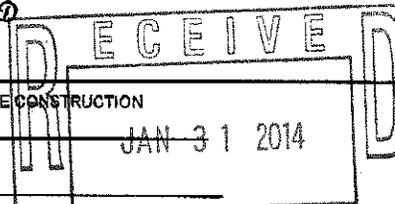


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SD



PRINTED: 01/23/2014  
FORM APPROVED  
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>185150 | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING<br><br>B. WING                              | (X3) DATE SURVEY COMPLETED<br><br>12/12/2013 |
| NAME OF PROVIDER OR SUPPLIER<br><br>KNOTT COUNTY HEALTH & REHABILITATION CENTER |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br>388 PERKINS MADDEN ROAD<br>HINDMAN, KY 41822 |  |

| (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 441<br>SS=D      | 483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS<br><br>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.<br><br>(a) Infection Control Program<br>The facility must establish an Infection Control Program under which it -<br>(1) Investigates, controls, and prevents infections in the facility;<br>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and<br>(3) Maintains a record of incidents and corrective actions related to infections.<br><br>(b) Preventing Spread of Infection<br>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.<br>(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.<br>(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.<br><br>(c) Linens | F 441         | See Attached  |                      |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Ruby Pigeon TITLE: Administrator (X6) DATE: 1-31-14

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.

Received Time Jan. 31. 2014 3:18PM No. 3380

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| F 441   | <p>Continued From page 1</p> <p>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:<br/>Based on observation, interview, record review, and review of facility policy, the facility failed to ensure an infection control program, including hand washing and proper use of contact precautions, to prevent the development and transmission of disease/infection was maintained for two of eighteen residents (Resident #2 and Resident #9). Staff was observed to omit hand washing and glove changes during wound care provided to Resident #2. Record review revealed Resident #9 had a physician's order for contact precautions; however, proper signage was not displayed on the resident's door and the appropriate personal protective equipment (PPE) was not available for staff use prior to providing care for Resident #9. Staff was observed to provide catheter care and incontinence care for Resident #9 without wearing the appropriate PPE.</p> <p>The findings include:<br/>Review of the facility policy entitled Infection Control Program, not dated, revealed hand washing or use of an alcohol based hand rub should be used when moving from a contaminated body site to a clean body site during care. Further review of the policy revealed gloves should be changed during patient care if moving from a contaminated site to a clean body site. Continued review of the policy revealed health care personnel caring for patients on</p> | F 441  |   |                      |  |

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| F 441   | <p>Continued From page 2</p> <p>contact precautions should wear a gown and gloves for all interactions that may involve contact with the patient. Further review of the policy revealed staff should don PPE before entry to a patient room and discard before exiting a patient room. Continued review of the policy revealed residents with contact precautions should have a sign placed on their door alerting visitors to check with the nurse prior to visiting.</p> <p>1. Review of the medical record for Resident #2 revealed the resident was admitted by the facility on 08/02/13 with diagnoses including hypertension, diabetes mellitus, and osteopenia.</p> <p>Observations on 12/12/13 at 12:25 PM of Licensed Practical Nurse (LPN) #1 providing wound care for Resident #2 revealed the LPN washed her hands and donned gloves prior to beginning wound care/dressing change to an unstageable area on the resident's right hip; however, the LPN did not wash her hands or change her gloves after removing the old dressing and continuing with wound care. Continued observation of wound care provided for Resident #2 revealed LPN #1 continued with wound care by changing the protective dressings to the left hip and left shoulder without washing her hands or changing her gloves. Further observation of wound care provided by LPN #2 revealed the LPN removed the soiled glove and dated and initialed the dressings and then put the soiled glove back on her hand to assist with positioning the resident and cleaning up the supplies.</p> <p>Interview on 12/12/13 at 1:20 PM with LPN #1 revealed the LPN was supposed to wash her hands and change her gloves when moving from</p> | F 441  |   |                      |  |

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| F 441   | <p>Continued From page 3</p> <p>one area to another during wound care. The interview further revealed the LPN had recently been trained on use of gloves and hand washing; however, the LPN was nervous and just forgot.</p> <p>Interview on 12/12/13 at 4:47 PM with the Infection Control Registered Nurse (RN #1) revealed hand washing and glove changes should be done when providing wound care after removing a soiled dressing and when moving from one area to another. The interview further revealed the staff had been trained on hand washing and infection control guidelines in November 2013 and RN #1 had not identified any issues with staff not changing gloves or washing hands as required.</p> <p>Interview on 12/12/13 at 3:03 PM with the Director of Nursing (DON) revealed hand washing and glove changes should be done during wound care after removing a soiled dressing and when moving from one area to another. The DON denied any problems had been identified during rounds with appropriate hand washing or glove changes.</p> <p>2. Review of the medical record for Resident #9 revealed the resident was admitted by the facility on 06/08/12 with diagnoses including Dementia with Psychosis, Hypertension, and Anemia. A review of physician orders, dated 12/06/13, revealed Resident #9 had an order for contact precautions related to the resident's urine being positive for Expanded Spectrum B-Lactamase (ESBL).</p> <p>Observations on 12/10/13, 12/11/13, and 12/12/13 of Resident #9's door revealed no signage in place or available PPE related to the</p> | F 441  |   |                      |  |

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| F 441 | <p>Continued From page 4<br/>resident being on contact precautions.</p> <p>Observation on 12/11/13 at 11:05 AM of State Registered Nurse Aide (SRNA) #3 and SRNA #5 providing incontinence care and catheter care to Resident #9 revealed the staff did not wear the appropriate PPE (gown) and did not don the PPE outside of the resident's room before entering the room.</p> <p>Interview on 12/12/13 with SRNA #3 at 10:12 AM and SRNA #5 at 10:17 AM revealed the staff was not made aware until 12/12/13 that Resident #9 was on contact precautions. The interview further revealed a sign and the proper equipment should have been placed on the resident's door so everyone would be aware the resident was on contact precautions and that a gown and gloves should have been worn when providing care to Resident #9. Continued interview revealed a resident's precautions are usually listed on the Kardex and passed on in report. The staff revealed they had recently been trained on the proper PPE for contact precautions.</p> <p>Interview on 12/12/13 at 2:05 PM with the Unit Manager (RN #2) revealed a sign and the proper PPE should be placed on a door for a resident on contact precautions. The interview further revealed a resident's precautions should also be listed on the Kardex so the information can be passed on in report. Continued interview revealed Resident #9 did have a sign on the door and the appropriate PPE available and was not sure what happened to it or how long it had not been in place.</p> <p>Interview on 12/12/13 at 10:25 AM with Infection Control RN #1 revealed Resident #9's urine was</p> | F 441 |  |  |
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| F 441   | Continued From page 5<br>ESBL positive and staff should wear a gown and gloves when in contact with the resident's urine. The interview further revealed a sign and the appropriate PPE had been placed on the door when the contact precautions were ordered; however, the RN was not sure what happened to the sign and the PPE unless the resident's roommate may have taken it down. Continued interview revealed the RN made rounds to ensure contact precaution signs and PPE were on the door, but she had not identified that Resident #9's were not on the door. The interview further revealed staff was trained on contact precautions the week before.<br><br>Interview on 12/12/13 at 3:03 PM with the DON revealed Resident #9 should have had a sign and PPE on the door for contact precautions and was not aware the resident did not have the appropriate signage and PPE on the door. | F 441  |   |  |

**Knott County Health and Rehabilitation Center****Annual Survey December 10-12, 2013****Plan of Correction****F441**

1. Resident #2 is receiving dressing changes by nurses utilizing appropriate hand washing and glove changes as indicated by acceptable professional standards. Appropriate PPE and proper signage was attached to resident #9 door on December 12, 2013. Resident #9 is receiving peri/catheter care by staff utilizing the proper PPE.
2. All residents that have treatments/dressing changes ordered are receiving wound care in compliance with Infection Control Program standards, specifically in regards to appropriate hand washing and glove changes. All nurses have been observed by Administrative Nursing Staff to ensure guidelines are being followed to prevent the development and transmission of disease/infection. All residents that require contact precautions have PPE available for use, appropriate signage and contact precautions are being followed per Infection Control Program standards to ensure guidelines are being followed to prevent the development and transmission of disease/infection.
3. An in-service with nursing staff was conducted by D.O.N. & Administrator on December 27-2013 on Infection Control with emphasis on hand washing and glove changes during wound care/dressing changes and use of PPE, appropriate signage for resident in contact precaution to ensure guidelines are being followed to prevent the development and transmission of disease /infection. All nursing staff has been checked off to ensure Infection Control guidelines were followed.
4. The CQI Committee designee will conduct observation of nurses providing dressing changes to ensure proper hand washing and glove changes are being followed when removing soiled dressings, cleaning areas, and application of new dressings in compliance with Infection Control Program Standards. These observations will be conducted at random times and will include three nurses per week for one month then monthly for the next quarter and bi-annually thereafter. The CQI designee will also make rounds throughout the facility bi-weekly for the next month and weekly for the next quarter to specifically observe for proper signage regarding precautions and availability of proper PPE. The CQI Committee designee will conduct observations of staff providing direct care to ensure they are utilizing PPE appropriately for residents identified with precautions as defined by the Infection Control Program. These observations will be done every week for one month, then monthly for one quarter. Any identified irregularities will be corrected immediately and reported to the CQI Committee for further review.
5. Completion Date January 30, 2014

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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: 1978</p> <p>Survey under: NFPA 101 (2000 Edition) Chapter 19 (existing health care)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and resident rooms</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Diesel, installed 2008</p> <p>A life safety code survey was initiated and concluded on 12/12/13, for compliance with Title 42, Code of Federal Regulations, §483.70 and found the facility in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p> | K 000   |   |                      |   |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE                      |   |   | TITLE   |                      | (X6) DATE   |

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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| K 000  | <p>INITIAL COMMENTS</p> <p>Building: 1a</p> <p>Plan Approval: 2008</p> <p>Survey under: NFPA 101 (2000 Edition) Chapter 18 (new health care)</p> <p>Facility type: SNF/NF</p> <p>Type of structure: Type V (000)</p> <p>Smoke Compartments: 5</p> <p>Fire Alarm: Complete fire alarm with smoke detectors in corridors and resident rooms</p> <p>Sprinkler System: Complete automatic sprinkler system</p> <p>Generator: Type II, Diesel, installed 2008</p> <p>A standard Life Safety Code survey was conducted on 12/12/13. Knott County Health and Rehabilitation Center (Debra K. Reynolds Wing) was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 90. The facility is licensed for 92 beds.</p> | K 000   |   |                      |   |
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