

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

PRINTED: 01/22/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
(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 282 SS=D	<p>A standard health survey was conducted 01/07/14 - 01/09/14 and a Life Safety Code survey was conducted on 01/07/14 with deficiencies cited at the highest scope and severity at an "E".</p> <p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide care according to the comprehensive care plan for one (1) of twenty (20) sampled residents. The facility care planned Resident #17 to have preventative cream applied after each incontinent episode; however, observation and interview revealed this was not done. The facility assessed the resident to be at risk for pressure ulcer formation. Refer to F314.</p> <p>The findings include:</p> <p>The facility did not provide a policy for implementation of the care plan.</p> <p>Review of the clinical record for Resident #17 revealed the resident had resided at the nursing facility since December 2012. Review of the most current Minimum Data Set (MDS) assessment, dated 01/05/14, revealed the facility assessed the</p>	F 282	<p>"The preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law."</p> <p>F 282-</p> <ol style="list-style-type: none"> On 1/9/14, resident #17, Care Plan and Nursing Assistant Care Plan was reviewed updated, as needed, by the DON and MDS nurses. On 1/28/14, SRNA # 3 was educated on following care plans. All Care Plans and Nursing Assistant Care Plans will be reviewed and updated as indicated by 2/14/14 by the Director of Nursing, Unit Managers and MDS nurses. New orders will be brought to morning clinical meeting to validate care plans and nursing assistant care plan is updated and matches. Nursing staff was re-educated by 2/5/14 by the Staffing Coordinator on 	

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

X Michelle Glover

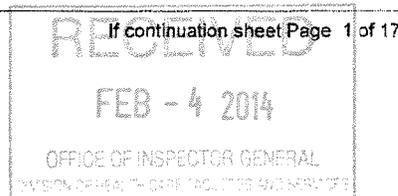
TITLE

X Administrator

(X6) DATE

X 2/4/14

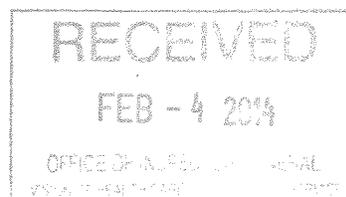
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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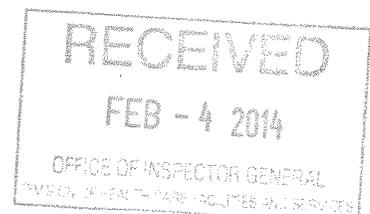
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F 282	<p>Continued From page 1</p> <p>resident to be frequently incontinent of bowel and bladder and placed the resident on a every two hour check and change program. The MDS assessment revealed the resident had no pressure ulcer formation, but identified the resident was at risk for developing pressure ulcers. Review of the comprehensives care plan for risk of skin breakdown, dated 10/28/13, revealed an approach to apply preventative skin cream after each incontinent episode. The facility assessed the resident to need extensive assist from staff for bed mobility, transfers, toileting needs, bathing, and personal hygiene.</p> <p>Observation of incontinent care for Resident #17, on 01/09/14 at 7:50 AM, revealed Certified Nursing Assistant (CNA #3) removed a disposable brief that was soiled with urine. The CNA cleaned the resident's perineal area with peri-wash and then applied a clean disposable brief. CNA #3 did not apply any type of preventive cream.</p> <p>Interview with CNA #3, on 01/09/14 at 8:58 AM, revealed she did not apply a preventative cream because the resident did not have any redness. She stated she would only apply the cream if she saw redness.</p> <p>Review of the Nursing Assistant Care Plan for January 2014 revealed instructions to apply barrier cream as needed/redness.</p> <p>Interview with the MDS Coordinator, on 01/09/14 at 9:05 AM, revealed she would update the Nursing Assistant Care Plan quarterly whenever an MDS assessment was completed. She stated Resident #17's care plan was last reviewed on 10/28/13 and a decision was made to continue</p>	F 282	<p>following care plans and nursing assistance care plans; which included updating with new orders, checking for discrepancies, and reviewing at beginning of shift.</p> <p>4. Unit Managers/Staff Nurses/SDC will observe no less than 5 residents per week x 2 weeks to ensure nursing assistant care plans are being followed; then observe no less than 10 residents per month x 2 months, then observe no less than 10 residents quarterly. All observations will be presented to facility QA Committee no less than quarterly for one year for further recommendations</p> <p>5. Completion date:</p>	2/15/14	



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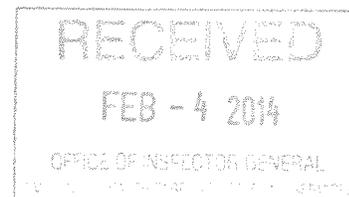
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F 282	Continued From page 2 the invention to apply preventive skin cream after each incontinent episodes. She stated that approach was still a current intervention. She indicated any resident who is incontinent of bowel or bladder needed a skin barrier cream according to facility policy for skin care. She stated when she had updated the Nursing Assistant Care Plan in October 2013, she should have written specific instructions to avoid confusion. Interview with the Unit Manager, on 01/09/14 at 10:20 AM, revealed preventative skin barrier cream was provided to all residents who are incontinent. The Unit Manager and surveyor observed a tube of Secura Protective cream in Resident #17's top drawer of the night stand, available for use. Review of the label revealed the use of the cream was for prevention of incontinent dermatitis associated with exposure to urine and feces. The Unit Manager stated the nurse aides were supposed to use the cream after each incontinent episode.	F 282			
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by:	F 314	F 314 1. On 1/9/14, resident #17, Care Plan and Nursing Assistant Care Plan was updated by the DON and MDS nurses to reflect preventative cream to be applied after every incontinent episode. 2. All Care Plans and Nursing Assistant Care Plans were reviewed and updated on 1/9/14 by the Director of Nursing, Unit Managers and MDS Nurses to reflect the use of preventative cream after every incontinent episode. 3. Nursing staff will be re-educated by Staffing Coordinator on using preventative cream on all residents after		



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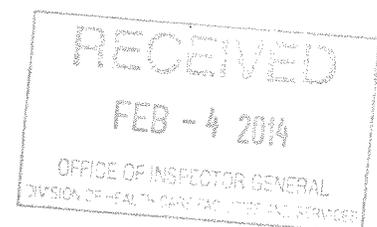
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F 314	<p>Continued From page 3</p> <p>Based on observation, interview, record review and review of the facility's pressure ulcer policy, it was determined the facility failed to provide preventive care treatment to prevent pressure ulcer formation for one of twenty (20) sampled residents. The facility assessed Resident #17 to be at risk for pressure ulcer development related to bowel/bladder incontinence and dependence on staff for bed mobility, transfers, and toileting needs. A care plan approach was to apply barrier cream after each incontinent episode. Observation of incontinent care revealed the staff failed to apply the barrier cream after an incontinent episode.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Pressure Ulcers, revised December 2010, revealed it was the practice of the facility to assess each resident for risk of developing pressure ulcers, identify risk factors, and provide care and services to reduce that risk. The facility would conduct weekly skin assessment for each resident. Review of the quick guide to skin care that the facility utilized to determine what skin product to use for each resident revealed for skin intact that was exposed to urine/feces the recommendation would be to cleanse, moisturize and protect the skin. The soiled area was to be cleaned and then a thin layer of protective ointment or moisturizing body cream was to be applied after each incontinent episode. The protective barrier product was to protect skin by preventing contact with irritating substances such as urine or feces.</p> <p>Review of the clinical record revealed Resident #17 had resided at the facility since December 2012. A review of the most current diagnoses</p>	F 314	<p>each incontinent episode and prn by 2/14/14.</p> <p>4. Unit Managers/Staff Nurses/SDC will observe no less than 5 residents per week x 2 weeks to ensure nursing assistant care plans are being followed; then observe no less than 10 residents per month x 2 months, then observe no less than 10 residents quarterly. All observations will be presented to facility QA Committee no less than quarterly for one year for further recommendations</p> <p>5. Completion date:</p>	2/15/14	



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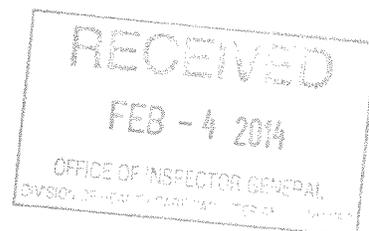
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F 314	<p>Continued From page 4</p> <p>included Severe Alzheimer's Disease, Diabetes, Congestive Heart Failure, and Depressive Disorder. Review of the significant change in status assessment, dated 10/19/13, and the most current Minimum Data Set (MDS) quarterly assessment, dated 01/05/14, revealed the facility assessed the resident to need extensive assist from staff for bed mobility, transfers, toileting needs, bathing, and personal hygiene. The facility assessed the resident to be frequently incontinent of bowel and bladder and was placed on an every two hour check and change program. The assessments revealed the resident had no open areas noted at that time but the facility identified the resident to be a high risk for pressure ulcer development. Preventative measures to be implemented were a pressure reduction mattress, incontinent care every two hours, and a preventative skin cream to be applied after each incontinent episode. In addition, weekly skin assessments were to be conducted. Review of the comprehensive care plan for risk of skin breakdown, dated 10/28/13, revealed an approach was developed to apply preventative skin cream after each incontinent episode.</p> <p>Observation of incontinent care for Resident #17, on 01/09/14 at 7:50 AM, revealed Certified Nursing Assistant (CNA) #3 performed this task. CNA #3 removed Resident #17's disposable brief, it was soiled with urine. The CNA cleaned the resident's perineal area with peri-wash foam cleanser, using front to back movements. Once the perineal area was clean, a clean disposable brief was applied without application of any protective cream.</p> <p>Review of the Nursing Assistant Care Plan for January 2014 revealed instructions to apply</p>	F 314		



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F 314	<p>Continued From page 5 barrier cream as needed/redness.</p> <p>Interview with License Practical Nurse (LPN) #2, on 01/09/14 at 8:47 AM, revealed the Nursing Assistant Care Plan could be updated by any nurse when there was a change in the resident's status. She stated the Minimum Data Set (MDS) nurse would update the care plans when the comprehensive care plan was reviewed quarterly.</p> <p>Interview with CNA #3, on 01/09/14 at 8:58 AM, revealed she did not apply a preventative cream because the resident did not have any redness. She stated she would only apply the cream if she saw redness.</p> <p>Interview with the MDS Coordinator, on 01/09/14 at 9:05 AM, revealed she would update the Nursing Assistant Care Plan quarterly whenever an MDS assessment was completed. She stated Resident #17's care plan was last reviewed on 10/28/13 and she decided to continue with the intervention to apply preventive skin cream after each incontinent episodes. She stated any resident who was incontinent of bowel or bladder, needed a skin barrier cream according to facility policy. She stated she should have written that information on the Nursing Assistant Care Plan to avoid confusion.</p> <p>Interview with the Unit Manager, on 01/09/14 at 10:20 AM, revealed preventative skin barrier cream was provided to all residents who are incontinent. Observation with the Unit Manager, on 01/09/14 at 10:25 AM, revealed a tube of Secure Protective cream located in the top drawer of the resident's night stand. The label stated the cream was used for the prevention of incontinent dermatitis associated with exposure to</p>	F 314		



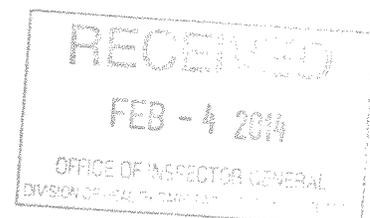
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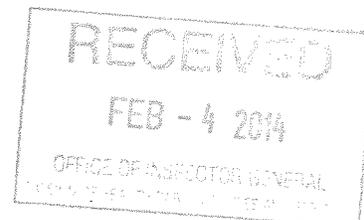
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F 314	Continued From page 6 urine and feces. The Unit Manager stated the nurse aides were supposed to use the cream after each incontinent episode. She stated since the cream was available, she assumed the staff was using it. She indicated the resident was at risk for pressure ulcer development.	F 314		
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 Ambassador Rounds Checklist, it was determined the facility failed to ensure an environment free from accidents and hazards in nine (9) of fifty-nine (59) residents' restrooms located on five (5) of six (6) hallways, emergency call cords were either too short or wrapped around grab bars which would not allow a resident to activate the emergency call light if he/she fell to the floor. The findings include: The facility did not have a policy for monitoring the emergency call systems in resident toilet areas, but provided a copy of a checklist used by personnel involved in the facility's monitoring process titled, Ambassador Rounds. The	F 323	F 323 1. On 1/9/14, the Maintenance Director replaced or unwrapped emergency pull cords in 106, 107, 108, 202, 301, 406, 601, 602 and 604. 2. Maintenance and Housekeeping conducted rounds throughout the facility to check all emergency pull cords. All emergency call pull cords out of compliance were replaced or unwrapped. 3. All employees were educated by the Staffing Coordinator by 2/5/14 regarding proper positioning of emergency call pull cords to ensure residents can reach pull cords.	



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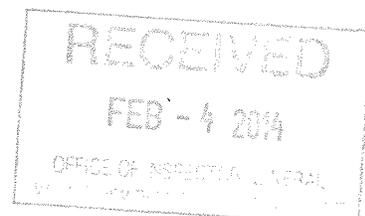
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F 323	<p>Continued From page 7 checklist included a sub-section labeled call lights operative & in reach.</p> <p>Observation, on 01/07/14 at 12:02 PM, revealed emergency pull cords in the resident restrooms were either too short or were wrapped around the grab bars in the restrooms in resident rooms 106, 107, 108, 202, 301, 406, 601, 602, and 604.</p> <p>Observation, on 01/09/14 at 9:15 AM, during the environmental rounds with the facility's Maintenance Director, revealed the pull cords remained in the same position in resident bathrooms 106, 107, 108, 202, 301, 406, 601, 602, and 604.</p> <p>Continued observation, on 01/09/14 at 9:25 AM during rounds with the Maintenance Director, revealed the emergency call light cord was wrapped several times around the grab bar next to the toilet in resident room 202. When the Maintenance Director pulled the section of the call light cord dangling below the grab bar, the emergency call light failed to activate.</p> <p>Interview, on 01/09/14 at 9:25 AM, with the Director of Maintenance, revealed the call light would activate if the resident was seated on the toilet and he/she pulled the cord above the grab bar. However, with the cord wrapped around grab bar, the Maintenance Director stated the emergency call light would not activate if a resident fell and tried to pull the section of the cord below the grab bar. The Maintenance Director stated emergency call lights that were not fully functional at all times could prevent the resident from receiving immediate staff assistance in the event of a fall or another medical emergency.</p>	F 323	<p>4. Department Managers will monitor use of emergency call pull cords, in resident bathrooms, during Ambassador rounds utilizing the Ambassador round checklist tool. Department Managers will observe no less than 10 residents/week x 2 weeks; then no less than 10/month x 2 months; then 10 residents bathrooms quarterly. All observations will be presented to facility QA Committee no less than quarterly for one year for further recommendations</p> <p>5. Completion date:</p>	2/15/14	



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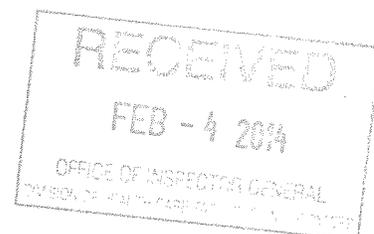
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F 323	Continued From page 8 Interview, on 01/09/14 at 1:30 PM, with the Administrator revealed environmental monitoring occurred via the facility's Ambassador Program. Administrative staff was responsible for making rounds in designated areas of the building on a daily basis which included residents' rooms and restrooms. A checklist was utilized to ensure all areas were observed; however, emergency call lights in the resident restrooms were not on the checklist. If problems were identified, the staff members were responsible for completing and submitting a work order to the Maintenance Director. The Maintenance Director was responsible for logging and tracking the progress and completion of any maintenance/repair issues reported to his department.	F 323			
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in	F 431	F 431 1. On 1/8/14, Tubersol and Pneumovax was discarded from the refrigerator on Magnolia Court by the nursing staff. 2. All refrigerators were checked for medications that were expired and any such items were discarded. This was completed by the Unit Manager on 1/8/14.		



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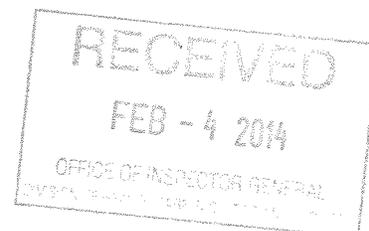
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F 431	Continued From page 9 locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. 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 ensure medications ready for use were not expired for one (1) of two (2) nursing units. Tubersol and Pneumovax were expired and available for use. The findings include: Review of the facility's policy and procedure titled Preparation and General Guidelines, Vials and Ampules of Injectable Medications, not dated, revealed opened multidose medications may be used according to the guidelines for that product. These guidelines will be affixed to the product, in the directions on the label or posted at the facility. Review of the facility's daily medication cart/treatment cart cleaning log, revealed it was a monthly log that included checking for expired medications/supplies. In addition	F 431	3. Licensed Nurses and CMTs will be re-educated by the Staff Development Coordinator on disposing of unlabeled/expired medications and by 2/5/14. This education will be repeated quarterly for 2 quarters then annually. All newly hired staff will be educated on this practice during orientation and education will be completed by Staff Development Coordinator . 4. A daily audit will be conducted by the Charge Nurse to check refrigerators for expired medications. Expired medications will be discarded immediately. Unit Managers/Staff Development will conduct monthly audits for 3 months then quarterly for one year and report all on all audits to the facility QA Committee no less than quarterly for one year, for further recommendations. 5. Compliance date:	2/15/14	



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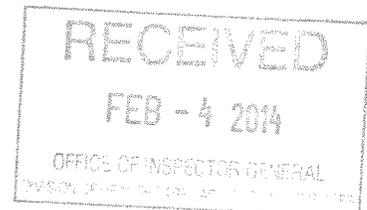
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/09/2014
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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F 431	<p>Continued From page 10</p> <p>medications/supplies were to be dated and labeled with the signature of the person checking the carts. Further review revealed there was nothing on the form directing staff to check medications in the refrigerator for expiration dates.</p> <p>Review of the Centers for Disease Control and Prevention Medication Storage and Handling, 12th Edition, Chapter 5, page 70, revealed opened multidose vials should be dated and discarded within 28 days unless the manufacturer specified a different (shorter or longer) date for that opened vial.</p> <p>Observation, on 01/08/14 at 7:15 AM, revealed the Magnolia Court medication room refrigerator, contained a multidose vial of Tubersol that was opened and dated 11/07/13. In addition, a multidose vial of Pneumovax was opened and dated 11/14/13. Both boxes had a label that stated, expires thirty (30) days after opening.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 01/08/14 at 7:20 AM, revealed both multidose vials of medications were expired. She stated each shift was to check the medications in the refrigerator for expired dates. She stated she was not sure of a back up plan, but stated night shift (11-7) checked the temperatures of the refrigerator and for expired medications.</p> <p>Interview with Registered Nurse (RN) #2, on 01/08/14 at 7:20 AM, revealed night shift checked the refrigerator temperatures, but everyone should be checking for expired medications in the refrigerator.</p> <p>Interview with the Unit Manager for Magnolia</p>	F 431		



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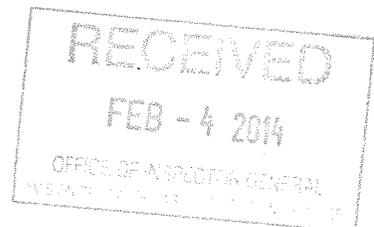
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F 431	Continued From page 11 Court, on 01/08/13 at 2:55 PM, revealed the system for ensuring medications were not expired was every time the nurses changed shift they should have checked the refrigerator for expired medications. She went on to say that one (1) time a week, night shift was to complete a thorough inspection of the refrigerator for expired medications and utilize the check sheet. The UM stated the form did not include a specific check for the refrigerator. She stated she guessed it was not getting done. She acknowledged there was a risk for decreased efficacy of the medication if the medication was not disposed of when expired. Review of the facility's in-service training records, revealed nurses had been in-serviced on 08/29/13. In addition, just below the company name it was hand written in for 11-7 to check refrigerator/med carts/treatment carts nightly.	F 431			
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.	F 441	F 441 1. On 1/8/14, SRNA #4 was re-educated on Infection Control, perineal care and hand washing by the Staffing Coordinator. On 1/8/14, a skin assessment was completed on resident #5; On 1/10/14, a skin assessment on resident #16, was completed by Licensed Staff for any signs or symptoms of infection or skin irritation that may be related to SRNA #4 not performing perineal care per facility protocol.		



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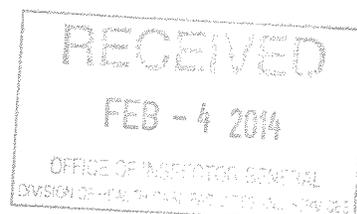
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F 441	<p>Continued From page 12</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility 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, record review and review of the facility's policy, it was determined the facility failed to maintain an Infection Control Program that would prevent transmission of disease and infection for two (2) of seven (7) incontinent residents, of total sample of twenty (20) residents, Residents #5 and #16. The facility staff failed to maintain clean technique incontinent care for Residents #5, and #16. In addition, the staff failed to perform hand hygiene according to the facility's policy.</p> <p>The findings include: Review of the facility's policy regarding Perineal</p>	F 441	<p>2. Skin audits, 24 hour reports, and lab results will be reviewed for all residents by 2/14/14, by the Unit Managers and Director of Nursing (DON), for the past 30 days to identify any resident with signs or symptoms of infection or irritation that may be the result of failure to follow the infection control policy.</p> <p>3. Nursing staff will be re-educated on the Infection Control Policy, perineal care and hand washing by the SDC, Unit Managers and DON. This education will consist of a video called, "SCA Personal Care/ Perineal Video." This training will be completed by 2/14/14. This education will put emphasis on appropriate glove changing protocol and complete perineal care. Perineal care skills pre and post test will be performed by the SDC/Unit Managers/DON. These will be completed by 2/14/14. Any deficient practice will be addressed by the Unit Managers/ DON immediately. SRNA skills checklist and the infection control policy will be reviewed with all nursing employees upon hire and no less than annually thereafter.</p>	



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F 441	Continued From page 13 Care, not dated, revealed instructions on how to perform perineal care for the female and male patients. For the female patient, separate the labia and use gentle downward strokes from front to back and avoid the area around the anus. Review of facility's policy titled Hand Hygiene, dated August 2012, revealed the facility would use hand hygiene as a means to prevent the spread of infection. All personnel would be trained and would follow procedures to prevent the spread of infections. This would include hand washing and alcohol based hand sanitizers. Hand hygiene should be performed after removal of gloves. 1. Observation of Certified Nursing Assistant (CNA) #4 perform perineal care and incontinent care for Resident #5, on 01/08/14 at 11:42 AM, revealed the disposable brief she removed was soiled with urine and stool. CNA #5 and Licensed Practical Nurse (LPN) #2 was present to assist with turning the resident. CNA #4 sprayed peri-wash onto a clean wash cloth and cleaned the labia with downward strokes, front to back. The resident was turned and feces was cleaned from the resident with a clean wash cloth. However, the CNA used back and forward motions across the anus. She then washed the surrounding skin around the anus, buttocks, and coccyx area with the same wash cloth. Closer observation revealed the resident had a dark spot on the coccyx and a small open area to the right buttock. CNA #4 cleaned these areas with the soiled wash cloth. LPN #2 then applied a barrier cream to the buttocks and coccyx area. A discussion regarding the small open area to the right buttocks was conducted between the surveyor and the nurse. During the discussion,	F 441	4. UM/Staff Nurses/SDC/DON will observe no less than 10 residents per week receiving perineal care x 4 weeks, then will observe no less than 10 residents per month x 2 months, then observe no less than 15 residents quarterly. All observations will be presented to facility QA Committee no less than quarterly for one year for further recommendations 5. Completion date:	2/15/14	



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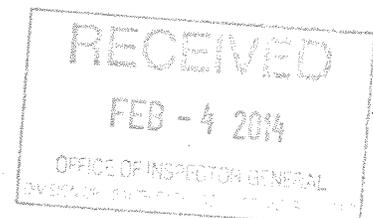
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F 441	<p>Continued From page 14</p> <p>CNA #4 touched the open area to the right buttock with her soiled glove that she had cleaned feces from the anus. CNA #4 then applied a clean brief and touched the resident's clothing and bed linens with the soiled gloves. She then removed the gloves and washed her hands.</p> <p>Interview with CNA #4, on 01/08/14 at 11:50 AM, revealed she had been nervous and forgot to change her gloves and perform hand hygiene after cleaning feces from the resident. She stated she should have removed her gloves and washed her hands immediately after cleaning feces. She indicated she had been trained on proper hand hygiene, but just forgot. She stated she had not seen the small open area this morning during care and it must have just happened. She stated she should not have touched the open area with her soiled glove.</p> <p>Interview with CNA #5, on 01/08/14 at 11:55 AM, revealed she had noticed CNA #4 had broken clean technique while performing peri-care and did not intervene because she did not know if she could.</p> <p>Interview with LPN #2, on 01/08/14 at 11:58 AM, revealed she had identified CNA #4 had broken clean technique when she did not change her gloves or perform hand hygiene after cleaning feces from the resident. In addition, she stated she saw the CNA touch the small open area with the soiled glove. However, she stated she did not intervene and instruct the CNA on proper technique for perineal care and hand hygiene, she replied, she did not know if she could.</p> <p>Interview with the Staff Development Nurse, on</p>	F 441		
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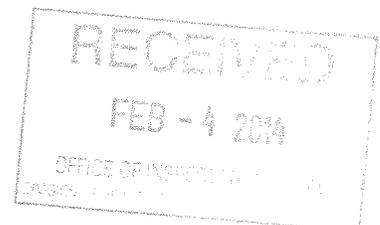
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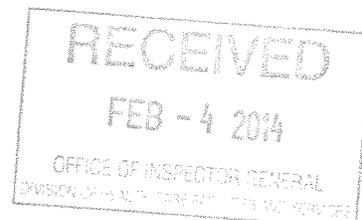
F 441	<p>Continued From page 15</p> <p>01/09/14 at 1:05 PM, revealed all staff were trained on peri-care techniques and hand hygiene after the survey last year. She stated new employees received training on hand hygiene and peri-care during orientation. Each employee must complete annual training as well and this included return demonstration. Staff are trained to follow facility policy. Continued interview revealed she conducted random audits and observed perineal care and hand hygiene for ten (10) resident each quarter. These audits were taken to the Quality Assurance (QA) meetings. She stated she had not found any problems during the audits with 100% compliance. Review of the training records revealed CNA #4 had received training on peri-care in July 2013 and infection control on 03/12/13.</p> <p>Interview with the Administrator, on 01/09/14 at 2:00 PM, revealed the QA committee had focused on peri-care and hand hygiene because it was cited last year. She stated all staff were re-trained and audits were being conducted. She stated the audits revealed 100% compliance. She revealed the Staff Development nurse, both Unit Managers, and Director of Nursing observed staff performing perineal care and randomly observed hand hygiene. She stated Urinary Tract Infections (UTI) are tracked to determine a problem and base training on those figures.</p> <p>Review of Resident #5's clinical record revealed the resident experienced a Urinary Tract Infection on 11/27/13.</p> <p>2. Observation, on 01/09/14 at 9:30 AM, revealed Certified Nursing Assistant (CNA) #2 provided Peri Care for Resident #16. The CNA completed the the technique correctly per facility policy while</p>	F 441		
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F 441	Continued From page 16 cleaning the front side of the peri area going from front to back. After the CNA rolled the resident over to the right side, the CNA proceeded to wipe the resident from the sacrum down over the anal area into the peri area. There was no stool visible. Interview with CNA #2, on 01/09/14 at 9:45 AM, revealed she completed the peri care procedure front to back per policy. After discussion of the technique used after Resident #16 was rolled to the side she stated she wash the back side in the wrong direction and messed it up. Interview with the Unit Manager for the Magnolia Dr. Unit, on 01/09/13 at 12:50 PM, revealed she completed infection control monitoring for the unit and had not noticed an increase in Urinary Tract Infections. She stated CNA #2 most likely got nervous when the surveyor was watching her. She stated she had not completed any random observations of CNA's completing peri care for residents, but had instructed the nurses to do random unannounced audits/observation of CNA's completing peri care on dependent residents.	F 441			



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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: 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type II (111)</p> <p>SMOKE COMPARTMENTS: five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/07/14. Hart County Health Care Center was found not 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). The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *X Michelle Glover* TITLE *X Administrator* (X6) DATE *X 2/4/14*

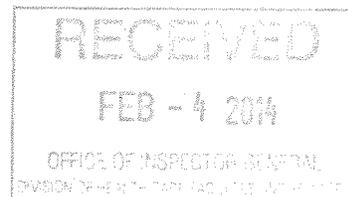
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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If continuation sheet Page 1 of 7
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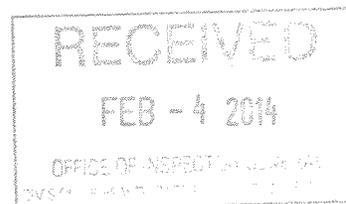
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 027 SS=E	Deficiencies were cited with the highest deficiency identified at "E" level. NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¾-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors located in a smoke barrier would resist the passage of smoke in accordance with NFPA standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, ninety (90) residents, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey. The facility failed to ensure doors located in a smoke barrier would resist the passage of smoke. The findings include: Observation, on 01/07/14 at 12:49 PM, with the	K 027	<p>K027</p> <ol style="list-style-type: none"> The Director of Maintenance repaired cross corridors on 100 and 400 halls on 1/28/14 by applying adhesive gasketing to doors to meet NFPA 99 code. Director of Maintenance checked all cross corridor doors throughout center on 1/7/14 to ensure compliance with NFPA 99. No other issues noted. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 2/14/14 and provide a current copy of the standard . The cross corridors will be reviewed on the TELS maintenance schedule to be conducted and repaired on a monthly basis. These checks will be recorded in the TELS program and reviewed by the Regional Director of Facility Management no less than quarterly to ensure the checks are being completed. Director of Maintenance will report any ongoing issues to the Administrator who will report on same to the facility QA Committee for one year. Compliance Date 	2/15/14



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185381	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 01/07/2014
NAME OF PROVIDER OR SUPPLIER HART COUNTY HEALTH & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1505 SOUTH DIXIE STREET HORSE CAVE, KY 42749	
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K 027	<p>Continued From page 2</p> <p>Maintenance Director revealed the cross corridor doors located between the 100 Hall from the Lobby Hall, and in the 400 Hall had a gap larger than an eighth of an inch and would not resist the passage of smoke when closed.</p> <p>Interview, on 01/07/14 at 12:49 PM, with the Maintenance Director revealed he was not aware the doors had too large of a gap to resist smoke. Further interview with the Maintenance Director revealed he was not aware of a policy for doors located in smoke partitions.</p> <p>Interview, on 01/07/14 at 1:59 PM, with the Administrator revealed she was not aware the doors had too large of a gap to resist smoke. Further interview with the Administrator revealed she was not aware of a policy for doors located in smoke partitions.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>19.3.7.6*. Requires doors in smoke barriers to be self-closing and resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles.</p> <p>Reference: NFPA 80 (1999 Edition) Standard for Fire Doors 2-3.1.7 The clearance between the edge of the door on the pull side shall be 1/8 in. (+/-) 1/16 in. (3.18 mm (+/-) 1.59 mm) for steel doors and shall not exceed 1/8 in. (3.18mm) for wood doors.</p>	K 027		



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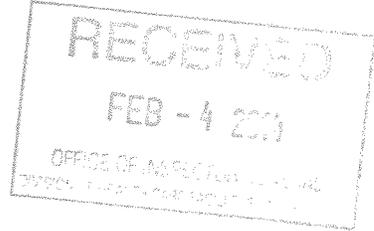
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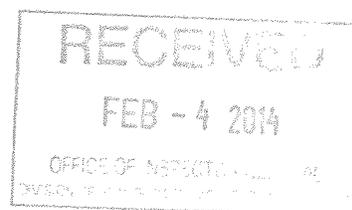
K 027	Continued From page 3 Reference: NFPA 80 (1999 Edition) 2-4.1 Closing Devices. 2-4.1.1 Where there is an astragal or projecting latch bolt that prevents the inactive door from closing and latching before the active door closes and latches, a coordinating device shall be used. A coordinating device shall not be required where each door closes and latches independently of the other.	K 027		
K 076 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential	K 076	K076 1. The Director of Maintenance covered two receptacles, in the oxygen storage room, with a solid plate cover, and moved two light switches by 1/28/14 to ensure compliance with NFPA 99 Code. 2. This is the only oxygen storage area. There were no other rooms to check. 3. Regional Director of Facility Management to provide education on the NFPA Standards to facility maintenance staff by 2/14/14 and provide a current copy of the standard .	



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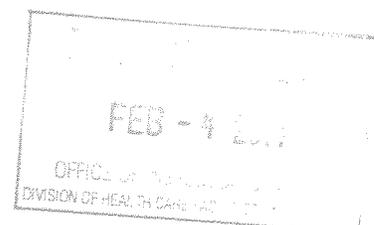
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K 076	<p>Continued From page 4</p> <p>to affect one (1) of five (5) smoke compartments, thirty two (32) residents, staff and visitors. The facility is certified for one hundred four (104) beds with a census of ninety eight (98) on the day of the survey. The facility failed to ensure there was no ignition source below five (5) feet from the floor with the storage of greater than 300 cubic feet of oxygen.</p> <p>The findings include:</p> <p>Observation, on 01/07/14 at 1:33 PM, with the Maintenance Director revealed fifty one (51) E type oxygen tanks stored in the 500 Hall Oxygen Storage Room. The room had two (2) light switches and two (2) receptacles installed below five (5) feet from the floor. Oxygen storage greater than 300 cubic feet cannot have an ignition source installed below five (5) feet from the floor.</p> <p>Interview, on 01/07/14 at 1:33 PM, with the Maintenance Director revealed he was not aware of the requirements for oxygen storage. Further interview with the Maintenance Director revealed he was not aware of a policy for oxygen storage.</p> <p>Interview, on 01/07/14 at 1:59 PM, with the Administrator revealed she was not aware of the requirements for oxygen storage. Further interview with the Administrator revealed she was not aware of a policy for oxygen storage.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an</p>	K 076	<p>4. The Director of Maintenance will report any ongoing issues to the facility QA Committee quarterly for one year.</p> <p>5. Compliance Date</p>	2/15/14



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K 076	Continued From page 5 enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.	K 076		



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K 076	Continued From page 6 8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING	K 076			

