

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

PRINTED: 04/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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 364 SS=F	<p>483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</p> <p>Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure meat was palatable and food was delivered timely to ensure the food was delivered at a resident acceptable temperature for four (4) of twenty-four (24) sampled residents (Residents #1, #11, #17 and #21) and five (5) of six (6) unsampled residents (Unsampled Residents A, B, C, D, and F). The Resident Council Members voiced concerns about the food being delivered cold and the meat not palatable during the Quality of Life Interview, on 03/24/15.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Food Preparation and Safety, revised August 2014, revealed meals would be delivered promptly to ensure maximum temperatures were retained to preserve the quality of the food. The meal delivery time was planned for the most efficient</p>	F 364	<p>This Plan of Correction is prepared and executed because it is required by the provisions of State and Federal law and not because North Hardin Health and Rehabilitation agrees with the citations noted on the pages of this Statement of Deficiencies.</p> <ol style="list-style-type: none"> The residents identified were interviewed by the Dietary Manager between Monday 4/13/2015 and Friday 4/17/2015 to discuss food concerns, food preferences and dining location preferences. Nurse Managers will review dining room seating assignments and revise based on resident care needs by 4/17/2015. Tray cart order will be revised to match new dining room seating to ensure timely delivery of trays to residents. Other interviewable residents will be interviewed regarding food concerns by the Dietary Manager or Assistant Dietary Manager by 4/30/2015. Dietary Manager will attend Resident Council meetings monthly for 3 months to discuss any food-related issues. Dietary Manager will monitor for resolution of issues and follow-up with residents as needed. 	5/1/2015

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

X *Ronald J. Jones*

TITLE

X *Administrator*

(X6) DATE

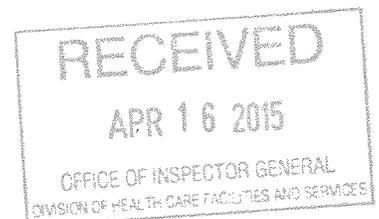
X *4/16/15*

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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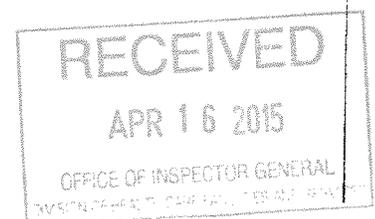
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F 364	<p>Continued From page 1</p> <p>use of the staffs time to ensure quick and accurate delivery of a meal to the dining room table or bedside. Hot food would leave the kitchen at 135 degrees Farenheit (F) or above and cold foods would be at or below 41 degrees (F) when the meal left the kitchen.</p> <p>1. Interview during the Quality of Life Assessment Group Interview, on 03/24/15 at 1:30 PM, revealed complaints of tough meats and cold food served during the lunch and dinner meals. Unsampled Residents A, B, C, D, and F and Sampled Residents #1 and #17 all stated the hot food was frequently served cold during lunch and dinner. In addition, the meats were tough when served. Unsampled Residents A, B and D stated the meat was tough most of the time at the dinner meal. Unsampled Resident B stated the chicken breast was tough and had choked on it twice when eaten the day before. Unsampled Resident D stated the spare ribs were especially tough when served. Resident #1 stated the food was frequently served cold in the Sunroom Dining area.</p> <p>Review of the facility's list of interviewable residents provided on 03/24/15, revealed Unsampled Resident A, B, C, D and F were identified as interviewable.</p> <p>Review of Resident #11's Quarterly Minimum Data Set (MDS), completed on 01/23/15, revealed the facility assessed the resident with the score of thirteen (13) of fifteen (15) on the Brief Interview Mental Status (BIMS), as cognitively intact and interviewable.</p> <p>Interview with Resident #11, on 03/25/15 at 9:20 AM, revealed the hot food was served cold</p>	F 364	<p>3. Unit Managers and Dietary Manager will update all seating charts and tray cart configuration to ensure residents are in appropriate locations to receive proper assistance with meals and that tray pass efficiency is optimized. This will be completed by 4/17/2015. Education on proper food temps and proper preparation of meats will be provided to Dietary staff by 4/30/2015. The Dietary Consulting Company will visit the facility to monitor cooks on proper preparation and cooking of meats by 4/30/2015. Additionally, Facility will acquire additional plate pellets as well as repair/replace the pellet warmer and plate warmer.</p> <p>4. Tray Audits will be completed daily for 5 days from 4/20/2015-4/24/2015 then weekly for 3 months by the Dietary Manager or Registered Dietitian to evaluate food temperatures and preparation of meats. Dietary Manager will complete Interviews with 10% of interviewable residents regarding food temperatures and meat concerns weekly for 4 weeks beginning 4/27/2015 then monthly for 3 months. Dietary Manager will add the question "Do you have any concerns regarding food temps, food service or meats" to quarterly resident review for interviewable residents. This will be instituted by 4/27/2015. Audits and interviews will be presented to the QA Committee quarterly who will monitor compliance with the POC.</p>		



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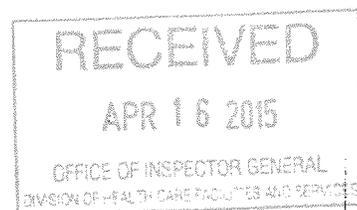
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F 364	<p>Continued From page 2</p> <p>frequently during lunch and dinner. The resident stated the staff would warm the food up if asked, but after that point, the food really got worse. The resident stated the meats were dry and tough and the tough meat concerns had been discussed with the staff when the food was served.</p> <p>Review of the Resident Council Minutes for the months of December 2014, January 2015 and February 2015, revealed no documented concerns of cold food temperatures or unpalatable meat.</p> <p>2. Observation of the breakfast meal in the Sun Room dining room (Restorative Dining), at the East Nurses Station, on 03/25/15 at 7:55 AM, revealed a food cart was delivered and three (3) staff members began to pass trays to the residents. There were a total of nine (9) residents in the Sun Room dining room. Six (6) residents were being assisted with eating and three (3) residents were watching television.</p> <p>Observation of the same food cart, on 03/25/15 at 8:00 AM, revealed Certified Nursing Assistant (CNA) #3, pulled the food cart to the 200 Hall on the East Unit and delivered one tray.</p> <p>Observation of the same food cart, on 03/25/15 at 8:05 AM, revealed CNA #3 delivered a tray to the 300 Hall on the East Unit. Once CNA #3 delivered the tray to the 300 Hall she came back to the Sun Room dining room to help assist with feeding. Four (4) trays remained in the food cart.</p> <p>Observation of the same food cart, on 03/25/15 at 8:20 AM, revealed four (4) resident trays were still present in the food cart. Four (4) staff members continued to assist the residents with eating. The</p>	F 364			



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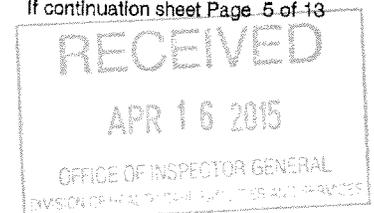
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F 364	<p>Continued From page 3</p> <p>same three (3) residents remained watching television.</p> <p>Observation of the Sun Room dining room, on 03/25/15 at 8:25 AM, revealed CNA #2 obtained a tray from the food cart (leaving three (3) trays in the food cart) and took a resident from the television area to assist them with eating leaving two residents watching television. At this time only three (3) staff members were present in the Sun Room dining room. The remaining two residents were assisted with eating at this time. One tray remained on the food cart. CNA #2 then delivered Resident #21's meal to him/her; thirty-eight (38) minutes later. Resident #21 lived on the 300 Unit.</p> <p>Interview with CNA #2, on 03/25/15 at 8:33 AM, revealed there was not enough staff to assist the residents with eating. CNA #2 stated the residents had to be assisted in cycles because of the lack of staff. CNA #2 stated today was the most staff they had to assist the residents with eating. CNA #2 stated she was not aware. Resident #21 received their meal tray late and the food could have been cold since it was delivered so late.</p> <p>Interview with CNA #3, on 03/25/15 at 8:45 AM, revealed she thought she had passed all of the meal trays on the unit. CNA #3 stated Resident #21 normally received their meal tray on time.</p> <p>Interview with Resident #21, on 03/25/15 at 8:33 AM, revealed sometimes the food was delivered late.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/26/15 at 2:24 PM, revealed she did not</p>	F 364			



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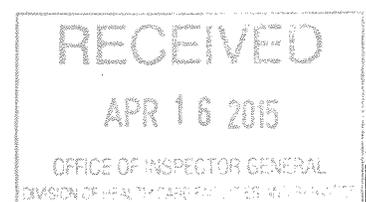
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F 364	<p>Continued From page 4</p> <p>know what nurse was assigned to the Sun Room dining room. LPN #1 stated she thought the residents were to receive their food immediately and that thirty-eight (38) minutes was to long of a wait. LPN #1 stated they wanted to serve quality food to the residents.</p> <p>Interview with Registered Nurse (RN) #1, on 03/26/15 at 2:37 PM, revealed there was no nursing staff monitoring the Sun Room dining room during meals.</p> <p>Interview with the Unit Manager of the East Unit, on 03/26/15 at 2:40 PM, revealed she monitored the staff in the sun room during meals and walked through everyday. She stated all the residents in the sun room were to receive their meal trays at the same time. The Unit Manager stated the staff she had on day shift were brand new and were nervous. The Unit Manager stated there were no nursing staff assigned to the Sun Room dining room and none of the CNA's informed her that they needed help with meal pass. The Unit Manager stated she asked the staff why they were delivering meals to the 200 and 300 units and the staff stated those meals were speciality trays. The Unit Manager stated she would like all the residents to receive their meal trays as soon as it came to the hall.</p> <p>Interview with the Director of Nursing (DON), on 03/26/15 at 2:00 PM, revealed when the food came onto the unit the food was to be delivered immediately. It was not acceptable for the food to be delivered thirty-eight (38) minutes after the trays arrived to the unit. The DON stated the Unit Managers and Nursing staff was to help assist in the dining room. The DON stated she had not monitored the Sun Room dining room in the last</p>	F 364		



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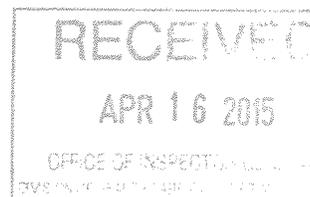
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F 364	<p>Continued From page 5</p> <p>two (2) months and was not aware of the dining room experience for the residents.</p> <p>3. Observation of a Test Tray during the lunch meal and delivered to the East Nursing Unit, on 03/25/15 at 12:31 PM, revealed the Turkey Ala King tempted at 102 degrees (F), the broccoli tempted at 88 degrees (F) and the pork chop tempted at 112 degrees (F).</p> <p>Observation and Interview with the Dietary Manager tasting the food on the test tray, on 03/25/15 at 12:31 AM, revealed she thought the Turkey Ala King and the broccoli could have been delivered warmer. The Dietary Manager stated the pork chop was very chewy, dry and hard to cut. The Dietary Manager stated she tried to do a test tray everyday of the meals and had no complaints. The Dietary Manager stated she was not aware the residents were waiting for meals as long as thirty-eight (38) minutes. The Dietary Manager stated she had not completed audits on the delivery of meal trays on the units or how long it took to deliver the food trays. The Dietary Manager stated when the food was delivered cold and non-palatable, the residents were at risk of low intakes, weight loss and possible skin breakdown.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 03/26/15 at 2:24 PM, revealed if food was delivered late or cold, she was concerned with the Diabetic residents not receiving food on time and the food possibly making the residents sick because the food was cold.</p> <p>Interview with the East Unit Manager, on 03/26/15 at 2:40 PM, revealed she did not want the</p>	F 364			



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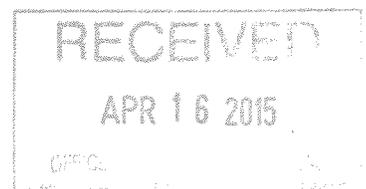
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F 364	Continued From page 6 residents to wait long for their meals because the temperatures of the food drops and bacteria could grow on the cold food. This could affect the taste of the food and the residents would not want to eat. The Unit Manager stated the residents could become malnourished, suffer from skin breakdown, dehydration and weight loss.	F 364		
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	F 441	1. Dedicated B/P cuffs and stethoscopes added to resident rooms identified during survey (301, 400, 500, 602 and 610) on 3/26/2015. An in-service was completed by the DON with Therapy Department staff regarding Infection Control policies and use of PPE/handwashing on 3/30/2015. In-service on Infection Control, PPE use and Handwashing was completed with Nursing staff by Unit Manager on 4/1/2015. 2. DON, ADON and/or Nurse Managers reviewed MD orders and Nursing Report Sheets daily (Monday-Friday) from 3/27/2015 through 4/16/2015 to determine if there were any adverse events related to staff not using PPE during isolation and not washing their hands appropriately.	5/1/2015



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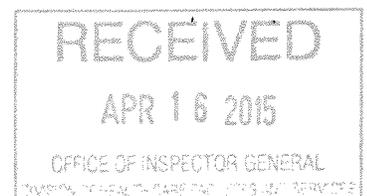
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F 441	<p>Continued From page 7</p> <p>communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after 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, and facility policy review, it was determined the facility failed to ensure prevention of disease transmission for residents in five (5) of six (6) isolation rooms (rooms 301, 400, 500, 602, and 610) had no dedicated blood pressure cuffs or stethoscopes in the rooms. In addition, six (6) of six (6) staff were observed not using Personal Protective Equipment (PPE) or not washing their hands per the facility policy (Physical Therapy Tech (PT Tech), Licensed Practical Nurse (LPN) #4, Certified Nursing Assistant (CNA) #4, CNA #5, CNA #6 and LPN #9).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Isolation - Categories of Transmission-Based Precautions, dated August 2011, revealed residents with known or suspected Clostridium-Difficile infection</p>	F 441	<p>3. Director of Staff Development to provide additional training on Isolation procedures, PPE and Handwashing by 4/30/2015 to Nursing Staff, Housekeeping Staff and Therapy Staff. Newly hired employees will receive education on Isolation procedures, PPE and handwashing during orientation. Therapy staff will be required to attend annual facility inservice on Isolation procedures, PPE and handwashing. A checklist for isolation cart contents will be created by 4/17/2015. Unit Managers will complete daily audits of Isolation carts that are in-use 4/20/2015 through 4/30/2015. Thereafter, Unit Managers will conduct monthly audits of isolation cart contents for 3 months.</p> <p>4. DON, ADON and Unit Managers will observe staff members daily for proper use of PPE and handwashing from 4/20/2015-4/24/2015. Re-education will be provided immediately as needed. After 4/24/2015 DON, ADON and Unit Managers will conduct monthly observations of staff for proper use of PPE and handwashing. Audits and one-on-one education opportunities will be presented to the QA Committee quarterly who will monitor compliance with the POC.</p>	



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F 441	<p>Continued From page 8</p> <p>should be placed in Contact Precautions, staff should wear gloves and gowns when entering the residents' rooms for any contact with the resident or potentially contaminated items and staff should wash their hands with soap and water after disposing PPE. Further review of the facility policy revealed non-critical resident-care equipment such as blood pressure cuffs and stethoscopes should be dedicated to the resident in Contact Precautions.</p> <p>Observation of Room 610, on 03/24/15 at 9:00 AM, revealed a PT Tech touched the arm of Resident #13 (in Contact Precautions) and his/her wheelchair handles when she wheeled Resident #13 out of room 610. The PT Tech was observed wearing no PPE at that time and did not wash her hands with soap and water prior to leaving room 610. Further observation at this time revealed LPN #4 stopped the PT Tech and Resident #13 in the hallway to give the resident medication. Prior to the medication administration, LPN #4 took Resident #13's blood pressure with a communal blood pressure cuff and stethoscope she had removed from the top of the medication cart and placed the contaminated blood pressure cuff and stethoscope back on the top of the medication cart when she was through without sanitizing it.</p> <p>Interview with the PT Tech, on 03/24/15 at 9:10 AM, revealed it was her understanding she did not need to wear any PPE when entering the room of a resident in Contact Precautions once they had been to therapy and she did not need to wash her hands with soap and water upon leaving the resident's room.</p> <p>Interview with LPN #4, on 03/25/15 at 9:15 AM,</p>	F 441		



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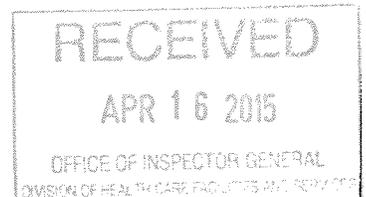
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 9</p> <p>revealed she was aware room 610 was a Contact Precaution, but that did not mean the resident needed a dedicated blood pressure cuff or stethoscope in his/her room. She stated a dedicated blood pressure cuff and stethoscope would be used for residents with other kinds of infections; however, she could not identify what those infections were. She further stated using the communal blood pressure cuff and stethoscope for a resident who needed a dedicated blood pressure cuff and stethoscope could spread infection to other residents.</p> <p>Observation of isolation room 610, on 03/26/15 at 12:00 PM, revealed CNA #4 was in the room to deliver the resident's lunch tray. CNA #4 failed to wear any PPE and brushed her clothing up against the resident's bed and overbed table and did not wash her hands with soap and water prior to leaving the resident's room.</p> <p>Interview with CNA #4, on 03/26/15 at 12:15 PM, revealed she knew room 610 was for Contact Precautions. She stated she should have worn a gown and gloves when she entered the room of a resident in Contact Precautions and she had just forgotten because she was rushing to deliver the residents' lunch tray.</p> <p>Observation, on 03/25/15 at 8:05 AM, revealed CNA #5 delivered a breakfast tray to room 602. The CNA proceeded to enter the room with only gloves on. The CNA placed the tray on the overbed table in front of the resident, pulled the string to turn the light on, and raised the head of the bed by pushing the buttons on the side rail. The CNA then went to the resident bathroom and washed her hands before leaving the room.</p>	F 441		

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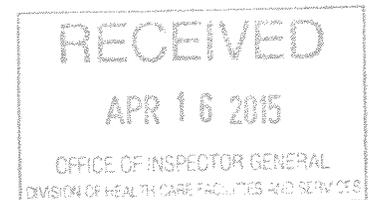
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 441	<p>Continued From page 10</p> <p>Interview, on 03/25/15 at 8:06 AM, with CNA #5 revealed she was not required to put on full PPE for residents in isolation for C.diff unless she was providing incontinent care for the resident.</p> <p>Observation, on 03/25/15 at 8:10 AM, revealed CNA #6 applied full PPE to deliver a breakfast tray to room 610. After setting up the breakfast tray the CNA removed her PPE, walked out in the hallway and used hand sanitizer to disinfect her hands.</p> <p>Interview, on 03/25/15 at 8:11 AM, with CNA #6 revealed she was not aware of the medical reason, for isolation precautions in room 610. When CNA # 6 was informed the resident was in isolation for C.diff, she stated she had not completed the training on isolation for C.diff and was still in training as a new employee.</p> <p>Observation, on 3/26/15 at 9:45 AM, revealed LPN # 9 was giving medications to Unsampled Resident G in room 6E. LPN #9 used dedicated equipment to assess the residents lungs, gave medications orally, then placed the dedicated equipment in the room. She then proceeded to remove her PPE and leave the room without washing her hands.</p> <p>Interview with LPN #9, on 03/26/15 at 9:50 AM, revealed Unsampled Resident G was in isolation for C.diff and this was an ongoing problem with this resident. She stated was not aware she needed to wash her hands for residents with C.diff, and stated she was not surprised the use of hand sanitizer was not effective against C.diff.</p> <p>Observation of resident rooms identified as Contact Precautions (Room 301, Room 400,</p>	F 441			



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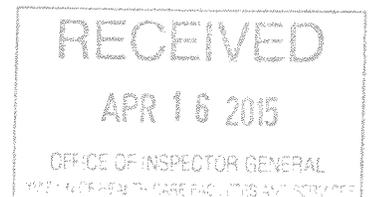
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/26/2015	
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
(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 441	<p>Continued From page 11</p> <p>Room 500, Room 602 and Room 610), on 03/26/15 from 11:15 AM to 11:30 AM, revealed none of those rooms contained a dedicated blood pressure cuff or stethoscope in the room.</p> <p>Interview with LPN #8, on 03/26/15 at 9:20 AM, revealed staff was to wear a gown and gloves at all times when entering the room of a resident in Contact Precautions and to wash their hands with soap and water prior to leaving the room to prevent the spread of disease. She also stated it was her understanding that all residents in Contact Precautions should have a dedicated blood pressure cuff and stethoscope in the room.</p> <p>Interview with the Staff Development Nurse, on 03/26/15 at 1:30 PM, revealed she had only been on the job of Staff Development Nurse for six (6) weeks and she had not done any monitoring of staff using PPE appropriately.</p> <p>Interview with the Certified Occupational Therapy Assistant (COTA) in charge of the Therapy Department, on 03/26/15 at 11:00 AM, revealed the therapy staff should wear PPE of a gown and gloves when entering the room of a resident in Contact Precautions and they should wash their hands with soap and water prior to leaving the resident's room.</p> <p>Interview with the Director of Nursing, on 03/26/15 at 3:30 PM, revealed the staff should wear a gown and gloves when entering the room of a resident in Contact Precautions. She stated the staff should wash their hands with soap and water after removing their PPE and there should be a dedicated blood pressure cuff and stethoscope in each resident's room who was in Contact Precautions. The DON further stated</p>	F 441		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 03/26/2015
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160		
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F 441	Continued From page 12 she felt the staff did not always adhere to infection control standards of practice and the facility policy.	F 441			



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185180	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 03/25/2015
NAME OF PROVIDER OR SUPPLIER NORTH HARDIN HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 599 ROGERSVILLE RD. RADCLIFF, KY 40160	
(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: 1986, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III (Unprotected)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II, 60 KW generator, Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey utilizing the 2786S, Short Form, was conducted on 03/25/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		

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

Donald W. Brown

TITLE

Administrative

(X6) DATE

4-11-15

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 145 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.

OFFICE OF INSPECTOR GENERAL