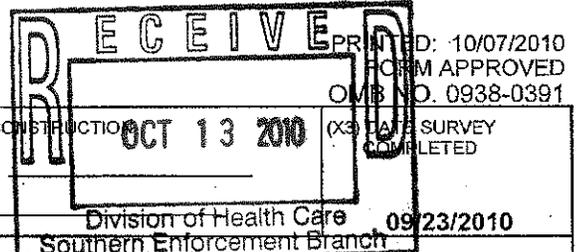


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185148	(X2) MULTIPLE COMPLETION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/23/2010
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NAME OF PROVIDER OR SUPPLIER  WILLIAMSBURG NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 287 N ELEVENTH ST, P O BOX 719 WILLIAMSBURG, KY 40769
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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
F 000	INITIAL COMMENTS  A standard health survey was conducted on September 21-23, 2010. Deficient practice was identified with the highest scope and severity at "D" level.  An abbreviated standard survey (KY15338) was also conducted at this time. The allegation was unsubstantiated with no deficient practice identified.	F 000		
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. (3) The facility must require staff to wash their	F 441		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Gurbow, Administrator TITLE: Administrator (X6) DATE: 10/11/2010

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

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F 441	<p>Continued From page 1</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens 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, and review of facility policy, it was determined the facility failed to maintain an effective infection control program. Observation on September 22, 2010, revealed staff failed to wash/sanitize hands during the provision of care for resident #5.</p> <p>The findings include:</p> <p>Review of the facility policy on hand hygiene (not dated) revealed staff was required to change gloves during patient care if moving from a contaminated site to a clean body site.</p> <p>Observation on September 22, 2010, at 9:30 a.m., revealed Licensed Practical Nurse (LPN) #2 conducted a complete skin assessment on resident #5. Resident #5 was found to have a soiled brief during the assessment. LPN #2 provided incontinence care and failed to remove the soiled gloves or wash his/her hands before continuing with the skin assessment. LPN #2 went on to cover the resident and adjust the pillow with the soiled gloves on.</p> <p>Interview with LPN #2 on September 23, 2010, at</p>	F 441		

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F 441	Continued From page 2	F 441		
F 465 SS=D	<p>3:05 p.m., revealed the LPN should have removed the soiled gloves after conducting incontinence care. The LPN further stated after removing gloves the hands should have been washed and clean gloves applied before continuing with the skin assessment.</p> <p>483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON</p> <p>The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain a safe, sanitary, and comfortable environment for residents, staff, and the public. The medication room on the 300 Hall was observed to have soiled cabinets and drawers. A geri-chair in resident room 223 was observed to have torn, ragged arms.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Observation of the medication room on the 300 Hall revealed the cabinets and drawers were soiled and in need of housekeeping services. There were areas of dried spilled material and debris observed inside the drawers.</li> </ol> <p>An interview conducted with Licensed Practical Nurse (LPN) #3 on September 23, 2010, at 1:15 p.m., revealed the nursing staff was responsible to keep the room clean.</p> <ol style="list-style-type: none"> <li>2. Observation of room 223 revealed a geri-chair</li> </ol>	F 465		

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F 465	Continued From page 3 with torn and ragged arms.  An interview conducted with the Maintenance Supervisor on September 23, 2010, at 2:05 p.m., revealed he/she had not received a work order from staff to remove the geri-chair. The Maintenance Supervisor stated the facility did not repair the geri-chairs with torn, ragged arms; these chairs were removed and replaced.	F 465		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to maintain accurate clinical records in accordance with accepted professional standards and practices for residents #13 and #21.  The findings include:  1. Observations of resident #13 on September 21-22, 2010, revealed no evidence of a Foley	F 514		

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F 514	<p>Continued From page 4</p> <p>catheter. In addition, a skin assessment conducted on September 22, 2010, at 10:45 a.m., revealed resident #13 did not have an indwelling Foley catheter.</p> <p>A review of the medical record for resident #13 revealed the resident was admitted to the facility on November 20, 2007, with the following diagnoses: Arthritis, Degenerative Joint Disease, Alzheimer's, Dementia, Glaucoma, Hypothyroidism, Hypokalemia, and Hemorrhoids. The medical record revealed resident #13 had a hospital stay in March 2010 and returned to the facility on March 13, 2010, with an indwelling Foley catheter. A review of the medical record revealed no physician's order to discontinue the Foley catheter for resident #13; in addition, the facility nurse's notes did not document that the Foley catheter had been discontinued for resident #13. A review of the treatment record revealed the nurses on each shift had initialed that resident #13 had a Foley catheter for September 18-22, 2010, however, a review of the intake and output record revealed that resident #13's Foley catheter had been discontinued on September 18, 2010. A review of the care plan revealed the care plan had not been updated regarding the removal of the Foley catheter for resident #13.</p> <p>An interview was conducted with Registered Nurse (RN) #1 on September 22, 2010, at 2:10 p.m. RN #1 stated he/she was unaware resident #13 no longer had a Foley catheter and did not know when the catheter had been removed. RN #1 stated when he/she initialed the treatment record RN #1 was indicating resident #13 had a Foley catheter that was patent/draining. RN #1 stated he/she had not checked to see if the resident had a Foley catheter when making</p>	F 514			

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F 514	<p>Continued From page 5</p> <p>rounds and giving medications. RN #1 stated when a Foley catheter was removed the nurse caring for the resident was responsible for notifying the resident's physician and writing orders accordingly. RN #1 stated when an order was written a copy of the order was given to the nursing supervisor and the nursing supervisor updated the care plan.</p> <p>An interview conducted with RN #5 on September 22, 2010, at 3:45 p.m., revealed the floor supervisor (RN #4) and RN #5 monitored physician's orders and 24-hour shift reports. RN #5 stated the floor supervisor updated the care plans.</p> <p>An interview was conducted with RN #3 on September 22, 2010, at 4:00 p.m. RN #3 stated resident #1's catheter came out on September 18, 2010, on the night shift. RN #3 stated resident #1 was voiding without difficulty and he/she called the physician's office and left a message with office staff for the physician to call the facility regarding resident #1. RN #3 stated the physician did not call back before RN #3's shift ended and he/she had reported this to the oncoming nurse. RN #3 stated he/she was not concerned because resident #1 was voiding without difficulty. RN #3 stated he/she forgot to document this in the medical record. RN #3 stated he/she did not know why RN #3 continued to initial on the treatment record that resident #1 had a Foley catheter.</p> <p>An interview was conducted with RN #4 on September 23, 2010, at 1:50 p.m. RN #4 stated he/she was unaware resident #1 no longer had a Foley catheter. RN #4 stated he/she did not get a copy of an order to remove the Foley catheter,</p>	F 514		

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F 514	<p>Continued From page 6 and had not reviewed the 24-hour shift reports for that time period.</p> <p>2. A review of the medical record for resident #21 revealed the resident was admitted to the facility on April 9, 2008, with diagnoses of Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, Degenerative Joint Disease, and Hypertension. A review of resident #21's plan of care revealed the resident was to utilize a right knee brace worn during the day for ambulation and transfer and to be taken off at night. Further review of the Certified Nursing Assistant (CNA) Flow Sheet revealed staff had initialed each day to indicate the resident had utilized the knee brace during the shift.</p> <p>Observations of resident #21 on September 23, 2010, at 10:30 a.m., 1:25 p.m., and 2:10 p.m., revealed no knee brace was in use for the resident.</p> <p>An interview conducted with CNA #2 at 1:25 p.m. on September 23, 2010, revealed the CNA had initialed the CNA Flow Sheet to indicate the knee brace was in use. CNA #2 further stated he/she did not ever remember resident #21 using a knee brace, but the CNA stated he/she initialed the flow sheet anyway.</p> <p>An interview with Licensed Practical Nurse (LPN) #3 conducted on September 23, 2010, at 1:25 p.m., revealed he/she was unaware resident #21 required the use of a knee brace.</p> <p>An interview with CNA #3 conducted on September 23, 2010, at 1:40 p.m., revealed a brace had been utilized at one time, however, not recently.</p>	F 514		

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F 514	Continued From page 7  An interview with the Director of Nursing (DON) conducted on September 23, 2010, at 2:40 p.m., revealed a recommendation had been made by Therapy for a knee brace at one time, however, the resident refused to wear it most of the time. The DON further stated the CNAs should not have initialed the flow sheets if the resident was not using the brace and that the nurses should have monitored the flow sheets to ensure care was documented correctly.	F 514			

Williamsburg Health and Rehabilitation Center

Plan of Correction

Annual Survey- September 21-23, 2010

F441 483.65 Infection Control, Prevent Spread, Linens

1. Resident # 5 is receiving all appropriate infection control standards during resident care, including proper hand washing before and after incontinence care, after removal of gloves and after care is complete.
2. All residents in the facility could have potentially been affected by this deficiency.
3. An inservice was conducted with all nursing staff by unit supervisors and Director of Nursing regarding infection control procedures specifically hand washing. Information on proper hand washing/glove changing techniques, including washing hands before care, after removal of gloves and after care is complete. Inservices were completed on September 24<sup>th</sup>, 2010.
4. The QA designee will observe hand washing techniques for 5 residents per week for one month, then 2 residents per week for 3 months to ensure proper infection control standards are utilized including appropriate hand washing. Any irregularities will be corrected immediately and will be reported to the QA committee for further review.
5. September 30, 2010

Williamsburg Health and Rehabilitation Center  
Plan of Correction  
Annual Survey- September 21-23<sup>rd</sup>, 2010

F 465 483.70(h) Safe/Functional/Sanitary/Comfortable Environment

1. The geri-chair in resident room # 223 was removed from the room and placed in Maintenance for repair. All cabinets and drawers in the medicine room on 300 hall were cleaned.
2. All equipment including geri-chairs in rooms and in facility were checked by Maintenance Supervisor for torn, ragged arms. Any problems were corrected immediately. All facility medicine room drawers and cabinets were checked to ensure cleanliness.
3. The Maintenance/Housekeeping Supervisors were inserviced on September 24<sup>th</sup>, 2010 by administrator on checking rooms on a daily basis for any equipment including geri-chairs for needed repairs. All staff were inserviced by administrator on reporting and removal of any piece of equipment in need of repair (torn, ragged arms). All staff instructed on completing work orders and to remove any damaged equipment from the floor immediately. All nurses were inserviced on September 24<sup>th</sup>, 2010 by unit supervisors on proper cleaning of medicine rooms including drawers and cabinets. A cleaning schedule was initiated for all nurses.
4. The QA designee will check 5 rooms weekly for 1 month and 5 rooms per month for 3 months to ensure all equipment is in good repair. Any irregularities will be corrected immediately and reported to QA committee for further review.
5. September 30, 2010

Williamsburg Health and Rehabilitation Center  
Plan of Correction  
Annual Survey- September 21-23<sup>rd</sup>, 2010

F514 483.5(l) (1) Resident Records-Complete/Accurate/Accessible

1. Physician and Family notified. An order was written to discontinue the foley catheter and the treatment records have been corrected to reflect that resident #13 has no foley catheter. For resident #21 the physician and family have been notified on resident refusal to wear the knee brace. The knee brace has been discontinued and the nurse aide flow sheet has been corrected to reflect that resident #21 has no knee brace.
2. All resident physician orders, treatment records, and nurse aide flow sheets have been reviewed for accuracy.
3. Inservice was held on September 24<sup>th</sup>, 2010 by Director of Nurses and Unit Supervisors with all nursing staff regarding accurate clinical records and the importance of notifying either the charge nurse or unit supervisor of an error in the resident record. All physician orders, treatment records, and nurse aide flow sheets will be checked for accuracy at the end of each month to ensure accurate clinical records are in place for the upcoming month. Any problems will be corrected immediately.
4. The QA designee will review 5 clinical records weekly for 1 month and 5 records monthly for 3 months to ensure accurate clinical record documentation. Any irregularities will be corrected immediately and reported to QA committee for further follow up.
5. September 30<sup>th</sup>, 2010