

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

PRINTED: 07/05/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/20/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF TRIMBLE COUNTY			STREET ADDRESS, CITY, STATE, ZIP CODE 50 SHEPHERD LANE BEDFORD, KY 40006		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A standard health survey was conducted on 06/18/13 through 06/20/13 and a life safety code survey was conducted on 06/20/13. Deficiencies were cited with the highest scope and severity of an "E".	F 000	Signature Healthcare of Trimble County does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the 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 potential applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.		
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 professional practice.	F 441			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

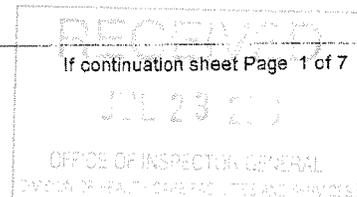
(X6) DATE

Elisia [Signature]

Administrator

7-22-13

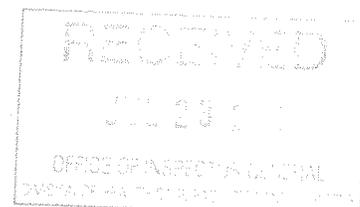
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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F 441	Continued From page 1 (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, review of the clinical record, and review of the facility policy, it was determined the facility failed to implement an infection control program for three (3) of fifteen (15) sampled residents (Residents #1, #4, and #6). Contact isolation precautions were not followed for Resident #1. In addition, inappropriate hand hygiene was used for Resident's #4 and #6 during treatment. The findings include: Review of the facility policy, Admission of residents with Communicable Disease revised August 2012, revealed a resident admitted to the facility with a history of multidrug-resistant organisms (MDRO), such as MRSA, and Clostridium difficile (C-diff) and that require infection control restrictions would be placed on appropriate isolation precautions. Review of the facility policy, Isolation- Initiating Transmission- Based Precautions revised August 2012, revealed Transmission based precautions, which included contact precautions, would be initiated when there was a reason to believe a resident had a communicable infectious disease. Transmission- based precautions	F 441	Completion Date 7/20/2013 F 441 1. On 6/19/2013 RN #1 and CNA #1 that had cared for Resident #1 was instructed by the Director of Nursing the importance of donning a PPE gown prior to entering a residents room that was in contact isolation. On 6/20/2013 LPN #1 was instructed by the Director of Nursing the proper way and timing of when to wash hands related to resident care and contact. 2. On 6/19/2013 the ADON ensured resident with a physician order for isolation had the proper signage outside their room, and that proper PPE was available for all staff to utilize prior to entering an isolation room.		



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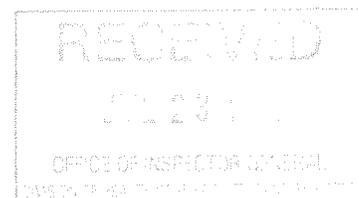
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F 441	Continued From page 2 would remain in effect until the physician discontinued them. Additionally, when transmission-based precautions were implemented protective equipment would be maintained near the resident's room so everyone entering the room would have access. The facility policy, Isolation- Categories of Transmission-Based Precautions, revised August 2012, revealed transmission-based precautions would be used when caring for residents who were documented or suspected of having a communicable disease or infection that could be transmitted to others. Contact precautions would be used with residents known or suspected of infection from microorganisms that could be transmitted by direct contact with the resident or by indirect contact with environmental surfaces or resident-care items in the resident's environment. Infections requiring contact precautions include MDRO and diarrhea associated with C-diff. Gloves should be worn when entering the resident's room and changed after having contact with infective material. Gloves should be removed before leaving the room and hands hygiene performed. After hand washing, potentially contaminated items should not be touched. Additionally, a disposable gown should be worn upon entering the room and not to allow clothing to contact potentially contaminated surfaces. The facility policy, Handwashing dated December-2010, revealed staff would wash their hands to prevent the spread of infection. Staff would wash hands before and after caring for a resident and/or their rooms, including when handling anything the resident had touched. Hands should be washed in procedural order that	F 441	Any resident in the facility have the potential to be effective by the deficient practice of staff not washing their hands appropriately and at appropriate times. 3. On 6/20/2013 the facility policy on Isolation-Categories of Transmission-Based Precautions, Standard Precautions, and Handwashing/Hand Hygiene were reviewed by the Director of Nursing, Administrator and Regional RN. On 7/1/2013 the following managers: DON, ADON, Activity Director, HR, Housekeeping/Laundry, Maintenance, Social Services, Business Office, and Chaplin were in-serviced by a DON from a sister facility on the updated isolation policy and procedure. By 7/19/2013 staff in all departments will be in-service by one of the following people the Director of Nursing, Housekeeping/Laundry Director or Dietary Manager on the revised isolation policy including the proper use of PPE.	



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F 441	<p>Continued From page 3</p> <p>included turn on the water, wash hands, rinse hands, dry hands, and use the disposable towel to turn off the faucet. Additionally, staff should not touch the faucet with bare hands.</p> <p>Review of the facility Inservice Program Attendance Record, dated 12/31/12 thru 4/19/13 revealed Licensed Practical Nurse (LPN) #1 received training in infection control on 02/06/13, 03/04/13, and 03/11/13.</p> <p>1. Observation, on 06/18/13 at 11:55 AM, of Resident #1's room revealed a precautions sign on the door, a person protective equipment (PPE) cart inside the doorway, and soiled linen and biohazard carts in the resident's room.</p> <p>Observation of Resident #1, on 06/18/13 at 11:57 AM, revealed the resident was in the dining room sitting in a geri chair with bilateral legs elevated and bilateral heel boots on.</p> <p>On 06/19/13 at 3:19 PM, observation of Resident #1's skin assessment and wound care revealed precautions sign on the door and a PPE cart in the room. Certified Nurse Assistant (CNA) #1 and Registered Nurse (RN) #1 entered the resident's room and applied gloves. Neither applied a protective gown. The CNA assisted the RN with holding the resident's leg and rolling the resident to the side while the RN provided wound care to Resident #1's legs and feet.</p> <p>Interview, on 06/20/13 at 11:20 AM, with CNA #1 revealed that Resident #1 was on isolation precautions for MRSA in the wounds on the legs and feet. CNA #1 stated that because the infection was only in the wound, and only nurses</p>	F 441	<p>The updated policy and procedure for isolation is as followed:</p> <ol style="list-style-type: none"> The charge nurse will determine the need for isolation precautions and type of precautions to be used based on resident diagnosis per the CDC guidelines. The charge nurse will contact the housekeeping department who will bring up isolation carts, biohazard barrels and notification signage for staff and visitors. The charge nurse will update the 24 hours report to include room number and type of isolation precautions to be used. The charge nurse will be responsible to ensure that signage is on the residents door to alert visitors and staff and that isolation carts/barrels are available and stocked. Nurse will utilize a check sheet to ensure all stapes have been followed. The check sheet will be turned into the DON and ADON. 	



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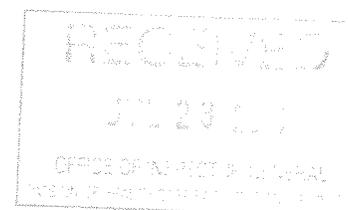
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F 441	<p>Continued From page 4</p> <p>cared for the wounds, then only the nurses needed to wear the gown while providing care. CNA #1 stated she had been trained in precautions and believed it was only for the person caring for the resident's wound. CNA #1 stated it was possible for the organism to get from the wound to the bed linens and resident's clothing, which could get on staff clothing and lead to cross contamination to others. The aide stated she had not seen any staff member wear a gown when going into the resident's room.</p> <p>On 06/20/13 at 1:05 PM, interview with Registered Nurse (RN) #1 revealed Resident #1 was placed on contact isolation precautions when admitted from the hospital as the resident was on the same precautions when a patient in the hospital. The RN stated a protective gown should be worn when coming in contact with a resident on contact isolation and she should have put on a gown when changing the resident's wound dressing. She stated she was trained to wear PPE when a resident was on isolation precautions. The RN stated not wearing a gown during care of the resident on contact isolation precautions could spread the infection to other resident or take home to the community. Interview with the Director of Nursing (DON), on 06/20/13 at 1:05 PM and 1:15 PM, revealed Resident #1 had a history of MRSA and was placed on contact isolation precautions. The DON stated staff should wear PPE gown and gloves when they came into contact of the resident's wound, including during treatment.</p> <p>2. Observation, on 06/19/13 at 9:05 AM, during a skin assessment and treatment for Resident #4 revealed Licensed Practical Nurse (LPN) #1</p>	F 441	<p>e. To ensure that all staff is aware of what PPE to use for each type of isolation precaution, a color coding system has been established to identify the type of PPE that will be used. Color coded precautions with needed PPE will be available with all isolation carts and at the nurses' station for easy staff accessibility.</p> <p>f. By 7/19/2013 staff in all departments will be educated by either the DON, Housekeeping/Landry supervisor, and Dietary Manager on the color coded isolation precaution system.</p> <p>g. The color coded isolation precaution system will be added to the new employee orientation process.</p> <p>By 7/19/2013 staff in all departments will be in-service by one of the following individuals Director of Nursing, Housekeeping/Laundry Director or Dietary Manager on the appropriate techniques of handwashing and the appropriate times to perform handwashing.</p>	



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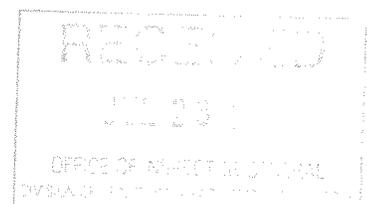
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F 441	<p>Continued From page 5</p> <p>washed her hands and turned off the water with her bare hands on two (2) occasions. After the second hand wash, the LPN #1 then placed the resident's glasses on the resident, opened the curtain, elevated the head of the bed, straightened the resident's bed covers, exited the resident's room and began to sign the Treatment Administration Record (TAR).</p> <p>Interview with LPN #1, on 06/20/13 at 11:00 AM, revealed turning the water off with bare hands instead of using a paper towel was not important as she had worn gloves after washing her hands. She stated she had been trained to turn off the water with bare hands and did not need to use a paper towel. The LPN also stated she did not need to wear gloves to touch a resident, only needed to sanitize hands afterward. The LPN stated she did not remember if she used hand sanitizer before signing the TAR.</p> <p>On 06/20/13 at 1:15 PM, interview with the DON revealed a paper towel should have been used to turn off the water during the skin assessment and treatment for Resident #4. The DON stated hands could become contaminated, even with gloves on and that was why hands were washed during the assessment and treatment. She also stated the LPN should have used hand sanitizer when leaving the resident's room, before signing the TAR. The DON stated turning off the water with bare hands and not sanitizing after touching the resident and environment did not clean organisms off her hands.</p> <p>3. Observation, on 06/19/13 at 3:00 PM, of a skin assessment and treatment for Resident #6 revealed LPN #1 washed her hands and turned</p>	F 441	<p>4. When there is a resident in isolation the ADON will observe staff when entering the residents' room, during care and when leaving the residents room. The ADON will make this observation at least 3 times a week for 3 months. If the ADON or notes a breach in the infection control policy and procedure she will stop the staff member immediately, address the issue and assist the staff with proper infection control practice. Weekly for 3 months the ADON will supply the DON with a report noting any issues with staff properly following isolation/infection control policies. The report from the ADON will include the actions she took to educate and correct the noted issue. Monthly the ADON will supply the Quality Assurance Committee with a report of her observations, interventions and education of staff related to residents who are in isolation and over all infection control. The Quality Assurance Committee will</p>		



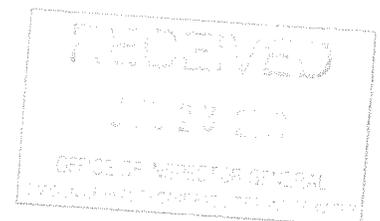
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F 441	<p>Continued From page 6</p> <p>off the water with her bare hands twice. Additionally, LPN #1 applied a protective barrier cream to the resident's buttocks, between the buttocks, applied additional cream to the same gloved hand and applied to the resident's peri area, and applied the cream going from the buttocks to the peri area, back to front.</p> <p>Interview, on 06/20/13 at 11:00 AM, revealed the cream should be applied back to front and that was how she had been trained. At 11:30 AM, the LPN stated she should have applied the cream front to back, from the peri area to the buttocks.</p> <p>On 06/20/13 at 1:15 PM, interview with the DON revealed the nurse should have changed her gloves and washed her hands after applying the cream to the buttocks and before applying the cream to the peri area. The DON stated the peri area should have been treated first, followed by hand washing, changed gloves, and then treat buttocks. She stated applying to the buttocks first and using the same glove to apply to the peri area could have transmitted infection from the buttock area to the peri area.</p>	F 441	<p>review the reports for compliance with facility policy and procedure on isolation and infection control. The above stated audits will be reviewed by the Quality Assurance committee monthly for 3 months. After the initial three months the staff observation audit will occur once a month for the next twelve months. If at any time there is more than 10% of the residents' population in isolation a weekly audit of staff observation will occur to ensure proper infection control policy and procedure is being followed. If it is found that staff is not practicing proper infection control technique the staff observation audit will return to three times a week for three months. This cycle will continue until compliance is maintained.</p>		



An audit will be completed 3 times a week for three months on different shifts by the DON or ADON to ensure proper hand washing technique is occurring. If a staff member is found to practice improper handwashing techniques the DON or ADON will immediately educate the staff member on the proper handwashing technique, and ask the staff member to re-wash their hands to demonstrate understanding of the instruction. Monthly the DON will supply the Quality Assurance committee with a report from the handwashing audits. The audits will be reviewed by the Quality Assurance committee monthly for 3 months. After the initial 3 months the staff observation audit will occur once a month for the next 12 months. If the Quality Assurance committee finds that 20% or more of the staff are being re-educated on proper handwashing techniques the Quality Assurance committee will recommend a re-inservicing of all staff on the proper technique and timing of handwashing. The in-service will be conducted by the DON, Housekeeping supervisor, or Dietary Manager. This cycle will continue until compliance is maintained.



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1977</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is natural gas.</p> <p>A standard Life Safety Code survey was conducted on 06/20/13. Signature Healthcare of Trimble County was found to be in compliance with the requirements for participation in Medicare and Medicaid.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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