

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

PRINTED: 08/10/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185190	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/05/2010
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NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031
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F 441	<p>Continued From page 7</p> <p>The findings include:</p> <p>Observation of a Licensed Practical Nurse (LPN) on 08/03/10 at 11:37am revealed the nurse went into Resident #4's room, who was on contact precautions for a history of MRSA of the sputum. The LPN put on a gown and gloves and then took Resident #4's finger stick. The LPN then placed the strip in the sharps box, and used a Sani-cloth to wipe down the glucometer. The LPN then placed the glucometer in the holder, took off her gown and gloves and placed them in the resident's garbage can. The nurse was observed two (2) more times doing the same procedure for Residents #2 and #3.</p> <p>Interview with the LPN on 08/03/10 at 4:30pm revealed she was not aware that she did not change her gloves to clean the glucometer. She further stated that she should have changed her gloves because her gloves were considered dirty and the glucometer should be cleaned with a clean pair of gloves. The LPN revealed that she was in-serviced on glucometer use at the end of December, early January. The LPN further related that she could have transferred an organism to another resident.</p> <p>Interview with the Director of Nursing (DON) on 08/03/10 at 4:40pm revealed she does audits at least a couple of times a week. The DON also has different people auditing as well. We have had 12 to 15 audits in July. The DON further agreed that gloves should be changed when cleaning the glucometer machine.</p> <p>Record Review of the Accu-check Isolation Audit Sheet - TCU revealed that after completing the blood glucose test, slide the plastic bag off the</p>	F 441	<ol style="list-style-type: none"> Residents #2, 3 and 4 suffered no adverse affects. No residents who have accuchecks done have developed any adverse affects. Nurse cited was counseled. All staff underwent competency training on the accucheck machine in January 2010. A step-by-step instruction sheet is posted on the inside front cover of Medication Administration Record binder for reference. All staff received infection control in-service with emphasis on glucometers in January 2010. Education was immediately sent out to staff post survey exit and staff meeting on August 17, 2010. Monitoring by Director and assigned nurse night shift nurse a minimum of two times a week. Results will be reported to the Evidence Based Care Committee monthly for 2 months and then quarterly thereafter. 	<p>08/17/10</p> <p>per Ms. Riddon</p> <p>09/07/10</p>
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NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL NORTHEAST	STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031
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F 441	<p>Continued From page 8</p> <p>glucometer onto the towel on the computer or cart. Remove PPE, with gloves being last. Perform hand hygiene, apply gloves and wipe the accu-check machine with Sani-cloth wipes after use.</p> <p>The Infection Control - Glucose Monitoring Policy and Procedure revised on 01/14/10 revealed, the accu-check inform meter requires cleaning or disinfecting when visibly soiled with blood or body fluids or when it comes into contact with areas known or suspected to contain infectious agents such as skin that is not intact. The accu-check inform meter must be disinfected after each use in an isolation room. Cleaning is done with Sani-cloth plus wipes.</p>	F 441		
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NAME OF PROVIDER OR SUPPLIER BAPTIST HOSPITAL NORTHEAST			STREET ADDRESS, CITY, STATE, ZIP CODE 1025 NEW MOODY LANE LA GRANGE, KY 40031	
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K 000	INITIAL COMMENTS	K 000		
K 038 SS=F	<p>A Life Safety Code survey was initiated and concluded on 08/04/10. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest scope and severity deficiency identified was an "F".</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that all exits were readily accessible.</p> <p>The findings include:</p> <p>Observation on 08/04/10 at 3:15pm, revealed a sign on the door leading from TCU that stated "Exits are locked from 9:00 PM till 4:30 AM ". The observation was confirmed with the HVAC Technician.</p> <p>Interview on 08/04/10 at 3:15pm, with the HVAC Technician, revealed that the doors automatically lock during this time and the only way to exit the facility was through the doors at the emergency room. Further interview revealed that the doors unlock when the fire alarm was activated or if</p>	K 038	<p>This Plan of Correction is not an admission of any deficiency contained in the Statement of Deficiencies; however, the Facility remains committed to the delivery of quality healthcare services and will continue to make whatever changes and improvements may be necessary to satisfy this objective and ensure CMS and the State that services are being provided in compliance with the applicable condition of participation.</p>	8/24/10

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



TITLE

Nursing Home Administrator

(X6) DATE

8/25/2010

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.

AUG 27 2010

SCANNED BY: [illegible]
DATE: [illegible]

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K 038	Continued From page 1 security unlocks the doors with the computer system. Reference: NFPA 101 (2000 edition) 19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. Exception No. 1: Door-locking arrangements without delayed egress shall be permitted in health care occupancies, or portions of health care occupancies, where the clinical needs of the patients require specialized security measures for their safety, provided that staff can readily unlock such doors at all times. (See 19.1.1.1.5 and 19.2.2.2.5.) Exception No. 2*: Delayed-egress locks complying with 7.2.1.6.1 shall be permitted, provided that not more than one such device is located in any egress path. Exception No. 3: Access-controlled egress doors complying with 7.2.1.6.2 shall be permitted.	K 038	<ol style="list-style-type: none"> 1. No residents were found to be affected. 2. All residents had the potential of being affected, however, emergency egress is immediately available and all staff are trained on how to release locking system. No emergency release has been required since magnetic locks placed. 3. Magnetic locks on all 3 TCU doors were released on August 24, allowing egress from inside. Bids for Delay Egress Magnetic lock were requested from two companies. One bid has been received, awaiting the 2nd. These locks to be installed immediately after awarding of bid. (Attachment D) 4. New locks will meet standards set forth in 7.2.1.6.1. No monitoring will be required. 	
K 050 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2	K 050		

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K 050	Continued From page 2 This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to conduct fire drills at various times according to NFPA standards. The findings include: Record review on 08/04/10 at 3:57pm, revealed the facility conducted fire drills each quarter at the same time. First shift's was always scheduled at 10:00am, second shift's was always scheduled at 3:30pm, and third shift's was always scheduled at 6:00am. This was confirmed with the HVAC Technician. Interview on 08/04/10 at 3:57pm, with the HVAC Technician, revealed that drills are conducted this way for scheduling purposes but the staff is unaware of when the drills are conducted.	K 050	1. No residents were affected. 2. Fire drills were conducted quarterly on each shift according to law, therefore no residents was at risk. 3. Fire drills will continue to be done quarterly, but will be scheduled at different times each shift. (Attachment E). 4. Director of Engineering keeps log of all fire drills and assigns time of drill. Reports go to Safety Committee	8/24/10 per Mr. Riddon KCF
K C72 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that corridors were maintained free from obstructions to full instant use in the case of fire or other emergency.	K 072		

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K 072	Continued From page 3 The findings include: Observation on 08/04/10 at 4:34pm, revealed that (2) lifts, (1) soiled linen cart, and (1) mobile computer was unattended in TCU South Hallway. Further observation revealed (1) soiled linen cart in TCU North Hallway. The observation was confirmed with the HVAC Tech. Interview on 08/04/10 at 4:34pm, with staff, revealed these items are routinely left out in the hallway.	K 072	<ol style="list-style-type: none"> No residents were found to be affected. Emergency drills completed according to regulations result in all obstructions being removed from hallways 100% of the time. Staff is well trained in emergency procedures. Not residents were identified as being affected. All equipment was immediately removed from hallways. Two rooms adjacent to TCU were designated as storage rooms. All staff were notified to place all equipment in rooms after use. All staff were assigned responsibility for keeping hallways clear. Director will monitor for compliance 5 days a week and will assign staff to monitor on weekends. Results of monitor will be reported to Evidence Based Committee for 2 months and thereafter based on committee recommendation. 	08/24/10 09/07/10 per Mr. Redson HR

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