

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

PRINTED: 09/05/2012
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 C 08/27/2012
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 000	INITIAL COMMENTS An abbreviated survey was initiated on 08/25/12 and concluded on 08/27/12 to investigate KY18915. The Division of Health Care substantiated the allegation with deficiencies cited at the highest s/s="E". The facility had opportunity to correct before remedies would be imposed.	F 000	F-323 1. All razors, chemicals, medications and personal care items were removed and or properly stored in the shower room on 08/27/2012 by the Unit Manager.	
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to implement their policies to provide a safe environment free from accident hazards for all residents. Two (2) of four (4) shower rooms (East women and West men shower rooms) revealed used razors laying on the floor, on top of two full sharp containers, and inside a large plastic soap container attached to the shower wall. In addition, there were several bottles of All-Purpose cleaner with warning labels stating harmful if swallowed sitting on the shower floor, sink counter, and inside an unlocked cabinet. The findings include:	F 323	2. All shower rooms were inspected by the Unit Manager on 08/27/2012 to ensure all potentially hazardous items were stored properly. 3. Nursing and Housekeeping staff will be in-serviced on the proper storage of chemicals and the disposal of all potentially hazardous items such as razors and needles, as well as the proper storage of all personal care items. This in-service will be provided by the Director of Staff Development and the ADON and Unit Managers. The education will begin on 08/27/2012 and will be completed by 09/28/2012. All newly hired staff will be educated on the proper storage of personal care items and the disposal of potentially	Completed by 09/29/2012

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

TITLE

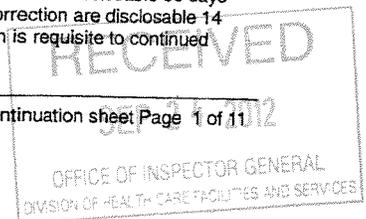
(X6) DATE

Don Swin

ADMINISTRATOR

9-24-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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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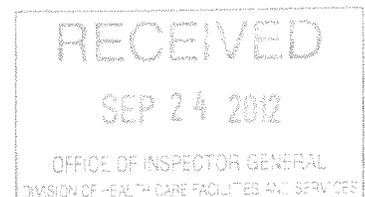
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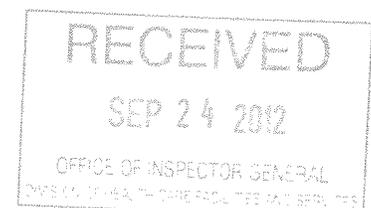
F 323	<p>Continued From page 1</p> <p>Review of the facility's policy, page 4, for proper disposal of sharps (revised July 2009) revealed all contaminated sharps must be placed in appropriate containers immediately or as soon as possible. Sharp containers are located in the medication rooms, on the medication carts, and shower rooms. Disposable sharps containers are to be replaced when they are 3/4 full. The full containers will be securely closed and placed in a durable container until pick up by the biohazardous waste company.</p> <p>The facility provided a chemical storage policy (no date) that stated chemicals shall be stored in locked rooms, cabinets, or housekeeping carts when not in use. Under procedures for general safety, cleaning solutions are to be properly stored in the locked cabinet in the shower room.</p> <p>Observation of the East Women's shower room, on 08/25/12 at 12:00 PM, revealed two full red sharp containers sitting on the sink counter. Two used disposable razors had been placed on top of a full sharps container. In addition, a gallon jug of all purpose cleaner was sitting on the floor under the sink. The jug was opened without a cap. Another gallon jug of cleaner was observed inside an unlocked cabinet located beside the shower's sink. The warnings on the bottle stated, "keep out of reach of children." "Harmful to humans and domestic animals." "Avoid eyes." The active ingredient was ammonia.</p> <p>Observation of the West Men's shower room, on 08/25/12 at 12:10 PM, revealed a used razor lying on the floor and three (3) used razors placed in an empty soap dispenser. Four opened cans of shaving cream was observed to be on the shower</p>	F 323	<p>hazardous items during orientation by the Director of Staff Development. This education will be repeated for three months, then no less than annually. Beginning 09/18/2012 all shower rooms will be inspected at the end of each shift to ensure all potentially hazardous items are properly stored. A log will be signed by an LPN assigned to this task.. LPN's assigned this task will be given instructions on what to look for and how to conduct these inspections. The instructions will be communicated by the Unit Managers or the ADON. This was begun on 09/18/2012 and will be completed by 09/28/2012. The log will be reviewed by the Unit Managers daily and documented by the Unit Managers the results of their review. Any problems noted on the inspections will be corrected when found and a notation made on the log will alert the Unit Manager to problems noted. This was started on 09/18/2012.</p> <p>4. The ADON or shift supervisor will inspect the shower rooms and monitor the logs daily for two weeks</p>	Completed by 09/29/2012
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F 323	<p>Continued From page 2</p> <p>stall floor. Observation of an unlocked cabinet in the shower room revealed multiple personal hygiene products i.e. hair spray, lotions, deodorant, and shaving cream were stored in the cabinet. There was no resident's name on the hygiene items. A can of Granulex spray (no resident's name) with caution instructions to keep out reach of children, avoid eyes, and can be fatal if swallowed, was observed in the unlocked cabinet. A tube of Nystatin cream, opened with no cap and no resident's name, was observed inside a small basket in the unlocked cabinet. In addition, there were two (2) spray bottles of all purpose cleaner sitting on the sink counter. The shower room was unlocked and accessible to cognitively impaired residents on that unit.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 08/25/12 at 12:20 PM, revealed the staff did not normally give showers on the weekends unless requested by residents. She stated personal hygiene products and chemicals are to be locked in the shower cabinet and used razors are to be placed in the sharp container. She stated the evening shift must have failed to clean the shower room after use and left the razors and shaving cream items on the shower floor. She stated each aide was responsible for cleaning the shower room after use and personal hygiene items are to be placed back into the cabinet and locked. She stated she had not been in the shower room today. She revealed the door to the shower room was never locked. She did not know why the all purpose cleaner was in the shower room.</p> <p>Interview with the Unit Manager for the West Unit, on 08/25/12 at 12:25 PM, revealed showers are</p>	F 323	<p>then weekly for three months to ensure the logs are completed and shower rooms inspected as assigned. The ADON, shift supervisor, or Unit Manager will document that they have completed the task of shower room inspections and monitoring the logs. This was started on 09/19/2012. Results of audits will be presented to the facility safety committee monthly for three months, then as assigned by the safety committee to ensure sustained compliance. The inspection logs will then be reviewed by the safety committee monthly to determine the need for additional audit, education and review. The ADON, or DON will report results of the audits and the recommendations of the Safety Committee to the QA Committee at least Quarterly for one year unless issues have continued to occur and then the QA Committee shall take action to resolve those issues and sustain compliance and continue receiving reports from the ADON or DON until Compliance has been consistent for six months.</p>	Completed by 09/29/2012	



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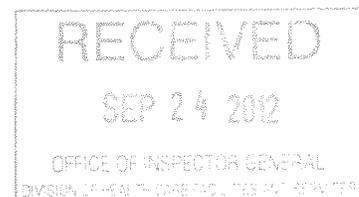
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F 323	<p>Continued From page 3</p> <p>given Monday-Friday on both days and evenings. She stated the shower room had not been used today; therefore, the evening shift was the last ones to use the shower room. She indicated the evening shift must have left the used razors and shaving cream laying about the shower floor. She stated it was the responsibility of the nursing aides to clean the shower room after use. That would include placing razors into the sharp container and putting hygiene products into a locked cabinet. She indicated the two spray bottles of cleaner were used to clean the shower room. However, she could not say who had placed the cleaner in the shower room. She validated cognitively impaired residents resided on that unit and could enter the unlocked shower room where the chemicals were found.</p> <p>Interview with the House Supervisor, on 08/25/12 at approximately 2:30 PM, revealed she had recently taken the weekend House Supervisor position and was still trying to work in a routine. She stated she had not checked the shower rooms and was not aware of the chemicals and razors left unattended. She stated staff did not normally give showers on weekends; therefore, she had not considered checking them. She indicated she performed environmental rounds but that did not include the shower rooms. She stated the two (2) full sharp containers in the East Women's shower room should have been removed and staff should have obtained an empty sharp container to put the used razors in.</p> <p>Interview with the Interim Director of Nursing, on 08/27/12 at 10:20 AM, revealed razors are suppose to be placed in the sharp containers. Chemicals are suppose to be stored in the locked</p>	F 323		
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F 323	Continued From page 4 cabinets in the shower rooms. She stated the oversight of the nurse aides was not provided.	F 323	F-441	
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. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	1. A waste receptacle was placed in the room of resident #4 on 08/25/2012 by house-keeping staff. An appropriate supply of gowns and gloves were placed on 08/25/2012 by the LPN. Staff on duty, including housekeepers, were instructed to follow our policies regarding hand washing, wearing gloves and proper waste disposal for patients in isolation. This was done 08/25/2012 by ADON, Unit Manager and House Supervisor. A waste receptacle was placed in the room of patient A on 08/25/2012 by housekeeping staff. A supply of isolation gowns and gloves were placed outside the room on 08/25/2012 by LPN. Staff on duty including, housekeepers were instructed on 08/25/2012 by the ADON and Unit Manager to follow policies regarding hand washing, wearing gloves and proper waste disposal for patients in isolation.	Completed by 09/29/2012



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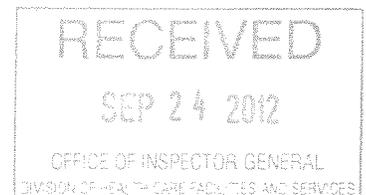
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F 441	Continued From page 5 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Infection Control policies (Isolation), it was determined the facility failed to implement and maintain their infection control program to prevent transmission of disease and infection. Observation revealed Personal Protective Equipment (PPE) was not always available, signage not posted, and staff failed to utilize PPE according to the facility's policy for three (3) of four (4) residents in isolation. Residents #4, #8, and unsampled A. This included both the East and West Wings. The findings include: Review of the facility's policy for notice of transmission-based precautions (revised 8/1/12) revealed Orange colored signs are to be placed outside the resident's room to alert staff and visitors of isolation precautions. The Isolation-categories policy (revised 8/1/12) for contact precautions revealed the staff were to wear gloves when entering the room. In addition, the Hand Hygiene policy (revised 8/1/12) stated guidelines for good hand hygiene to prevent the spread of infection. The policy instructed staff to wash their hands for at least fifteen (15) seconds using antimicrobial soap and water before and after entering isolation precaution settings. The policy stated hand hygiene is always the final step after removing and disposing of PPE. The policy for PPE (revised 8/1/12) instructed staff to	F 441	A waste receptacle was placed In the room of Resident #8 on 08/27/2012 by housekeeping staff. A supply of isolation gowns and gloves were placed outside the room on 08/27/2012 by LPN. Staff on duty were instructed on 08/27/2012 by the ADON and Housekeeping supervisor to follow policies regarding hand washing, wearing gloves and proper waste disposal for patients in isolation. Unit Managers and or LPN's assigned to rooms are checking isolation areas at least daily to assure PPE's are available to staff and to assure proper waste disposal receptacles are in place. The results of these checks will be documented by the Unit Manager or LPN and any negative findings will be corrected immediately. These checks started on 08/25/2012 but documentation of the checks began on 09/19/2012. 2. To identify other residents who may be affected the Unit Managers reviewed all residents in isolation to determine that the waste receptacles are in place	Completed 09/29/2012
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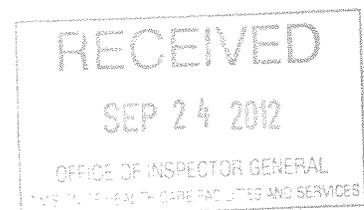
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F 441	<p>Continued From page 6</p> <p>discard used gloves into the designated waste receptacle inside the isolation room. Review of the orange sign used for contact precautions revealed hand hygiene should be performed prior to entering the room and to wear gloves. After care would include to discard trash in the room and perform hand hygiene.</p> <p>1. Observation during the tour of the facility, on 08/25/12 at 11:05 AM, revealed a sign outside Resident #4's room stating to see nurse before entering the room. A bedside table was placed outside the room with a gown and box of gloves sitting on top of the table. Observation revealed a housekeeper went into the room with a small carpet cleaner. The housekeeper then moved the resident's wheelchair touching the resident's clothing. The housekeeper did not put on gloves nor wash her hands. The housekeeper came out of the room to obtain supplies and did not wash her hands. Observation of the room revealed no designated waste receptacle inside the isolation room.</p> <p>Interview, with the housekeeper after the observation, revealed she did not have to wear gloves because she did not touch the resident. She stated only nursing wore gloves. When asked where was the waste receptacle, she answer she did not know.</p> <p>Interview with CNA #1, on 08/25/12 at 11:10 AM, revealed the resident was in contact isolation for Clostridium Difficile (C-Diff) and staff are suppose to wear gloves and gowns whenever entering the room. She stated staff had been told to wash hands with soap and water or use hand sanitizer after removing gloves.</p>	F 441	<p>and PPE's are properly placed and available for use. This was completed on 08/28/2012.</p> <p>3. To assure these issues do not recur we are doing the following:</p> <p>A. Staff from all departments will receive in-service training on Isolation policy and procedures they must follow, including waste and linen disposal, hand washing and use of personal protective equipment. This training will be followed with a brief test to determine they have a clear understanding of isolation procedure. This training will be done by the Director of Staff Development, Unit Managers, and the ADON starting on 09/21/2012 to be completed by 09/28/2012 and then monthly for three months with annual training no less than annually.</p> <p>B. Unit Secretaries will be responsible to check all isolation rooms at the beginning of their shift to determine PPE's are adequately stocked. It will be the responsibility of the nurse assigned to that room to assure it remains stocked during their shift. This change started on 09/18/2012.</p>	Completed 09/29/2012
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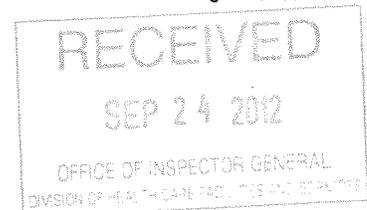
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F 441	Continued From page 7 Review of Resident #4's clinical record revealed the resident had resided at the nursing facility since 12/16/11. The resident had foul smelling stools and was treated for C-diff toxin, on 07/09/12 for two weeks. The physician gave the diagnosis of recurrent C-diff colitis. On 08/03/12, a stool culture tested positive for C-diff toxin. The lab report had an alert that stated "organism of significance, appropriate isolation precautions. . 2. Observation of unsampled Resident A, on 08/25/12 at 11:40 AM, revealed an orange sign on the resident's door stating the resident was in contact precautions. One gown in a plastic bag was observed lying on the handrail with a box of gloves. No table was set up in the hallway. In addition, no waste receptacle was in the resident's room. Interview with the Unit Manager for the West Wing, on 08/25/12 at 11:40 AM, revealed there was a table with PPE on; but, she did not know what happened to it. She stated the resident was in isolation for C-diff. She revealed there had not been a designated waste receptacle placed in the resident's room. 3. Observation of Resident #8's room, on 08/25/12 at 1:05 PM, revealed an orange contact precautions sign outside the resident's door. There was a bedside table outside the door with no gowns and a box of gloves with only one glove available. There was no waste receptacle for the PPE inside the resident's room. Interview with the same Unit Manager, at the time	F 441	4. To monitor and ensure these solutions are sustained the floor nurses will check these isolation rooms a least three times per day for two weeks to assure they are stocked properly with PPE's and waste receptacles are in place. These checks will be before breakfast, after lunch and by 10:30pm for the evening shift. This will start on 09/18/2012. Any findings will be handled immediately and the ADON notified. LPN's will be instructed on what to check for when completing this task by the Unit Manager, Shift Supervisor, or DON. The Results of the checks shall be documented by the LPN assigned the task and will begin 09/19/2012. The Unit Managers or shift supervisor also will observe these patients as they are given care to ensure proper hand washing and glove use per facility policy. This shall be done periodically at least one time per week. These checks will start on 09/18/2012. Their findings will be reported to the ADON who will report findings to the QA Committee quarterly for at least six	Completed by 09/29/2012
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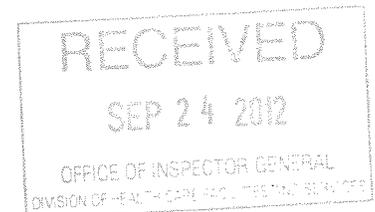
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F 441	<p>Continued From page 8 of observation, revealed PPE should be available for staff. She stated a waste receptacle had not been placed in the resident's room.</p> <p>Review of the clinical record revealed Resident #8 had resided at the nursing facility since March 24, 2009. Culture from the resident's gastrostomy tube on 08/22/12 revealed the drainage was positive for Methicillin Resistant Staphylococcal Aureus (MRSA). The resident was placed in contact precaution with PPE of gloves and gown.</p> <p>Observation, on 08/27/12 at 2:05 PM, revealed no gloves available for PPE. At 2:20 PM, CNA #2 entered Resident #8's room without washing hands or donning gloves. The CNA took a thermometer in the room, took the resident's temperature, then assisted the resident out into the hallway. The resident walked down toward the West Wing nurses' station and back. The CNA was observed to touch the resident's clothing with ungloved hands during the ambulation. The resident was walked back to the resident's room and assisted to bed. The CNA pulled the bed covering over the resident then left the room without washing her hands.</p> <p>Interview with CNA #2, on 08/27/12 at 2:30 PM, revealed when asked what PPE she was suppose to use, she replied make sure hands are clean. She stated she did not have to wear gloves when in the room, only if she did something for the resident. She stated she would wear gloves whenever she provided incontinent care. She validated she had not washed her hands nor put on gloves before or after leaving the resident's room.</p>	F 441	<p>Months for their review to determine we are remaining in compliance. If the reports are Negative the QA Committee will make recommendations to improve compliance and the ADON will continue to report results to the QA Committee quarterly for at least another six months.</p>	
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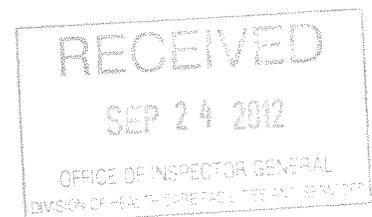
Completed by
09/29/2012



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

PRINTED: 09/05/2012
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 C 08/27/2012
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	<p>Continued From page 9</p> <p>Interview with the Unit Manager who was present during CNA #2's interview, on 08/27/12 at 2:30 PM, revealed the CNA was suppose to wash her hands and apply gloves prior to entering the resident's room and before leaving. She revealed a waste receptacle had been placed in the resident's room.</p> <p>Interview with the staff development nurse, on 08/27/12 at 3:30 PM, revealed all staff received training on hand hygiene, PPE, and isolation precautions during orientation with a video shown to staff. He stated he provided in depth training January 2012 to nursing regarding isolation precautions. He tried to provide training twice a year and as any problems arose. He revealed for contact isolation, PPE would be gloves and gown. Those PPE items should be placed on a table outside the resident's room. A designated waste receptacle should be in rooms where residents are in isolation. Staff are to wash hands before and after glove use and gloves are to be worn always in isolation rooms. He indicated the facility followed the Center for Disease Control guidelines. He stated housekeepers are suppose to wear gloves and wash hands just like nursing.</p> <p>Interview with the Assistant Director of Nursing, on 08/27/12 at 3:45 PM, revealed she was responsible for the infection control program. She stated she tracks and trends infections and reviews isolation precautions. She stated staff have been taught to wash hands and apply gloves before and after care of residents who are in isolation. She stated PPE should be available and trash receptacles should be in the resident's room. She revealed she had not identified the break in use of PPE.</p>	F 441			



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