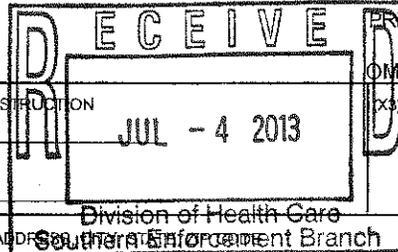


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 06/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185330	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  06/13/2013
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NAME OF PROVIDER OR SUPPLIER  CAMPBELLSVILLE NURSING AND REHABILITATION CENTER	STREET ADDRESS 1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718
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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	F 000		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</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 ensure catheter care and incontinence care was provided in a manner to prevent the spread of infection for two of fifteen sampled and seven unsampled residents (Residents #8 and #13). The facility failed to ensure that proper hand washing techniques to prevent cross-contamination were performed by facility staff when incontinence care was provided for Resident #8. In addition, the facility failed to ensure proper technique was performed in an effort to prevent microbes from the digestive tract from being introduced into the urinary tract during incontinence care provided for Resident #13.</p> <p>The findings include:</p>	<p>F 315</p> <p>1. Resident #8 and Resident # 13 physician was notified of concerns with catheter care, hand washing and glove changing by the Director of Nursing immediately. No new orders noted. All residents have the potential to be affected. The facility Medical Director was notified of concerns with catheter care, hand washing and glove changing by the Administrator with no new orders noted.</p> <p>2. The Education and Training Director (ETD) has completed observations of care being provided to all residents with catheters to identify any issue with hand washing, catheter care and glove changing. This was completed on No issue noted. The ETD will observe peri-care being provided to 15 patients by 7/20/2013 to identify any concerns with peri care, hand washing and glove changing. Any issue identified will be reported to the family and physician immediately and staff retraining will be completed immediately. The ADON will randomly observe care being provided to 10 patients by 7/20/2013 to identify any issue with glove changing and hand washing. Any issue identified will be reported to the family and physician immediately. Staff re training will be completed immediately.</p>	7/26/2013	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nelda Beard TITLE: Administrative (X6) DATE: 7-4-13

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

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NAME OF PROVIDER OR SUPPLIER  CAMPBELLVILLE NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1980 OLD GREENSBURG ROAD CAMPBELLVILLE, KY 42718	
(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 315	Continued From page 1  1. A review of the facility policy related to Handwashing (dated July 2012) revealed hand hygiene and glove changes should be performed between tasks and procedures on the same resident to prevent cross-contamination of different body sites.  Review of the medical record revealed the facility admitted Resident #8 on 12/21/12 with diagnoses including Diabetes Mellitus, Chronic Renal Failure, and Benign Prostate Hypertrophy.  Further record review revealed a culture and sensitivity test was conducted on 05/23/13 of Resident #8's urine. The test revealed Escherichia Coli (E-coli) was present in the resident's urine. Review of the June 2013 physician's orders revealed the physician had prescribed Levaquin (antibiotic), 500 mg, to be administered every other day for three weeks for treatment of the urinary tract infection (E-coli).  Observations of Foley catheter care and incontinence care for Resident #8 on 06/11/13, at 3:55 PM, revealed Certified Nurse Aide (CNA) #1 washed her hands and put on gloves and proceeded to provide incontinence care and Foley catheter care for the resident. CNA #1 was observed to clean feces from the resident's peri-rectal area by cleaning the area from front to back. The CNA then proceeded to provide Foley catheter care to Resident #8 without changing gloves or washing her hands.  Interview conducted with CNA #1 on 06/11/13, at 4:05 PM, revealed the CNA had been trained to wipe the perineal area from front to back when	F 315	3. ETD to retrain all staff regarding hand washing and changing gloves with a written competency to ensure infection control policy is followed. This will be completed by 7/20/2013. ETD to retrain all licensed nurses and C.N.A. staff regarding catheter care with a competency 7/20/2013. DON/ADON will monitor 3 CNAs or nurses providing care to 5 residents weekly x 4 weeks beginning 7/21/2013 to ensure all care is completed per the infection control policy that includes hand washing, glove changing and catheter/pericare. Staff nurses to randomly observe care being provided by a C.N.A. every shift beginning the week of 7/21/2013 x 10 shifts then at least one C.N.A weekly x 4 weeks to ensure hand washing, glove changing and catheter care or pericare is being performed per infection control policy. All new hires will receive competency for hand washing, glove changing and pericare/catheter care by the ETD beginning 7/21/2013.	7/26/2013

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NAME OF PROVIDER OR SUPPLIER  <b>CAMPBELLSVILLE NURSING AND REHABILITATION CENTER</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>1960 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718</b>	
(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)
F 315	<p>Continued From page 2</p> <p>providing incontinence care. The CNA stated she had also been trained to perform handwashing and change gloves when providing direct care to the resident. CNA #1 stated she should have washed her hands and changed gloves after cleaning the bowel movement from Resident #8's rectal area.</p> <p>Interview with the Director of Nurses (DON) on 06/13/13, at 1:50 PM, revealed she was also responsible for the Infection Control program. The DON stated handwashing and glove changes should be conducted between incontinence care and Foley catheter care. The DON stated in-service training was provided routinely for incontinence care and Foley catheter care. The DON also stated "spot checks" and observations were conducted to monitor staff's technique and infection control practices when providing incontinence care and Foley catheter care. In addition, the DON stated urinary tract infections were tracked/trended as part of the infection control program and no specific problems had been identified related to urinary tract infections present with E-coli bacteria associated with catheter use.</p> <p>2. A review of the policy, "Providing Perineal Care" (no date) revealed the female's vulva area or a male's penis should be cleaned before the peri-rectal area to prevent microbes from the digestive tract from being introduced into the vagina or urethra, where they can cause infection.</p> <p>On 06/13/13 at 10:30 AM, Certified Nurse Aide (CNA) #1 was observed to provide incontinence care to Resident #13. CNA #2 was observed to wipe the resident's perineal area from the back</p>	F 315	<p>4. QA Committee consisting of at least the Administrator, DON, ETD, Social Services, Activities Director and the Medical Director to meet at least monthly beginning 7/2013 to review all audit findings and revise plan as needed. This will be ongoing until issue considered corrected.</p> <p>5. Date of Compliance 7/26/2013.</p>

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F 315	Continued From page 3 (rectal area) to the front (vaginal/urethral area).  Interview with CNA #2 on 06/13/13 at 10:45 AM revealed the CNA was trained to wipe the perineal area from the front to the back when providing incontinence care to residents. CNA #2 said she was nervous and had failed to perform the incontinence care appropriately.  Interview with Licensed Practical Nurse (LPN) #1 on 06/13/13 at 2:15 PM revealed CNAs were required to check and change residents every two hours and incontinence care was provided as needed. According to LPN #1, CNAs should wipe from the front of the resident's perineum to the back, peri-rectal area in order to prevent infections. LPN #1 stated that periodic checks were performed throughout the day to ensure CNAs were performing tasks appropriately.  Interview with the Director of Nursing (DON) on 06/13/13 at 2:25 PM revealed the DON frequently "popped in" to residents' rooms when CNAs were performing incontinence care to check for appropriate skills. The DON said problems were addressed immediately and in-services were provided for staff. The DON said CNA #2 should have followed facility policy when providing the incontinence care for Resident #13.	F 315		
F 366 SS=E	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced	F 366		

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F 366	<p>Continued From page 4</p> <p>by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to honor food preferences and/or offer food substitutes for nine of fifteen sampled and seven unsampled residents (Residents #7, #2, A, B, C, D, E, F, and G). Residents #7, A, and B received carrots during the noon meal on 06/13/13 even though the tray card identified carrots as a food dislike. In addition, Residents #2, C, D, E, F, and G voiced concerns with the facility honoring their food preferences.</p> <p>The findings include:</p> <p>Review of the facility policy entitled "Procedure for Food Preferences" (no date) revealed food preferences would be noted upon admission, and at least annually, with recommendations from the interdisciplinary team and as needed. The policy further noted food preferences would be noted on the resident's tray card to assist staff with honoring food preferences.</p> <p>1. Resident #7 was observed during the lunch meal on 06/12/13, at 12:05 PM, to receive his/her lunch tray in the resident's room. The tray consisted of baked chicken, potatoes, carrots, a roll, fruit for dessert, and milk. Review of the resident's tray card revealed the resident's food dislikes included carrots, cabbage, roast beef, beets, and broccoli.</p> <p>Resident #7 stated, "I really don't like carrots," in an interview conducted on 06/12/13, at 12:10 PM.</p> <p>Interview with Dietary Cook #1 on 06/12/13, at 12:20 PM, revealed the cook was responsible to</p>	F 366	<p>1. Resident # 7, Resident A, Resident President C, Resident D, Resident E, Resident F and Resident G was interviewed on 06/14/13 by the Food Service Manager to update individual food preferences, food preference assessment completed tray cards updated and food preferences are being honored.</p> <p>No resident was affected by this issue but the Medical Director was notified by the Administrator on 06/14/13 and no new orders were noted.</p> <p>2. The Food Service Manager completed a 100% audit of food preferences and interviewed all residents or family members to identify all residents' individual food preferences. This was completed on 07/17/13.</p> <p>Any changes to food preferences was immediately noted, tray card changed and food served per preferences immediately.</p> <p>By 7/20/2013 Administrator, DON, ADON, ETD and Food Service Manager to monitor one meal to identify that food preference are being honored for all residents.</p> <p>Any issue identified will be immediately corrected.</p> <p>All new admitted residents will have a food preference assessment completed by Food Service Manager beginning 7/21/2013 within 3 working days of admission to identify individual food preferences.</p>	7/26/2013

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F 366	<p>Continued From page 5</p> <p>review the resident's tray card for food preferences when placing the food onto the plate. Dietary Cook #1 stated the Dietary Aide was responsible to check the tray at the end of the serving line for accuracy.</p> <p>Interview with Dietary Aide #1 on 06/12/13, at 12:25 PM, revealed she was responsible to add the beverages and condiments to the resident's tray. Dietary Aide #1 stated she did not check the tray for accuracy or food preferences because she assumed the Dietary Cook knew what she was putting on the resident's tray.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #2 on 06/13/13, at 1:30 PM, revealed the CNA was responsible to check the resident's tray card for food preferences before setting the tray up for the resident. CNA #2 stated she worked during the lunch meal on 06/12/13, but could not recall if she had set up Resident #7's tray.</p> <p>2. Further observations of the noon meal served in the main dining room of the facility on 06/12/13, at 12:15 PM, revealed Residents A and B were seated in the dining room. Review of the resident's trays revealed Resident A was served carrots and Resident B received pureed carrots. Residents A and B's tray cards revealed the residents did not like carrots.</p> <p>Resident A was assessed by the facility to be noninterviewable due to cognitive status and could not be interviewed.</p> <p>The facility assessed Resident B to be noninterviewable, and an interview attempted on 06/13/13 at 1:25 PM revealed the resident made</p>	F 366	<p>7/26/2013</p> <p>3. ETD to re educate all nursing and dietary staff regarding honoring food preferences and reading tray cards to ensure all residents receive their individual food preferences. This will be completed by 7/21/2013.</p> <p>Administrator re educated Food Service Manager regarding procedure for obtaining food preferences, tray card accuracy, and updating food preferences periodically on Administrator, DON, ADON and Food Service Manager to randomly monitor at least 5 trays being served to ensure tray cards are correct and food preferences are honored 3 x weekly x 4 weeks beginning week of 7/22/2013.</p> <p>ETD and Food Service Manager to audit at least 3 records each week x 4 weeks beginning week of 7/22/2013 to ensure food preferences are up to date and that tray card matches preferences.</p> <p>Social Services Director to interview 5 residents weekly x 4 weeks beginning week of 7/22/2013 to ensure food preferences are being honored.</p> <p>4. QA Committee consisting of at least the Administrator, DON, ETD, Social Services, Activities Director and the Medical Director to meet at least monthly beginning 7/2013 to review all audit findings and revise plan as needed. This will be ongoing until issue considered corrected.</p> <p>5. Date of Compliance 7/26/2013.</p>

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F 366	<p>Continued From page 6</p> <p>no attempt to answer questions that were asked.</p> <p>Interview conducted with CNA #3 on 06/13/13, at 1:45 PM, revealed resident trays should be checked by the staff person who set up the resident's tray to make sure the tray was correct. The CNA stated this included checking for food preferences.</p> <p>3. Interview with a group of interviewable residents (Residents C, D, E, F, and G) on 06/12/13 at 9:30 AM revealed the residents felt that no one paid attention to what they preferred to eat and did not offer substitutes. The residents felt that the kitchen staff needed to update the food preferences for each of the residents.</p> <p>Interview with Resident #2 on 06/12/13 at 2:00 PM revealed the resident did not like the food at the facility and stated, "They often give me foods that I have told them I don't like." According to the resident, during the evening meal on 06/12/13, he/she received salmon patties and stated, "I don't like fish."</p> <p>Resident #2's tray card was reviewed with likes and dislikes listed on the tray card. The dislikes listed fish as a dislike.</p> <p>The Dietary Manager (DM) stated in interview conducted on 06/12/13, at 12:30 PM that the dietary staff was responsible to ensure the residents' food preferences were honored. The DM stated he talked with the residents to identify food preferences. The DM stated he had monitored the tray line and conducted random tray audits to ensure food preferences were being honored and had not identified any problems</p>	F 366		

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F 366  F 469 SS=E	<p>Continued From page 7 related to the meal service.</p> <p><b>483.70(h)(4) MAINTAINS EFFECTIVE PEST CONTROL PROGRAM</b></p> <p>The facility must maintain an effective pest control program so that the facility is free of pests and rodents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policy, it was determined the facility failed to have an effective pest control program to ensure the facility was free of pests. Gnats were observed in resident rooms, hallways, and the dining room on 06/11/13, 06/12/13, and 06/13/13.</p> <p>The findings include:</p> <p>A review of the facility's annual pest control service agreement (11/01/12) revealed the facility would be sprayed monthly, or as needed for roaches and ants. The contract did not specify any control for gnats.</p> <p>Observation on 06/11/13 at 5:50 PM revealed gnats in the dining room area and hallway near the nursing station during the evening meal service.</p> <p>Observation on 06/12/13 at 4:20 PM during medication pass in room 31-1 revealed gnats in the room.</p> <p>Observation on 06/13/13 at 9:30 AM revealed</p>	F 366  F 469	<p>1. No resident was identified. All residents have the potential to be affected. Facility pest control provider treated the entire facility on 6/19/13. The Medical Director was notified of this issue on 06/14/13 by the Administrator.</p> <p>2. The Administrator and Environmental Services Director (ESD) made a walking round of the entire center on 6/17/13 to identify any gnats or pests. Any issue identified was immediately treated by the pest control vendor. The Administrator /ESD to interview at least 3 residents on each hall 5 x week x 4 weeks beginning week of 7/22/2013 to identify any pests in rooms or patient care areas. Any issues identified will be immediately corrected. The Facility pest control vendor to treat the center and investigate for pests or gnats at least 1 x per week x 4 weeks, then bi-weekly x 2 months, then monthly to identify any issue with pests or gnats. Any issue identified will be immediately resolved.</p>	7/26/2013

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F 469	Continued From page 8 gnats in room 24-2 and in the hallway outside of room 24.  Interview with Resident #2 on 06/12/13 at 2:00 PM revealed gnats were a problem in the facility and the resident kept his/her room door closed to prevent gnats from getting into the room as well as to provide privacy.  Interview with Resident #6 on 06/13/13 at 9:30 AM revealed gnats were a real problem especially during meal service. Resident #6 stated, "I eat in my room and the gnats will come and land on my food."  Interview with Residents C, D, E, F, and G on 06/12/13 at 9:30 AM revealed gnats in the facility were a problem and aggravation.  Interview with the Ombudsman on 06/12/13 at 10:00 AM revealed the facility had been made aware of the gnats being a problem in the building.  Interview with the Maintenance Director on 06/12/13 at 2:00 PM revealed the pest control company gave a chemical to the facility to use in the drains for the gnats and the Maintenance Director was using the chemical once or twice weekly. According to the Maintenance Director, the gnats were coming from the dish room and into other areas of the facility.	F 469	3. ETD to re educate all staff to report gnats or pests in the center to the ESD or Administrator by 7/20/2013. ESD and Housekeeping Services Manager to make walking rounds in the center 5 x weekly x 4 weeks beginning the week of 7/22/2013 to ensure no gnats or pests are present in the center. Any issue identified will be reported to the pest control vendor and their services repeated within 48 hours. The Facility pest control vendor to treat center 1 x per week x 4 weeks, then bi-weekly x 2 months, then monthly to ensure no pests or gnats are present in the center. Housekeeping Services Director to re educate all housekeeping staff regarding treating drains and sinks daily with a solution to decrease gnats and pests daily. This will be completed by 7/15/2013.  4. QA Committee consisting of at least the Administrator, DON, ETD, Social Services, Activities Director and the Medical Director to meet at least monthly beginning 7/2013 to review all audit findings and revise plan as needed. This will be ongoing until issue considered corrected.  5. Date of Compliance 7/26/2013.	7/26/2013	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185330</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>06/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>CAMPBELLSVILLE NURSING AND REHABILITATION CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1980 OLD GREENSBURG ROAD CAMPBELLSVILLE, KY 42718</b>		
(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>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One story, Type 111 (000)</p> <p>SMOKE COMPARTMENTS: Three</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system</p> <p>GENERATOR: Type II natural gas generator</p> <p>A life safety code survey was initiated and concluded on 06/12/13, for compliance with Title 42, Code of Federal Regulations, 483.70(a) and found the facility to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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