

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

PRINTED: 03/03/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185434	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/20/2014
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NAME OF PROVIDER OR SUPPLIER THE HERITAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 192 BACON CREEK ROAD CORBIN, KY 40702
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F 000	INITIAL COMMENTS A Standard Health Survey for recertification was conducted on 02/18-02/20/14 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest S/S of an "D". The Life Safety Code inspection was conducted on 02/19/14 with no deficiencies.	F 000		
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 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	F 441	The Heritage Nursing Facility does not believe and does not admit any deficiencies existed, either before, during or after the survey. The Heritage Nursing Facility reserves the right to contest the survey findings through informal dispute resolution, formal 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 meant to establish any standard of care, contract obligation or position and The Heritage Nursing Facility reserves the right to raise all possible contentions and defenses in any type of civil or criminal claims, 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 The Heritage Nursing Facility does not waive, and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Heritage Nursing Facility offers the responses, credible allegations of compliance and plan of correction as part of its ongoing effort to provide quality care to its residents. 1. It is and always has been the policy of The Heritage to ensure that each resident receive treatment utilizing proper hand washing and glove technique. Additionally, it is and always has been the policy of	

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

TITLE

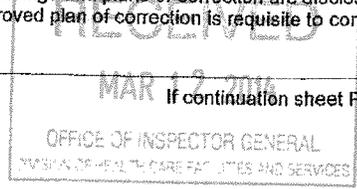
(X6) DATE

Cathy Willes

Adm.

X 03/12/14

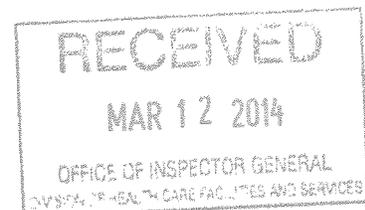
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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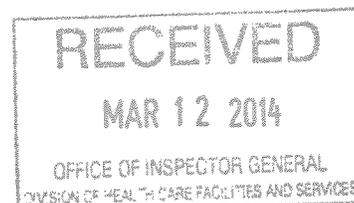
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F 441	<p>Continued From page 1</p> <p>hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy titled Preparation and General Guidelines, it was determined the facility failed to use proper hand washing and glove technique during topical treatments for multiple sites for one (1) of seventeen (17) sampled residents (Resident #1) and three (3) of ten (10) unsampled residents, Unsampled Residents A, B, and C. A staff nurse failed to wash her hands or change her gloves when applying topical ointments to Resident #1's buttock and scrotal area then moved to a secondary site of the bilateral anterior lower legs.</p> <p>In addition, the facility failed to ensure toothbrushes were labeled and stored according to facility policy to prevent the spread of disease and infection for (1) of seventeen (17) sampled residents (Resident #2) and seven (7) of 10 (10) unsampled residents. (Unsampled Residents D, E, F, G, H, I, and J).</p> <p>The findings include:</p> <p>1. Review of the facility's policy regarding Preparation and General Guideline, revised</p>	F 441	<p>The Heritage to ensure that residents receive care in a manner that prevents the spread of infection. Immediately upon realizing the mistake of Nurse #1, as identified by Nurse #1, Nurse #2 cleansed the legs of Resident #1 with soap and water. She then washed her hands, donned new gloves and applied the ointment to the affected leg. Additionally, those toothbrushes not properly labeled &/or stored were immediately discarded with new ones placed in plastic bags, labeled with the resident's name.</p> <p>2. All residents with treatments involving wound care &/or application of creams/ointments have been monitored for signs and symptoms of infection. This was done through weekly monitoring of vital signs, specifically temperature. They will have treatments completed using proper handwashing and donning of gloves as is indicated by accepted professional practice. All residents who have natural teeth &/or dentures will have toothbrushes that are stored properly in plastic bags, clearly labeled with the resident's name.</p> <p>3. The Director of Nursing has provided inservice education to all nurses and certified medication technicians that reviewed the</p>		



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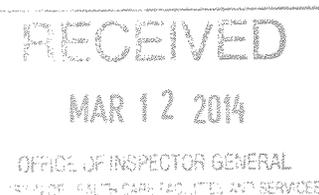
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F 441	<p>Continued From page 2</p> <p>12/18/12, revealed listed under Administration, number eight (8) stated hands are washed before and after administration of topical, ophthalmic, otic, parenteral, enteral, rectal, and vaginal medications.</p> <p>Review of the clinical record for Resident #1 revealed the facility admitted the resident on 6/12/13, with diagnoses of Chronic Respiratory Failure, Pneumonia, Muscle weakness, Chronic Obstructive Pulmonary Disease, and Venous Insufficiency. Review of the nurse's notes revealed the resident had been hospitalized on three occasions, since December 2013, with diagnoses of exacerbation of COPD, and Pneumonia. Review of the current plan of care revealed the resident was at risk for pain, and changes in skin integrity related to a limited mobility status post hospitalization for Venous Insufficiency involving the right lower extremity and left shin, and Venous Dermatitis.</p> <p>Observation, during the skin assessment/treatment for Resident #1, on 02/19/14 at 3:12 PM, revealed LPN #1 washed her hands and applied gloves prior to the application of a topical cream to the resident's healing fistula incision involving the scrotum and buttocks area. LPN #2, who was assisting LPN #1, proceeded to wash her hands and applied gloves to complete a second topical treatment of Silvadene cream to the raised dark scabbed areas on the resident's anterior bilateral lower legs; caused from frostbite several years ago. During the treatment, LPN #1 began to assist LPN #2 by smoothing out the Silvadene cream to the scabbed areas; however, LPN #1 did not</p>	F 441	<p>proper protocol for treatments, including proper handwashing procedure and appropriate frequency of glove changes. All nursing employees have received inservice education on the proper procedure for the storage and labeling of toothbrushes to promote infection control. The first inservice training was held on February 20, 2014 with sessions continuing through March 6, 2014, ensuring that all employees were reached.</p> <p>4. The Director of Nursing and/or the Wound Care Nurse will conduct unannounced observation of 20% of treatments quarterly to ensure compliance with facility policy. The Director of Nursing will conduct on a monthly basis, for 6 months, monitoring of 20% of residents to ensure compliance with Infection Control policy regarding toothbrushes. This will continue for the next six months and discontinue if no additional problems are noted.</p> <p>5. Completion date: 03/07/14</p>	



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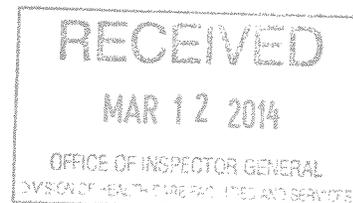
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F 441	<p>Continued From page 3</p> <p>wash her hands or change her soiled gloves prior to doing so. Observation revealed the same soiled gloves, used to apply the cream to the scrotal area, were used to assist with the second treatment.</p> <p>Interview with LPN #1, on 02/19/14 at 3:30 PM, revealed she realized what she had done after she smoothed out the Silvadine cream. The LPN stated the policy would be to wash her hands and change her gloves before completing a second treatment.</p> <p>Interview with the Director of Nursing, on 02/20/14 at 1:51 PM, revealed she was in charge of Infection Control, and all nurses had wound care monitored by competency checks every year. The DON also stated the Wound Nurse was responsible for observing the nurses periodically to complete dressing changes. The DON also revealed that hand washing and gloves should be changed before and after each treatment change.</p> <p>Interview with the Wound Nurse, on 02/20/14 at 2:20 PM, revealed she was responsible for completing observation of the nurses for wound care to ensure proper technique was used. She stated hand washing and gloves are policy for completing each treatment.</p> <p>2. The facility did not provide a specific policy for the care and storage of toothbrushes; however, provided the educational hand-outs from a staff meeting, on 09/20/13, in which the subject of oral</p>	F 441	<p>the next six months and discontinue if no additional problems are noted.</p> <p>5. Completion date: 03/07/14</p>		



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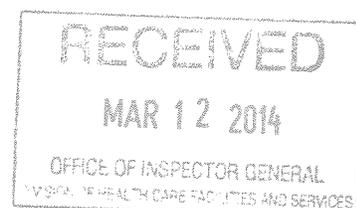
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F 441	<p>Continued From page 4</p> <p>care was covered. The hand-out stated: Do oral care and brush the resident's teeth. Store tooth brushes in medicine cabinet in resident's room or in wash basin. Make sure tooth brushes are labeled with resident's name and in plastic bag or plastic bag is labeled with resident's name. Throw away tooth brushes that are not labeled and get new ones.</p> <p>Review of the Centers for Disease Control and Prevention Infection Control and the Use and Handling of Toothbrushes revealed the mouth was home to millions of microorganism (germs), in bacteria, blood, saliva, oral debris, and toothpaste. Because of this contamination, a common recommendation was to rinse one's toothbrush thoroughly with tap water following brushing. Limited research has suggested that even after being rinsed visibly clean, toothbrushes could remain contaminated with potential pathogenic organisms. The CDC recommended replacing your toothbrush every 3-4 months, or sooner if the bristles appear worn or splayed. This recommendation is based on the expected wear of the toothbrush and its subsequent loss of mechanical effectiveness, not on its bacterial contamination.</p> <p>Continued review of the Disease Control and Prevention revealed the likelihood of toothbrush cross-contamination in this environment was very high due to tooth brushes being stored improperly. In addition a small chance existed that toothbrushes could become contaminated with blood during brushing. Although the risk for disease transmission through toothbrushes was still minimal, it was a potential cause for concern.</p> <p>Observations, on 02/18/14 at 10:00 AM, during</p>	F 441			



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F 441	<p>Continued From page 5</p> <p>the initial tour, in semi-private room 302 of Unsampld Resident D and Unsampld Resident E, revealed two toothbrushes, one green toothbrush and one white toothbrush laying together on the bathroom sink, unlabeled, and uncovered.</p> <p>Observations made, on 02/20/14 at 11:00 AM, in semi-private room 302 of Unsampld Resident D and Unsampld Resident E, revealed one toothbrush was unlabeled and uncovered, with no plastic bag.</p> <p>Observations, on 02/18/14 at 10:25 AM, during the initial tour, in semi-private room 308 of Unsampld Resident F and Unsampld Resident G, revealed one unlabeled toothbrush, and no plastic bag.</p> <p>Observations, on 02/20/14 at 11:05 AM, in semi-private room 308, of Unsampld Resident F and Unsampld Resident G, revealed one toothbrush was unlabeled and uncovered, with no plastic bag.</p> <p>Observations, on 02/20/14 at 11:05 AM, in semi-private room 308, of Unsampld Resident F and Unsampld Resident G, revealed one toothbrush was unlabeled and uncovered, with no plastic bag.</p> <p>Observations, on 02/18/14 at 10:30 AM, during the initial tour in semi-private room 310 of Unsampld Resident H and Unsampld Resident I, revealed two unlabeled toothbrushes laying in a wire basket on the bathroom sink with no plastic bag.</p> <p>Observations, on 02/20/14 at 11:10 AM, in</p>	F 441			



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F 441	<p>Continued From page 6</p> <p>semi-private room 310 of Unsampled Resident H and Unsampled Resident I, revealed two unlabeled and uncovered toothbrushes with no plastic bag.</p> <p>Observations, on 02/18/14 at 10:35 AM, during the initial tour in semi-private room of 311 of Resident #2 and Unsampled Resident J, revealed one unlabeled toothbrush laying in a wire basket in the bathroom, and no plastic bag.</p> <p>Observations, on 02/20/14 at 11:15 AM, in semi-private room 311 of Resident # 2 and Unsampled Resident J revealed one tooth brush was unlabeled and uncovered, with no plastic bag.</p> <p>An interview with CNA #1 and CNA #2, on 02/18/14 at 10:05 AM, revealed the toothbrushes were to be stored in a zip-lock bag, labeled with the resident's name on the zip-lock bag, or the toothbrush.</p> <p>An interview with RN #1 and the CQI Wound care nurse, on 02/20/14 at 9:10 AM, revealed the residents toothbrushes should be labeled, dated, and placed in a plastic bag.</p> <p>An interview with the Director of Nursing, on 02/20/14 at 1:45 PM, revealed that it was her expectation that all of the residents' toothbrushes be labeled and stored in a bag.</p>	F 441			

