

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

PRINTED: 06/01/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/18/2012
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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 000	INITIAL COMMENTS An Abbreviated Survey investigating KY#00018242 was conducted 05/09/12 through 05/16/12 and an Extended Survey was conducted 05/17/12 through 05/18/12. KY#00018242 was substantiated. Immediate Jeopardy was identified on 05/15/12 and was determined to exist on 05/02/12 at 42 CFR 483.65 Infection Control, F-441 and 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "K". The facility was notified of the Immediate Jeopardy on 05/15/12.	F 000		
	<p>The facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in order to prevent the development and transmission of disease and infection. The facility failed to ensure the disinfectant used for the whirlpool tubs was effective against Vancomycin Resistant Enterococcus (VRE). Additionally, the facility failed to obtain a disinfectant effective against VRE after becoming aware, on 05/11/12, the current product in use had not been tested against VRE. Resident #2 was diagnosed with VRE on 04/29/12. Review of the Nursing Assistant Care Plan revealed Resident #2 received a whirlpool tub bath on Wednesdays and had received a whirlpool bath on 05/02/12 and 05/09/12. The resident resided on a forty (40) bed unit, and thirty-seven (37) of the residents received a whirlpool tub bath in the same whirlpool as Resident #2. The facility also failed to ensure staff was knowledgeable in regards to Contact Precautions for hand hygiene and use of gowns while providing care to Resident #2. Additionally, the facility Administration failed to ensure the effectiveness</p>			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Angela B. [Signature]* TITLE *Administrator* (X8) DATE *6-11-12*

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

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F 000	<p>INITIAL COMMENTS</p> <p>An Abbreviated Survey investigating KY#00018242 was conducted 05/09/12 through 05/16/12 and an Extended Survey was conducted 05/17/12 through 05/18/12. KY#00018242 was substantiated. Immediate Jeopardy was identified on 05/15/12 and was determined to exist on 05/02/12 at 42 CFR 483.65 Infection Control, F-441 and 42 CFR 483.75 Administration, F-490 at a Scope and Severity (S/S) of a "K". The facility was notified of the Immediate Jeopardy on 05/15/12.</p> <p>The facility failed to establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in order to prevent the development and transmission of disease and infection. The facility failed to ensure the disinfectant used for the whirlpool tubs was effective against Vancomycin Resistant Enterococcus (VRE). Additionally, the facility failed to obtain a disinfectant effective against VRE after becoming aware, on 05/11/12, the current product in use had not been tested against VRE. Resident #2 was diagnosed with VRE on 04/29/12. Review of the Nursing Assistant Care Plan revealed Resident #2 received a whirlpool tub bath on Wednesdays and had received a whirlpool bath on 05/02/12 and 05/09/12. The resident resided on a forty (40) bed unit, and thirty-seven (37) of the residents received a whirlpool tub bath in the same whirlpool as Resident #2. The facility also failed to ensure staff was knowledgeable in regards to Contact Precautions for hand hygiene and use of gowns while providing care to Resident #2. Additionally, the facility Administration failed to ensure the Effectiveness</p>	F 000	<p>This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.</p>	

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F 441	<p>Continued From page 2</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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 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 review of the facility's policy, it was determined the facility failed to establish and maintain an infection control program designed to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of disease and infection.</p> <p>The facility failed to ensure the disinfectant used for sanitizing whirlpool tubs was effective against all Multi-Drug Resistant Organisms (MDROs), specifically Vancomycin Resistant Enterococcus [(VRE)- specific species of bacteria which are known to be resistant to Vancomycin, an antibiotic used to treat infections]. Resident #2 was</p>	F 441	<p>Bourbon Height's updated Infection Control Program is designed to investigate, control, and prevent infections in the facility.</p> <p>The updated infection control program sets forth criteria as to what procedures are necessary for each individual resident. The infection control program also requires maintenance of records of incidents and corrective actions related to infections. In addition, as to the preventing spread of infection, the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. The policy also prohibits employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>The policy requires staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>The policy requires personnel to handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>The Infection Control Program and Manual was updated on June 8, 2012. It was reviewed and approved by the Infection Control Committee and the Medical Director on June 8, 2012. The staff was inserviced on the updated Infection control policy manual June 6, 7 and 8, 2012. The updated infection control policies went into effect on June 8, 2012.</p> <p>The actions specified below have been taken to remove the conditions giving rise to the finding of immediate jeopardy as reported in the OIG Immediate Jeopardy Notification dated May 15, 2012, which alleges violation of 42 CFR 483.65 Infection Control and reported as F441.</p>

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F 441	<p>Continued From page 3</p> <p>diagnosed with VRE 04/29/12. Resident #2 took a whirlpool tub bath in the same whirlpool as thirty-seven (37) other residents on 05/02/12 and 05/09/12. The facility failed to obtain a disinfectant effective against VRE after becoming aware, on 05/11/12, the product in use had not been tested against VRE. Residents received whirlpool tub baths on 05/14/12 with the same disinfectant still in use.</p> <p>In addition, the facility failed to ensure staff was knowledgeable related to Contact Isolation precautions as evidenced by observation of a staff member exiting Resident #2's room, who had been diagnosed with VRE in his/her urine, to dispose of trash and did not wash or sanitize his hands after the disposal. This same staff member was later observed to take a cup from Resident #2's room, open the closet and bathroom doors in the room, and exit the room without washing or sanitizing his hands. Further observation revealed Licensed Practical Nurse (LPN) #1 did not wear a gown when performing an in and out catheter procedure on Resident #2.</p> <p>Based on the above findings, it was determined the facility's failure to maintain an infection control program designed to provide a safe, sanitary and comfortable environment in order to prevent the development and transmission of disease and infection is likely to cause serious injury, harm, impairment, or death. Immediate Jeopardy was identified on 05/15/12 and determined to exist on 05/02/12,</p> <p>The facility provided an acceptable credible Allegation of Compliance (AoC) on 05/18/12 with the facility alleging removal of the Immediate</p>	F 441	<p>When notified that an immediate jeopardy situation had been identified to exist at Bourbon Heights, immediate steps were taken on May 15, 2012 to investigate, correct and rectify the situation, as well as steps to prevent future issues with infection control. Below is a comprehensive list of immediate corrective actions that have been taken. Items were accomplished on May 18, 2012 and represent the Facility's continuing efforts toward improving quality of care and compliance.</p> <ul style="list-style-type: none"> • <u>Cause of the Immediate jeopardy was identified.</u> The Immediate Jeopardy finding related to the Facility's use of a disinfectant for cleaning of whirlpool baths. Contrary to representations made by the Vendor who supplies the Facility, a disinfectant used by the Facility to clean the whirlpool baths was not labeled to be effective to destroy VRE. (Please note that the active ingredients in this disinfectant have been approved by the EPA to be specific for VRE.) When this was discovered, the Facility discontinued use of the whirlpools and obtained a new disinfectant that was labeled as effective against all MDRO's including VRE. • <u>The Facility has identified all residents that may be at potential risk for harm.</u> To identify the residents who may have bathed in the whirlpool during the same time as the resident with VRE, records were reviewed to identify residents that had used the whirlpool tubs from April 29, 2012 until May 18th, 2012 when use of the whirlpool tubs was permanently discontinued. 	05/18/2012

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F 441	<p>Continued From page 4</p> <p>Jeopardy on 05/18/12. Immediate Jeopardy was verified removed on 05/18/12 as alleged prior to exiting with the facility, with remaining non-compliance at 42 CFR 483.65 Infection Control, with a scope and severity of an "E", while the facility develops and implements a Plan of Correction and the facility's Quality Assurance continues to monitor to ensure a safe, sanitary and comfortable environment and to prevent the development and transmission of disease.</p> <p>The findings include:</p> <p>1. Review of the facility's policy entitled, "Cleaning of Whirlpool Tub", undated, revealed the standard was for the whirlpool to be "cleaned to prevent cross-contamination". Further review revealed the whirlpool was to be cleaned with an approved cleaning solution. The policy referred to the use of a product entitled "Cen-Klean" for the cleaning of the whirlpool tubs.</p> <p>Interview, on 05/10/12 at 4:00 PM, with the Infection Control (IC) Nurse revealed the Cen-Klean mentioned in the "Cleaning of Whirlpool Tub" policy had been "phased out" and a product entitled, "Simply Solutions" was being used. She stated the Infection Control policy needed to be updated.</p> <p>Interview, on 05/16/12 at 12:45 PM, with the Housekeeping Supervisor revealed the Cen-Klean had not been used in the facility since 2001.</p> <p>Observation, on 05/10/12 at 4:30PM, of the label on a gallon jug of the Simply Solutions disinfectant stored in the janitor's closet, revealed no documented evidence the product was effective against Vancomycin Resistant</p>	F 441	<p><u>Steps taken to remove the immediate jeopardy.</u></p> <ol style="list-style-type: none"> 1. The disinfectant was changed to a disinfectant tested and labeled to be effective to destroy VRE on May 15th, 2012. 2. Infection Control Nurse, Ashley Kincaide was consulted to review the situation and to determine actions necessary to abate any deficiency. The two employees, Kim Blavins, LPN and Robert Akemon, Nurse Aide who allegedly violated the Infection Control Policy were identified and immediately inserviced regarding the Infection Control Policy. Ms. Kincaide began inservicing all staff; performed the necessary culturing of the whirlpools and assisted in the removal of the jeopardy. 3. The use of the whirlpool baths was permanently discontinued on May 16th, 2012. The electronic panels were disconnected to prevent any further use. 4. All disinfectants and cleaning supplies used in the Facility were reviewed to assure that they were effective to destroy VRE by May 16, 2012. 5. Vendors were notified in writing that the Facility would not purchase any cleaning supplies that were not tested and labeled to be effective to destroy VRE on May 16, 2012. 6. As of May 16, 2012, all residents using the whirlpool baths during the same time as a resident with VRE were identified. 7. The Facility Medical Director, Dr. Ferrell, was consulted on actions that should be taken as a result of the whirlpool situation. 8. With the Medical Director's input and approval, a tool was developed for nursing staff to use when assessing residents for signs and symptoms of VRE infection. 9. As of May 16, 2012, the residents who were identified to have used the whirlpool bath during the time the resident with VRE used the bath were individually assessed to determine whether any resident had signs or symptoms of VRE. 	05/15/2012 05/16/2012 05/16/2012 05/16/2012 05/16/2012

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F 441	<p>Continued From page 5</p> <p>Enterococcus (VRE). Interview at that time with the IC Nurse revealed Resident #2 had been diagnosed with VRE in his/her urine. Observation, on 05/10/12 at 4:35 PM, of the Unit 1 whirlpool tub room, where Resident #2 resided, revealed a disinfectant entitled "Simply Solutions" was present to disinfect the whirlpool tub after use.</p> <p>Interview, on 05/11/12 at 11:45 AM, with the Simply Solutions manufacturer's Regulatory Compliance Director, revealed the Simply Solutions product was not effective against Vancomycin-Resistant Enterococcus. Further interview revealed the Simply Solutions disinfectant had never been tested against VRE.</p> <p>Observations of the Unit 1, Unit 2, and Unit 3 whirlpool tub rooms, on 05/11/12 from 12:55 PM to 1:06 PM, revealed Simply Solutions disinfectant to be present for use in sanitizing the whirlpool tubs.</p> <p>Interview, on 05/11/12 at 4:23 PM, with the Housekeeping Supervisor, who oversees the ordering of products, revealed she was unaware the Simply Solutions disinfectant was not effective against VRE.</p> <p>Interview, on 05/11/12 at 4:34 PM, with the facility's Administrator revealed she had entrusted her supplier to ensure the facility had a disinfectant for the whirlpool tubs that would "kill everything". The surveyor informed her of what the manufacturer had reported in the interview at 11:45 AM. She stated that was "disturbing" as she was not aware the Simply Solutions had never been tested against VRE.</p>	F 441	<p>10. For the residents who were identified to have wounds or open areas that had used the whirlpool baths since April 29, 2012, a culture was taken and sent to be tested for VRE on May 16, 2012.</p> <p>11. The Infection Control Nurse, Ashley Kincaide, and the Medical Director, Dr. Ferrell, reviewed Facility Infection Control Policy to assure that it specifically included information about VRE and made changes where necessary. In addition, inservice training regarding the Facility's Revised Infection Control Policy was performed and conducted by Willas Gray, Assistant Director of Nursing; Ashley Kincaide, Infection Control Nurse; and Deanna Eads, Director of Nursing. Inservice for staff absent on this date was conducted via telephone and inservice for employees on leave will be conducted before they return to work.</p> <p>12. Changes were made to the Infection Control Policy to assign the Infection Control Nurse the duty of reviewing all new resident prescriptions for antibiotics as well as new reports of resident wounds on a daily basis. The Infection Control Nurse shall determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies. The Infection Control Nurse shall report any changes that need to be made to the Administrator. The Infection Control Nurse shall also report new types of infections/bacteria and resident wounds to the Quality Control Committee. This policy was added to the Facility's Infection Control Policies on May 16, 2012.</p>

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F 441	<p>Continued From page 6</p> <p>Review of Resident #2's medical record revealed an admission date of 07/02/09 with diagnoses which included Chronic Obstructive Pulmonary Disease (COPD), and a history of Urinary Tract Infections (UTIs).</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 03/14/12, revealed the facility assessed the resident to have a Brief Interview of Mental Status (SIMS) score of five (5) which indicated Resident #2 was severely impaired cognitively.</p> <p>Review of the Comprehensive Care Plan, dated 03/21/12, revealed Resident #2 was frequently incontinent of bladder. Interventions included monitor for signs and symptoms of urinary tract infection.</p> <p>Review of the Urine Culture results reported on 04/29/12, revealed Resident #2 had greater than 100,000 CFU (colony forming units) per ml (milliliter) of VRE. Continued review of the Comprehensive Care Plan revealed the care plan was updated on 05/01/12 to include information related to the urinalysis results received that indicated the resident had VRE. Further review revealed Contact Precautions were implemented on that date.</p> <p>Review of the Nursing Assistant Care Plan, for 05/2012, revealed Resident #2 was to receive a "specialty tub" (whirlpool) bath every Wednesday, on the 3:00 PM to 11:00 PM shift. Further review of the Nursing Assistant Care Plan revealed the State Registered Nursing Assistants (SRNAs) signed off on Wednesday, 05/02/12 and</p>	F 441	<p>13. An in-service training on infection control practices and VRE was conducted by Willas Gray, Assistant Director of Nursing; Ashley Kincaide, Infection Control Nurse; Deanna Eads, Director of Nursing; and Barbara Traylor, Housekeeping Supervisor, for Housekeeping and Nursing Staff with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures, including hand washing and proper use of gloves and protective gowns, as well as linen precautions. This training was completed by May 16, 2012 for all members of the Housekeeping and staff.</p> <p>14. An in-service training for all staff on infection control policy as well as VRE specifically was conducted, which included training about the signs and symptoms of VRE infection as well as proper infection control procedures and techniques by May 18, 2012 with the facility-wide in service completed by May 17th, 2012.</p> <p>15. Infection Control procedures were reviewed with the staff caring for the Resident with VRE infection to assure that proper procedures were being followed to prevent the spread of the infection by May 18, 2012.</p> <p>16. The attending physician for the Resident ordered tests to determine if the resident still had the VRE infection on May 16, 2012.</p> <p>17. Isolated bathroom facilities were immediately appointed for Resident #2 upon notification of possible VRE</p> <p>• <u>The Facility has implemented systemic changes to ensure that jeopardy will not reoccur.</u></p> <p>As of May 16, 2012, the Facility has initiated a new policy and procedure to ensure that immediate jeopardy will not reoccur by assigning the Infection Control Nurse the responsibility of reviewing the disinfectant and cleaning supplies used by Facility on a quarterly basis to determine if the supplies are appropriate to address the infection control needs of the Facility.</p>	05/16/20 05/18/20 04/27/20 05/16/20 05/16/20

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F 441	<p>Continued From page 7</p> <p>Wednesday, 05/09/12 that Resident #2's care was provided which included the "specialty tub" (whirlpool) bath.</p> <p>Interview, on 05/11/12 at 3:10PM, with SRNA #12, and on 05/11/12 at 4:18 PM with SRNA#13 revealed Resident #2 had been receiving a whirlpool tub bath on Wednesdays on the 3:00 PM to 11:00 PM shift.</p> <p>Interview, on 05/15/12 at 4:00PM, with the Director of Nursing (DON) revealed there were thirty-seven (37) total residents who received whirlpool tub baths on Unit 1, in the same whirlpool as Resident #2.</p> <p>Interview, on 05/15/12 at 5:10PM, with the Housekeeping Supervisor revealed she had been informed of there being VRE in the building "a week or week and a half ago". She stated she was only informed of resident infections verbally during the morning meeting, at which all Department Heads were present. In addition, she stated if she was not present in the morning meeting there was no system in place to ensure she was made aware of new organisms. The Housekeeping Supervisor stated that sometimes communication didn't get passed along. According to the Housekeeping Supervisor, who supervised the Supply Clerk, if she was not made aware of a need for a different product then she couldn't inform the Supply Clerk of what to order. She stated she felt it was the Infection Control (IC) Nurse's responsibility to ensure the products used by nursing staff were effective against VRE.</p> <p>Observations of the Unit 1, Unit 2, and Unit 3 whirlpool tub rooms on 05/14/12 revealed the</p>	F 441	<p>Additionally, the Infection Control Nurse shall report the findings to the Administrator so that changes can be made if necessary. The new policy also requires the Infection Control Nurse to monitor the prescribing of antibiotics to Residents and Resident Wounds to patients on a daily basis to determine if changes in disinfectant and cleaning supplies are necessary. If so, the Infection Control Nurse shall communicate the need to change supplies immediately to the Administrator. The Infection Control Nurse is also required to report any new infections/bacteria or wounds to the Quality Assurance Committee as well as any change in disinfectant and cleaning supplies.</p> <p>By making the review of cleaning supplies a function of the Infection Control Nurse and incorporating this into the job description and Facility Infection Control Policy, controls are now in place which assure that when residents experience new types of infections/bacteria, Facility disinfectants and cleaning supplies will be reviewed for effectiveness. Likewise, the Infection Control Nurse is to report to the Quality Assurance Committee, which is made up of Administrator, Director of Nursing, Social Services Director, Activities Director, Quality Assurance Director, Housekeeping Supervisor, Maintenance Director, Dining Services Director, MDS Coordinator and Business Office Manager which reviews these decisions.</p>	

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F 441	<p>Continued From page 8</p> <p>Simply Solutions disinfectant to still be in use, even though the facility had been notified of the product's ineffectiveness against VRE on 05/11/12. Interview, on 05/15/12 at 5:53 PM, with State Registered Nursing Assistant (SRNA) #18 revealed she had given three (3) whirlpools on Unit 1 on 05/14/12. She stated she had disinfected the whirlpool tub with the Simply Solutions disinfectant. When asked if she had been informed not to use the Simply Solutions, she stated "No, that's all we had to clean it with". Interview, on 05/16/12 at 4:45 PM, with SRNA #24 revealed she had given a whirlpool tub bath on 05/14/12 on Unit 1. She stated she had used the same disinfectant as she had always used (Simply Solutions). According to the SRNA she had not been informed to use anything different.</p> <p>Interview, on 05/15/12 at 3:10 PM, with the Supply Clerk revealed she was not notified until 05/14/12 to order a new product for use of disinfecting the whirlpool tubs. She stated the Simply Solutions disinfectant was still in use on 05/14/12. Further interview with the Supply Clerk, at 3:41 PM, revealed she "guessed" she should have ensured the Simply Solutions was effective; however, no one had told her to do this. In addition, she stated she and the IC Nurse should have looked at it together.</p> <p>2. Review of the facility's Infection Control policy revealed a policy entitled, "Policy and Procedure for MULTIDRUG RESISTANT ORGANISMS", undated, which included Vancomycin-Resistant Enterococcus (VRE) infections, revealed staff should follow "Standard Precautions" for all resident care. Continued review of the policy revealed Standard Precautions, under the</p>	F 441	<ul style="list-style-type: none"> <u>The Facility has implemented plans to monitor its performance to ensure that these solutions that have been identified are sustained.</u> To assure that changes in cleaning supplies are made when Residents experience a new infection/bacteria, the Quality Assurance Committee will review the Infection Control Nurse's reports of new infections/bacteria as well as wounds and changes in disinfectant and cleaning supplies on a quarterly basis. The Quality Assurance Committee will be able to determine if new infection/bacteria is reported without a necessary change in disinfectant and cleaning supplies from the reports that are made by the Infection Control Nurse. Because the Quality Assurance Committee receives information from other sources (Director of Nursing and other Disciplines) about new infections/bacteria and wounds, it will be able to monitor whether the Infection Control Nurse performs the required reviews. <u>The Facility has included dates of corrective action.</u> The Facility is confident that the situation creating immediate jeopardy was corrected by Friday evening, May 18th, 2012.

05/18/201

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/18/2012
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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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Continued From page 9

"Bloodborn Pathogen Exposure Plan", undated, stated gowns should be worn during procedures that were likely to generate splashing of blood or body fluids.

Observation during the initial tour of the facility, on 05/09/12 at 11:55 AM, revealed the door to Resident #2's room had signage posted stating "Contact Precautions". Continued observation, on 05/10/12 at 1:35 PM, revealed gowns and gloves were available in the room.

Observation, on 05/16/12 at 1:27PM, of Licensed Practical Nurse (LPN) #1 revealed the LPN performed an in and out catheter procedure on Resident #2, who was on Contact Precautions for VRE in his/her urine. Observation revealed LPN #1 did not wear a protective gown during the procedure.

Interview, on 05/16/12 at 1:33 PM, with LPN #1 revealed she was not aware of the facility's policy on when she should wear a gown. She stated she had always been told to wear a gown if there was a "big mess", such as stool. The LPN stated she had the "urine under control" when she performed the in and out catheter procedure.

Interview, on 05/17/12 at 3:32 PM, with the Director of Nursing (DON) revealed she would expect her nurses to wear a gown when performing an in and out catheter procedure on a resident with Contact Precautions.

3. Observation, on 05/10/12 at 9:40 AM, of Unit 1 revealed SRNA #5 to exit Resident #2's room, who was on Contact Precautions related to a diagnosis of VRE, with a red biohazard bag which

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In addition, in order to prevent any future issues regarding infection control, assigned members of the Quality Assurance Committee will observe weekly and conduct random inspections each shift for proper gowning, hand hygiene, and other infection control issues. In addition, all staff has an ongoing responsibility to report any violations of the Infection Control Policy to the Charge Nurse. The Charge Nurse will then investigate and report to the Quality Assurance Committee. A Quality Assurance observation form has been implemented and reviewed every morning by QA committee. The infection Control Nurse has been and will be attending daily QA meetings to discuss new antibiotics for all residents with infections as a communication tool.

Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The Facility remains committed to the providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Allegation of Removal of Immediate Jeopardy/Allegation of Compliance to be an admission of the finding of deficient practices.

06/08/2012

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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361
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F 441	<p>Continued From page 10</p> <p>he placed on the dirty linen/trash cart. SRNA #5 proceeded down the hall without washing or sanitizing his hands. Observation, the same day at 1:40 PM, revealed SRNA #5 opened and closed the closet and bathroom doors in Resident #2's room and took a cup of water from the resident, and proceed out of the room to another resident's room without washing or sanitizing his hands.</p> <p>Interview, on 05/10/12 at 1:40PM, with SRNA#5 revealed he knew Resident #2 had Contact Precautions in place and he should have washed his hands after disposing of the trash that morning. Further interview at 1:50 PM with SRNA #5 revealed he should have washed his hands prior to exiting Resident #2's room earlier.</p> <p>Interview, on 05/17/12 at 3:32PM, with the Director of Nursing (DON) revealed staff should wash their hands after disposing of trash from Resident #2's room. She further stated her expectations were that staff wash or sanitize their hands prior to exiting Resident #2's room.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 05/18/12 with the facility alleging removal of the Immediate Jeopardy on 05/18/12.</p> <p>Review of the facility's AoC revealed the following:</p> <p>1. The Infection Control (IC) Nurse was consulted to review the situation and determine actions necessary and performed culturing on the whirlpool tubs on 05/14/12. The results are pending.</p>	F 441		

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F 441	<p>Continued From page 11</p> <p>2. The disinfectant was changed to a disinfectant tested to be effective to destroy VRE on 05/15/12.</p> <p>3. The use of whirlpool bathtubs was permanently discontinued on 05/16/12.</p> <p>4. All disinfectants and cleaning supplies used in the facility were reviewed by the Housekeeping Supervisor to assure they were effective to destroy VRE on 05/16/12.</p> <p>5. Vendors were notified in writing that the facility would not purchase any cleaning supplies that were not tested to be effective to destroy VRE on 05/16/12.</p> <p>6. As of 05/16/12, all residents using the whirlpool baths during the same time as Resident #2 were identified.</p> <p>7. The facility's Medical Director was consulted on actions that should be taken as a result of the whirlpool situation.</p> <p>8. With the Medical Director's input and approval, a tool was developed for nursing staff to use in assessing residents for signs and symptoms of VRE infection.</p> <p>9. As of 05/16/12, the residents who were identified to have used the whirlpool bath during the time as Resident #2 used the bath, were individually assessed to determine whether any resident had signs or symptoms of VRE.</p> <p>10. For residents identified to have wounds or open areas that had used the whirlpool since</p>	F 441		

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F 441	<p>Continued From page 12</p> <p>04/29/12, a culture was taken and sent to be tested for VRE on 05/16/12 with the results pending.</p> <p>11. The IC Nurse and Medical Director reviewed the facility Infection Control policy to assure it specifically included information about VRE, and made changes where necessary on 05/16/12.</p> <p>12. Changes were made to the Infection Control policy to assign the IC Nurse the duty of reviewing all new resident prescriptions for antibiotics, as well as, new reports of resident wounds on a daily basis. The IC Nurse shall determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies. The IC Nurse shall report any changes that need to be made to the Administrator. The IC Nurse shall also report new types of infections/bacteria and resident wounds to the Quality Control Committee. This procedure was added to the facility's Infection Control policy on 05/16/12.</p> <p>13. An inservice training on infection control practices and VRE was conducted, by the IC Nurse, with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures for all members of the Housekeeping staff on 05/16/12.</p> <p>14. The attending Physician for Resident #2 ordered tests to determine if the resident still had the VRE infection on 05/16/12, with the results pending.</p> <p>15. An inservice training for all staff on the Infection Control policy and Contact Precautions,</p>	F 441		

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F 441	<p>Continued From page 13</p> <p>as well as VRE specifically, was conducted by the IC Nurse which included training about the signs and symptoms of VRE infection, as well as proper infection control procedures and techniques, with the facility-wide inservice completed by 05/17/12. Inservice for staff absent on this date was conducted via telephone and inservice for employees on leave will be conducted before they return to work.</p> <p>16. Infection Control procedures and Contact Precautions were reviewed with the staff caring for Resident #2, who had the VRE infection, to assure the proper procedures were being</p> <p>followed to prevent the spread of the infection by 05/18/12.</p> <p>17. The Quality Assurance Committee will review the IC Nurse's reports of new infections/bacteria, as well as, wounds and changes in disinfectant and cleaning supplies on a quarterly basis.</p> <p>The surveyors validated the corrective action taken by the facility, prior to exit on 05/18/12, as follows:</p> <p>*Observation on 05/18/12 of the whirlpool tub rooms revealed no evidence of the Simply Solutions. Further observation revealed a product entitled, "Dispatch" which according to the label was effective against VRE.</p> <p>*Interview, on 05/18/12 at 5:47 PM, with the Infection Control (IC) Nurse revealed she had helped prepare staff inservices, and assisted with the inservicing of staff on the infection control issues.</p>	F 441		

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F 441	<p>Continued From page 14</p> <p>*Observation, on 05/18/12, revealed the whirlpool tubs were no longer in use and had been disabled.</p> <p>*Interview, on 05/18/12 at 5:16PM, with the Housekeeping Supervisor revealed on 05/15/12, she had reviewed all the facility cleaning/disinfectant products to ensure they were effective against VRE. Review of the literature provided indicated the products were effective against VRE.</p> <p>*Review of the letters sent to all the facility vendors/suppliers revealed they were dated 05/16/12. Interview, on 05/18/12 at 5:13PM, with the Administrator revealed all facility vendors/suppliers had been notified via the letters that the facility would not purchase any cleaning supplies that were not tested to be effective to destroy VRE on 05/16/12.</p> <p>*Interview, on 05/18/12 at 5:47PM, with the IC Nurse revealed all residents who had used the whirlpool tub, during the same time as Resident #2 were identified and assessed for signs and symptoms of VRE and this was verified through record review. Cultures were performed on residents with wounds, suprapubic catheter, residents with G-tubes (feeding tube), and residents on antibiotics which was verified through record review, with results pending. In addition, the IC Nurse stated all the whirlpool tubs were cultured on 05/14/12 and 05/16/12.</p> <p>*Interview, on 05/18/12 at 3:30PM, with the Medical Director revealed the facility had consulted with him regarding the whirlpool tubs and the decision to discontinue the whirlpool use</p>	F 441		

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F 441	<p>Continued From page 15</p> <p>was made. Continued interview revealed he was involved in the policy revisions.</p> <p>*Review of the "Signs and Symptoms of VRE" tool developed for nursing staff to use in assessing residents for signs and symptoms of VRE revealed all Unit 1 (unit on which Resident #2 resided) residents were assessed beginning on 05/16/12. With the Medical Director's input and approval, a tool was developed for nursing staff to use in assessing residents for signs and symptoms of VRE infection. Interview, on 05/18/12 at 3:30 PM, with the Medical Director revealed he had reviewed and approved the tool prior to it's use.</p> <p>*Interview, on 05/18/12 at 5:45 PM, with the IC Nurse and Medical Director revealed they had reviewed the facility's infection control policy to assure it included information related to VRE. Changes were made as necessary.</p> <p>*Review of the revised Infection Control policy revealed the IC Nurse had been assigned to review of all new resident prescriptions for antibiotics, as well as, new reports of resident wounds on a daily basis. Continued review revealed the IC Nurse was to determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies and report any changes that need to be made to the Administrator. Further review of the policy revealed the IC Nurse was to report new types of infections/bacteria and resident wounds to the Quality Control Committee. The revision was made to the policy on 05/18/12 per interview on 05/18/12 at 5:13PM with the Administrator.</p>	F 441		

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F 441	<p>Continued From page 16</p> <p>*Interview, on 0 /18/12 at 5:40 PM, with the IC Nurse validated that she was aware of her responsibility outlined in the new Infection Control policy.</p> <p>*Interview, on 05/18/12 at 5:47 PM, with the IC Nurse and Director of Nursing (DON) revealed an inservice training on infection control practices and VRE was conducted with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures for all members of the Housekeeping. Further interview revealed all staff was inserviced on me Infection control policy and VRE. They stated staff was inserviced on signs and symptoms of VRE infection and infection control procedures with the facility-wide inservice completed by 05/17/12. Staff was inserviced regarding the care of Resident #2 and the procedures to follow to prevent the spread of infection.</p> <p>*Review of the Inservice Sign-in sheets revealed inservices regarding the infection control policy were conducted on 05/17/12. Further review revealed evidence some staff was inserviced via telephone and validation that the facility conducted the inservice education for all staff. Interview, on 05/18/12 at 5:13PM, with the Administrator revealed there were six (6) staff members who had not been inserviced, however would not be allowed to work until they received the inservice.</p> <p>*Interviews were conducted on 05/18/12 to verify that staff had received education and verify staffs' knowledge of the new Infection control policy as</p>	F 441		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 05/18/2012
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F 441	<p>Continued From page 17</p> <p>follows: Housekeeping Supervisor at 5:13 PM, Licensed Practical Nurse (LPN) #3 at 6:34 PM, Feeding Assistant #14 at 6:38PM, Kentucky Medication Aide (KMA) #18 at 6:41 PM, State Registered Nursing Assistant (SRNA) #24 at 6:48 PM, SRNA #15 at 6:49 PM, Registered Nurse (RN) #2 at 6:50 PM, KMA #15 at 6:54 PM, SRNA #25 at 6:55 PM, Feeding Assistant #19 at 7:00 PM, SRNA #16 at 7:03PM, Housekeeper #21 at 7:11 PM, Housekeeper #4 at 7:15 PM, and SRNA #17 at 7:17 PM. All staff verbalized knowledge of the new infection control policy and procedure, Contact Precautions and was aware of the discontinuation of the Simply Solution cleaner and the use of the whirlpool tubs.</p> <p>*Review of Resident #2's record revealed a urinalysis (U/A) with culture and sensitivity (C&S) were ordered on 05/16/12. Interview, on 05/18/12 at 3:30 PM, with the Medical Director, who was the resident's attending Physician, revealed he had ordered the U/A with C&S to see if Resident #2 still had a VRE infection in his/her urine. He stated he ordered it to be obtained via an in and out catheter procedure.</p> <p>*Interview, on 05/18/12 at 4:38 PM, with the Quality Assurance Director revealed the Quality Assurance Committee will review the IC Nurse's reports of new infections/bacteria, as well as, wounds and changes in disinfectant and cleaning supplies on a quarterly basis.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361	
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F 490	<p>Continued From page 18</p> <p>practicable physical, mental, and psychosocial well-being of each resident.</p> <p>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's Administration failed to ensure the facility was administered in a manner that enabled it to use its resources effectively and efficiently to attain or maintain the highest practicable, physical, or psychosocial well-being of each resident. The facility failed to have an effective system in place to ensure programs, policies and procedures were implemented.</p> <p>The facility's Administration failed to maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in order to prevent the development and transmission of disease and infection as evidenced by failure to ensure the disinfectant used for the whirlpool tubs was effective against Vancomycin Resistant Enterococcus [(VRE)- specific species of bacteria which are known to be resistant to Vancomycin, an antibiotic used to treat infections]. The facility's Administration failed to ensure a disinfectant effective against VRE was obtained after receiving information, on 05/11/12, that the current product in use had not been tested against VRE. The facility also failed to ensure Contact Precautions were followed. (Refer to F-441)</p> <p>Based on the above findings it was determined the facility's failure to have an effective</p>	F 490	<p>This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of the Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by State and Federal law and does not constitute acceptance or agreement with any claim or statement herein.</p> <p>It is the policy of Bourbon Heights Nursing Home ("Bourbon Heights") to ensure that the facility is administered in a manner that enables it to use its resources effectively and efficiently to attain and maintain the highest practicable, physical and/or psychosocial well-being of each resident, on an individual basis, as well as residents as a whole.</p> <p>Further, it is the policy of Bourbon Heights to have an effective system in place to ensure programs, policies and procedures are implemented.</p> <p>In order to meet substantial compliance, upon notification of the disinfectant allegedly not being specific for VRE, the Administrator made an immediate inquiry to the supplier of the disinfectant regarding her previous conversation with the Distributor, who had assured her that it was effective against VRE. Bourbon Heights determined that all residents have the potential to be affected by the deficient practice. As such, Infection control policy manuals were totally updated to include all aspects of F tag 441 and to address specifically MDRO's and disinfectant use in order to ensure no residents would be affected. The Infection Control Policy Manual was approved by the Infection Control Committee and the Medical Director, in service of all staff on the updated manual was completed on June 8th, 2012. The Quality Assurance Committee will observe weekly each shift for proper gowning, hand hygiene, and other infection control issues.</p>	06/08/2012

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185283	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED C 05/18/2012	
NAME OF PROVIDER OR SUPPLIER BOURBON HEIGHTS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2000 SOUTH MAIN STREET PARIS, KY 40361		
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F 490	<p>Continued From page 20</p> <p>and Infection Control (IC) Nurse revealed they were not aware the Simply Solutions product had not been tested against VRE. Observation on 05/14/12 revealed Simple Solutions was still being used to disinfect the whirlpool bathtubs, even though Administration was informed on 05/11/12 this product was no effective against VRE.</p> <p>Interview, on 05/11/12 at 4:34PM, with the facility's Administrator revealed she had entrusted her supplier to ensure the facility had a disinfectant for the whirlpool tubs that would "kill everything". The surveyor informed her of what the manufacturer had reported in the interview on 05/11/12 at 11:45 AM that day, which was the product had not been tested against VRE. She stated that was "disturbing" as she was not aware the Simply Solutions had never been tested against VRE.</p> <p>Interview, on 05/18/12 at 5:00 PM, with the Administrator revealed she had relied on the whirlpool supplier to send the facility a product that would "kill" all organisms and he (the supplier) had indicated the Simply Solutions would. The Administrator stated the Housekeeping Supervisor and Supply Clerk were responsible for monitoring the products used to ensure they were effective and the Housekeeping Supervisor oversees all the facility's supplies. She stated the facility had policies in place and she relied on the Department Heads to follow the policies. The Administrator indicated the Quality Assurance Committee was responsible for updating policies.</p> <p>Interview, on 05/18/12 at 4:38 PM, with the</p>	F 490	<p>11. The Infection Control Nurse and Medical Director reviewed the facility Infection Control policy to assure it Specifically included information about VRE, and made changes where necessary on 05/16/12.</p> <p>12. Changes were made to the Infection Control policy to assign the IC Nurse the duty of reviewing all new resident prescriptions for antibiotics, as well as, new reports of resident wounds on a daily basis. The IC Nurse shall determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies. The IC Nurse shall report any changes that need to be made to the Administrator. The IC Nurse shall also report new types of infections/bacteria and resident wounds to the Quality Control Committee. This procedure was added to the facility's infection Control policy on 05/16/12.</p> <p>13. An inservice training on Infection control practices and VRE was conducted, by the IC Nurse, with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures for all members of the Housekeeping staff on 05/16/12.</p> <p>14. The attending Physician for Resident #2 ordered three separate tests to determine if the resident still had the VRE infection. The test results on 5/20/12, 5/25/12, and 06/03/12 were all negative for VRE.</p> <p>15. An inservice training for all staff on the Infection Control policy and Contact Precautions, as well as VRE specifically, was conducted by the IC Nurse which included training about the signs and symptoms of VRE infection, as well as proper infection control procedures and techniques, with the facility-wide inservice completed by 05/17/12.</p>	<p>05/16/2012</p> <p>05/16/2012</p> <p>05/20/12</p> <p>5/26/12,</p> <p>06/03/12</p> <p>05/17/2012</p>

<p>F 490</p>	<p>Continued From page 21</p> <p>Quality Assurance Director revealed the Administrator was part of the Quality Assurance Committee. Continued interview with the Administrator, on 05/18/12 at 5:00PM, revealed when asked when the infection control policy had last been updated, she stated she did not know. Interview with the Housekeeping Supervisor revealed even though the facility's policy stated Cen-Kleen was to be used to disinfect the whirlpool tubs, this product had not been in use since 2001. Further interview, on 05/18/12 at 5:00 PM, with the Administrator revealed she did not know when the Cen-Kleen use had been discontinued and the Simply Solutions initiated. (Refer to F-44'1).</p> <p>Review of the facility's AoC revealed the following:</p> <ol style="list-style-type: none"> 1. The Infection Control (IC) Nurse was consulted to review the situation and determine actions necessary and performed culturing on the whirlpool tubs on 05/14/12. The results are pending. 2. The disinfectant was changed to a disinfectant tested to be effective to destroy VRE on 05/15/12. 3. The use of whirlpool bathtubs was permanently discontinued on 05/16/12. 4. All disinfectants and cleaning supplies used in the facility were reviewed by the Housekeeping Supervisor to assure they were effective to destroy VRE on 05/16/12. 5. Vendors were notified in writing that the facility would not purchase any cleaning supplies that 	<p>F 490</p>	<p>In addition, all staff has an ongoing responsibility to report any violations of the Infection Control Policy to the Charge Nurse. The Charge Nurse will then investigate and report to the Quality Assurance Committee. Inservice for staff absent on this date was conducted via telephone and inservice for employees on leave will be conducted before they return to work.</p> <p>16. Infection Control procedures and Contact Precautions were reviewed with the staff caring for Resident #2, who had the VRE Infection, to assure the proper procedures were being followed to prevent the spread of the infection by 05/18/12.</p> <p>17. The Quality Assurance Committee will review the IC Nurse's reports of new infections/bacteria, as well as, wounds and changes in disinfectant and cleaning supplies on a quarterly basis.</p> <ul style="list-style-type: none"> • The Facility has included dates of 05/18/2012 corrective action. <p>The Facility is confident that the situation creating immediate jeopardy was corrected by Friday evening, May 18th, 2012.</p> <p>In addition, in order to prevent any future issues regarding infection control, the Quality Assurance Committee, which consists of Angela Forsythe, Administrator; Deanna Eads, Director of Nursing; Charlotte Roberts, Assistant Administrator; Kim Mullins, Dining Services Director; Gary Arnold, Maintenance supervisor; Teresa Earlywine, Quality Assurance Director; Sharon Patterson, Social Services Director; Barbara Traylor, Housekeeping Supervisor; Willis Gray, Assistant Director of Nursing; Paulette Cook, Activities Director; Janet Caswell, MDS Coordinator; Dr. James L. Ferrell, Medical Director; Ashley Kincaide, Infection Control Nurse will assign members to observe weekly and conduct random inspections each shift for proper gowning, hand hygiene, and other infection control issues. A Quality Assurance observation form has been implemented and reviewed every morning by QA committee. The Infection Control Nurse has been and will be attending daily QA meetings to discuss new antibiotics for all residents with infections as a communication tool.</p>	<p>05/18/2012</p> <p>06/08/2012</p>
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F 490	<p>Continued From page 22</p> <p>were not tested to be effective to destroy VRE on 05/16/12.</p> <p>6. As of 05/16/12, all residents using the whirlpool baths during the same time as Resident #2 were identified.</p> <p>7. The facility's Medical Director was consulted on actions that should be taken as a result of the whirlpool situation.</p> <p>8. With the Medical Director's input and approval, a tool was developed for nursing staff to use in assessing residents for signs and symptoms of VRE infection.</p> <p>9. As of 05/16/12, the residents who were identified to have used the whirlpool bath during the time as Resident #2 used the bath, were individually assessed to determine whether any resident had signs or symptoms of VRE.</p> <p>10. For residents identified to have wounds or open areas that had used the whirlpool since 04/29/12, a culture was taken and sent to be tested for VRE on 05/16/12 with the results pending.</p> <p>11. The IC Nurse and Medical Director reviewed the facility Infection Control policy to assure it specifically included information about VRE, and made changes where necessary on 05/16/12.</p> <p>12. Changes were made to the Infection Control policy to assign the IC Nurse the duty of reviewing all new resident prescriptions for antibiotics, as well as, new reports of resident wounds on a daily basis. The IC Nurse shall</p>	F 490	<p>Bourbon Heights is an excellent nursing facility with a committed staff and dedicated board of directors. The Facility remains committed to the providing a delivery of high quality health care and will continue to make whatever changes and improvements necessary to satisfy that objective. Please do not consider the filing of this Allegation of Removal of Immediate Jeopardy/Allegation of Compliance to be an admission of the finding of deficient practices.</p>	

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F 490	<p>Continued From page 23</p> <p>Determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies. The IC Nurse shall report any changes that need to be made to the Administrator. The IC Nurse shall also report new types of infections/bacteria and resident wounds to the Quality Control Committee. This procedure was added to the facility's Infection Control policy on 05/16/12.</p> <p>13. An inservice training on Infection control practices and VRE was conducted, by the IC Nurse, with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures for all members of the Housekeeping staff on 05/16/12.</p> <p>14. The attending Physician for Resident #2 ordered tests to determine if the resident still had the VRE infection on 05/16/12, with the results pending.</p> <p>15. An inservice training for all staff on the Infection Control policy and Contact Precautions, as well as VRE specifically, was conducted by the IC Nurse which included training about the signs and symptoms of VRE infection, as well as proper infection control procedures and techniques, with the facility-wide inservice completed by 05/17/12. Inservice for staff absent on this date was conducted via telephone and inservice for employees on leave will be conducted before they return to work.</p> <p>16. Infection Control procedures and Contact Precautions were reviewed with the staff caring for Resident #2, who had the VRE infection, to assure the proper procedures were being</p>	F 490		

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F 490	<p>Continued From page 24</p> <p>followed to prevent the spread of the infection by 05/18/12.</p> <p>17. The Quality Assurance Committee will review the IC Nurse's reports of new infections/bacteria, as well as, wounds and changes in disinfectant and cleaning supplies on a quarterly basis.</p> <p>The surveyors validated the corrective action taken by the facility, prior to exit on 05/18/12, as follows:</p> <p>*Observation on 05/18/12 of the whirlpool tub rooms revealed no evidence of the Simply Solutions. Further observation revealed a product entitled, "Dispatch" which according to the label was effective against VRE.</p> <p>*Interview, on 05/18/12 at 5:47PM, with the Infection Control (IC) Nurse revealed she had helped prepare staff inservices, and assisted with the inservicing of staff on the infection control issues.</p> <p>*Observation, on 05/18/12, revealed the whirlpool tubs were no longer in use and had been disabled.</p> <p>*Interview, on 05/18/12 at 5:16PM, with the Housekeeping Supervisor revealed on 05/15/12, she had reviewed all the facility cleaning/disinfectant products to ensure they were effective against VRE. Review of the literature provided indicated the products were effective against VRE.</p> <p>*Review of the letters sent to all the facility vendors/suppliers revealed they were dated</p>	F 490		

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F 490	<p>Continued From page 25</p> <p>05/16/12. Interview, on 05/18/12 at 5:13 PM, with the Administrator revealed all facility vendors/suppliers had been notified via the letters that the facility would not purchase any cleaning supplies that were not tested to be effective to destroy VRE on 05/16/12.</p> <p>*Interview, on 05/18/12 at 5:47 PM, with the IC Nurse revealed all residents who had used the whirlpool tub, during the same time as Resident #2 were identified and assessed for signs and symptoms of VRE and this was verified through record review. Cultures were performed on residents with wounds, suprapubic catheter, residents with G-tubes (feeding tube), and residents on antibiotics which was verified through record review, with results pending. In addition, the IC Nurse stated all the whirlpool tubs were cultured on 05/14/12 and 05/16/12.</p> <p>*Interview, on 05/18/12 at 3:30PM, with the Medical Director revealed the facility had consulted with him regarding the whirlpool tubs and the decision to discontinue the whirlpool use was made. Continued interview revealed he was involved in the policy revisions.</p> <p>*Review of the "Signs and Symptoms of VRE" tool developed for nursing staff to use in assessing residents for signs and symptoms of VRE revealed all Unit 1 (unit on which Resident #2 resided) residents were assessed beginning on 05/16/12. With the Medical Director's input and approval, a tool was developed for nursing staff to use in assessing residents for signs and symptoms of VRE infection. Interview, on 05/18/12 at 3:30PM, with the Medical Director revealed he had reviewed and approved the tool</p>	F 490		

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F 490	<p>Continued From page 26 prior to it's use.</p> <p>*Interview, on 05/18/12 at 5:45PM, with the IC Nurse and Medical Director revealed they had reviewed the facility's infection control policy to assure it included information related to VRE. Changes were made as necessary.</p> <p>*Review of the revised Infection Control policy revealed the IC Nurse had been assigned to review of all new resident prescriptions for antibiotics, as well as, new reports of resident wounds on a daily basis. Continued review revealed the IC Nurse was to determine whether any reports of new bacteria or infections warrant an immediate change in disinfectants and cleaning supplies and report any changes that need to be made to the Administrator. Further review of the policy revealed the IC Nurse was to report new types of infections/bacteria and resident wounds to the Quality Control Committee. The revision was made to the policy on 05/16/12 per interview on 05/18/12 at 5:13 PM with the Administrator.</p> <p>*Interview, on 05/18/12 at 5:40 PM, with the IC Nurse validated that she was aware of her responsibility outlined in the new Infection Control policy.</p> <p>*Interview, on 05/18/12 at 5:47PM, with the IC Nurse and Director of Nursing (DON) revealed an inservice training on infection control practices and VRE was conducted with special focus on use of disinfectants, proper cleaning techniques, and a review of proper infection control procedures for all members of the Housekeeping. Further interview revealed all staff was inserviced</p>	F 490		

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F 490	<p>Continued From page 27</p> <p>on the infection control policy and VRE. They stated staff was inserviced on signs and symptoms of VRE infection and infection control procedures with the facility-wide inservice completed by 05/17/12. Staff was inserviced regarding the care of Resident #2 and the procedures to follow to prevent the spread of infection.</p> <p>*Review of the Inservice Sign-in sheets revealed inservices regarding the infection control policy were conducted on 05/17/12. Further review revealed evidence some staff was inserviced via telephone and validation that the facility conducted the inservice education for all staff. Interview, on 05/18/12 at 5:13PM, with the Administrator revealed there were six (6) staff members who had not been inserviced, however would not be allowed to work until they received the inservice.</p> <p>*Interviews were conducted on 05/18/12 to verify that staff had received education and verify staffs' knowledge of the new infection control policy as follows: Housekeeping Supervisor at 5:13PM, Licensed Practical Nurse (LPN) #3 at 6:34 PM, Feeding Assistant #14 at 6:38PM, Kentucky Medication Aide (KMA) #18 at 6:41 PM, State Registered Nursing Assistant (SRNA) #24 at 6:48 PM, SRNA#15 at 6:49PM, Registered Nurse (RN) #2 at 6:50 PM, KMA #15 at 6:54 PM, SRNA #25 at 6:55 PM, Feeding Assistant #19 at 7:00 PM, SRNA#16 at 7:03PM, Housekeeper#21 at 7:11PM, Housekeeper#4 at 7:15PM, and SRNA #17 at 7:17PM. All staff verbalized knowledge of the new infection control policy and procedure, Contact Precautions and was aware of the discontinuation of the Simply Solution cleaner and</p>	F 490			

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F 490	<p>Continued From page 28</p> <p>the use of the whirlpool tubs,</p> <p>*Review of Resident #2's record revealed a urinalysis (U/A) with culture and sensitivity (C&S) were ordered on 05/16/12. Interview, on 05/18/12 at 3:30 PM, with the Medical Director, who was the resident's attending Physician, revealed he had ordered the U/A with C&S to see if Resident #2 still had a VRE infection in his/her urine. He stated he ordered it to be obtained via an in and out catheter procedure.</p> <p>*Interview, on 05/18/12 at 4:38 PM, with the Quality Assurance Director revealed the Quality Assurance Committee will review the IC Nurse's reports of new infections/bacteria, as well as, wounds and changes in disinfectant and cleaning supplies on a quarterly basis.</p>	F 490		