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

PRINTED: 06/26/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185120		04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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F 000	INITIAL COMMENTS AMENDED 06/25/12 (Changes made to F280) An abbreviated survey (KY #18140) was initiated on 04/13/12 with Immediate Jeopardy identified on 04/19/12 and determined to exist on 12/05/11 and ongoing at 42 CFR 483.20 Resident Assessment at F280, 42 CFR 483.25 Quality of Care at F309, 42 CFR 483.65 Infection Control at F441 and 42 CFR 483.75 Administration at F490. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care at F309. The annual recertification survey was conducted on 04/25/12 through 04/28/12 and the Life Safety Code survey was conducted on 04/25/12. Deficiencies were cited with the highest S/S at a "K." The facility failed to assess, monitor, evaluate, effectively treat, and care plan residents with identified rashes and failed to 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 for twelve residents, (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #13, and #25), who were identified as having rashes. Residents #1, #2, #3, #5, #9 and #10 were treated by the facility for Scabies (an infestation with mites). On 04/19/12, the facility presented a list of twenty-two residents in the facility currently identified with rashes; however, according to the AoC, the facility conducted a skin sweep and Symptom Screen of all residents in the building and identified 35 residents symptomatic of rashes out of the total census of 136. Resident #9 was first identified with a rash on 04/20/11 and has had itching for 14 months,	F 000	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jan Rau | TITLE: ED | (X6) DATE: 6/26/12

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 000	Continued From page 1 Resident #1 was first identified with a rash on 12/05/11 and developed cellulitis due to the rash and Resident #3 was first identified with a rash on 12/16/11 and was administered Ativan because the itching was causing the resident to be anxious. Additionally, thirteen facility staff have presented with rashes for which eight staff reported being treated for Scabies either by their physician or through treatment provided by the facility; however, the recommended guidelines for treating the remainder of the residents and the staff members, was not followed to prevent re-infestation. The facility failed to implement the policy and procedure "Infection Control and Prevention Program" related to key surveillance activities, definition of the infection, calculation of the infection rates and data analysis. The facility failed to follow the "Infection Control, Infectious Disease, Scabies Management " policy. An extended survey was conducted on 04/28/12, which determined the Immediate Jeopardy (IJ) had been removed at F280, F309, F441 and F490 on 04/22/12, as alleged in the facility's acceptable Allegation of Compliance (AOC), received on 04/26/12. While the IJ was removed at F280, F309, F441 and F490, continued non-compliance remained as follows: F280 at a S/S of a "D"; F309, F441 and F490 at a S/S of an "E." The facility's Performance Improvement Committee had not completed the monitoring and analysis of information, nor had the opportunity to develop a plan to ensure correction of the deficient practice to prevent non-compliance reccurrence.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279	F 279 – See attachment	5/25/12

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F 279	Continued From page 2 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy/procedure, it was determined the facility failed to develop a comprehensive care plan with specific approaches for one resident (#12), in the selected sample of twenty-eight residents, related to a urinary tract infection (UTI). Findings include: A review of the facility's "Comprehensive Care Plan" policy and procedure, dated 05/28/08, revealed "the Comprehensive Care Plan is	F 279		

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F 279	Continued From page 3 developed for each resident within seven days after completing the comprehensive assessment and the care plan is reevaluated and modified as necessary to reflect changes in care, service and treatment." A record review revealed Resident #12 was admitted to the facility on 11/22/11 with diagnoses to include Parkinson's Disease, Urinary Retention related to Prostatic Hypertrophy and Diabetes Mellitus. A review of the nursing care plan, dated 03/13/12, revealed there was no evidence an infection care plan was implemented for Resident #12. A review of the physician's order and the Medication Administration Record (MAR), dated 04/19/12, revealed a new order for "Bactrim DS one (1) tablet by mouth (PO) twice a day times 14 days related to a urinary tract infection (UTI). An interview with Licensed Practical Nurse (LPN) #2, on 04/26/12 at 3:15 PM, revealed it was the nurse's responsibility to implement a care plan related to a UTI, on 04/19/12, when the physician's order was received for Bactrim DS. An interview with LPN #3, on 04/26/12 at 4:00 PM, revealed she was the nurse who noted the physician's order for Bactrim DS on 04/19/12 related to a UTI and documented in the nurse's notes. She stated, "I forgot to do an infection care plan. I should have completed the care plan." An interview with the Director of Nursing (DON), on 04/27/12 at 3:10 PM, revealed she expected	F 279		

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F 279	Continued From page 4 care plans to be in place for residents who have UTIs. She stated, "[he/she] does not have an actual infection care plan for the UTI" on 04/19/12.	F 279		
F 280 SS=J	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy and procedure, it was determined, the facility failed to review and revise the comprehensive care plan for two residents (#9 and #25), in the selected sample of twenty-eight residents, related to rashes. On 04/19/12, the facility presented a list of twenty-two	F 280	F 280 – See attachment	5/25/12

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F 280	Continued From page 5 residents in the facility currently identified with rashes; however, according to the Allegation of Compliance (AoC), the facility conducted a skin sweep and Symptom Screen of all residents in the building and identified 35 residents symptomatic of rashes out of the total census of 136. Resident #9 was first identified with a rash on 04/20/11 and has had itching for 14 months, while the care plan identified the resident was having pain from itching in 12/2011, there was no revisions made to the care plan related to the problem of the rash. The facility identified Resident #25 as having a rash; however, failed to revise the care plan related to the resident's skin condition to address the Resident's development of the rash and the Resident's "unrelenting" itching. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/19/12 and found to exist on 12/05/11 and was ongoing. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F309. The facility was notified on 04/19/12. It was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of a "D," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process. (Refer to F441 and F490) Findings include: A review of the facility's policy and procedure for the "Comprehensive Plan of Care," dated	F 280		

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F 280	Continued From page 6 05/28/08, revealed "A comprehensive plan of care is developed for each resident within seven (7) days after completing the comprehensive assessment. The care plan is re-evaluated and modified as necessary to reflect changes in care: quarterly with the assessment; and with a significant change of assessment. Update the care plan, during the course of delivery to reflect goals attained (resolve a problem), improvement (interventions modified or deleted), new problems (resultant of change of condition or resident event), or modified interventions (resultant change of condition or resident event)." 1. A record review revealed the facility admitted Resident #9 on 02/24/10 with diagnoses to include Right above the Knee Amputation, Congestive Heart Failure and Peripheral Vascular Disease. Interview with Registered Nurse (RN) #1, on 04/27/12 at 8:30 AM and 04/28/12 at 10:20 AM, revealed a rash was observed on Resident #9 since approximately 04/20/11, when documentation on the resident "Weekly Skin Check Sheet" revealed the resident "continued to have a red, pimply, scattered rash to the abdomen." An interview with Licensed Practical Nurse (LPN) #1, on 04/26/12 at 3:00 PM, revealed the problem for Resident #9 started last year after another resident was admitted with a similar rash. A review of the clinical record revealed prescriptions, dated 04/26/11, 05/17/11 and 06/23/11, of topical steroidal creams and oral steroids. On 06/14/11, there was a treatment with a one-time dose of a topical cream for a parasitic infestation. On 07/25/11, there was another	F 280		

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F 280	Continued From page 7 topical steroid and a pill for itching, and on 08/03/11, there was Vaseline Synalar ointment. On 09/07/11, there was an oral dose of a broad spectrum anti-parasitic agent. A review of the care plan for pain, dated 12/07/11, revealed the problem "I have itching from my neck to my knees." The interventions were to apply skin lotions, as ordered. Further record review revealed, on 02/16/12, the facility administered another oral dose of an anti-parasitic agent to Resident #9; however, there were no updates or new interventions for the comprehensive care plan, regarding the itching, or regarding the spread of the rash or treatments. There was no evidence of evaluations of the treatments for effectiveness in alleviating the itch or resolving the rash. A review of the quarterly Minimum Data Set (MDS), dated 02/25/12, revealed the resident was cognitively independent with decision-making skills and required the extensive assistance of two staff members with bed mobility, and a sling and a mechanical lift for transfers. An observation and interview with Resident #9, on 04/25/12 at 3:50 PM, revealed the resident suffered with symptoms, related to a persistent rash, "for fourteen months" and had "suffered and itched all over, was broke out with little bitty bumps that got bigger" and stated "now I've heard it was scabies." He/she also stated, at first, the rash was confined to the scalp area and then spread to his/her neck as well as to his/her hands. An observation during a skin assessment, on 04/26/12 at 10:20 AM, revealed red, raised and scattered areas of a rash on the resident's upper extremities.	F 280		

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F 280	Continued From page 8 An interview with the MDS Coordinator/RN, on 04/28/12 at 3:55 PM, revealed the problem noted on the change of condition form, would not have been carried over to the comprehensive care plan, if it was a condition that was expected to resolve within a two-week timeframe, such as a skin tear or a sore throat, that was treated. The rash the resident experienced was treated and the coordinator stated she thought it was resolved and stated this resident's rash and resulting itching, "probably should have been carried over to the comprehensive care plan for continued monitoring." 2. A record review revealed the facility admitted Resident #25 on 09/15/10 with diagnoses to include Chronic Kidney Disease and Senile Dementia with Behavioral Disturbance. A review of the care plan for skin breakdown, dated 05/25/11, revealed the monitoring pressure sores on his/her feet and the problem of poor circulation and the need for weekly skin assessments. However, there was no mention of a rash or itching, documented since approximately 02/17/12, when the physician ordered medication for itching. A review of the quarterly MDS assessment, dated 02/21/12, revealed the resident was independent of cognitively independent with decision-making skills and independent with all activities of daily living except for bathing, which required the assistance of two staff members. A review of the Resident Weekly Skin Check Sheet, the Care Plan updates, and the progress	F 280		

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F 280	Continued From page 9 notes revealed the resident was noted to scratch and pick at scabs since 03/21/12. The area was described as red bumps on the back side of his/her bilateral legs, a rash, and red areas to the chest, abdomen, trunk, bilateral legs and upper back. A review of the Weekly Non-Pressure Skin Condition Report revealed the rash and open sores were not monitored on this record. An observation of Resident #25, on 04/25/12 at 10:45 AM, and on 04/27/12 at 10:05 AM, revealed the resident scratching his/her legs and complaining "it itched until I could hardly bear it." A skin assessment revealed multiple areas of open sores on the upper and lower back, bilateral buttocks and both arms and legs. An area on the right lower leg had a scant amount of blood "oozing" from the wound area, and dried blood was noted on the sheet below the resident's leg. The resident stated he/she had always picked at skin sores, and stated the itching was "unrelenting." An interview with RN #1, on 04/27/12 at 3:10 PM, revealed the resident's rash and open sores were worse than when she evaluated the resident on 04/26/12, and the resident had a history of picking at sores. The rash was first documented, on 03/21/12, on a skin assessment and an order was received for a topical antifungal. The resident did have an order for Vistaril, a medication prescribed for anxiety and itching, since 02/17/11, which was discontinued on 04/10/12, due to the resident having tremors. This medication was restarted on 04/27/12. However, review of the comprehensive care plan revealed no documented evidence that the facility revised the care plan and established	F 280		

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F 280	Continued From page 10 interventions to address the Resident's rash and itching since identified on 02/17/12. An interview with the Director of Nursing (DON), on 04/28/12 at 3:45 PM, revealed she expected the licensed staff to utilize the "Weekly Non-Pressure Skin Condition Report" and the policy to track and trend rashes, and re-evaluate the progress or lack of progress with the prescribed treatment. She stated the assessment and monitoring of the rashes should have been placed on the comprehensive care plans. She also stated the itching should have been carried over to the comprehensive care plans, if the itching was current at the time of the quarterly review. A credible allegation of compliance for removal of the Immediate Jeopardy was received on 04/26/12. The Immediate Jeopardy was verified removed on 04/28/12, prior to exit. The alleged date of removal was 04/22/12. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 04/22/12. Observations, interviews and record review revealed the facility had taken the following actions: Licensed Nurses conducted body audits on 04/19/12 for Residents #1 through #10. A skin sweep and Symptom Screen was conducted by licensed staff on all residents in the facility on 04/19/12. Physicians were notified and orders were received for all residents for treatment for scabies on 04/20/12. Mass treatment was completed on all residents on 04/20/12. Skin scrapings were conducted on four random residents. The care plans were updated for each	F 280		

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F 280	Continued From page 11 resident. The executive Director and Director of Nursing consulted with the health department on 04/20/12. All staff were contacted and questioned regarding having a rash or itching. A symptom screen was completed on all staff members on 04/20/12 and 04/21/12. All residents' clothing and linens were removed from rooms and bagged on 04/20/12. All laundry was washed and dried at a temperature of 140 degrees. All residents' rooms were deep cleaned on 04/20/12 and 04/21/12. Privacy curtains were laundered. Items that could not be laundered were bagged for a period of 10 days before they will be returned to the residents. All common areas, offices and Rehab Gym were deep cleaned on 04/20/12 and 04/21/12. Physician orders and shift report are reviewed daily by the DON Monday through Friday and the Weekend Supervisor on weekends for any indication of any residents with rash or infections starting on 04/21/12. All facility staff were educated related to infection control policies on scabies and recommendations from the Centers of Disease Control on 04/20/12, 04/21/12 and 04/22/12. Family members of all residents were called and made aware of the rash and scabies and were given information on scabies on 04/19/12 and 04/20/12. Infection Control Rounds, Personal Protective Equipment and Hand Hygiene Surveillance Tools were implemented and conducted daily starting 04/21/12. The Performance Committee to include the Medical Director met on 04/19/12 and again on 04/20/12. Residents identified as symptomatic as well as those that were clinically contraindicated to receive treatment are receiving daily skin audits by the Licensed Nurse starting on 04/21/12. The Infection Control committee is meeting weekly to	F 280		

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F 280	Continued From page 12 review Infection control case logs. The Staff Development Coordinator was tracking and trending findings and will report to the Performance Improvement Committee. An interview with the Administrator, on 04/28/12 at 2:25 PM, revealed the facility was continuing to monitor where they were in the action plan, if there were any new symptomatic residents and employees, verifying that Surveillance tools are conducted timely and identifying if any trends. She stated the results of the surveillance tools, monitoring and tracking of rashes would be reported at the next Performance Improvement Committee meeting. She revealed the Performance Improvement Committee meets the third Wednesday of every month. Although it was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of a "D," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process.	F 280		
F 309 SS=K	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced	F 309	F 309 – See attachment	5/25/12

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	186120		04/28/2012

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F 309	Continued From page 13 by: Based on observation, record review, family interview, staff interview, and a review of the facility's policy/procedure, the facility failed to provide the necessary care and services to attain or maintain the highest practicable physical, mental and psychosocial well being for ten residents (#1, #2, #3, #4, #5, #6, #8, #9, #13, and #25), in the selected sample of twenty-eight residents, related to the assessment, care, monitoring, evaluation and treatment of rashes. On 04/19/12, the facility presented a list of twenty-two residents in the facility currently identified with rashes; however, according to the AoC, the facility conducted a skin sweep and Symptom Screen of all residents in the building and identified 35 residents symptomatic of rashes out of the total census of 136. Resident #9 was first identified with a rash on 04/20/11 and has had itching for 14 months. Resident #1 was first identified with a rash on 12/05/11 and developed cellulitis due to the rash. Resident #3 was first identified with a rash on 12/16/11 and was administered Ativan because the itching was causing the resident to be anxious. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/19/12 and found to exist on 12/05/11 and was ongoing. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F309. The facility was notified on 04/19/12. It was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation	F 309		

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F 309	Continued From page 14 through the facility's Quality Assurance process. (Refer to F441 and F490) Findings include: A review of the facility's policy/procedure, "Infection Control, Infectious Diseases, Scables Management," revised January 2007, revealed procedures that included Implementation of Contact Precautions (due to the communicability of scabies) until a diagnosis is confirmed by a physician or a nurse practitioner. A private room is indicated but if not possible, obtain a physician's order to treat the roommate. Wear long sleeve gowns during close contact with the resident, their clothing or bed linens. Cover the wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. The facility did not have an Infection Control policy that addressed rashes. 1. A record review revealed the facility admitted Resident #1 on 05/13/09 with diagnoses to include Hypertension, Osteoarthritis and Dementia. A review of the physician's progress notes, dated 12/05/11, revealed Resident #1 complained of a rash and the Advanced Practice Registered Nurse (APRN) documented observing small scabbed areas on the right upper chest. The APRN ordered Triamcinolone cream 0.1% (an anti-inflammatory cream) to be applied to the chest twice daily for ten days to treat the rash. A review of weekly skin assessments, dated 12/08/11 through 12/19/11, revealed a rash was	F 309		

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F 309	Continued From page 15 present on the resident's right chest, right arm and left buttocks, then both arms, the trunk and back of the neck with some improvement noted on 12/19/11. The rash presented as pale pink on 12/23/11 through 12/26/11, and started to reappear on the chest, on 12/27/11, as red areas. On 01/05/12, the facility treated Resident #1 for scabies per orders from the Dermatology Clinic. A rash was noted to spread to the left shoulder on 01/08/12, and by 01/15/12, the rash was documented as spreading to the upper torso. Documentation, on 01/21/12, revealed the resident continued to complain of itching. On 01/31/12, the rash was noted on the right side of the chest, as well as scratched areas on the left upper arm. A review of the annual Minimum Data Set (MDS) assessment, dated 03/14/12, revealed the facility assessed Resident #1 as severely cognitively impaired and required extensive assistance of one to two staff for most activities of daily living. Further review revealed, on 03/20/12, a rash was noted on the resident's neck and he/she complained of itching. Review of a pathology report of a punch biopsy from the right shoulder, dated 03/22/12, revealed "a pattern that was mostly suggestive of scabies with an intense inflammatory reaction". The biopsy, dated 03/22/12, confirmed a diagnosis of scabies, and Resident #1 was again treated for scabies. An interview with the Physician's Assistant from the Dermatology Clinic, on 04/18/12 at 1:39 PM, revealed the pathology report of Resident #1's biopsy, dated 03/22/12, confirmed a diagnosis of	F 309		

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F 309	Continued From page 16 scabies. Record review revealed, on 04/05/12, the resident was noted with multiple small to large sized red raised "bumps" around the neck, on the left arm, lower extremities, the abdomen, chest and left inner thigh. A review of the comprehensive care plan, updated 04/05/12, revealed a problem due to biopsy results with an approach "to apply Elimite cream 5% (treatment for scabies) and wash off in the morning." Record review revealed, on 04/13/12, the left side of Resident #1's face, ear lobe and throat were swollen and warm to touch, and the resident complained of pain upon touch. The facility treated Resident #1 a third time for scabies, and he/she received an antibiotic for a diagnosis of Cellulitis (a bacterial infection) on the left side of the face. Another care plan update, on 04/13/12, related to the complaint of itching revealed an approach "to apply Elimite cream 5% to the scalp only and wash off in the morning." An observation, on 04/13/12 at 10:30 AM, revealed Resident #1 was in his/her room sitting in a wheelchair (w/c) beside the bed. The left side of Resident #1's face and top lip was red and swollen. The resident pulled back his/her left ear to reveal the back of the ear and the hairline. Resident #1 stated there were "bugs" in his/her bed and he/she itched and clawed from head to toe. The resident stated he/she was "broke out all over" and cannot sleep at night. Resident #1 pulled up his/her pant legs and sleeves which revealed a rash over his/her arms and legs. An interview with Resident #1's family member,	F 309		

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F 309	Continued From page 17 on 04/14/12 at 5:00 PM, revealed the resident started to itch after his/her roommate developed a rash in November 2011. She stated she was told by a family member of the roommate that the resident had Scabies. She stated Resident #1 was seen by a physician who informed the family that the rash looked like scabies and treated the resident for it. She stated Resident #1 continued to complain of itching from January through April and she believed the resident has had scabies the entire time. She further stated staff never used any type of isolation precautions while providing care during treatment for scabies for Resident #1 or his/her room mate. An interview on 04/18/12 at 2:00 PM with Licensed Practical Nurse (LPN) revealed residents with rashes are monitored daily by way of weekly skin audits. 2. A record review revealed the facility admitted Resident #2 on 10/21/08 with diagnoses to include Chronic Obstructive Pulmonary Disease, Failure to Thrive, Chronic Respiratory Failure, Parkinson's Disease, Anxiety and Dementia. Review of daily skin assessments, dated 10/24/11, revealed Resident #2 showed signs and symptoms of a skin rash. Review of the Treatment Administration Record dated 11/01/11-11/30/11 revealed orders dated 10/24/11 for Lotrisone cream to be applied to arms chest and abdomen every shift for a diagnosis of Eczema, Vistaril 10 milligrams (mg) every six hours by mouth as needed for itching and Sween cream (a moisturizer) applied daily to arms, chest, and back (not to be applied within two hours of the Lotrisone cream.)	F 309		

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F 309	Continued From page 18 A review of physician's orders from a Dermatology Clinic, dated 11/03/11, revealed orders for Elimite 5% cream (treatment for scabies) apply as directed, repeat in one week and Atarax 10 mg (a medication for itching) and Triamcinolone 0.1% Pandel cream (an anti-inflammatory) to be applied twice daily as needed An interview with the Dermatologist, on 04/16/12 at 2:45 PM, revealed although it was difficult to diagnosis scabies, the clinical symptoms were clear. Resident #2 presented to the clinic with all the clinical symptoms so he felt it was safe to treat him/her as such. A skin assessment on 11/07/11 documented "skin condition improving" this documentation of the rash. Review of the Medication Administration Record (MAR) dated 12/01/11 - 12/31/11 revealed Resident #2 was administered Vistaril 10 mg for compliant of itching on 12/16/11. Review of a skin assessment completed on 12/29/11 revealed the facility assessed and determined the "rash to torso now spreading to the front of legs, treatment in place." Further review of the 12/2011 (MAR) revealed the facility administered Vistaril 10 mg to Resident #2 on 12/31/11 for complaint of itching. The facility did not provide evidence of any further actions taken after the skin assessment showing signs and symptoms of the worsening of the rash. Further review of daily skin assessments, dated for 01/2012, revealed the facility assessed Resident #2 as continuing to have signs and symptoms of a skin rash during that period of time. Review of the Treatment Administration Records (TAR) for 01/12 revealed no	F 309		

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F 309	Continued From page 19 documentation of a change in treatment. Review of the MAR dated 01/01/12 -01/31/12 revealed the facility administered Resident #2 the same medication for complaint of itching on 01/06/12 and 01/30/12. Further review of daily skin assessments, dated for 02/2012, revealed the facility assessed Resident #2 as continuing to have signs and symptoms of a skin rash during that period of time. Review of the Treatment Administration Records (TAR) for 02/12 revealed no documentation of a change in treatment. Review of the MAR dated 02/01/12- 02/29/12 revealed the facility administered medication for complaint of itching on 02/06/12 to Resident #2. Further review of daily skin assessments, dated for 03/2012, revealed the facility assessed Resident #2 as continuing to have signs and symptoms of a skin rash during that period of time. Review of the Treatment Administration Records (TAR) for 03/12 revealed no documentation of a change in treatment. Review of the MAR dated 03/01/12-03/31/12 revealed the resident was administered by the facility the medication for complaint of itching on 03/27/12. Review of a significant change MDS dated 03/19/12 revealed the facility assessed Resident #2's cognition as intact and requiring extensive assistance of one to two staff for bed mobility, transfer and most activities of daily living. An interview on 04/13/12 at 10:30 AM with Resident #2, revealed he/she had a rash but it was better now, he/she stated the rash had itched "something terrible". On 04/17/12 at 4:50 PM,	F 309		

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F 309	Continued From page 20 Resident #2 stated staff did not don gowns or any type of protective garment, other than gloves when providing care for him/her. Further review of the MAR, dated 04/01/12-04/30/12, revealed Resident #2 was administered the medication Vistaril 10 mg for itching on 04/24/12 by the facility. Review of the comprehensive care plan, dated 05/18/11, revealed a goal for "bumps on my skin will heal by the next review," with an approach to "monitor the bumps on my skin and notify the MD if not healing." The care plan did not reflect changes in treatment of the rash. Further review of daily skin assessments, dated 10/24/11 through 03/18/12, revealed Resident #2 was never free of the signs and symptoms of a skin rash during that period of time. Resident #2 was treated by the facility for Scabies during a facility wide mass treatment. An interview on 04/18/12 at 2:00 PM with Licensed Practical Nurse (LPN) revealed residents with rashes are monitored daily by way of weekly skin audits. 3. A record review revealed the facility admitted Resident #3 on 06/25/11 with diagnoses to include Stroke and Depression. A review of the quarterly MDS assessment, dated 02/27/12, revealed the facility assessed Resident #3 as cognitively intact and requiring extensive assistance of one to two staff for all care. Review of the weekly Non-Pressure Skin Condition Report dated 12/16/11 revealed the facility identified Resident #3's rash on that date.	F 309		

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F 309	Continued From page 21 The rash was noted on the left upper back side and hip. The rash was described as sparce and red and a treatment of Topicort was indicated on the report. Documentation revealed the resident complained of itching on 12/30/11. On 01/20/12 the weekly Non-Pressure Skin Condition Report revealed the resident had areas that were fading and new areas were noted and treatment was noted to be continued, with progress noted as no change noted through 02/26/12. Documentation revealed the resident complained of itching on 12/30/11, 01/27/12, 02/10/12. A review of the physician's orders for Resident #3, dated 02/28/12, revealed "Ativan 0.5 mg(milligrams) by mouth twice daily for anxiety." A review of a pathology report dated 03/01/12 of a biopsy from Resident #3's left upper back revealed " the changes present in this biopsy specimen are consistent a hypersensitivity reaction to include drug eruption or arthropod (mite) assault. The specimen lacks the characteristic epidermal changes to support a chronic Eczematous Dermatitis" Documentation revealed the resident complained of itching on 03/08/12, 03/22/12, 03/29/12. Review of a weekly skin check sheet dated 04/12/12 revealed "continued with rash to torso and extremities, also noted behind ears with treatment in place." The facility did not provide evidence of any further actions taken after the skin assessment showing signs and symptoms of the rash not improving and spread of the rash. An observation, on 04/13/12 at 10:05 AM, revealed Resident #3 received a bed bath. The	F 309		

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F 309	Continued From page 22 resident was observed with an extensive rash over his/her trunk, front and back and upper and lower extremities. An interview with Resident #3, on 04/13/12 at 2:30 PM, revealed the rash was present for four to five months and "itched so bad" at night, he/she could not sleep. Resident #3 stated he/she was put on a "nerve pill" because the rash was getting on his/her "nerves." The resident stated he/she thought the rash was getting better, but yesterday it got worse again. An interview with Resident #3, on 04/17/12 at 5:00 PM, revealed staff never used any gowns while providing care for him/her. An interview with the Physician's Assistant (PA) at the Dermatology Clinic, on 04/18/12 at 1:39 PM, revealed she saw Resident #3 at the clinic on 03/01/12. She stated the pathology report of Resident #3's biopsy, completed on 03/01/12, was not conclusive due to the similarity in the pattern for mite reaction, as well as that of a drug reaction. She further stated, after conversations with nursing staff at the facility and being told there were no changes in the resident's medications, she ruled out a drug reaction and decided to treat Resident #3 for Scabies. The facility began treating Resident #3 for scabies on 04/18/12. An observation, on 04/19/12 at 10:25 AM, revealed three housekeeping staff deep cleaned Resident #3's room and reported the resident was being showered in the shower room. 4. A record review revealed the facility admitted Resident #4 on 06/26/06 with diagnoses to include Reflux, Failure to Thrive with peg tube placement, Seizure Disorder, Mental Retardation,	F 309		

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F 309	Continued From page 23 Depression, Anorexia and Obsessive Compulsive Disorder A review of the quarterly MDS, dated 02/01/12, revealed the facility assessed Resident #4 as moderately cognitively impaired and required extensive assistance of one staff for bed mobility, transfers, walking in room, eating, toileting, personal hygiene and bathing. An observation, on 04/13/12 at 10:50 AM, revealed Resident #4 was in his/her w/c propelling himself/herself in the hallway on wing #1. The resident was noted with a red rash on his/her bilateral hands and web spaces. The resident denied pain or discomfort from itching. The rash was noted to spread up the resident's forearms. An interview with Unit Manager (UM) for wing #1, on 04/17/12 at 4:45 PM, revealed she had just discovered the rash on Resident #4 and the Medical Director was notified, and a treatment of Triamcinolone (an anti-inflammatory cream) was ordered. The UM stated Resident #4 was a wanderer and had a weekly skin assessment completed, on 04/13/12, and there was no mention of a rash. An interview with Certified Nurse Aide #8, on 04/17/12 at 4:50 PM, revealed she noticed the rash the previous night and notified Licensed Practical Nurse (LPN) #4. An interview with LPN #4, on 04/18/12 at 5:00 PM, revealed she was made aware of the rash on Resident #4 by the CNA the previous day. She stated the resident was not on contact	F 309		

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F 309	Continued From page 24 precautions and the Medical Director was suppose to see her the next day, which was the usual day she made rounds. She stated all the residents on wing #1, including Resident #4's roommate, were to have skin audits every shift and several new rashes were identified. An observation, on 04/18/12 at 4:50 PM, revealed Resident #4 was awake and alert in the bed without any notice of contact precautions in place. 5. A record review revealed the facility admitted Resident #5 on 12/07/07 with diagnoses to include Alzheimer's Dementia, Anxiety. The quarterly MDS assessment, dated 02/02/12, revealed the facility assessed Resident #5 as moderately cognitively impaired, and required extensive assistance of two staff members with all activities of daily living (ADLs). A review of the Resident Weekly Skin Check Sheets revealed the rash started, on approximately 02/12/12, with "red bumps on the bilateral arms, neck, upper back, abdomen and upper thighs." A physician's order, dated 02/22/12, revealed an order for a topical cream for parasitic infestation to be applied at the hour of sleep (HS) and to repeat in one week. A Weekly Non-Pressure Skin Condition Report, dated 02/22/12, revealed the resident had a rash, "everywhere but on [his/her] head," and was "healed" on 03/13/12. On 04/08/12, red bumps were noted on his/her left upper back, breast and left side, and the resident's nails were trimmed.	F 309		

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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F 309	Continued From page 25 An observation of a skin assessment, on 04/27/12 at 9:55 AM and 10:55 AM, revealed the resident had a few scattered areas of a red, raised rash on the upper chest and left upper arm and was noted scratching his/her left arm area. 6. A record review revealed the facility admitted Resident #6 on 06/20/11 with diagnoses to include Hypertension, Intercranial Hemorrhage, and Severe Osteoporosis. A review of the quarterly MDS, dated 02/29/12, revealed the facility assessed Resident #6 as cognitively intact, requiring extensive assistance of one to two staff for all care except eating. A review of the Resident Progress notes, dated 03/23/12, revealed a condition change form with a new order related to itching and mild rash for Atarax 25 mg at hour of sleep. A condition change form, dated 03/26/12, revealed to continue the Atarax with Clobetasol ointment due to complaint of itching. A review of the weekly skin audits, dated 03/27/12 through 04/22/12, revealed the resident continued to have the rash. On 04/09/12, documentation revealed large red "bumps" were noted on the abdomen and back, with the resident complaining of itching. Review of a Physician Telephone Order dated 04/20/12 revealed orders for Permethrin 5% cream (treatment for scabies) applied to body from the neck down to the soles of the feet to resident symptomatic of asymptomatic, use long sleeved gowns and gloves upon entering the room and repeat the treatment in one week. The treatment was done during a facility wide mass treatment.	F 309		

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F 309	Continued From page 26 An observation of Resident #6 on 04/26/12 at 8:25 AM revealed contact precautions in place UM #1 stated the precautions were initiated "due to a reaction Resident #6 had to the treatment for scabies." On 04/26/12 at 9:30 AM, an observation of a skin assessment of Resident #6, performed by UM #1 revealed a red patchy rash covering the entire trunk, front and back, both arms and the left thigh. An interview with Resident #6, on 04/26/12 at 1:05 PM, revealed he/she had the rash for "some time," but could not remember how long. He/she stated the rash itched terribly and nothing had helped until the ointment was applied all over his/her body the other day, and now the itching was better. 7. A record review revealed the facility admitted Resident #8 on 07/10/09 with diagnoses to include Hypertension, Gastroesophageal Reflux Disease, Hyperlipidemia, Hypothyroid, Anxiety Disorder, Depression, Psychotic Disorder, Asthma, Chronic Obstructive Pulmonary Disease, Cellulites, Dementia, Myalgia and Myositis. A review of the significant change MDS assessment, dated 04/04/12, revealed the facility assessed Resident #8 to be cognitively intact and able to make needs known, but required extensive assistance to perform Activities of Daily Living (ADLs). A review of a dermatology consult, dated 10/06/11, revealed the resident was diagnosed	F 309		

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F 309	Continued From page 27 with Psoriasis and Scabies. Review of the Resident Progress Notes, dated 10/06/11, revealed the resident received Elimite 5% cream and Ivermectin treatments per order from dermatology. A review of the Resident Weekly Skin Check Sheet, dated 10/11/11, revealed documentation "continues with scattered raised red areas"; however, the Weekly Non-pressure Skin Condition Report does not identify or track the rash. A review of the Resident Weekly Skin Check Sheet, dated 03/02/12, revealed documentation of red bumps/rash to the bilateral upper arms. Weekly Non-pressure Skin Condition Report for the same time frame did not identify or track the rash. Further review revealed the resident received treatment for scabies, on 04/19/12; however there was still no notation related to the rash in the Weekly Non-pressure Skin Condition Report identifying or tracking progress of a treatment as of 04/27/12. An Interview with Registered Nurse (RN) #1, on 04/28/12 at 1:13 PM, revealed she expected the Weekly Non-pressure Skin Condition Report to be filled out whenever the rash was identified and used to track treatment and progress of the rash. Observation of a skin assessment, on 04/28/12 at 9:55 AM, revealed the rash on Resident #8's back to be concentrated to the lower posterior thoracic region. Bruising was also noted to the posterior of the resident's upper arms. RN #1	F 309		

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F 309	Continued From page 28 stated the area was from scratching. 8. A record review revealed the facility admitted Resident #9 on 02/24/10, with diagnoses to include Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and a Right Above the Knee Amputation. A review of the quarterly Minimum Data Set (MDS), dated 02/25/12, revealed the resident was independent in cognition and decision-making and required the extensive assistance of two staff members with bed mobility and a sling and mechanical lift for transfers. An interview with RN #1, on 04/27/12 at 8:30 AM and 04/28/12 at 10:20 AM, revealed a rash was observed on Resident #9, since approximately 04/20/11. An interview with Licensed Practical Nurse (LPN) #1, on 04/26/12 at 3:00 PM, revealed the problem started last year for Resident #9, after another resident was admitted with a similar rash and staff members and their family members came down with the same type of rashes. The LPN stated "the one common denominator in all these rashes was this building." A review of the Weekly Non-Pressure Skin Condition Report, dated 12/08/11 through 12/29/11 revealed the resident experienced a rash to the anterior and posterior trunk areas, shoulders and to the top of the right thigh, that was first observed on 12/08/11, and the resident was never free of the condition. In addition, review of the assessments did not describe the actual locations of the rash. There was no	F 309		

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F 309	Continued From page 29 evidence of an evaluation of the progression and/or improvement or decline of the status of the rash on the resident's body. For example, review of the skin assessment, anatomical drawings, the description of the rash varied from red, raised bumps to "continuing rash" and documentation in the nursing notes revealed no mention in the nursing notes other than an occasional mentions of a "rash continued." There was no evidence the facility conducted on-going assessments or documented the findings for the resident in order to identify the persistence and/or spread of the rash. A review of the physician orders, for 2011 through 2012, revealed the resident was treated with medications used to treat itching from parasites, under the skin, on 06/14/11, 09/07/11, 02/16/12 and on 04/19/12. The recommended guideline of treating the entire facility, residents and staff members was not followed to prevent reinfestation, based on the Centers for Disease Control (CDC) Guidelines, until 05/19/12. Physician's orders, dated 04/26/11, 05/17/11 and 06/23/11, revealed prescriptions for topical steroidal creams and oral steroids. On 06/14/11, there was a treatment administered, with a one time dose of a topical cream, Permethin, for a parasitic infestation. On 07/25/11, there was a treatment with another topical steroid and a pill for itching. On 08/03/11, there was a treatment with Vaseline Synalar ointment. On 09/07/11, an oral dose of a broad spectrum anti-parasitic agent was prescribed. On 12/17/11, the resident was referred to a dermatologist for a consult regarding a "red pruritic rash." On 12/28/11, the resident received treatment with a Medrol Dose Pack, a prescription of oral steroids for "Multifactoral	F 309		

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F 309	Continued From page 30 Pruritis." On 12/30/11, the resident was treated with equal parts of Kenalog and Aquaphor, topically, as needed for itching and the physician ordered the resident to wear mittens, at night, to prevent scratching. On 01/17/12, after a dermatology consult, the resident was administered DepoMedrol, intramuscularly for a diagnosis of "rash." On 01/23/12, Nystatin powder was ordered topically, every shift, and A and D Ointment was ordered topically, as needed, "to sooth affected areas." On 01/25/12, the resident was treated with Ultravate Ointment topically, three times a day. On 01/29/12, Ultravate was discontinued and the resident was treated with Nystatin cream, three times a day. On 02/16/12, the resident was seen by a dermatologist who prescribed Prednisone, Atarax and Elimite Cream, which was to be repeated in one week. On 02/17/12, the resident was prescribed Atarax, three times a day, for itching. A review of the History and Profile, dated 02/28/12, revealed the physician's documentation indicated "apparently, there has been an outbreak of Scabies, at the nursing home." And the resident "had some lesions on his/her leg and has been scratching." On 03/05/12, the order for Atarax was increased to four times a day. On 04/03/12, the resident was prescribed Sarna Lotion to the back, chest, abdomen, legs, neck and bilateral arms, every shift, as needed for a diagnosis of "Pruritis." On 04/19/12, after another dermatology consult, the resident was again prescribed Elimite Cream, to be repeated in one week. The recommended CDC guidelines were not followed until 05/19/12, when every resident and staff members and the facility environment was treated. While the facility continued to treat the rash, there was no evidence the facility ever	F 309		

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F 309	Continued From page 31 evaluated the effectiveness of the treatment and failed to resolve the rash that continued to spread to several other residents in the facility. A review of the care plan for pain, dated 12/07/11, revealed "I have itching from my neck to my knees." The interventions were to apply skin lotions, as ordered. There were no updates or new interventions for the comprehensive care plan regarding the itching. The interventions of the Care Plan Update, which were generated with each order mentioned in the previous paragraph, were to administer the medication or topical ointment prescribed, with the goal of the resident having no rash or skin irritation. The goal was not met and was not reevaluated and the interventions were not evaluated for effectiveness. An interview with Resident #9, on 04/25/12 at 3:50 PM, revealed the resident complained of the development on an itchy rash on his/her body. An observation and interview with Resident #9, on 04/26/12 at 10:20 AM, revealed Resident #9 suffered with the symptoms related to a persistent rash, "for fourteen months." The resident stated he/she had "suffered and itched all over" and was "broke out with little bitty bumps that got bigger" and stated "now I've heard it was scabies." At first, the rash was confined to the scalp area and spread to his/her neck and then to the hands. The skin assessment revealed red, raised rashes, scattered over the back, torso, arms and wrists. 9. A record review revealed the facility Resident #25 on 09/15/10 with diagnoses to include Senile Dementia, Psychosis with Behavioral Disturbance	F 309		

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F 309	Continued From page 32 and Chronic Kidney Disease. A review of the quarterly MDS assessment, dated 02/21/12, revealed the resident was cognitively independent with decision-making skills and independent with all activities of daily living except for bathing, which required the assistance of two staff members. A review of the Resident Weekly Skin Check Sheet, the Care Plan updates, and the progress notes revealed the resident was noted scratching and picking at the scabs since 03/21/12. The area was described as red bumps on the back side of the bilateral legs, a rash and red areas were noted to the chest, abdomen, trunk, bilateral legs and upper back. A review of the Weekly Non-Pressure Skin Condition Report revealed the rash and open sores were not monitored on this record. An observation of Resident #25, on 04/25/12 at 10:45 AM and on 04/27/12 at 10:05 AM, revealed the resident was scratching his/her legs and stated, "it itched until I could hardly bear it." A skin assessment revealed multiple areas of open sores on the upper and lower back, bilateral buttocks and both arms and legs. An area on the right lower leg had a scant amount of blood "oozing" from the wound area and dried blood was noted to the sheet below the resident's leg. The resident stated he/she had always picked at skin sores, yet stated the itching was "unrelenting." An interview with RN #1, on 04/27/12 at 3:10 PM, revealed the resident's rash and open sores were worse now than when she evaluated the resident	F 309		

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F 309	Continued From page 33 on 04/26/12, and the resident had a history of "picking" at any sore. The rash was first documented, on 03/21/12, and an order was received for a topical antifungal. The resident did have an order for Vistaril, a medication prescribed for anxiety and itching, since 02/17/11, but was discontinued on 04/10/12, due to the resident having tremors. This medication was restarted on 04/27/12. 10. A record review revealed the facility admitted Resident #13 on 04/01/11 with diagnoses to include Senile Dementia, a History of Convulsions and a Subdural Hematoma. A review of the Resident Weekly Skin Assessments, dated 01/22/12, revealed the resident experienced "a few scattered red bumps on the upper body, bilateral arms and chest," and the resident "complained of itching." A review of the quarterly MDS, dated 02/15/12, revealed the resident was moderately cognitively impaired and made few decisions. He/she required the extensive assistance of two staff members with ADLs. A review of the physician's orders revealed the resident was treated with a topical antifungal, on 03/01/12 and again on 03/09/12, and was not properly treated for a rash, until 04/19/12. An observation of a skin assessment, on 04/26/12 at 11:00 AM, revealed a slightly red raised rash on the resident's abdominal area. The resident stated she experienced "quite a bit of itching."	F 309		

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F 309	Continued From page 34 An interview with the MDS Coordinator/RN, on 04/28/12 at 3:55 PM, revealed the problem noted on the change of condition form, would not be carried over to the comprehensive care plan, if it was a condition that would be expected to resolve within a two-week timeframe, such as a skin tear or a sore throat that was treated. The rash the resident experienced was treated and the coordinator stated she thought it would be resolved, and stated this resident's rash and resulting itching, "probably should be carried over to the comprehensive care plan for continued monitoring." An interview with Certified Nurse Aide #10, on 04/26/12 at 3:45 PM revealed the first time she noticed the rash at the facility in March 2011, when Resident #28, who no longer resides at the facility, experienced an itchy rash. The CNA, who also experienced a rash and itching, received treatment at the hospital. The CNA reported to the DON and "some employees received a cream, but not all employees were treated." An interview with Licensed Practical Nurse #1, on 04/26/12 at 3:00 PM, revealed the problem started last year for Resident #9, after a resident was admitted with a rash and staff members and their family members came down with the same type of rashes. Staff members were told to go to the local convenient care for treatment. The LPN stated "the one common denominator in all these rashes was this building." During interview with the Director of Nursing (DON,) on 04/28/12 at 3:45 PM, she expeoted the licensed staff to utilize the "Weekly Non-Pressure Skin Condition Report" and policy, to track and trend the rash and re-evaluate the progress or	F 309		

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F 309	Continued From page 35 lack of progress with prescribed treatment. The assessment and monitoring of the rash should have be placed on the comprehensive care plan. and the DON stated the itching should be carried over to the comprehensive care plan if the itching was current at the time of the quarterly review for further monitoring of this situation. A credible allegation of compliance for removal of the Immediate Jeopardy was received on 04/26/12. The Immediate Jeopardy was verified removed on 04/28/12, prior to exit. The alleged date of removal was 04/22/12. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 04/22/12. Observations, interviews and record review revealed the facility had taken the following actions: Licensed Nurses conducted body audits on 04/19/12 for Residents #1 through #10. A skin sweep and Symptom Screen was conducted by licensed staff on all residents in the facility on 04/19/12. Physicians were notified and orders were received for all residents for treatment for scabies on 04/20/12. Mass treatment was completed on all residents on 04/20/12. Skin scrapings were conducted on four random residents. The care plans were updated for each resident. The executive Director and Director of Nursing consulted with the health department on 04/20/12. All staff were contacted and questioned regarding having a rash or itching. A symptom screen was completed on all staff members on 04/20/12 and 04/21/12. All residents' clothing and linens were removed from rooms and	F 309		

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F 309	Continued From page 36 bagged on 04/20/12. All laundry was washed and dried at a temperature of 140 degrees. All residents' rooms were deep cleaned on 04/20/12 and 04/21/12. Privacy curtains were laundered. Items that could not be laundered were bagged for a period of 10 days before they will be returned to the residents. All common areas, offices and Rehab Gym were deep cleaned on 04/20/12 and 04/21/12. Physician orders and shift report are reviewed daily by the DON Monday through Friday and the Weekend Supervisor on weekends for any indication of any residents with rash or infections starting on 04/21/12. All facility staff were educated related to infection control policies on scabies and recommendations from the Centers of Disease Control on 04/20/12, 04/21/12 and 04/22/12. Family members of all residents were called and made aware of the rash and scabies and were given information on scabies on 04/19/12 and 04/20/12. Infection Control Rounds, Personal Protective Equipment and Hand Hygiene Surveillance Tools were implemented and conducted daily starting 04/21/12. The Performance Committee to include the Medical Director met on 04/19/12 and again on 04/20/12. Residents identified as symptomatic as well as those that were clinically contraindicated to receive treatment are receiving daily skin audits by the Licensed Nurse starting on 04/21/12. The Infection Control committee is meeting weekly to review infection control case logs. The Staff Development Coordinator was tracking and trending findings and will report to the Performance Improvement Committee. An interview with the Administrator, on 04/28/12 at 2:25 PM, revealed the facility was continuing to	F 309		

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F 309	Continued From page 37 monitor where they were in the action plan, if there were any new symptomatic residents and employees, verifying that Surveillance tools are conducted timely and identifying if any trends. She stated the results of the surveillance tools, monitoring and tracking of rashes would be reported at the next Performance Improvement Committee meeting. She revealed the Performance Improvement Committee meets the third Wednesday of every month. Although it was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process.	F 309		
F 441 SS=K	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	F 441	F 441 – See attachment	5/25/12

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	185120		04/28/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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F 441	Continued From page 38 (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy/procedure review, the facility failed to 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 for twelve residents, (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #13, and #25), in the selected sample of twenty-eight residents, who were identified as having rashes. Residents #1, #2, #3, #5, #9 and #10 were treated by the facility for Scabies (an infestation with mites). On 04/19/12 at approximately 3:56 PM, the facility ' s infection control nurse presented the survey agency surveyor a list of twenty-two residents in the	F 441		

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F 441	Continued From page 39 facility currently identified with rashes; however, after immediate jeopardy was identified on this same date, the facility conducted a skin sweep and Symptom Screen of all residents in the building on 04/19/12 and identified 35 residents symptomatic of rashes out of the total census of 136, per the facility ' s Allegation of Compliance dated 04/26/12. Resident #9 was first identified with a rash on 04/20/11 and had experienced itching for 14 months, Resident #1 was first identified with a rash on 12/05/11 and developed cellulitis due to the rash. Resident #3 was first identified with a rash on 12/16/11 and was administered Ativan because the itching was causing the resident to be anxious. Additionally, thirteen facility staff have presented with rashes for which eight staff reported being treated for Scabies either by their physician or through treatment provided by the facility; however, the recommended guidelines for treating the remainder of the residents and the staff members, was not followed to prevent re-infestation. The facility failed to implement the policy and procedure "Infection Control and Prevention Program" related to key surveillance activities, definition of the infection, calculation of the infection rates and data analysis. The facility failed to follow the "Infection Control, Infectious Disease, Scabies Management " policy as evidenced by the facility not implementing Contact precautions and observations of the Medical Director having direct contact with three resident ' s rashes (Resident ' s #25, 8, and 9), ungloved. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/19/12	F 441		

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F 441	Continued From page 40 and found to exist on 12/05/11 and was ongoing. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F309. The facility was notified on 04/19/12. It was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process. (Refer to F309 and F490) Findings include: A review of the facility's policy and procedure, "Infection Control and Prevention Program" dated 10/31/09, revealed the facility's infection control program included, but was not limited to the following components: (a) Key surveillance activities, (b) Definition of Infection, (C) Calculation of infection rates and (d) Data analysis. Essential elements of the surveillance system were to include, use of standardized definitions and listings of the symptoms of the infection and use of surveillance tools such as, (1) Infection surveys and data collection templates, (2) Walking rounds throughout the facility, (3) Identification of segment of the population at risk for the infection, (4) Identification of the processes or outcomes selected for surveillance, and (5) Statistical analysis of data that can uncover an outbreak, and feedback of the results to the primary caregivers so they can assess the residents for sign of infection. A review of the facility's policy and procedure, Infection Control, Infectious Diseases, Scabies	F 441		

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F 441	Continued From page 41 Management, revised January 2007, revealed procedures that included Implementation of Contact Precautions (due the communicability of scabies) until a diagnosis is confirmed by a physician or a nurse practitioner. A private room is indicated but if not possible, obtain a physician's order to treat the roommate. Wear long sleeve gowns during close contact with the resident, their clothing or bed linens. Cover wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. A review of the Center for Disease Control and Prevention (CDC), updated November 2, 2010, revealed for prevention, early detection, treatment, and implementation of appropriate isolation and infection control practices are essential in preventing scabies outbreaks. Institutions should maintain a high index of suspicion that undiagnosed skin rashes and conditions may be scabies, even if characteristic symptoms of scabies are absent (e.g. no itching). Also noted was Appropriate isolation and infection control practices (e.g. gloves gowns, avoidance of direct skin to skin contact, etc) should be used when providing hands-on care to patients who might have scabies. 1. A record review revealed the facility admitted Resident #1 on 05/13/09 with diagnoses to include Left (Lt) Hip and Lt wrist fractures, Hypertension, Reflux, Osteoarthritis and Dementia. A review of the physician's progress notes, dated 12/05/11, revealed Resident #1 complained of a rash and the Advanced Practice Registered	F 441		

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F 441	Continued From page 42 Nurse (APRN) documented observing small scabbed areas on the right upper chest. The APRN ordered Triamcinolone cream 0.1% (an anti-inflammatory cream) to be applied to the chest twice daily for ten days to treat the rash. A review of weekly skin assessments, dated 12/08/11 through 12/19/11, revealed a rash was present on the resident's right chest, right arm and left buttocks, then both arms, the trunk and back of the neck with some improvement noted on 12/19/11. The rash presented as pale pink on 12/23/11 through 12/26/11, and started to reappear on the chest, on 12/27/11, as red areas. There was no documented evidence of a change in treatment from 12/08/11 through 12/27/11. On 01/05/12, the facility treated Resident #1 for scabies per orders from the Dermatology Clinic. A rash was noted to spread to the left shoulder on 01/08/12, and by 01/15/12, the rash was documented as spreading to the upper torso. Documentation, on 01/21/12, revealed the resident continued to complain of itching. On 01/31/12, the rash was noted on the right side of the chest, as well as scratched areas on the left upper arm. Further review revealed, on 03/20/12, a rash was noted on the resident's neck and he/she complained of itching. Review of a pathology report of a punch biopsy from the right shoulder, dated 03/22/12, revealed a pattern that was mostly suggestive of scabies with an intense inflammatory reaction. The biopsy, dated 03/22/12, confirmed a diagnosis of scabies, and Resident #1 was again treated for scabies. An interview with the Physician's Assistant from	F 441		

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F 441	Continued From page 43 the Dermatology Clinic, on 04/18/12 at 1:39 PM, revealed the pathology report of Resident #1's biopsy, dated 03/22/12, confirmed a diagnosis of scabies. Record review revealed, on 04/05/12, the resident was noted with multiple small to large sized red raised "bumps" around the neck, on the left arm, lower extremities, the abdomen, chest and left inner thigh. A review of the comprehensive care plan, updated 04/05/12, revealed a problem due to biopsy results with an approach "to apply Elimite cream 5% (treatment for scabies) and wash off in the morning." Record review revealed, on 04/13/12, the left side of Resident #1's face, ear lobe and throat were swollen and warm to touch, and the resident complained of pain upon touch. The facility treated Resident #1 a third time for scabies, and he/she received an antibiotic for a diagnosis of Cellulitis (a bacterial infection) on the left side of the face. Another care plan update, on 04/13/12, related to the complaint of itching revealed an approach "to apply Elimite cream 5% to the scalp only and wash off in the morning." An observation, on 04/13/12 at 10:30 AM, revealed Resident #1 was in his/her room sitting in a wheelchair (w/c) beside the bed. The (Lt) side of Resident #1's face and top lip was red and swollen. The resident pulled back his/her Lt ear to reveal the back of the ear and the hairline. Resident #1 stated there were "bugs" in his/her bed and he/she itched and clawed from head to toe. The resident stated he/she was "broke out all over" and cannot sleep at night. Resident #1 pulled up his/her pant leg and sleeves which	F 441		

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F 441	Continued From page 44 revealed a rash over his/her arms and legs. Observation of the resident's room and outside the room in the hallway revealed no evidence contact precautions had been initiated as per the facility ' s " Infection Control, Infectious disease, Scabies management " which included implementation of contact precautions until a diagnosis is confirmed ...wearing long sleeve gowns during close contact with the resident, their clothing or bed linens. An interview with Resident #1's family member, on 04/14/12 at 5:00 PM, revealed the resident started to itch after his/her roommate developed a rash in November 2011. She stated she was told by a family member of the roommate that the resident had Scabies. She stated Resident #1 was seen by a physician who informed the family that the rash looked like scabies and treated the resident for it. She stated Resident #1 continued to complain of itching from January through April and she believed the resident has had scabies the entire time. 2. A record review revealed the facility admitted Resident #2 on 10/21/08 with diagnoses to include Chronic Obstructive Pulmonary Disease, Failure to Thrive, Chronic Respiratory Failure, Parkinson's disease, Anxiety and Dementia. Review of the comprehensive care plan, dated 05/18/11, revealed a goal for "bumps on my skin will heal by the next review," with an approach to "monitor the bumps on my skin and notify the MD if not healing." Review of weekly skin assessments, dated 10/24/11- 10/31/11, revealed Resident #2 was	F 441		

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F 441	Continued From page 45 never free of the signs and symptoms of a skin rash during that period of time. A review of physician's orders from a Dermatology Clinic, dated 11/03/11, revealed a treatment for Resident #2's scabies was ordered on that date. There was no further documentation of a change in treatment; however, physician notification was noted. An interview with the Dermatologist, on 04/16/12 at 2:45 PM, revealed although it was difficult to diagnosis scabies, the clinical symptoms were clear. Resident #2 presented to the clinic with all the clinical symptoms so he felt it was safe to treat him/her as such. Further review of the skin assessments, dated 10/31/11 through 03/18/12 revealed the resident was never free of the signs and symptoms of a skin rash during that time period. Review of the facility ' s Significant Change MDS Assessment, dated 03/19/12, revealed the facility assessed Resident #2 as cognitively intact. An interview with Resident #2, on 04/17/12 at 4:50 PM, revealed staff did not don gowns or any type of protective garment, other than gloves when providing care for him/her. Observation of the resident's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. 3. A record review revealed the facility admitted Resident #3 on 06/25/11 with diagnoses to include Pulmonary Embolism, Coronary Artery Disease, Osteoarthritis, Stroke and Depression.	F 441		

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F 441	Continued From page 46 A review of the quarterly MDS assessment, dated 02/27/12, revealed the facility assessed Resident #3 as cognitively intact and requiring extensive assistance of one to two staff for all care. A review of the physician's orders for Resident #3, dated 02/28/12, revealed "Ativan 0.5 mg(milligrams) by mouth twice daily for anxiety." An observation, on 04/13/12 at 10:05 AM, revealed Resident #3 receiving a bed bath. The resident was observed with an extensive rash over his/her trunk, front and back and upper and lower extremities. An interview with Resident #3, on 04/13/12 at 2:30 PM, revealed the rash was present for four to five months and "itched so bad" at night, he/she could not sleep. Resident #3 stated he/she was put on a "nerve pill" because the rash was getting on his/her "nerves." The resident stated he/she thought the rash was getting better, but yesterday it got worse again. An interview with Resident #3, on 04/17/12 at 5:00 PM, revealed staff never used any gowns while providing care for him/her. Observation of the resident's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. An interview with the Physician's Assistant (PA) at the Dermatology Clinic, on 04/18/12 at 1:39 PM, revealed she saw Resident #3 at the clinic several times. She stated the pathology report of Resident #3's biopsy, completed on 03/01/12, was not conclusive due to the similarity in the pattern for mite reaction, as well as that of a drug reaction. She further stated, after conversations with nursing staff at the facility and being told there were no changes in the resident's	F 441		

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F 441	Continued From page 47 medications, she ruled out a drug reaction and decided to treat Resident #3 for Scabies. The facility began treating Resident #3 for scabies on 04/18/12. 4. A record review revealed the facility admitted Resident #4 on 06/26/06 with diagnoses to include Reflux, Failure to thrive with peg tube placement, Seizure Disorder, Mental Retardation, Depression, Anorexia and Obsessive Compulsive Disorder. A review of the quarterly MDS, dated 02/01/12, revealed the facility assessed Resident #4 as moderately cognitively impaired and required extensive assistance of one staff for bed mobility, transfers, walking in room, eating, toileting, personal hygiene and bathing. An observation, on 04/13/12 at 10:50 AM, revealed Resident #4 was in his/her w/c propelling him/herself in the hallway on wing #1. The resident was noted with a red rash on his/her bilateral hands and web spaces. The rash was noted to spread up the resident's forearms. Resident #4 denied any pain or discomfort from itching. An interview with Unit Manager (UM) for wing #1, on 04/17/12 at 4:45 PM, revealed she discovered the rash on Resident #4 on 04/17/12, the Medical Director was notified on 04/17/12, and a treatment of Triamcinolone (an anti-inflammatory cream) was ordered. The UM stated Resident #4 was a wanderer and had a weekly skin assessment completed, on 04/13/12, and there was no mention of a rash.	F 441		

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F 441	Continued From page 48 An interview with Certified Nurse Aide #8, on 04/17/12 at 4:50 PM, revealed she noticed the rash the previous night and notified Licensed Practical Nurse (LPN) #4. An interview with LPN #4, on 04/18/12 at 5:00 PM, revealed she was made aware of the rash on Resident #4 by the CNA the previous day. She stated the resident was not on contact precautions and the Medical Director was supposed to see her the next day, which was the usual day she made rounds. She stated all the residents on wing #1, including Resident #4's roommate, were to have skin audits every shift and several new rashes were identified. An observation, on 04/18/12 at 4:50 PM, revealed Resident #4 was awake and alert in the bed. Observation of the resident's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. 5. A record review revealed the facility admitted Resident #5 on 12/07/07 with diagnoses to include Alzheimer's Dementia, Anxiety and Anemia. The quarterly MDS assessment, dated 02/02/12, revealed the facility assessed Resident #5 as moderately cognitively impaired, and required extensive assistance of two staff members with all activities of daily living (ADLs). A review of the Resident Weekly Skin Check Sheets revealed the rash started, on approximately 02/12/12, with "red bumps on the bilateral arms, neck, upper back, abdomen and upper thighs."	F 441		

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F 441	Continued From page 49 A physician's order, dated 02/22/12, revealed an order for a topical cream for parasitic infestation to be applied at the hour of sleep (HS) and to repeat in one week. A Weekly Non-Pressure Skin Condition Report, dated 02/22/12, revealed the resident had a rash, "everywhere but on [his/her] head," and was "healed" on 03/13/12. On 04/08/12, red bumps were noted on his/her left upper back, breast and left side, and the resident's nails were trimmed. An observation of a skin assessment, on 04/27/12 at 9:55 AM by UM #1, revealed the resident had a few scattered areas of a red, raised rash on the upper chest and left upper arm and was noted scratching his/her left arm area. Observation of the resident's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. 6. A record review revealed the facility admitted Resident #6 on 06/20/11 with diagnoses to include Non-displaced Right Hip fracture, Hypertension, Intracranial Hemorrhage, Reflux, and Severe Osteoporosis. A review of the quarterly MDS, dated 02/29/12, revealed the facility assessed Resident #6 as cognitively intact, requiring extensive assistance of one to two staff for all care except eating. A review of the Resident Progress notes, dated 03/23/12, revealed a condition change form with a new order related to itching and mild rash for Atarax 25 mg at hour of sleep. A condition change form, dated 03/26/12, revealed to continue the Atarax with Clobetasol ointment due	F 441		

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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
F 441	Continued From page 50 to complaint of itching. On 04/09/12, documentation revealed large red "bumps" were noted on the abdomen and back, with the resident complaining of itching. A review of the weekly skin audits, dated 03/27/12 through 04/22/12, revealed the resident continued to have the rash and was treated for scabies, on 04/20/12, during a facility wide treatment. An observation, on 04/26/12 at 9:30 AM, during Resident #6's skin assessment revealed a red patchy rash covering the entire trunk, front and back, both arms and the left thigh. An interview with Resident #6, on 04/26/12 at 1:05 PM, revealed he/she had the rash for "some time," but could not remember how long. He/she stated the rash itched terribly and nothing had helped until the ointment was applied all over his/her body the other day, and now the itching was better. 7. A record review revealed the facility admitted Resident #7 on 02/28/08 with diagnoses to include Hypothyroidism, Alzheimer's disease, and Osteoarthrosis. Review of the Infection Control Log submitted by the Infection Control Nurse revealed Resident #7 was identified by the facility as having a rash with an onset date of 04/09/12. Review of the Resident Progress notes dated 04/09/12 at 9:10 PM revealed the physician was notified of the rash on Resident #7's right leg. On 04/11/12 at 10:30 AM documentation revealed an order was received to monitor the rash every shift	F 441		

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	185120		04/28/2012

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F 441	Continued From page 51 and notify of any changes. A condition change form, dated 04/12/12, revealed a rash on the back side of the right leg with an order for Triamcinolone cream. Observation on 04/13/12 at 11:00 AM of Resident #7's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. On 04/15/12, a note was added at 6:10 PM, "continued with a rash to bilateral legs, treatment applied twice daily with no sign or symptoms of scratching. Review of the quarterly MDS, dated 04/17/12, revealed the facility assessed Resident #7 as severely cognitively impaired and totally dependent on the staff for all care. A review of the quarterly assessment notes, on 04/17/12, did not mention the rash on Resident #7's legs. Review of the weekly non-pressure skin condition report noted in the resident's record did not address a skin rash from the period of 04/09/12 through 04/28/12. Review of the care plan, updated 04/20/12, revealed "skin integrity impaired" after a physician's order to treat with 5% Permethrin cream (treatment for scabies). 8. A record review revealed the facility Resident #25 on 09/15/10 with diagnoses to include Senile Dementia, Psychosis with Behavioral Disturbance and Chronic Kidney Disease. Record review revealed on 02/17/12 the physician ordered Resident #25 Vistaril, a medication prescribed for anxiety and itching. A review of the quarterly MDS assessment, dated 02/21/12, revealed the resident was cognitively independent with decision-making skills and independent with all activities of daily living except for bathing, which required the assistance of two staff members.	F 441		

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F 441	Continued From page 52 A review of the Resident Weekly Skin Check Sheet, the Care Plan updates, and the progress notes revealed the resident was noted scratching and picking at the scabs since 03/21/12. The area was described as red bumps on the back side of the bilateral legs, a rash and red areas were noted to the chest, abdomen, trunk, bilateral legs and upper back. Record review revealed an order was received for a topical antifungal on 03/21/12. A review of the Weekly Non-Pressure Skin Condition Report revealed no evidence the rash and open sores were being monitored on this record. Observation of skin assessment rounds by two State Agency surveyors, on 04/18/12 at 5:50 PM, with the Facility ' s Medical Director and the Unit Coordinator, revealed the Medical Director washed her hands, then performed her assessment of the Resident #25 ' s rash areas; however, touched the rash areas ungloved, then washed her hands. However, review of the facility ' s " Infection Control, Infectious Diseases, Scabies Management " , revised January 2007, revealed procedures that included Implementation of Contact Precautions (due the communicability of scabies). Wear long sleeve gowns during close contact with the resident, their clothing or bed linens. Cover wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. An observation of Resident #25, on 04/25/12 at 10:45 AM and on 04/27/12 at 10:05 AM, revealed the resident was scratching his/her legs and complaining, "It itched until I could hardly bear it." A skin assessment by UM #1 revealed multiple	F 441		

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F 441	Continued From page 53 areas of open sores on the upper and lower back, bilateral buttocks and both arms and legs. An area on the right lower leg had a scant amount of blood "oozing" from the wound area and dried blood was noted to the sheet below the resident's leg. The resident stated he/she had always picked at skin sores, yet stated the itching was "unrelenting." Observation of the resident ' s room and outside the room in the hallway revealed no evidence contact precautions had been initiated. An interview with RN #1, on 04/27/12 at 3:10 PM, revealed the resident's rash and open sores were worse now than when she evaluated the resident on 04/26/12, and the resident had a history of "picking" at any sore. The rash was first documented, on 03/21/12, and an order was received for a topical antifungal. The resident did have an order for Vistaril, a medication prescribed for anxiety and itching, since 02/17/11, but was discontinued on 04/10/12, due to the resident having tremors. This medication was restarted on 04/27/12. 9. A record review revealed the facility admitted Resident #8 on 07/10/09 with diagnoses to include Hypertension, Gastroesophageal Reflux Disease, Hyperlipidemia, Hypothyroid, Anxiety Disorder, Depression, Psychotic Disorder, Asthma, Chronic Obstructive Pulmonary Disease, Cellulites, Dementia, Myalgia and Myositis. A review of a dermatology consult, dated 10/06/11, revealed the resident was diagnosed with Psoriasis and Scabies. Review of the Resident Progress Notes, dated 10/06/11, revealed the resident received Elimite 5% cream	F 441		

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F 441	Continued From page 54 and Ivermectin treatments per order from dermatology. A review of the Resident Weekly Skin Check Sheet, dated 10/11/11, revealed documentation "continues with scattered raised red areas"; however, the Weekly Non-pressure Skin Condition Report showed no evidence the facility had identified or tracked the rash. A review of the Resident Weekly Skin Check Sheet, dated 03/02/12, revealed documentation of red bumps/rash to the bilateral upper arms. Weekly Non-pressure Skin Condition Report for the same time frame did not identify or track the rash. An Interview with Registered Nurse (RN) #1, on 04/28/12 at 1:13 PM, revealed she expected the Weekly Non-pressure Skin Condition Report to be filled out whenever the rash was identified and used to track treatment and progress of the rash. An interview with the Director of Nursing (DON,) on 04/28/12 at 3:45 PM, revealed the licensed staff should have utilized the "Weekly Non-Pressure Skin Condition Report" to track and trend the rash and to evaluate the progress or lack of progress weekly with prescribed treatment. A review of the significant change MDS assessment, dated 04/04/12, revealed the facility assessed Resident #8 to be cognitively intact and able to make needs known, but required extensive assistance to perform Activities of Daily Living (ADLs). Observation of skin assessment rounds by two	F 441		

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F 441	Continued From page 55 State Agency surveyors, on 04/18/12 at 5:50 PM, with the Facility ' s Medical Director and the Unit Coordinator, revealed the Medical Director had assessed Resident #25 and was observed touching Resident #25 ' s rash areas ungloved. She then washed her hands and proceeded to go into Resident #8 ' s room to perform an assessment at 6:00 PM. An observation of Resident#8's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. During the assessment, the two State Agency surveyors observed the Medical Director specifically; touch the rash areas on Resident #8 ' s chest, arms and shoulders without being gloved despite the facility ' s " Infection Control, Infectious Diseases, Scabies Management " , revised January 2007, revealed procedures that included Implementation of Contact Precautions. Wear long sleeve gowns during close contact with the resident, their clothing or bed linens. Cover wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. Further review revealed the facility treated Resident #8 for scabies, on 04/19/12. However there was still no notation related to the rash in the Weekly Non-pressure Skin Condition Report identifying or tracking progress of a treatment as of 04/27/12. Observation of a skin assessment, on 04/28/12 at 9:55 AM, revealed the rash on Resident #8's back to be concentrated to the lower posterior thoracic region. Bruising was also noted to the posterior of the resident's upper arms. RN #1 stated the area was from scratching. An	F 441		

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F 441	Continued From page 56 observation of Resident#8's room and outside the room in the hallway revealed no evidence contact precautions had been initiated. 10. A record review revealed the facility admitted Resident #9 on 02/24/10 with diagnoses to include Congestive Heart Failure, Hypertension, Peripheral Vascular Disease and Right above the Knee Amputation. A review of the clinical record, dated 04/26/11 and 05/17/11 revealed prescriptions with topical steroidal creams and oral steroids. On 06/14/11, there was a treatment with a one time dose of a topical cream for parasitic infestation. On 06/23/11, the resident was treated again with topical steroidal creams and oral steroids. On 07/25/11, there was a treatment with another topical steroid and a pill for itching. On 08/03/11, there was a treatment with Vaseline Synalar ointment. On 09/07/11, there was a treatment with an oral dose of a broad spectrum anti-parasitic agent. A review of the skin assessment documentation for the period of December 2011 revealed a lack of detail and description to demonstrate the specific location and extent of the rash. A review of the care plan for pain, dated 12/07/11, revealed "I have itching from my neck to my knees." The interventions were to apply skin lotions, as ordered. There were no updates or new interventions for the comprehensive care plan regarding the itching. Further review of the skin assessment documentation, dated 12/08/11, revealed "a rash was noted to the anterior and posterior trunk, shoulder and top of the right thigh." Throughout December 2011 and January 2012, documentation revealed the rash lacked evidence	F 441		

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F 441	Continued From page 57 of healing. On 01/31/12, there was no evidence of the rash and no further documentation of the rash on the "Weekly Non Pressure Skin Condition Report'. However, the "Resident Weekly Skin Check Sheet," dated 01/31/12, stated the rash continued on the resident's trunk, bilateral upper extremities and upper thighs. There was no evidence of evaluation of the progression and/or improvement or decline of the status of the rash on the resident's body. For example, review of the skin assessment documentation revealed the description of the rash varied from red, raised bumps to continuing rash, and on the anatomical drawings, there was no indication of the areas or the drawings being marked with dots, circles and some X's. Topical steroids and antifungals were prescribed. Steroid dose packs were ordered in December 2011 and January 2012 for a "Multifactorial Pruritis." On 02/16/12, the resident was treated with a topical cream for a parasitic infection. On 02/16/12, there was another oral dose of an anti-parasitic agent. A review of the quarterly Minimum Data Set (MDS), dated 02/25/12, revealed the resident was independent in cognition and decision-making and required the extensive assistance of two staff members with bed mobility and a sling and mechanical lift for transfers. Review of the February through April 2012 skin assessment documentation revealed a continued lack of detail and description to demonstrate the specific location and extent of the rash even though the resident continued to experience rashes and intense itching throughout March and April. Record review revealed Resident #9 experienced increased discomfort from the rash.	F 441		

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F 441	Continued From page 58 The rash had spread to cover the resident's trunk, arms, legs and hands. Observation of skin assessment rounds by two State Agency surveyors, on 04/18/12 at 5:50 PM, with the Facility ' s Medical Director and the Unit Coordinator, revealed the Medical Director had assessed Resident #25 and was observed touching Resident #25 ' s rash areas ungloved. She then washed her hands and proceeded to go into Resident #8 ' s room to perform an assessment at 6:00 PM. During the assessment, the two State Agency surveyors observed the Medical Director specifically; touch the rash areas on Resident #8 ' s chest, arms and shoulders without being gloved. The Medical Director proceeded to an unsampled resident ' s room then arriving to Resident #9 ' s room at 6:07 PM and was observed to touch Resident #9 ' s rash areas ungloved; however, washing her hands before and after, despite the facility ' s " Infection Control, Infectious Diseases, Scabies Management " , revised January 2007, revealed procedures that included Implementation of Contact Precautions (due the communicability of scabies). Wear long sleeve gowns during close contact with the resident, their clothing or bed linens. Cover wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. Additionally, Resident #9 stated, during the assessment that he/she had been " itching for over a year, it ' s terrible. " The resident further stated that he/she got new ones in the creases of his/her left arm and on his/her back.	F 441		

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F 441	Continued From page 59 An interview with Resident #9, on 04/25/12 at 3:50 PM, revealed the resident complained of the development on an itchy rash on his/her body. There was no evidence the facility had conducted on-going assessments or documented the findings for the resident in order to identify the persistence and spread of the rash. An observation and interview with Resident #9, on 04/26/12 at 10:20 AM, revealed Resident #9 suffered with the symptoms related to a persistent rash, "for fourteen months." The resident stated he/she had "suffered and itched all over" and was "broke out with little bitty bumps that got bigger" and stated "now I've heard it was scabies." At first, the rash was confined to the scalp area and spread to his/her neck and then to the hands. The skin assessment revealed red, raised rashes, scattered over the back, torso, arms and wrists. Observation of the resident ' s room and outside the room in the hallway revealed no evidence contact precautions had been initiated. Interview with RN #1, on 04/27/12 at 8:30 AM and 04/28/12 at 10:20 AM, revealed a rash was observed on Resident #9, since approximately 04/20/11, with documentation to the resident Weekly Skin Check Sheet stating the resident "continued with a red, pimply, scattered rash on the abdomen." An interview with Licensed Practical Nurse #1, on 04/26/12 at 3:00 PM, revealed the problem started last year for Resident #9, after another resident was admitted with a similar rash and staff members and their family members came down with the same type of rashes.	F 441		

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F 441	Continued From page 60 11. A record review revealed the facility admitted Resident #10 on 01/12/07 with diagnoses to include Paranoia, Anxiety, Depression, Insomnia, Alzheimer's Disease and Profound impairment of both eyes. A review of the Weekly Skin Check Sheets revealed a rash was present on Resident #10 on 01/01/12. A review of a consultation report from the Dermatology Clinic, dated 02/16/12, revealed the reason for the consult as "skin rash remains worse to the back of the left shoulder and back area, the rash has scattered onto the chest, abdomen and now at the top of the lower legs." It was noted the resident had been on Triamcinolone 0.25% and it was not effective. The conclusion was Resident #10 had scabies and needed to be treated. The note concluded with instructions on the application of the treatment and care for the resident clothing and bedding. Review of the quarterly MDS assessment, dated 02/21/12, revealed the facility assessed Resident #10 as severely cognitively impaired and dependent on staff for mobility and activities of daily living. The resident was incontinent of bowel and bladder. An interview with Resident #10's primary care physician, on 04/19/12 at 1:17 PM, revealed he was aware there was a problem in the facility with rashes, but was unaware of Resident #10 or any other residents in the facility being treated for Scabies. He stated he saw a facility employee in his office that day who had a rash that was	F 441		

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F 441	Continued From page 61 characteristic of Scabies, and he had referred her to a Dermatologist because he was not sure about the rash. He further stated, had he known there were other employees and residents at the facility that were treated for scabies he would have treated him/her. He stated he was going to call the employee back and order treatment for him/her. 12. A record review revealed the facility admitted Resident #13 on 04/01/11 with diagnoses to include Senile Dementia, a History of Convulsions and a Subdural Hematoma. A review of the Resident Weekly Skin Assessments, dated 01/22/12, revealed the resident experienced "a few scattered red bumps on the upper body, bilateral arms and chest," and the resident "complained of itching." A review of the quarterly MDS, dated 02/15/12, revealed the resident was moderately cognitively impaired and made few decisions. He/she required the extensive assistance of two staff members with ADLs. A review of the physician's orders revealed the resident was treated with a topical antifungal, on 03/01/12 and again on 03/09/12, and was not properly treated for a rash, until 04/19/12. An observation of a skin assessment by UM#1 and LPN#1, on 04/26/12 at 11:00 AM, revealed a slightly red raised rash on the resident's abdominal area. The resident stated she experienced "quite a bit of itching." No evidence of contact precaution was observed inside or	F 441		

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F 441	Continued From page 62 outside the resident ' s room An interview with the MDS Coordinator/RN, on 04/28/12 at 3:55 PM, revealed the problem noted on the change of condition form, would not be carried over to the comprehensive care plan, if it was a condition that would be expected to resolve within a two-week time frame, such as a skin tear or a sore throat that was treated. The rash the resident experienced was treated and the coordinator stated she thought it would be resolved, and stated this resident's rash and resulting itching, "probably should be carried over to the comprehensive care plan for continued monitoring." Interviews with facility staff revealed thirteen staff has developed rashes of which nine were treated for scabies. CNA (#1) revealed, on 04/13/12 at 10:05 AM, she had a rash in November, 2011 and was treated by her physician for Scabies. She stated she made the facility aware. Interview with CNA #2, on 04/14/12 at 7:46 PM, reported she had the rash on her arms, chest, abdomen and back for three weeks that she reported to the Infection Control Nurse. She was seen by a physician and treated for scabies. She stated the rash was better on her body, but the same rash was still on her hands. She stated the facility was aware of the rash remaining on her hands and she used hypoallergenic gloves while providing care for residents. An interview with CNA #3, on 04/14/12 at 8:03 PM, revealed she had a rash on her hands and abdomen two months ago. She was seen by a	F 441		

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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
F 441	Continued From page 63 physician and treated for Scabies. She stated she reported this to the Infection Control Nurse who told her the physician lied to her because skin scrapings completed on residents in the facility proved the rashes in the facility were not related to scabies. She stated she was off the next three days and the facility did not ask for a physician's statement when she returned to work. She stated the rashes have been going on for a year and she took it home to her little girl, who had to be treated as well. She stated the rash was now back on her hands, abdomen, and behind her knees. She stated she reported the return of the rash to the Infection Control Nurse two weeks ago. She has not been removed from providing resident care. The facility presented an Employee Incident Report, dated 03/31/12, submitted by CNA #4, stating she had consistent itching and rash, and was being treated for scabies. She noted that she had treated her daughter twice as well as her granddaughters and that many residents and workers in the facility were suffering from itching. An interview with CNA #5, on 04/19/12 at 2:35 PM, revealed she was treated for Scabies last year in June or July by the facility's Nurse Practitioner (APRN). She stated the former Director of Nursing had a rash during that time, so the APRN started giving cream to everyone. She stated staff had to show the APRN the rash and sign for the cream. She stated she was never off work or removed from resident care. She stated she still had the cream and has treated herself three additional times when the residents have had another outbreak.	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/28/2012

NAME OF PROVIDER OR SUPPLIER
KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL

STREET ADDRESS, CITY, STATE, ZIP CODE
3740 OLD HARTFORD RD
OWENSBORO, KY 42303

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F 441	Continued From page 64 An interview with CNA #6, on 04/19/12 at 1:00 PM, revealed she was treated for scabies twice, but did not go to the physician because back then the facility was passing out cream to the staff. An interview with CNA #10, on 04/26/12 at 3:45 PM, revealed the first time she noticed the rash was last March when a resident experienced a rash with itching. The CNA received treatment at the hospital. The CNA reported this to the DNS and "some employees received a cream for this, but not all employees were treated." An interview with Restorative Aide #1, on 04/13/12 at 12:35 PM, revealed she was treated for Scabies within the past six months. An interview with LPN #1, on 04/15/12 at 7:51 PM, revealed staff members were told to go to the local urgent care center for treatment. She stated she was educated by the facility on Scabies by way of a handout. She stated she sought out treatment in January and was told by the facility the rash was not related to work but more likely related to something at home. She went to convenient care and was given treatment for and literature on Scabies. When she reported this to the Infection Control Nurse at the facility, she was told Scabies was rampant in the community so it was probably community acquired. The LPN stated "the one common denominator in all these rashes was this building," referring to the facility. LPN #1 stated this past Friday she was again diagnosed with Scabies, as well her son. She stated she again reported the diagnosis to the Infection Control Nurse, who told her there were no active cases of Scabies in the facility. She stated the facility did	F 441		

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F 441	Continued From page 65 not require her to be off work for twenty-four hours or ask for a physician's stated when she returned to work the next day. An interview with the Infection Control Nurse, on 04/13/12 at 6:14 PM, revealed when a resident was diagnosed with Scabies, an infection control bag was hung on the resident's door (mask, gloves, gowns, and linen bags). She stated the resident was not isolated once the cream was applied. The staff used standard universal precautions. Twenty-four hours after the resident was treated, all of the resident's belongings were bagged and removed from the room and the room was deep cleaned by housekeeping. The resident's roommate was not removed from the room other than when the room was being deep cleaned. She stated no extra precautions were used other than standard precautions. On 04/17/12 at 10:20 AM, the Infection Control Nurse stated tracking of the resident's response to treatment would be completed in the resident's progress notes and presented as an Infection Control Log for the month of March 2012 that listed residents in the facility noted with rashes. Of the sixteen residents listed, only five had a date of onset noted with little to no information related to the location, description or the progression of the rash. She also presented an Infection Control Log for April 2012 that she stated was incomplete. She stated there was no tracking of the rashes in January and February 2012 because she was not aware she was supposed to be doing them. She stated the staff float between wing one (1) and wing four (4), but they do not usually float to wing (2); however, if need be, staff float wherever needed. On 04/19/12 at 3:56 PM, the Infection Control Nurse	F 441		

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F 441	Continued From page 66 stated employees do not report treatment of scabies to her if they use their own private physician. She was only able to present Employee Incident Reports of three staff who were treated for scabies. She stated the facility was not doing anything at the present time to decrease the number of rashes other than treating the rashes as ordered. She presented an updated list for April 2012 of twenty-two (22) residents in the facility who currently had rashes. She stated, in the past, the facility has completed skin scrapings to check for scabies, but none have been in the past six months. An interview with CNA #9, on 04/13/12 at 3:45 PM, revealed she has had a rash but has not been treated for scabies. She stated she took care of residents with rashes and those who have received treatment of Scabies used gloves only after the nurse provided the treatment. She was not told to use a cover gown or shoe covers and has not seen any isolation/infection control kits hanging on the residents' doors after treatment. An interview with CNA #8, on 04/17/12 at 3:50 PM, revealed she had a rash a month ago that went away without treatment. She stated she worked at the facility for ten months and when she first started working at the facility, she was told by other staff some of the residents had Scabies. She stated staff was rumored to have rashes that were due to scabies. She decided to use precautions by using a cover gown, but was told by her unit nurse that she could only use a cover gown if the resident was ordered to be in isolation. She stated she has not observed anyone using a cover gown or isolation precautions for the residents who have rashes.	F 441		

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F 441	Continued From page 67 She stated she was in-serviced on scabies by the facility by a paper handout. An interview with Unit Manager #1, for wings #1 and #4, on 04/13/12 at 11:20 AM, revealed skin rashes were assessed weekly for any progress or change and the treatment was changed if the rash was not getting better. She stated the physician had not identified what caused the rashes, as the rashes were different with each resident. An interview with the Assistant Director of Nursing (ADON) with two State Surveyors present, on 04/17/12 at 5:00 PM, revealed the problem with rashes had been ongoing since 04/11/11. She stated the facility's Interdisciplinary Team (IDT) meets every Wednesday to discuss what the facility has entitled "Other Skin." Every resident with "other skin" has their name listed on a board in the conference room and they are discussed with the Unit Managers (UM). They look at the resident's current treatment. The physician usually ordered a treatment for a certain number of days, then re-evaluated. If the resident was no better, then they called the physician for orders. She stated the Medical Director followed the majority of the residents, but some have their own private physicians. They follow the physician's orders. They have completed skin scrapings in the past, but none recently. The Medical Director will not give orders to do scrapings on everyone and does not want to put Elimite, which is an insecticide on residents, unless they have an outbreak. She stated all residents get a weekly body audit and the CNAs do body audits on bath days. She stated the rashes were tracked and trended by way of a communication board and	F 441		

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F 441	Continued From page 68 were addressed in the Interdisciplinary Team meeting on Wednesdays. She further stated there was no conclusive evidence the rashes were or were not Scabies. Review of the manufacture ' s website, elimite.net, revealed " Elimite (Permethrin) 5% cream is a topical scabicidal agent which is commonly used for the treatment of Sarcoptes scabiei infestation (otherwise known as Scabies), " which is a drug requiring physician prescription. An interview with the Director of Nursing Services (DNS), on 04/13/12 at 6:30 PM, revealed the rashes were frequently discussed with the Medical Director and she made the decision related to the treatment. She further stated, on 04/13/12 at 6:30 PM, revealed the facility's policy did not require that the roommate of a resident being treated for scabies to be removed from the room. They do skin assessments to monitor the roommate. They have discussed this with the Medical Director and in her opinion the treatment for scabies was toxic and does not like to treat prophylactically. She stated the facility has completed a number of things to try and determine the cause of the rashes to include an environmental air study, spoke to the Health Department's Infection Control personal related to the rashes and was told the facility was doing everything we should be doing, and it was felt there was nothing else the facility could do. The DNS stated they looked at the soap and laundry detergent used by the facility. She stated they were unable to get a Dermatologist to come into the facility, so they have sent residents out to see a dermatologist. When the rashes do not clear up, they refer the residents back to the Medical Director and she made the decision for treatment.	F 441		

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F 441	Continued From page 69 The DNS stated she had no documentation of the process. An interview with the Supervisor of Infection Control at the County Health Department, on 04/17/12 at 10:45 AM, revealed she spoke to the DNS in January related to rashes in the facility. She stated they discussed control measures such as cleaning the linen and the use of a disinfectant detergent. She stated she was told that skin scrapings for Scabies had all come back negative and was unaware there were residents in the facility being treated for scabies. An interview with the former APRN, on 04/27/12 at 11:30 AM, revealed she worked at the facility for four years, but left four months ago. She stated she treated a few staff with the Elimite Cream. She did not remember if she treated the former DNS, but did remember her showing her a rash. An interview with the former DNS, on 04/27/12 at 11:50 AM, revealed she saw a Dermatologist for a rash on her abdomen last spring while she worked at the facility and was treated with Elimite cream. She stated a few residents were treated on wing (1) one and staff were being treated at one point. She stated staff was complaining of feeling like they were being bitten. An interview with the Medical Director, on 04/13/12 at 5:50 PM, revealed in her opinion there have been no definitive confirmed diagnosis of Scabies in the facility. She stated she felt the vast majority of the rashes were related to environmental geriatric skin rashes and hysteria that has been fanned by facility staff. She stated	F 441		

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F 441	Continued From page 70 there was no way to confirm if the rashes were caused by scabies or by commonalities associated with the aging population. She stated the residents that have been treated for scabies have not gotten better. On 04/18/12 at 6:30 PM, an interview with the Medical Director revealed she felt some of the rashes were related to drug reactions and some were related to a Neurodermatitis (chronic itching and scratching which eventually becomes a habit). The itching could be associated with staff entering the resident's room and asking them if they we itching and if their "bugs" were back. She further stated the pattern of the rash was not consistent with scabies and the residents only scratched where they can reach. When the Medical Director was questioned about skin scrapings and how she could be sure the rashes were not caused by Scabies, she responded it was very difficult to diagnosis scabies by skin scrapings or biopsy because it was a default diagnosis. She stated she has treated some residents in the facility for scabies but does not treat residents prophylactically because the treatment was toxic in the elderly. She stated most of the residents responded best to emollients. She did not believe the rash had spread from one resident to another because there was no cause and effect that was identified. She stated each rash was different and not consistent with an endemic spread. She stated staff was being treated for Scabies because they were reporting they have Scabies and that was what they were being treated for. An interview with the Administrator, on 04/19/12 at 2:50 PM, revealed she was aware of the number of rashes in the facility and believed the facility has done everything they can to address	F 441		

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F 441	Continued From page 71 the problem. She stated they discussed residents with rashes in morning stand-up meetings and staff with rashes was turned in as employee incidents. She stated she does not recall if the former facility APRN treated any of the staff for scabies. The Administrator stated she discussed the number of rashes and the overall situation in the facility with the Medical Director several times. She stated she is not medically trained so she does not second guess the Medical Director. She does not believe there was any information that contradicted the findings of the Medical Director for any other medical clinician. She stated tracking of the rashes consisted of members of the IDT going to look at the rashes to determine if there were similarities, and they look to see if the rashes reoccurred, but the individual diagnosis was given by the physician. The Administrator stated the Medical Director said the rashes were caused by different types of skin conditions, and because the facility has not been able to determine that there was one single source, the rashes have been classified as "other skin." She stated tracking and trending of the rashes was completed mainly by discussion. An interview with Certified Nurse Aide #10, on 04/26/12 at 3:45 PM revealed the first time she noticed the rash at the facility was in March 2011, when Resident #28, who no longer resides at the facility, experienced an itchy rash. The CNA, who also experienced a rash and itching, received treatment at the hospital that same month requiring treatment for scabies. The CNA reported to the DON and "some employees received a cream, but not all employees were treated."	F 441		

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F 441	Continued From page 72 A credible allegation of compliance for removal of the Immediate Jeopardy was received on 04/26/12. The Immediate Jeopardy was verified removed on 04/28/12, prior to exit. The alleged date of removal was 04/22/12. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 04/22/12. Observations, interviews and record review revealed the facility had taken the following actions: Licensed Nurses conducted body audits on 04/19/12 for Residents #1- #10. A skin sweep and Symptom Screen was conducted by licensed staff on all residents in the facility on 04/19/12. Physicians were notified and orders were received for all residents for treatment for scabies on 04/20/12. Mass treatment was completed on all residents on 04/20/12. Skin scrapings were conducted on four random residents. The care plans were updated for each resident. The executive Director and Director of Nursing consulted with the health department on 04/20/12. All staff were contacted and questioned regarding having a rash or itching. A symptom screen was completed on all staff members on 04/20/12 and 04/21/12. All residents clothing and linens were removed from rooms and bagged on 04/20/12. All laundry was washed and dried at a temperature of 140 degrees. All residents rooms were deep cleaned on 04/20/12 and 04/21/12. Privacy curtains were laundered. Items that could not be laundered were bagged for a period of 10 days before they will be returned to the residents. All common areas, offices and Rehab Gym were deep cleaned on 04/20/12 and 04/21/12. Physician orders and shift report are reviewed daily by the DON Monday through	F 441		

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F 441	Continued From page 73 Friday and the Weekend Supervisor on weekends for any indication of any residents with rash or infections starting on 04/21/12. All facility staff were educated related to infection control policies on scabies and recommendations from the Centers of Disease Control on 04/20/12, 04/21/12 and 04/22/12. Family members of all residents were called and made aware of the rash and scabies and given information on scabies on 04/19/12 and 04/20/12. Infection Control Rounds, Personal Protective Equipment and Hand Hygiene Surveillance Tools were implemented and conducted daily starting 04/21/12. The Performance Committee to include the Medical Director met on 04/19/12 and again on 04/20/12. Residents identified as symptomatic as well as those that were clinically contraindicated to receive treatment are receiving daily skin audits by the Licensed Nurse starting on 04/21/12. The Infection Control committee is meeting weekly to review Infection control case logs. The Staff Development Coordinator was tracking and trending findings and will report to the Performance Improvement Committee. An interview with the Administrator, on 04/28/12 at 2:25 PM, revealed the facility was continuing to monitor where they were in the action plan, if there were any new symptomatic residents and employees, verifying that Surveillance tools are conducted timely and identifying if any trends. She stated the results of the surveillance tools, monitoring and tracking of rashes would be reported at the next Performance Improvement Committee meeting. She revealed the Performance Improvement Committee meets the third Wednesday of every month.	F 441		

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F 441	Continued From page 74 Although it was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E", based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process.	F 441		
F 490 SS=K	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy and procedure, it was determined the facility failed to administer in a manner which enabled it to use it's resources effectively and efficiently to attain the highest practical, physical, mental and psychosocial well-being for twelve residents (#1, #2, #3, #4, #5, #6, #7, #8, #9, #10, #13, and #25), that were identified with rashes, in a selected sample of twenty-eight residents. On 04/19/12, the facility presented a list of twenty-two residents in the facility currently identified with rashes; however, according to the AoC, the facility conducted a skin sweep and Symptom Screen of all residents in the building and identified 35 residents symptomatic of rashes out of the total census of 136. Resident #9 was first identified with a rash on 04/20/11 and has had itching for 14 months,	F 490	F 490 – See attachment	5/25/12

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KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL	3740 OLD HARTFORD RD OWENSBORO, KY 42303

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F 490	Continued From page 75 Resident #1 was first identified with a rash on 12/05/11 and developed cellulitis due to the rash. Resident #3 was first identified with a rash on 12/16/11 and was administered Ativan because the itching was causing the resident to be anxious. The facility failed to have an effective system in place to ensure it's Infection Control and Prevention Program was implemented related to providing a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection related to key surveillance activities, definition of the infection, calculation of the infection rates and data analysis. The facility failed to ensure an effective system was in place to ensure the "Infection Control, Infectious Disease, Scabies Management " policy was implemented for Residents #1, #2, #3, #5, #8, #9 and #10, who were treated by the facility for Scabies (an infestation with mites). The facility failed to have an effective system in place to identify quality care issues and to develop and implement appropriate plans of action to correct identified quality deficiencies related to ongoing rashes for twelve residents. This failure caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 04/19/12 and found to exist on 12/05/11 and was ongoing. Substandard Quality of Care was identified at 42 CFR 483.25 Quality of Care F309. The facility was notified on 04/19/12. It was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E," based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation	F 490		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185120	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 04/28/2012
NAME OF PROVIDER OR SUPPLIER KINDRED TRANSITIONAL CARE AND REHABILITATION - HIL		STREET ADDRESS, CITY, STATE, ZIP CODE 3740 OLD HARTFORD RD OWENSBORO, KY 42303	

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F 490	Continued From page 76 through the facility's Quality Assurance process. (Refer to F309 and F441) Findings include: A review of the facility's policy and procedure, "Infection Control and Prevention Program" dated 10/31/09, revealed the facility's infection control program included was not limited to the following components: (a) Key surveillance activities, (b) Definition of Infection, (C) Calculation of infection rates and (d) Data analysis. Essential elements of the surveillance system were to include, use of standardized definitions and listings of the symptoms of the infection and use of surveillance tools such as, (1) Infection surveys and data collection templates, (2) Walking rounds throughout the facility,(3) Identification of segment of the population at risk for the infection, (4) Identification of the processes or outcomes selected for surveillance, and (5) Statistical analysis of data that can uncover an outbreak, and feedback of the results to the primary caregivers so they can assess the residents for sign of infection. A review of the facility's policy and procedure, Infection Control, Infectious Diseases, Scabies Management with a revised date January 2007, revealed procedures that included Implementation of Contact Precautions (due the communicability of scabies) until a diagnosis is confirmed by a physician or a nurse practitioner. A private room is indicated but if not possible, obtain a physician's order to treat the roommate. Wear long sleeve gowns during close contact with the resident, their clothing or bed linens.	F 490		

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F 490	Continued From page 77 Cover wrist area by the gown and pull the gloves over the cuff of the gown. Treatment of the roommates and all contacts for an outbreak is recommended. A review of the facility's policy and procedure, Performance Improvement, revised 03/05/08 revealed the facility met the Quality Assessment and Assurance requirement through the Performance Improvement (PI) Committee. The PI committee identified and responded to quality deficiencies related to the facility operations and practices that caused negative outcomes. The committee was to meet at least monthly to identify issues the necessitated quality assessment and assurance activities and develop and implement appropriate plans to correct the identified quality deficiencies. A review of the the facility's policy and procedure, Center's Administration, revised 04/28/09 revealed the facility was to be operated under the direction of the Executive Director(Administrator) in accordance with federal, state, and local laws and professional standards. The Executive Director/ designee notifies the appropriate local and state authorities of any unusual occurrences including but not limited to communicable diseases and outbreaks of infections. On 04/17/12 at 10:20 AM, an interview with the Infection Control Nurse (ICN) revealed tracking of the resident response to treatment would be completed in the residents' progress notes. She presented an Infection Control Log for the month of March 2012 which listed residents in the facility noted with rashes. Of the sixteen (16) residents listed only five (5) had a date of onset noted with	F 490		

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F 490	Continued From page 78 little to no information related to the location, description, or the progression of the rash. She also presented an Infection Control Log for April 2012 which she stated was incomplete. She stated there was no tracking of the rashes in January and February 2012, because she was not aware she was suppose to be doing them. On 04/19/12 at 3:56 PM, the ICN stated employees do not report treatment of scabies to her if they use their own private physician. She presented Employee Incident Reports for three staff that were treated for scabies. She stated the facility was not doing anything at the present time to decease the number of rashes other than treating the rashes as ordered. She presented an updated list for April 2012 of twenty-two (22) residents in the facility that currently had rashes. She stated the facility has completed skin scrapings in the past to check for scabies, but none have been completed in the past six months. An interview with the Assistant Director of Nursing (ADON), on 04/17/12 at 5:00 PM, revealed the problem with rashes had been ongoing since 04/11/11. The physician usually ordered treatment for a certain number of days, then they re-evaluated. If the resident was not better, they notified the physician for orders. She stated the Medical Director followed the majority of the residents, but some have their own private physicians. They follow the physician's orders. They have completed skin scrapings in the past, but none recently due to the Medical Director not giving orders to do scrapings. She stated the Medical Director does not want to treat residents with Elimite, because the cream was an insecticide. She does not treat the residents unless they have an outbreak. They monitor	F 490		

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F 490	Continued From page 79 rashes by weekly body audits and the CNAs conduct body audits on bath days. Every resident with "other skin" has their name listed on a board in the conference room and they are discussed with the Unit Managers (UM) every Wednesday. She further stated there was no conclusive evidence the rashes were or were not Scabies. An interview with the Director of Nursing Services (DNS), on 04/13/12 at 6:30 PM, revealed the rashes were frequently discussed with the Medical Director who made the decision what to order as a treatment. The Medical Director's opinion about the treatment for scabies was that it was toxic, so she did not treat prophylactically. The DNS stated the facility has completed a number of things to try and determine the cause of the rashes to include an environmental air study, spoke to the Health Department's Infection Control personal related to the rashes and was told the facility was doing everything they should be doing, and it was felt there was nothing else the facility could do. The DNS stated they also looked at the soap and laundry detergent used by the facility. She stated they have been unable to get a Dermatologist to come into the facility, so they have sent some residents out to see a dermatologist. When the rashes do not clear up, they refer the residents back to the Medical Director and she makes the decision for treatment. The DNS stated she has no documentation of the process. An interview with the Supervisor of Infection Control at the County Health Department on 04/17/12 at 10:45 AM, revealed she spoke to the DNS in January related to rashes in the facility. She stated they discussed control measures such as cleaning the linen and the use of a disinfectant	F 490		

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F 490	Continued From page 80 detergent. She stated she was told that skin scrapings for Scabies came back negative and was unaware there were residents in the facility being treated for scabies. She stated she would follow-up with the facility and investigate the situation. An interview with the Medical Director, on 04/13/12 at 5:50 PM, revealed, in her opinion, there have been no definitive confirmed diagnosis of Scabies in the facility. She stated she felt the vast majority of the rashes were related to environmental geriatric skin rashes and hysteria that has been fanned by facility staff. She stated there was no way to confirm if the rashes were caused by scabies or by commonalities associated with the aging population, She stated the residents being treated for scabies have not gotten better. On 04/18/12 at 6:30 PM, an interview with the Medical Director revealed she felt some of the rashes were related to drug reactions and some were related to a Neurodermatitis (chronic itching and scratching which eventually becomes a habit). The itching could be associated with staff entering the resident's room and asking them if they itch and if their "bugs" are back. She further stated the pattern of the rash was not consistent with scabies and the residents scratched where they can reach. The Medical Director revealed it was very difficult to diagnosis scabies by skin scrapings or biopsy because it was a default diagnosis. She stated she has treated some residents in the facility for scabies but does not treat residents prophylactically because the treatment was toxic in the elderly. She stated most of the residents responded best to emollients. She did not believe the rash spread	F 490		

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F 490	Continued From page 81 from one resident to another because there was no cause and effect that was identified. She stated each rash was different and not consistent with an endemic spread. She stated staff were being treated for Scabies because they were going in and reporting they have Scabies and that was what they were being treated for. An interview with the Executive Director (ED), on 04/19/12 at 2:50 PM, revealed she oversees the Quality Assurance Committee meeting held monthly. The ED stated her involvement was to ensure all the information gets to the meetings. She stated tracking of the rashes consisted of members of the IDT going to look at the rashes to determine if there were similarities and if the rashes reoccurred. She stated an individual diagnosis was given by the physician. The ICN kept a map of the rashes so they could determine if there were any clustering of the rashes. The ED stated the Medical Director says the rashes were caused by different types of skin conditions, and because the facility has not been able to determine that there was one single source, the rashes have been classified as "other skin." She stated tracking and trending of the rashes was completed mainly by discussion. A credible allegation of compliance for removal of the Immediate Jeopardy was received on 04/26/12. The Immediate Jeopardy was verified removed on 04/28/12, prior to exit. The alleged date of removal was 04/22/12. Based on observations, interviews and record reviews, verification was made the Immediate Jeopardy was removed on 04/22/12. Observations, interviews and record review	F 490		

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F 490	Continued From page 82 revealed the facility had taken the following actions: Licensed Nurses conducted body audits on 04/19/12 for Residents #1- #10. A skin sweep and Symptom Screen was conducted by licensed staff on all residents in the facility on 04/19/12. Physicians were notified and orders were received for all residents for treatment for scabies on 04/20/12. Mass treatment was completed on all residents on 04/20/12. Skin scrapings were conducted on four random residents. The care plans were updated for each resident. The executive Director and Director of Nursing consulted with the health department on 04/20/12. All staff were contacted and questioned regarding having a rash or itching. A symptom screen was completed on all staff members on 04/20/12 and 04/21/12. All residents clothing and linens were removed from rooms and bagged on 04/20/12. All laundry was washed and dried at a temperature of 140 degrees. All residents rooms were deep cleaned on 04/20/12 and 04/21/12. Privacy curtains were laundered. Items that could not be laundered were bagged for a period of 10 days before they will be returned to the residents. All common areas, offices and Rehab Gym were deep cleaned on 04/20/12 and 04/21/12. Physician orders and shift report are reviewed daily by the DON Monday through Friday and the Weekend Supervisor on weekends for any indication of any residents with rash or infections starting on 04/21/12. All facility staff were educated related to infection control policies on scabies and recommendations from the Centers of Disease Control on 04/20/12, 04/21/12 and 04/22/12. Family members of all residents were called and made aware of the rash and scabies and given information on scabies on 04/19/12 and 04/20/12. Infection	F 490		

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F 490	Continued From page 83 Control Rounds, Personal Protective Equipment and Hand Hygiene Surveillance Tools were implemented and conducted daily starting 04/21/12. The Performance Committee to include the Medical Director met on 04/19/12 and again on 04/20/12. Residents identified as symptomatic as well as those that were clinically contraindicated to receive treatment are receiving daily skin audits by the Licensed Nurse starting on 04/21/12. The Infection Control committee is meeting weekly to review Infection control case logs. The Staff Development Coordinator was tracking and trending findings and will report to the Performance Improvement Committee. An interview with the Administrator, on 04/28/12 at 2:25 PM, revealed the facility was continuing to monitor where they were in the action plan, if there were any new symptomatic residents and employees, verifying that Surveillance tools are conducted timely and identifying if any trends. She stated the results of the surveillance tools, monitoring and tracking of rashes would be reported at the next Performance Improvement Committee meeting. She revealed the Performance Improvement Committee meets the third Wednesday of every month. Although it was determined the Immediate Jeopardy was removed on 04/22/12, non-compliance continued with the scope and severity of an "E", based on the facility's need to monitor for the on-going effectiveness of the corrective action taken and to ensure evaluation through the facility's Quality Assurance process.	F 490		