 PM, revealed the staff member serving the hot food was wearing gloves. Continued observation revealed the staff member went to other areas of the kitchen to replenish food on the steam table, plates, lifted the dome plate lids, took temperatures midway through the meal service, and served the bread with the same gloved hands. The staff member failed to change gloves at any time during the meal service.</p> <p>Interview with the staff member on 02/15/12, at 5:45 PM, revealed she never changed gloves but did not handle anything that would require her to change gloves.</p> <p>Interview with the DM on 02/16/12, at 12:50 PM, revealed the staff member should have changed gloves when going to other areas of the kitchen and returning to the steam table or used tongs to</p>	F 371	<p>Criteria 3: -Obtained trays that allow better air circulation for improved drying times for dinex bowls.</p> <p>-Inservice education has been provided by the RD and/or DM for the dietary staff on 03/09/12 thru 03/13/12 on the correct cleansing and air drying of dinex bowls, and hand sanitation and glove/utensil use in accordance with dietary infection control standards of practice.</p> <p>Criteria 4: The CQI indicator for the monitoring of dietary sanitation and hand hygiene will be utilized monthly as per the established CQI calendar under the supervision of the Dietary Manager.</p> <p>Criteria 5: March 16, 2012.</p>	

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
(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 371	Continued From page 21 pick the bread up.	F 371		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must 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	F 441 Infection Control 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. N 144 902 KAR 20:300-6(7)(b)2.a. Section 6 Quality of Life. Criteria 1: -Medication administration staff administer medications in accordance with infection control standards of practice including washing hands after each resident contact, and washing hands after administering eye drops. -The ice scoops are stored in the designated containers between each use. -A sign alerting the public to the use of isolation precautions will be used upon initiation of these procedures. There are no residents currently requiring any isolation precautions in the facility.	

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717		
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F 441	Continued From page 22 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies, it was determined the facility failed to ensure an effective infection control program was maintained to provide a safe, sanitary, and comfortable environment to prevent the transmission of disease and infections. Observation of medication pass on 02/14/12, revealed staff failed to wash/sanitize hands after the administration of eye drops for Resident #7 and continued to administer a sublingual medication. Additionally, staff failed to wash/sanitize hands between resident contact. Observation on 02/16/12, of ice pass revealed staff left the ice scoop in the ice cooler during the ice pass for eleven resident rooms. Further observation revealed the facility failed to alert the visitors/residents of Resident's #9's contact precautions that had been initiated on 02/13/12. The findings include: Review of the facility's policies titled Standard Precautions and Summary of Centers for Disease Control Universal Precaution Recommendations (located in Employee Orientation Booklet) (not dated) revealed staff was to wash hands before and after resident contact and after gloves were removed. Review of the facility's policy titled Ice Machines and Ice (not dated) revealed the ice scoop should be covered on a clean, hard surface when not in use. The policy directed staff that the ice scoop should not be stored in the ice	F 441	Criteria 2: -Medication administration staff administer medications in accordance with infection control standards of practice including washing hands after each resident contact, and washing hands after administering eye drops. This was determined by med pass administration observations conducted by the DON/ADON/Infection Control Nurse on 03/05/12, 03/06/12, and 03/07/12. -The ice scoops are stored in the designated containers between each use, as determined during compliance rounds conducted by the DON/ADON/NHA on 03/05/12, 03/06/12, and 03/07/12. -A sign alerting the public to the use of isolation precautions will be used upon initiation of these procedures. There are no residents currently requiring any isolation precautions in the facility.		

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
(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	<p>Continued From page 23</p> <p>bin. Review of the facility's policy titled Care of the Resident with Shingles (not dated) revealed non-immune staff members and/or visitors should not have contact with an infectious resident until the resident's lesions have crusted over.</p> <p>1. Observation of a medication pass on 02/14/12, at 11:55 AM, revealed Licensed Practical Nurse (LPN) #5 failed to wash/sanitize hands between the administration of eye drops and sublingual medication for Resident #7. LPN #5 applied clean gloves and administered Alcon Ophthalmic Drops, one drop in each eye, for Resident #7. LPN #5 then removed her gloves and discarded them in the trash. Without washing/sanitizing her hands LPN #5 applied clean gloves and administered Atropine Sulfate Ophthalmic Solution 1%, two drops under the tongue, for Resident #7. LPN #5 removed and discarded her gloves in the trash. Without washing/sanitizing her hands LPN #5 was observed to apply clean gloves and swab out Resident #7's mouth with a glycerin swab and apply lip balm to the resident's lips. LPN #5 then obtained a paper towel and wiped sputum out of Resident #7's emesis basin. LPN #5 then removed the gloves and discarded them in the trash.</p> <p>2. Continued observation of medication pass on 02/14/12, at 12:00 PM, revealed LPN #5 exited Resident #7's room without washing her hands and went to the medication cart that was situated at the doorway of Resident #12's room. LPN #5 was observed to open Resident #12's ordered medication packages and crush tablets in a medication crusher without washing her hands or applying clean gloves. LPN #5 mixed the crushed medications with approximately 30</p>	F 441	<p>Criteria 3: -Nursing staff have received inservice education on infection control standards of practice including but not limited to: -hand washing after each resident contact and after administration of eye drops during medication administration; proper storage of the ice scoop in the designated container; the placement of the designated signs on the resident room door when isolation precautions are initiated as provided by the DON/ADON/Infection Control Nurse on 03/06/12 thru 03/15/12.</p> <p>Criteria 4: The CQI indicators for the monitoring of Infection Control Standards of Practice will be utilized monthly X 2 months and then quarterly as per the established CQI calendar under the supervision of the DON/Infection Control Nurse.</p> <p>Criteria 5: March 16, 2012</p>	

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
(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	<p>Continued From page 24</p> <p>milliliters of water. LPN #5 then applied clean gloves and administered the crushed medications and water solution in Resident #12's G-tube. LPN #5 then removed her gloves and discarded them in the trash. LPN #5 was then observed to exit Resident #12's room and sanitize her hands with hand gel.</p> <p>Interview on 02/14/12, at 12:10 PM, with LPN #5 revealed she was aware she did not wash her hands in between the administration of Resident #7's eye drops and the sublingual medication. LPN #5 confirmed she should have washed her hands after wiping out Resident #7's emesis basin. Further interview with LPN #5 revealed she had been trained to wash/sanitize her hands between resident care; therefore, she should have washed her hands before delivering care to Resident #12.</p> <p>3. Observation on 02/16/12, at 12:10 PM, revealed CNA #9 was passing ice to residents on the 200 Hall. Further observation revealed CNA #9 obtained a resident's water pitcher from room 224. CNA #9 filled the resident's ice pitcher with ice from the ice cooler positioned in the hallway.</p> <p>Continued observation revealed CNA #9 left the ice scoop in the ice chest with the handle in contact with the ice. CNA #9 completed the ice pass for the residents on the 200 Hall and continued to leave the ice scoop in contact with the ice in the ice chest.</p> <p>Interview on 02/16/12, at 1:40 PM, with CNA #9 revealed the cart used for passing ice to residents had a covered holder for the ice scoop. CNA #9 stated she had passed ice to at least 11 resident</p>	F 441		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717		
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F 441	<p>Continued From page 25</p> <p>rooms and had failed to store the ice scoop in the holder. CNA #9 stated she had been trained to store the ice scoop in the covered holder and leaving the ice scoop in contact with the ice would spread germs to the residents.</p> <p>Interview on 02/16/12, at 2:20 PM, with the DON revealed staff was required to store the ice scoop in the covered holder on the ice cart. The DON stated to prevent contamination of the ice the handle of the ice scoop should never come in contact with the ice.</p> <p>4. Review of the medical record for Resident #9 revealed the resident was evaluated at the Emergency Room on 02/12/12, due to the development of pain and blister-like areas to the lower back and coccyx. Resident #9 returned to the facility with the diagnosis of Herpes Zoster (shingles).</p> <p>Review of the comprehensive care plan dated 02/12/12, revealed contact precautions were implemented for non-disseminated shingles. Observation during the initial tour on 02/13/12, and throughout the survey revealed the facility had failed to post a sign to alert staff and visitors that contact precautions were required.</p> <p>Interview on 02/16/12, at 2:20 PM, with the Infection Control Nurse revealed staff had notified her on 02/12/12, of Resident #9's diagnosis of shingles. The Infection Control Nurse stated she directed staff to implement contact precautions and to notify the other departments of the precautions. The Infection Control Nurse stated she checked to ensure staff had implemented the contact precautions upon returning to work on</p>	F 441			

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

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OMB NO. 0938-0391

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NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717	
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F 441	<p>Continued From page 26</p> <p>02/13/12. The Infection Control Nurse stated a sign should be posted that stated, "Please check at nurses' station before entering room." The Infection Control Nurse stated she realized a sign to alert staff and the public had not been posted and had intended to post the sign herself. The Infection Control Nurse stated she failed to obtain the sign and post the sign to ensure staff and the public were aware of the potentially contagious shingles.</p> <p>Phone interview on 02/16/12, at 4:00 PM, with LPN #7 revealed she notified Resident #9's physician on 02/12/12, of the resident's complaint of pain of the low back and buttocks and blistered areas were present. LPN #7 stated the resident was sent to the Emergency Room and returned to the facility on 02/12/12, with the diagnosis of shingles. LPN #7 stated she informed all staff of the contact precautions and instructed one pregnant employee to not enter Resident #9's room and the new diagnosis was passed on in shift report. LPN #7 stated she failed to post the sign to alert staff and the public and didn't feel it was necessary. LPN #7 stated if the areas were draining she would have ensured all aspects of contact precautions were implemented.</p>	F 441		

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185270	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 02/15/2012
NAME OF PROVIDER OR SUPPLIER CUMBERLAND VALLEY MANOR			STREET ADDRESS, CITY, STATE, ZIP CODE 301 S MAIN STREET, PO BOX 438 BURKESVILLE, KY 42717		
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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: 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Six</p> <p>COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM</p> <p>FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM)</p> <p>EMERGENCY POWER: Type II Diesel generator</p> <p>A life safety code survey was initiated and concluded on 02/15/12, for compliance with Title 42, Code of Federal Regulations, §483.70 (a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	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.