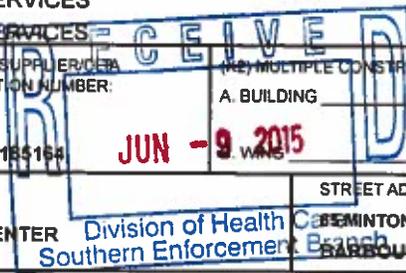


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185158	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ WING _____	(X3) DATE SURVEY COMPLETED 05/14/2015
--	--	---	--



NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE BIRMINGHAM HICKORY FARM ROAD BARBOURVILLE, KY 40906
---	---

(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 000	INITIAL COMMENTS	F 000		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p>	F 441	See attached	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Jenna Partin</i>	TITLE Administrator	(X8) DATE 6/8/15
--	------------------------	---------------------

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.

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 1</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to maintain an effective infection control program to prevent the development and transmission of disease and infection for one (1) of twenty-four (24) sampled residents (Resident #3). Facility staff failed to perform hand hygiene procedures after providing catheter care, incontinence care and before applying barrier cream for Resident #3.</p> <p>The findings include:</p> <p>Review of the Guidelines for Hand Hygiene policy (not dated) revealed employees should use an alcohol based hand rub if moving from a contaminated body site to a clean body site during care.</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 01/06/15 with diagnoses that include Cerebrovascular Accident (CVA), Hemorrhagic Cystitis, History of Infective Endocarditis, History of Urinary Tract Infection, Urolithiasis (the process of forming stones in the kidney, bladder, and/or urethra), Urinary Retention, Chronic Kidney Disease, Benign Prosthetic Hypertrophy, and Gross Hematuria Secondary to Foley Catheter Trauma.</p>	F 441			

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

PRINTED: 05/29/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/14/2015
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 2</p> <p>On 05/13/15 at 11:15 AM catheter care was observed for Resident #3. State Registered Nursing Assistant (SRNA) #1, SRNA #2, and Registered Nurse (RN) #1 were all observed to wash their hands and don gloves. During catheter care, SRNA #1 performed catheter care, then incontinence care, and then applied a barrier cream to the resident's sacrum and did not perform hand hygiene or change gloves between steps.</p> <p>Interview conducted with SRNA #1 on 05/14/15 at 2:55 PM revealed SRNA #1 had been trained to wash her hands and to change gloves when moving from a dirty site to a clean site. SRNA #1 stated she should have washed her hands and changed gloves after providing catheter care and incontinence care for Resident #3, and before applying barrier cream for the resident.</p> <p>Interview conducted with RN #1 on 05/14/15 at 3:00PM revealed that RN #1 had been trained to wash her hands and to change gloves when moving from a dirty site to a clean site. RN #1 stated hand hygiene and gloves should have been changed between catheter care, incontinence care, and before applying cream.</p> <p>Interview with the Director of Nursing (DON) on 05/14/15 at 4:00 PM revealed facility staff hand washing was monitored through catheter/incontinence care annually. The DON stated staff was trained to wash their hands and change gloves after providing catheter care, incontinence care, and before applying barrier cream.</p>	F 441			

Barbourville Health & Rehabilitation Center

Plan of Correction

Annual Survey

May 12th-14th, 2015

F441

1. Resident #3 was assessed to ensure no adverse outcomes were noted.
2. All residents on 200 unit had the potential to be effected. SRNA #1 received disciplinary action. SRNA # 1, SRNA # 2 and Registered Nurse #1 received 1:1 re-education by the Director of Nursing on peri-care, catheter care, hand washing, glove use, and the Infection Control Program. All SRNA's had 1:1 check off's on catheter care and peri care with return demonstration.
3. All nursing staff has been re-in serviced by the Director of Nursing and the Quality Assurance Nurse regarding peri-care, catheter care, hand washing, glove use, and the facility Infection Control Program. In-services were conducted on May 15th, May 25th, and May 29th, 2015.
4. The Clinical Coordinators, or their designee (the Quality Assurance Nurse in their absence) on each unit will observe three residents on each unit receiving catheter care, peri care, and incontinent care including glove use and hand washing. These audits will be done weekly for one month and then monthly for the next quarter. Any irregularities will be corrected immediately and reported to the CQI Committee for further follow-up.
5. Completed: June 14th, 2015.

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

PRINTED: 11/10/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185164	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 05/12/2015
NAME OF PROVIDER OR SUPPLIER BARBOURVILLE HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906		
(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 000	<p>INITIAL COMMENTS</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 2012</p> <p>SURVEY UNDER: 2000 New</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 11 (000)</p> <p>SMOKE COMPARTMENTS: Four</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 05/12/15 utilizing the short form, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility 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.