

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

PRINTED: 11/27/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185207	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 11/09/2012
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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056
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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
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F 000 INITIAL COMMENTS

The Abbreviated Survey investigating KY#00019266 was initiated on 11/08/12 and concluded on 11/09/12. KY#00019266 was substantiated and deficient practice was identified at 42 CFR 483.65 Infection Control (F441) at a Scope and Severity of an "E".

F 441 SS=E 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS

The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted

F 000 Maysville Nursing and Rehabilitation Facility does not believe nor does the facility admit that any deficiencies exist.

F 441 Maysville Nursing and Rehabilitation Facility reserves all rights to contest the survey findings through informal dispute resolution, legal appeal proceedings or any administrative or legal proceedings. This plan of correction does not constitute an admission regarding any facts or circumstances surrounding any alleged deficiencies to which it responds; nor is it meant to establish any standard care, contract, obligation or position. Maysville Nursing and Rehabilitation Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable peer review, quality assurance or self critical examination privileges which Maysville Nursing and Rehabilitation Facility does not waive, and reserves the right to assert in any administrative, civil, or criminal claim, action or proceeding. Maysville Nursing and Rehabilitation Facility offers its responses, credible allegations of compliance and plan of correction as

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Courney Burkhardt TITLE Administrator DATE 12/4/12

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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profesional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and record review, it was determined the facility failed to maintain an Infection Control Program to provide a safe and sanitary environment and to help prevent the transmission of disease and infection for one (1) of three (3) sampled residents (Resident #3). Observation of perineal care revealed the Certified Nursing Assistant (CNA) failed to remove her gloves and wash her hands after providing perineal care and before completing other care for the resident. In addition, observations revealed a CNA bagged trash in a resident room, deposited the bag in a collection bin and entered another resident's room and provided a snack, without washing her hands. Also, a CNA was observed to bring a full bag of soiled linen out of a resident's room, deposit the bag in the collection bin, and proceed to another resident's room to assist with toileting, without washing her hands.

The findings include:
Review of the facility's policy "Giving Female Perineal Care", undated, revealed staff was to remove and discard gloves after providing perineal care, and before completing resident

F 441 | part of its on-going effort to provide quality care to residents.

Maysville Nursing and Rehabilitation Facility strives to provide the highest quality care while ensuring the rights and safety of all residents.

N144 902 KAR 20:300-6(7)(b)2.a.
SECTION 6. QUALITY OF LIFE

It is and was on the day of survey the policy of Maysville Nursing and Rehabilitation Facility to establish an infection control program which investigates, controls, and prevents infection.

- The employees (CNAs) in question were retrained by the Nurse Aide Coordinator (NAC) on infection control practices on 11-8-12 & 11-9-12; specifically as it relates to perineal care, hand washing, donning & doffing of gloves, and proper disposal of trash/linens.
- The above mentioned CNAs in question were retrained on infection control practices on 11-8-12 & 11-9-12 and all dietary staff were reeducated by the Consultant Dietician and

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NAME OF PROVIDER OR SUPPLIER MAYSVILLE NURSING AND REHABILITATION FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 620 PARKER ROAD MAYSVILLE, KY 41056	
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F 441	<p>Continued From page 2 care.</p> <p>Review of Center for Disease Control guidelines for hand hygiene in healthcare settings, at www.cdc.gov, revealed the following: "Decontaminate hands if moving from a contaminated-body site to a clean-body site during patient care".</p> <p>Observation, on 11/09/12 at 2:30 PM, revealed CNA #5 provided perineal care for Resident #3. The CNA adjusted the resident's clothes, repositioned the resident in bed, fluffed the resident's pillow, and patted the resident's hand, without washing her hands or removing the gloves worn while providing the perineal care.</p> <p>Interview with CNA #5, on 11/09/12 at 2:35 PM, revealed she had been trained to remove her gloves after the perineal care and before completing other care.</p> <p>Interview with the Infection Control Nurse, on 11/09/12 at 12:10 PM, revealed staff should remove their gloves only if there was visible soiling after providing perineal care, and before "touching the resident all over".</p> <p>During a telephone conference with the Regional Vice President of Operations, on 11/09/12 at 12:20 PM, she agreed the CNA did not practice proper hand hygiene during provision of the perineal care for Resident #3.</p> <p>Review of the policy titled "Laundry Services", dated 2011, revealed it did not address how linens were to be handled by staff on the resident units.</p>	F 441	<p>Dietary Manager on infection control practices on 11-29-12; all nursing staff and administrative staff were reeducated on infection control practices on 11-30-12 by the Administrator and Nurse Aide Coordinator; and all housekeeping staff were reeducated on infection control practices on 11-26-12 & 11-30-12 by the Administrator and Housekeeping Supervisor.</p> <p>3. The NAC retrained the employees in question on 11-8-12 & 11-9-12 on infection control practices. All new employees will continue to be trained on infection control practices by the Nurse Aide Coordinator or departmental supervisor during their orientation period. All staff have been retrained on infection control practices as related to their departments as listed above. The in-services were conducted by the NAC, Administrator, Consulting Dietician, Dietary Manager and Housekeeping Supervisor.</p> <p>4. As part of the facility's ongoing Quality Assurance program, the Assistant Director of Nursing (or designee) will</p>	

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Review of Center for Disease Control Guidelines for hand hygiene in healthcare settings, at www.cdc.gov, revealed the following: "Decontaminate hands before having direct contact with patients"; and "Decontaminate hands after contact with inanimate objects in the immediate vicinity of the patient".

Observation, on 11/08/12 at 2:50 PM, revealed CNA/Trainee #1 secured a bag of soiled linen in a resident's room and placed it in the collection bin in the hall. Continued observation revealed the aide, without washing her hands, accepted a snack baggie from CNA #2 and carried it into another room and handed it to the resident.

Interview with CNA #2, on 11/08/12 at 3:15 PM, revealed she was the Team Leader for the CNAs. She stated her responsibilities included training of new CNA staff. In addition, she served as a "go-to" person for all aides on the unit. Continued interview revealed handwashing should occur after handling soiled linen bags, prior to providing care to any resident. She stated handwashing techniques and indications were included in the training of CNAs.

Interview with CNA/Trainee #1, on 11/08/12 at 3:40 PM, revealed she had been trained to wash her hands after handling anything contaminated. She stated she normally washed her hands immediately after disposing of soiled linens.

Observation, on 11/08/12 at 4:10 PM, revealed CNA/Trainee #3 exited a resident's room carrying a full bag of soiled linen. The aide had to push the bag down into the collection bin in the hall in

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observe at least 3 resident perineal care and opportunities for proper disposal of trash/linen tasks per week to ensure appropriate infection control techniques are being followed. These audits will continue for 6 months.

5. December 1, 2012

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F 441	<p>Continued From page 4</p> <p>order for the lid to close. Continued observation revealed the aide proceeded directly into another resident's room to answer a call light. On entering the room after the aide, she was observed to have placed a gait belt on the resident and was assisting him/her to the restroom.</p> <p>Interview with CNA/Trainee #3, on 11/08/12 at 4:15 PM, revealed she had been trained to wash her hands after handling soiled linens. She stated she got in a hurry and forgot.</p> <p>Interview with the Director of Nursing and the Infection Control Nurse, on 11/09/12 at 12:10 PM, revealed they did not consider the outside of a soiled linen bag to be contaminated unless it was leaking or had visible soiling.</p> <p>During telephone conference with the Regional Vice President of Operation, on 11/09/12 at 12:20 PM, she stated she did not consider the outside of a soiled linen bag to be contaminated unless it was leaking or had visible soiling.</p>
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