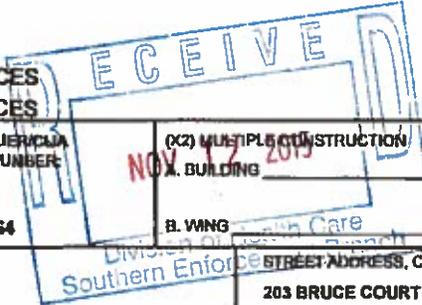


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185264	(X2) MULTIPLE CORRECTION BUILDING:  B. WING	(X3) DATE SURVEY COMPLETED  C 10/01/2015
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NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 203 BRUCE COURT DANVILLE, KY 40423
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(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
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 09/29-10/01/15. Deficient practice was identified with the highest scope and severity at "E" level.  An abbreviated survey (KY23885) was also conducted at this time. The complaint was unsubstantiated with no deficient practice identified.	F 000	Preparation and execution of this plan of correction does not constitute an admission of 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 Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge the alleged deficiencies below is not an admission that the alleged facts occurred as presented in the statements.	
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 observations, interviews, record review, and review of the facility's policy it was determined the facility failed to ensure that the residents' environment remained as free of accident hazards as possible for nine (9) of eighty-nine (89) residents that the facility assessed to "wander" throughout the facility. On 09/30/15, an electrical circuit breaker box was discovered to be unlocked and accessible to residents on the B-Corridor.  The findings include:  Review of the facility's policy titled "Electrical Safety for Residents," dated 04/11, revealed the	F 323	<u>OF</u>  <u>F 323 (SS=E) 483.25(h) FREE ACCIDENT HAZARDS/SUPERVISION/DEVICES</u>  <u>Corrective Action for Residents Found to Have Been Affected</u> The electrical circuit breaker box	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>[Signature]</i>	TITLE  <i>Executive Director</i>	(X6) DATE  10-23-15
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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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F 323	<p>Continued From page 1</p> <p>facility would inspect electrical outlets, extension cords, power strips, and electrical devices as part of routine fire safety and maintenance inspections. However, the electrical circuit breaker box was not addressed in the policy.</p> <p>Observation conducted on 09/30/15 at 11:11 AM revealed that an electrical circuit breaker box on the B-Corridor was unlocked and accessible to residents on that hallway. Further investigation revealed there was an open space between the box cover and the electrical breakers when the door was open exposing electrical wiring. There were not any residents in the B-Corridor during the observations.</p> <p>Review of a list provided by the facility Director of Nursing (DON) revealed the facility assessed nine residents as "wanderers" and stated those residents wandered throughout the facility, including the B-Corridor.</p> <p>Interview conducted with Maintenance staff on 09/30/15 at 11:15 AM revealed the Maintenance staff was unaware that the breaker box was unlocked. The Maintenance staff stated the box should have been locked and was probably left unlocked when they were working on something on the B-Corridor and forgot to lock it back.</p> <p>Interview conducted with the Maintenance Director on 10/01/15 at 10:45 AM revealed that the breaker box should have been locked and that it was an oversight that the box was unlocked.</p> <p>An interview conducted with the Executive Director on 10/01/15 at 10:31 AM revealed that the electrical circuit breaker box on the B-Corridor</p>	F 323	<p>on B-Corridor was locked immediately and is locked at all times when not being attended.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i> All electrical circuit breaker boxes have been reviewed to assure that these boxes are locked at all times when not being attended.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i> On 10-21-2015, the Executive Director reviewed and revised the policies, titled "Electrical Safety for Residents" to include the electrical circuit breaker box. On 10-2-2015, the Director of Maintenance inserviced Staff development RN. Staff development RN began inservicing all staff on 10-2-2015 completed on 10-23-2015 on the importance of assuring that electrical circuit breaker boxes are locked at all times. On 10-5-2015, the locking of electrical circuit breaker boxes was added to the daily maintenance checks.</p>		



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F 371	<p>Continued From page 3</p> <p>1. Review of the facility's policy for "Sanitation &amp; Infection Control," no date, revealed cleaning frequency was determined for all areas and equipment in the Dining Services Department. The policy further revealed the cleaning frequency list served as the basis for the assignment of cleaning duties to staff and for sanitization inspections. All staff was assigned areas and equipment cleaning tasks pertinent to their area. However, this policy did not directly address storing pots and pans wet or cleaning utensil drawers.</p> <p>Review of the facility's policy for "Policy and Procedures Maintenance," dated 04/02/15, revealed the facility will develop systems that promote good maintenance and safety of the facility, grounds, and equipment and that conform to the local, state, and federal requirements for applicable codes that relate to operation of the facility. However, the policy did not address cleaning/maintaining the air conditioner in the kitchen.</p> <p>Observations on 09/29/15 at 10:45 AM during the initial tour of the kitchen revealed the following: three utensil drawers that all had food particles inside the drawers and in contact with the clean utensils, and a ladle that had dried food on the food contact area. There were also five pans with excessive water and food particles on them put away on the storage rack ready for use. A window air conditioner (A/C) unit was observed to have a black fuzzy mold-like substance on the inside and outside of the A/C unit output vent in close proximity of a food preparation area.</p> <p>Interview with the Cook on 09/29/15 at 4:09 PM revealed that she cleans the drawers at night,</p>	F 371	<p>On 10-2-2015, the Maintenance Director cleaned the air conditioner. Beginning on 10-1-2015, Residents #8 and Residents D, E, and F do not have staff touching their food with bare hands.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents have the potential to be affected by F 371. The kitchen utensil drawers were thoroughly cleaned on 10-1-2015 by the Dietary Aides to assure that built-up dirt and food debris were avoided. On 10-2-2015, the Dietary Manager met with Dietary Staff to assure that pans are not stored wet and are absent food particles. On 10-2-2015, the Maintenance Director cleaned the air conditioner and the air conditioner is lacking any black substance. Beginning on 10-1-2015, no residents have staff touching their food with bare hands as evidenced by visual observations by the Director of Nursing and Unit Managers.</p>		

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F 371	<p>Continued From page 4</p> <p>even though the drawers are not on the cleaning list. The cook further stated pans should never be put away wet and she did not know why they were wet.</p> <p>Interview with the Dietary Manager on 09/30/15 at 3:13 PM revealed that the kitchen does not have a cleaning schedule for the window A/C unit, and that Maintenance was responsible for identifying problems with and cleaning the A/C unit. The Dietary Manager stated she had not identified a problem with it. The Dietary Manager stated that the pans should not have been put on the storage rack ready for use when they were wet, and the drawers should not have had food particles in them. The Dietary Manager stated she was not aware that the drawers were not on the cleaning list.</p> <p>Interview with the Maintenance Director on 10/01/15 at 10:45 AM revealed that dietary staff was responsible to identify problems with equipment and should have sent a work order on the A/C window unit to have it cleaned.</p> <p>Interview with the Registered Dietitian (RD) on 09/30/15 at 11:00 AM revealed kitchen staff does not have a cleaning schedule for the window A/C unit, and that Maintenance staff was responsible for identifying problems with and cleaning the A/C unit.</p> <p>Interview with the Executive Director on 10/01/15 at 10:31 AM revealed that she would expect Dietary to let her know when something needed repair or replacement, and the A/C unit should have been cleaned.</p> <p>2. A review of the facility policy titled "Assistance with Meals," with a revision date of October 2009,</p>	F 371	<p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i></p> <p>The facility policy for <i>Sanitation &amp; Infection Control</i> was reviewed and revised by the Food Service Director and approved by the Executive Director on 10-20-2015 to include storing pots and pans dry and the cleaning of utensil drawers. The facility policy for <i>Policy and Procedures Maintenance</i> was reviewed and revised on 10-20-2015 by the Maintenance Director and approved by the Executive Director to include the cleaning and maintenance of the air conditioner in the kitchen. The facility policy titled <i>Assistance with Meals</i> was reviewed and revised on 10-20-2015 by the Director of Nursing and approved by the Executive Director.</p> <p>On 10-21-2015, the Health Care Service Group (HCSG) District Manager educated the Food Service Director, the Food Service Director inserviced the Kitchen Staff on the importance of <del>sanitation practices to include cleaning utensil drawers, storing</del></p>		

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F 371	<p>Continued From page 5</p> <p>revealed residents shall receive assistance with meals in a manner that meets the individual needs of each resident. Further review of the policy revealed Nursing staff would take trays into resident rooms, set up trays, and open containers. There was no evidence the policy addressed bare hand contact with food.</p> <p>A review of the 2013 Food and Drug Administration (FDA) Federal Food Code Section 3-301.11 specifically prohibits bare hand contact with ready-to-eat foods especially in the elderly population.</p> <p>Observations of the evening meal service on 09/29/15 at 5:50 PM revealed State Registered Nurse Aide (SRNA) #4 set up the tray for Resident #8 and removed the resident's cookie from a wrapper with bare hands and placed the cookie on the serving tray. SRNA #4 was then observed to set up Resident D's tray, remove the resident's cookie from a wrapper with bare hands, and place the cookie on the serving tray. SRNA #7 was observed to set up the tray for Resident E and Resident F and was observed to touch the residents' cookies with bare hands when removing the cookies from the wrapper.</p> <p>Interview with SRNA #4 on 09/29/15 at 6:10 PM revealed she did not realize she was touching the resident's cookie with her bare hand and laying the cookie on the serving tray. According to the SRNA, she should have placed the cookie on the resident's plate and used the wrapper to handle the cookie to prevent touching the cookie.</p> <p>An interview conducted with SRNA #7 on 09/29/15 at 6:05 PM, revealed she was not aware she had touched the residents' cookies when</p>	F 371	<p>pans dry and without any food particles, and assuring that the kitchen air conditioner is placed on routine cleaning schedule to avoid any black substance. The Registered Dietitian will complete sanitation reports each week to include these areas to assure that compliance is maintained with F 371.</p> <p>100% Education of SRNA's began 10/2 and completed 10/23 by Staff development RN regarding the proper set up of food trays and how to open straws and items that are on the tray in packages, without touching them directly with their bare hands.</p> <p>Daily observations of meal service by Nursing Administration team began 10/2 to validate the education was effective.</p> <p><i>Plans to Monitor Performance for Sustained Solutions</i> Utensil drawers will be added to and remain on the dietary cleaning check list Dietary Manager will monitor and sign off drawers daily for one month. Drawers will be</p>	

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F 371	Continued From page 6 opening the wrapper and should not have touched the residents' food with her hands.  An interview conducted with the Director of Nursing (DON) on 10/01/15 at 1:10 PM revealed the DON monitored the meal service at least daily to identify concerns and was not aware SRNAs #4 and #7 were touching residents' food with their bare hands. According to the DON, food should not be handled with bare hands to prevent the spread of infection.	F 371	monitored by Dietary Manager weekly on sanitation audit District Manager will monitor drawers on weekly visits and on monthly unit inspections. Dietary manager will monitor pans for wet nesting daily for one month. Pans will also be monitored by Dietary Manager weekly on manager sanitation audits.	
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	F 441	District Manager will monitor pans during weekly visits and on monthly unit inspections. Proper food set up and serving added to yearly competencies for SRNA's. Infection control and safety surveillance rounds sheets updated to include observation of tray prep with emphasis on not touching food with bare hands.	

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F 441	<p>Continued From page 7</p> <p>direct contact will transmit the disease.</p> <p>(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, and review of facility policy it was determined the facility failed to maintain an effective infection control program to prevent the transmission of disease and infection for two (2) of eighteen (18) sampled residents (Residents #2 and #3) and two (2) unsampled residents (Residents A and C). Observation of wound care for Resident #2 on 09/30/15 at 10:35 AM revealed Licensed Practical Nurse (LPN) #1 removed Nu-Gauze (wound packing strip) from a container with ungloved hands, placed the packing strip into a plastic cup, and used ungloved fingers to push the packing strip into the cup. LPN #1 provided wound care for Resident #2 and packed the packing strip into the resident's open abdominal wound. Facility staff failed to follow facility policy and sanitize the blood glucose meter between resident use for Resident #3 and Resident A on 09/30/15 at 4:45 PM. Facility staff touched and repositioned Resident C's catheter bag and tubing with hands on 09/29/15 at 5:50 PM and failed to</p>	F 441	<p>Results of rounds will be discussed with the QA committee that meets monthly for recommendations and follow up.</p> <div style="border: 1px solid black; padding: 5px; width: fit-content; margin: 10px auto;">10-25-2015</div> <p><u>F 441 (SS=D) 483.65</u> <u>INFECTION CONTROL,</u> <u>PREVENT SPREAD, LINENS</u></p> <p><i>Corrective Action for Residents Found to Have Been Affected</i> LPN's #1 and #4 were immediately inserviced after their errors were noted by Staff Development RN on 9/30/15. All staff inserviced with handwashing after touching personal items of a resident PRIOR to tray prep by Staff Development RN beginning on 10/2/15 and completed on 10/23/15. All licensed nurses were re-educated on how to perform a clean dressing change, with emphasis on not touching dressing items with bare hands.</p>	

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F 441	<p>Continued From page 8</p> <p>wash/sanitize hands before setting up the resident's supper tray.</p> <p>The findings include:</p> <p>1. A review of the facility's policy titled "Wound Care Policy," (not dated) revealed staff would follow standard precautions and strict hand washing protocol for all wound care and/or patient care.</p> <p>Observation of wound care on 09/30/15 at 10:50 AM revealed LPN #1, while gathering the wound treatment supplies, reached into the Nu-Gauze packing strip bottle with ungloved hands, pulled out the packing strip, and pushed the packing strip into a plastic cup using ungloved fingers. LPN #1 washed her hands, put gloves on and proceeded to do wound care and packed the Nu-Gauze packing strip into Resident #2's open abdominal wound.</p> <p>Interview conducted with LPN #1 on 09/30/15 at 11:05 AM revealed she was nervous because she was being observed and stated, "I should have worn gloves when gathering my supplies, especially when using the packing strip."</p> <p>Interview with the Unit Manager who was also the facility's Wound/Treatment Nurse on 10/01/15 at 12:50 PM revealed she observed nurses perform wound care to ensure they were compliant with infection control. She stated she had not identified any concerns related to staff failing to wear gloves while gathering supplies for wound care.</p> <p>2. A review of the facility policy titled "Obtaining a Fingertick Glucose Level," Revised December</p>	F 441	<p>All Licensed nurses were re-educated on the disinfection of the Glucose meters with the use of Cavi wipes.</p> <p>All nurses passed competencies of dressing changes and glucose meter cleansing.</p> <p><i>Identification of Other Residents Having the Potential to be Affected</i></p> <p>All residents have the potential to be affected by F441. Under Direction of the Director of Nursing Resident #2 and Resident #3 dressing changes were immediately changed and performed correctly. Resident #2 and Resident #3 were monitored and observed with no signs or symptoms of infection or complications. Resident A and Resident C were each washed and properly sanitized in the appropriate areas. Resident A and Resident C were monitored and observed with no signs or symptoms of infection or complications.</p> <p><i>Measures or Systemic Changes Made to Avoid Reoccurrence</i></p> <p>Yearly competency added for glucose meter cleansing for Licensed nursing staff.</p>		

Infection control safety and surveillance rounds sheet updated to include direct observation of dressing change and cleaning of

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F 441	<p>Continued From page 9</p> <p>2011, revealed the blood glucose meter was required to be cleaned and disinfected between resident use. A review of the facility protocol for disinfecting the blood glucose meter was to wipe the meter with a CaviWipe (a disinfecting solution towelette) and allow the surface of the meter to remain wet for five minutes to disinfect the meter.</p> <p>Observations of blood glucose testing conducted on 09/30/15 at 4:45 PM revealed Licensed Practical Nurse (LPN) #4 removed a blood glucose meter from the medication cart, wiped the surface of the meter with an alcohol wipe, and then performed blood glucose testing on Resident #3. LPN #1 completed the blood glucose testing on Resident #3, then wiped the meter with an alcohol wipe, and then used the same meter to perform blood glucose testing on Resident A, failing to disinfect the blood glucose meter in accordance with facility policy/protocol.</p> <p>An interview conducted with LPN #1 on 09/30/15 at 5:15 PM revealed the LPN thought alcohol wipes could be used to disinfect the blood glucose meter between resident use.</p> <p>An interview with the Unit Manager on 09/30/15 at 5:23 PM revealed that CaviWipes were required to be utilized to clean and disinfect the blood glucose meter between resident use. Further interview with the Unit Manager revealed she was not aware that LPN #1 was using alcohol wipes instead of the CaviWipes as required.</p> <p>3. A review of the facility policy titled "Handwashing," (undated) revealed facility staff was required to wash/sanitize hands after contact with inanimate objects including medical equipment in the immediate vicinity of the</p>	F 441	<p><i>glucometer randomly and at least weekly.</i></p> <p><i>Random weekly checks will ensure different staff, different shifts, and different days of the week to ensure the Facility staff is following proper protocol and Facility is better equipped in infection control.</i></p> <p><i>Plans to Monitor Performance for Sustained Solutions</i></p> <p><i>Results of rounds will be discussed with the QA committee that meets monthly for recommendations and follow up.</i></p> <div style="border: 1px solid black; width: fit-content; margin: 10px auto; padding: 2px 10px;">10-25-2015</div>	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  188284	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  6 10/01/2015
NAME OF PROVIDER OR SUPPLIER  CHARLESTON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 289 BRUCE COURT DANVILLE, KY 40429	
(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 441	<p>Continued From page 10 resident.</p> <p>Observation of tray service for Resident C at the supper meet on 09/29/15 at 5:50 PM revealed State Registered Nurse Aide (SRNA) #7 delivered a meal tray to Resident C, set the tray on the resident's overbed table, and then moved the resident's catheter and tubing to position the overbed table. SRNA #7 then proceeded to set up the resident's tray without washing/sanitizing her hands.</p> <p>An interview conducted with SRNA #7 on 09/29/15 at 6:05 PM revealed the SRNA had not realized she had touched the resident's catheter bag and tubing when positioning the resident's overbed table and therefore did not wash her hands.</p> <p>An interview conducted with the Director of Nursing (DON) revealed setting up a tray was reviewed with SRNAs during orientation and the DON monitored tray service at least daily and had not identified any concerns.</p>	F 441		

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185264</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b>  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/29/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>CHARLESTON HEALTH CARE CENTER</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>203 BRUCE COURT DANVILLE, KY 40423</b>		
(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	
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: 1 story, Type III (200)</p> <p>SMOKE COMPARTMENTS: 6</p> <p>FIRE ALARM: Complete automatic fire alarm system.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II diesel generator.</p> <p>A life safety code survey using 2786-S (Short Form) was initiated and concluded on 09/29/15. The facility was found to be in substantial compliance with the Requirements with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire) for Participation for Medicare and Medicaid. The facility is licensed for ninety (90) beds with a census of eighty-six (86) residents on the day of the 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.