

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

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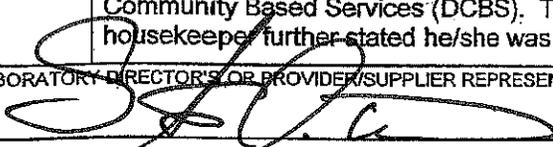
PRINTED: 10/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185157	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING OCT 12 2010	(X3) DATE SURVEY COMPLETED 09/09/2010
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NAME OF PROVIDER OR SUPPLIER ROCKCASTLE REGIONAL HOSPITAL AND RESPIRATORY CARE	STREET ADDRESS, CITY AND STATE ZIP CODE SOUTH NEW CENTRE AVENUE, Bldg 1110 MOUNT VERNON, KY 40456
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F 000	INITIAL COMMENTS A standard health survey was conducted on September 7-9, 2010. Deficient practice was identified with the highest scope and severity being at 'D' level.	F 000		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure that one (1) of eight (8) employees was knowledgeable on how and to whom they may report concerns, incidents, and grievances without the fear of retribution. The findings include: During an interview conducted on September 8, 2010, at 10:45 a.m., related to the reporting of resident abuse, housekeeper #1 was unable to provide information related to whom the housekeeper was responsible to inform when there was any allegation of abuse/neglect. The housekeeper stated he/she was unsure as to which supervisor to report an incident of resident abuse (e.g., housekeeping supervisor or nursing supervisor). The housekeeper stated he/she was unaware that incidents of alleged resident abuse were required to be reported immediately to the State Survey Agency and the Department for Community Based Services (DCBS). The housekeeper further stated he/she was unaware	F 226	*All long term care staff (clinical and non-clinical) to receive education on the facility's abuse policy. This will be done by the department managers. *All long term care staff (clinical and non-clinical) to receive additional training on abuse identification and reporting, in addition to their annual mandatory education that staff receive on abuse and neglect. Training to be provided by social services staff and will include different learning modalities. *Visual reminders will be posted throughout the long-term care units on abuse reporting which will include: who staff report concerns, incidents, or grievances to without fear of retribution. *Social services will conduct 25 random audits monthly, including staff from all shifts, to determine if any additional	10/22/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Pres. CEO	(X6) DATE 10/11/10
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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 226	Continued From page 1 of his/her responsibility to report allegations of abuse/neglect to a state agency if the facility failed to report the incident to the appropriate state agencies. Housekeeper #1 further stated he/she would not feel comfortable reporting beyond the facility to a state agency because the facility was very particular about "reporting through the chain of command." Review of the facility's Mandatory In-services-Self Testing dated March 17, 2010, revealed housekeeper #1 was in-serviced on Patient Rights, Abuse, Burnout and received a test score of 100 %. Interview conducted on September 9, 2010, at 4:30 p.m., with the Quality Director (QD) revealed all staff was in-serviced upon initial hire and annually regarding the facility's abuse policy. The in-services included a PowerPoint presentation with a self-test on the computer. Housekeeper #1 received a score of 100% on the test according to the QD. The QD stated additional in-services were provided monthly on various topics; however, no additional in-services on abuse had been provided for the staff. Review of the facility's policy on Resident Abuse revised September 2009 revealed the facility staff was required to report their knowledge related to allegations of abuse to administrative staff immediately.	F 226	continued from page 1 education may be required. Audits will be conducted for 6 months and will then be re-evaluated for continued need. *Data from random audits will be analyzed and reported to the Performance Improvement committee monthly. Completion date: Oct. 22, 2010		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission	F 441	*Education will be provided to nursing staff on East, West, South and South B related to incontinence care. *Education on "Personal Protective Equipment" and	10/22/10	

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F 441	<p>Continued From page 2 of disease and infection.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure staff washed their hands after each direct resident contact for which hand washing was indicated by accepted</p>	F 441	<p>continued from page 2</p> <p>"Hand Hygiene" policies will be provided to all long term care staff (clinical and non-clinical). *Critical elements of incontinence care will be posted for nursing staff education. *Observation of staff during incontinence care will be conducted to monitor for critical elements. *A total of 25 observations of critical elements of incontinence care will be conducted monthly by nursing leaders on the long term care units. *Observation data will be reported to nursing management and the Infection Control Committee.</p> <p>Completion date: Oct. 22, 2010</p>		

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F 441	<p>Continued From page 3</p> <p>professional practice. A Certified Nurse Aide (CNA) failed to wash/sanitize hands and change gloves when indicated while providing incontinence care to resident #9.</p> <p>The findings include:</p> <p>Observations of incontinence care provided for resident #9 conducted on September 7, 2010, at 3:20 p.m., revealed a CNA was observed to clean stool from resident #9 and wipe stool from the CNA's gloved hand. Further observation revealed the CNA continued to provide care for resident #9 without changing gloves and without washing/sanitizing the CNA's hands. The CNA was observed to dress resident #9 in a new gown, and reposition the resident's urinary catheter tubing, feeding tube, and tracheostomy tubing with the same gloves used to provide the incontinence care.</p> <p>An interview conducted with the CNA on September 7, 2010, at 3:25 p.m., revealed the CNA was nervous because the care was being observed by the surveyor and did not change gloves or wash hands when indicated.</p> <p>An interview conducted with the Infection Control Nurse on September 9, 2010, at 4:45 p.m., revealed that facility staff was randomly monitored to ensure compliance with hand hygiene. Further interview revealed that hand hygiene was a part of annual mandatory training and in addition staff was in-serviced on the spot if any concerns were identified during the random monitoring.</p> <p>A review of the facility policy regarding Personal Protective Equipment, with a review date of July</p>	F 441		

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F 441	<p>Continued From page 4</p> <p>2009, revealed that gloves were required to be changed between tasks and procedures on the same resident, after contact with material that may contain a high concentration of microorganisms.</p> <p>A review of the facility policy related to Hand Hygiene with a review date of July 2008 revealed staff was required to wash/sanitize hands when hands were visibly dirty or contaminated with proteinaceous material. Further review of the policy revealed that staff were required to change gloves/sanitize hands when moving from a contaminated body site to a clean body site.</p> <p>A review of in-service attendance records revealed the CNA was in-serviced on blood and body fluid precautions on May 6, 2010. No evidence of any random audits completed for the CNA regarding hand hygiene was provided.</p>	F 441		