

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

PRINTED: 06/14/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2012
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NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, PO BOX 250 BOONEVILLE, TN 37026 Division of Health Care Surrender Enforcement Branch
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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 000 F 156 SS=B	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted on 05/15-17/12. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services.</p>	F 000 F 156	<p>Preparation and execution of this plan of</p> <p>Correction does not constitute an admission of or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiency. This Plan of Correction is prepared solely because Federal and State Law require it. Compliance has been and will be achieved no later than the last completion date identified in the POC. Compliance will be maintained as provided in the Plan of Correction. Failure to dispute or challenge deficiencies below is not an admission that the alleged facts occurred as presented in the statements.</p> <p><u>F 156 (B) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</u></p> <p><i>Residents Found to Have Been Affected</i></p> <p>Residents and/or responsible parties of residents # 15, #16, and #17 have been given information regarding Medicare appeals, including contact information.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i></p> <p>All residents have the potential to be affected by F 156; however, all residents within the last 30 days that have had a change in pay source have received information regarding the appeals process and contact information.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy Perry</i>	TITLE <i>Administrator</i>	(X6) DATE <i>06/20/2012</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 156	Continued From page 1 including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart 1 of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and	F 156	Systemic Changes An inservice was conducted by the Administrator for the Medical Records Manager and the Business Office Manager on June 1, 2012; the MDS nurses were inserviced on June 7, 2012 regarding the requirements for proper notification of change in pay source to residents and responsible parties. A new Advanced Beneficiary Notice form letter was created and implemented on June 1, 2012 to notify residents and responsible parties of changes in pay status, the new form letter includes instructions and contact information for the appeals process. Monitoring Audits will be conducted monthly by the Administrator or Assistant Administrator of all residents that have had a change in pay status to ensure proper notification was made to residents and responsible parties. These audits will continue until compliance is sustained. Completion Date: June 20, 2012	06/20/12	

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F 156	<p>Continued From page 2</p> <p>provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, the facility failed to ensure the appropriate liability and appeal notices, including appeal information, had been provided for three of twenty-three sampled residents when a change of payor source occurred (Residents #15, #16, and #17). Although Residents #15, #16, and #17 received an Advance Beneficiary Notice related to termination of Medicare services/payment, the notices failed to include information related to the appeal process for these residents.</p> <p>The findings include: Review of the facility's policy regarding Resident</p>	F 156			

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F 156	<p>Continued From page 3</p> <p>Admission and Financial Agreement (no date), revealed the resident/responsible party would be given at least three days' notice prior to a change in pay source and the appeal information would be included.</p> <p>1. A review of the Advance Beneficiary Notice (ABN) to inform Resident #15's responsible party (R/P) of Medicare benefits revealed the Medicare coverage ended on 04/21/12. The letter informed the R/P that an appeal could be filed; however, there was no evidence included in the letter regarding the information/direction about how to file that appeal.</p> <p>2. A review of the Advance Beneficiary Notice (ABN) to inform Resident #16's responsible party (RP) of Medicare benefits revealed the Medicare coverage ended on 03/11/12. The letter informed the RP that an appeal could be filed; however, there was no evidence included in the letter regarding the information/direction about how to file that appeal.</p> <p>3. A review of the Advance Beneficiary Notice (ABN) to inform Resident #17's responsible party (R/P) of Medicare benefits revealed the Medicare coverage ended on 03/03/12. The letter informed the R/P that an appeal could be filed; however, there was no evidence included in the letter regarding the information/direction about how to file that appeal.</p> <p>An interview conducted with the Medical Records Manager on 05/17/12, at 2:45 PM, revealed she was responsible to send the notices regarding a change in payor source to the resident or the resident's responsible party. The manager stated</p>	F 156			

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F 156	Continued From page 4 she was not aware that the notice was required to include information related to appeal rights/procedures.	F 156	<u>F 253 (E) HOUSEKEEPING & MAINTENANCE SERVICES</u> <i>Residents Found to Have Been Affected</i> A deep cleaning of Resident Rooms 214, 216, 217 and 219 was completed on May 17, 2012 that included walls and equipment. The wall on the West Wing hall and the files on East Wing hall and East Wing bath were repaired on June 11, 2012. <i>Identification of Other Residents with the Potential to be Affected</i> Environmental rounds were conducted for each resident room and general areas by the Administrator, Housekeeping Manager and Maintenance Director on June 1, 2012 to identify any other concerns related to these departments. Work orders were completed as needed for any concerns identified. <i>Systemic Changes</i> A written Housekeeping policy was developed on June 8, 2012. The Administrator re-educated management staff on May 25, 2012 and June 8, 2012 on completing the CQI daily rounds with an emphasis on the tube feeding pumps, support poles and resident lifts.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. Resident equipment (feeding pumps, lifts, and bed frames) was soiled. Marred walls and chipped paint were observed on the West Wing hall. Tiles were observed broken and missing in the West Hall bath. The findings include: 1. An interview conducted with the Housekeeping Supervisor on 05/17/12, at 1:20 PM, revealed the facility did not have a written housekeeping policy. Additional interview revealed the resident rooms were cleaned daily and the facility had a deep clean schedule to ensure that each resident room was deep cleaned monthly. Observations conducted during the initial tour on 05/15/12, at 10:00 AM, revealed tube feeding residue on the wall in resident room 214B and	F 253		

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F 253	<p>Continued From page 5</p> <p>tube feeding residue on the bed frame in resident room 219A. Additional observations conducted with the housekeeper on 05/17/12, at 12:30 PM, revealed the tube feeding residue was still present on the wall in resident room 214B and on the bed frame in resident room 219A.</p> <p>An interview conducted with the Housekeeper on 05/17/12, at 12:30 PM, revealed the resident rooms were cleaned daily, however, the Housekeeper had not noticed the tube feeding residue on the wall or the bed frame.</p> <p>An interview conducted with the Housekeeping Supervisor revealed the Housekeeping Supervisor conducted weekly rounds to ensure resident rooms were clean and to identify concerns regarding cleaning of the resident environment. Additional interview revealed the Housekeeping Supervisor was not aware of the tube feeding residue in rooms 214B and 219A.</p> <p>2. A review of the facility policy for cleaning of resident equipment titled, East Wing Cleaning Schedule (undated), revealed tube feeding pumps were to be wiped down and made free of any milk product each night by nursing staff.</p> <p>Observations conducted during the initial tour on 05/15/12, at 10:00 AM, revealed tube feeding residue buildup on feeding pumps and support poles in resident rooms 214, 216, 217, and 219. Observations conducted during an environmental tour on 05/17/12, at 12:30 PM, revealed the tube feeding residue was still present on the feeding pumps. Additional observations conducted on the East Wing revealed two resident lifts with a buildup of dust/dirt.</p>	F 253	<p>The Housekeeping Supervisor will make daily rounds to assure rooms are clean. A check off sheet has been developed for the night supervisor to assure that tube feeding pumps, support poles, and resident lifts are cleaned according to the cleaning schedule. The night supervisor will give the check off sheets to the Director of Nursing.</p> <p>The Assistant Administrator will make daily rounds to assure that maintenance issues have work orders and that the work is completed timely.</p> <p>Monitoring The Administrator will review all compliance rounds daily (M-F) that are completed by the Housekeeping Supervisor and the Assistant Administrator to assure systems are followed and compliance sustained.</p> <p>Completion Date: June 20, 2012</p>	06/20/12	

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F 253	Continued From page 6 An interview conducted with Registered Nurse (RN) #4 revealed the feeding tube pumps and lifts were cleaned nightly by nursing staff and RN #4 would ensure the pumps were cleaned if a concern was identified. Further interview conducted with RN #4 revealed the RN was not aware the feeding tube pumps or the resident lifts had not been cleaned. According to RN #4, the RN was responsible to ensure resident equipment was clean for the unit but had not checked the equipment nor was aware the equipment needed to be cleaned. An interview conducted with the Director of Nursing (DON) on 05/17/12, at 2:05 PM, revealed it was nursing staff's responsibility to clean residents' feeding pumps, support poles, and lifts. Further interview revealed the DON completed monthly audits to ensure resident equipment was appropriately cleaned. The DON was not aware the feeding pumps, support poles, and resident lifts were not being cleaned. 3. A review of the facility policy titled Maintenance, dated 11/01/11, revealed that maintenance and repairs were to be completed in an effective and efficient manner utilizing the facility resources in the best interest of each resident. Observations conducted during an environmental tour with Maintenance staff revealed a wall on the West Wing hall that was marred and had chipped paint. In addition, the East Wing hall was observed to have broken and missing tiles in the East Wing bath near a bathtub.	F 253			

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F 253	Continued From page 7 A review of facility repair requisitions revealed no evidence the marred walls, chipped paint, or missing/broken tiles had been identified and/or reported by staff. An interview conducted with a facility Maintenance staff on 05/17/12, at 1:00 PM, revealed Maintenance staff made weekly rounds on Tuesdays to identify concerns. The Maintenance staff was not aware of the chipped, broken, missing tiles. According to the Maintenance staff, the marred walls on the West Wing nurses' station had been identified to need painting but no evidence of a schedule or a timeframe for the completion of the painting was presented to the survey team.	F 253		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the medication package insert, and review of the facility's policy, it was determined the facility failed to ensure one of twenty-three sampled residents was free of significant medication errors (Resident #19). A Registered Nurse (RN) was observed to mix two insulins together in the same syringe, which was not in accordance with manufacturer's directions, and administer the insulin to Resident #19. The findings include:	F 333	<u>F 333 (D) RESIDENTS FREE OF SIGNIFICANT MED ERRORS</u> <i>Residents Found to Have Been Affected</i> Resident #19 was assessed by the RN Unit Manager, the physician and responsible party was notified. No new orders were received. RN #3 that was responsible for the medication administration was immediately counseled, suspended, and no longer works for the facility.	

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F 333	<p>Continued From page 8</p> <p>Review of the facility's Administration of Insulin policy (no date), revealed when two insulins were drawn up no contamination of one insulin with the other should occur. The policy stated insulins from different manufacturers should be used together with caution due to possible interactions between the agents in the insulins.</p> <p>Review of the medication package insert for NovoLog 70/30 insulin revealed the insulin should not be mixed with any other insulin product, used intravenously, or used in insulin infusion pumps. The package insert did not identify the potential risks to individuals when NovoLog 70/30 insulin was mixed with other insulins.</p> <p>Observations during a medication pass conducted with Registered Nurse (RN) #3 on 05/16/12, revealed the RN administered NovoLog Regular Insulin (2 units) and NovoLog 70/30 Insulin (20 units) subcutaneously to Resident #16 at 5:00 PM. The RN was observed to mix both the insulins in the same syringe prior to administration.</p> <p>Interview with RN #3 on 05/17/12, at 12:30 PM, revealed the RN was not aware of the information provided in the medication package insert and did not know the two insulins should not be mixed together.</p> <p>Interview conducted with the facility's Registered Pharmacist on 05/17/12, at 10:15 AM, revealed NovoLog 70/30 Insulin should not be mixed with any other insulins. The Registered Pharmacist stated no studies had been conducted to evaluate the potential risks associated with the mixing of NovoLog Insulin with other insulins.</p>	F 333	<p><i>Identification of Other Residents with the Potential to be Affected</i> All residents with orders for insulin have the potential to be affected. See Systemic Changes below for compliance measures for F 333.</p> <p><i>Systemic Changes</i> An in-service was conducted by the Clinical Systems Manager and the DON for all licensed nurses regarding insulin administration including specific information on manufactures' recommendations related to mixing insulin. In-services occurred on 5/16/12, 5/17/12, and 5/31/12. A post-test was completed following the in-service.</p> <p>The Clinical Systems Manger will complete a skills check off for insulin administration on all licensed nurses, this audit will be completed on 6/18/12.</p> <p><i>Monitoring</i> The results of the skills check off for insulin administration will be submitted to the QAA Committee for their recommendations and follow-</p>	

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F 333	Continued From page 9	F 333	up. Additionally, the facility pharmacy will continue to monitor skills of nurses for insulin administration as they complete their audits of medication passes and demonstrations and refer to the QAA Committee.	
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP. Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to provide foods/liquids that were palatable and at the proper temperature during the evening meal on 05/15/12. The findings include: A review of the Tray Line and Meal Service Temperature policy (no date) revealed food would be served to residents at the appropriate temperatures; hot foods were to be served hot and the cold foods were to be served cold. The policy did not include specific timeframes for the resident meal trays to be distributed. A review of the meal services schedule revealed the Main Dining Room and the Florida Room food trays were scheduled to be delivered at 6:45 AM	F 364	Completion Date: June 20, 2012 <u>F 364 (E) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP</u> <i>Residents Found to Have Been Affected</i> All residents identified in F 364 are receiving their trays at the proper temperatures. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected; see the Systemic Changes below for compliance with F 364. <i>Systemic Changes</i> The dining committee met to review the meal service delivery system on June 7, 2012. A new delivery schedule has been implemented to assure that food is delivered and served at the proper temperatures.	06/20/12

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F 364	<p>Continued From page 10</p> <p>for breakfast, 11:45 AM for lunch, and at 5:15 PM for the evening meal.</p> <p>Observation conducted of the tray line at 5:00 PM on 05/15/12, revealed 11 resident food trays were already on the food cart to be transported to the Florida Room. The food cart was loaded completely with 16 food trays at 5:05 PM, and dietary staff pushed the first food cart to the side and proceeded loading a second food cart for the Florida Room. The first food cart was observed to be taken to the Florida Room at 5:10 PM, and the second food cart was observed to be taken to the Florida Room at 5:12 PM on 05/15/12. The last tray was removed from the first food cart at 5:30 PM (20 minutes later), and a test tray was obtained for food temperatures and palatability. The food temperatures were: mashed potatoes - 116.7 Fahrenheit, chicken sandwich - 121.6 Fahrenheit, hominy - 114.4 Fahrenheit, jello with bananas - 60.5 Fahrenheit, and milk - 53.5 degrees Fahrenheit. Palatability testing revealed the chicken sandwich, jello with bananas, and milk were not palatable.</p> <p>Further observations of the evening meal on 05/15/12, revealed six trays were transported from the kitchen in an open cart to the West Wing hall at 5:45 PM. Certified Nurse Aide (CNA) #1 was observed to answer other resident call lights, fall alarms, and to assist residents to the bathroom in between serving/feeding the residents the evening meal. At 6:28 PM (43 minutes later), CNA #1 was observed to remove the last tray and the surveyor intercepted the tray to check the food temperatures and palatability of the foods. The food temperatures were found to be: okra - 97.3 Fahrenheit, fish sandwich - 111.8</p>	F 364	<p>On June 11, 2012 additional staff was assigned to the Florida Dining Room to assist with meal service. On May 31, 2012 and June 8, 2012 Nursing and Dietary employees were in-serviced on proper food temperatures, meal service and the tray delivery process. On June 11, 2012 a nurse manager is assigned to complete a review of the dining rooms for proper delivery and proper temperatures of food.</p> <p>On June 19, 2012 the Registered Dietitian will complete weekly food temperature reviews on two random trays in each dining room and on each hall weekly.</p> <p>Monitoring The results of the reviews conducted by the dining room nurse manager and the Registered Dietitian will be submitted to the Quality Assessment and Assurance Committee (QAA) for their follow up and recommendations.</p> <p>Completion Date: June 20, 2012</p>	06/20/12	

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F 364	<p>Continued From page 11</p> <p>Fahrenheit, buttermilk - 57.6 Fahrenheit, and jello with bananas - 62.2 degrees Fahrenheit. Palatability testing revealed the food was not palatable.</p> <p>An interview conducted with Resident #4 on 05/15/12, at 6:25 PM, revealed the resident's food was cold and did not taste good. Resident #4 stated the food was "served cold most of the time."</p> <p>An interview conducted with the Dietary Manager (DM) at 11:40 AM on 05/15/12, revealed the facility wanted the trays for the Florida Room and the dining room to all be ready for delivery at the specified time, so all the residents could be served at the same time.</p> <p>An interview conducted with the cook at 6:30 PM on 05/15/12, revealed dietary staff had been instructed to have the two food carts for the Florida Room and the food cart for the dining room ready to be delivered at 6:45 AM for breakfast, 11:45 AM for lunch, and at 4:45 PM for the evening meal.</p> <p>Interview conducted with CNA #1 on 05/15/12, at 6:35 PM, revealed the CNA was the only person assigned to pass/feed the trays from the open cart on the West Wing hall. CNA #1 stated that it usually took about 45 to distribute/feed the six trays.</p> <p>Interview conducted with the Director of Nurses (DON) on 05/17/12, at 1:30 PM, revealed trays should be distributed to the residents within 15 to 20 minutes after the cart arrived at the units. The DON stated she was not aware that it was taking</p>	F 364			

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F 364	Continued From page 12 one CNA an extended amount of time to pass the trays on the West Wing hall. A second interview conducted with the DM on 05/17/12, at 2:15 PM, revealed the Registered Dietitian (RD) conducted random audits to food temperature and palatability. The DM stated no problems had been identified. The DM further stated the trays should be distributed to the residents within 15 to 20 minutes after the carts arrived on the unit.	F 364			
F 371 SS=D	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, the facility failed to store and serve food under sanitary conditions during the evening meal on 05/15/12. Three bowls of jello/banana dessert were observed to be transported uncovered from the kitchen to the West Wing hall in an open cart. The findings include: Review of the Dietary Food Handling policy (no	F 371	<u>F 371 (D) FOOD PROCURE, STORE/PREPARE/SERVE-SANITARY</u> <i>Residents Found to Have Been Affected</i> All food on resident trays referred to in F 371 are presently covered before delivery to the residents. <i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by the citation of F 371. See Systemic Changes below for correction.		

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F 371	<p>Continued From page 13</p> <p>date) revealed prepared foods should be transported to other areas in closed food carts or covered by a facility approved method.</p> <p>During the evening meal on 05/05/12, six trays were observed to be transported from the kitchen in an open cart to the West Wing hall at 5:45 PM. Three of the trays were observed to contain a bowl of jello/banana dessert that was not covered. The facility staff was observed to transport the trays down the hallway to the West Wing hall nurses' station and then up and down each hall located off the nurses' station with the food items uncovered.</p> <p>Interview with Certified Nurse Aide (CNA) #1 revealed the CNA was observed to transport the open cart to the West Wing hall on 05/15/12. CNA #1 stated she had not realized the food items were uncovered when the trays were transported and delivered to the residents. The CNA stated all food items were required to be covered when transported to areas outside the kitchen area.</p> <p>Interviews conducted with Dietary Aides #1 and #2 on 05/15/12, at 6:35 PM, revealed the food was required to be covered. Dietary staff stated they were rushed and did not ensure the jello was covered before it left the kitchen.</p> <p>Interview with the Dietary Manager (DM) on 05/17/12, at 2:15 PM, revealed all food items were required to be covered when transported to the different hallways in the facility. The DM stated the nursing staff was responsible to inform the Dietary staff when food was sent out uncovered.</p>	F 371	<p>Systemic Changes</p> <p>The dining committee met to review the meal service delivery system on June 7, 2012.</p> <p>The Dietary Staff were inserviced on May 31, 2012 regarding the importance of assuring that all food must be covered before being delivered and on May 31, 2012 the Nursing Staff were inserviced on assuring that food is covered before delivery.</p> <p>On June 11, 2012 the Assistant Administrator is assigned to complete a review of three random trays five times each week to assurance compliance with food being covered before delivery.</p> <p>Monitoring</p> <p>The results of the reviews completed by the Assistant Administrator will be submitted to the Dietary Committee who will provide recommendations and follow-up.</p> <p>Completion Date: June 20, 2012</p>	06/20/12	

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F 441 SS=E	<p>483.85 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p>	F 441	<p><u>F 441 (E) INFECTION CONTROL, PREVENT SPREAD, LINENS</u></p> <p><i>Residents Found to Have Been Affected</i> Residents #19, #20, and #21 were assessed by a licensed nurse for signs and symptoms of infection, no signs and symptoms were identified. The nursing staff involved have been counseled and re-educated.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 441. See Systemic Changes below for compliance.</p> <p><i>Systemic Changes</i> The policy and procedure for passing ice and water to residents has been updated to reflect specific times that employees are to perform hand hygiene. An in-service was conducted by the Clinical Systems Manager and the DON for all nursing staff regarding infection control and prevention practices. In-services occurred on 5/16/12, 5/17/12, and 5/31/12. A specific focus was</p>	

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F 441	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy, it was determined the facility failed to maintain an Infection Control Program designed to provide a safe and sanitary environment to prevent the development and transmission of disease and infection for three of twenty-three sampled residents (Residents #19, #20, and #21) and two unsampled residents (Residents A and B). Observation of a glucose monitoring test on 05/16/12, revealed facility staff failed to clean/sanitize the glucometer machine prior to or after obtaining a blood specimen to check Resident #19's blood sugar level. Facility staff failed to perform appropriate handwashing techniques during medication administration for Residents #20 and #21 on 05/17/12. In addition, staff failed to follow appropriate infection control techniques while passing ice to two unsampled residents (Residents A and B) on 05/16/12. The findings include: Review of the facility's Infection Control policy (no date) revealed aseptic and isolation techniques had been developed and taught to facility staff and specific infection control procedures were located in each department manual. Review of the Blood Sugar Finger Stick policy (no date) revealed the nurse was required to clean the glucometer with a bleach wipe on both the front and back side of the glucometer between each resident use.	F 441	placed on ice pass and hand washing. All licensed and certified nursing staff were in-serviced by the Clinical Systems Manager and the DON on infection control practices with medication administration and medical equipment, including the glucometer. In-services occurred on 5/16/12, 5/17/12, and 5/31/12. A post-test was completed following the in-service. The Clinical Services Manager or designee will complete skills validation checks on all nursing employees to ensure comprehension and competency on infection control practices during ice pass, medication administration, and glucometer use and cleaning. Audits will be completed by 6/18/12. Ongoing audits will be performed weekly on each unit by the Clinical Service Manager or designee by observing staff passing ice and water to ensure infection control policies are followed. Audits will be performed weekly on each unit by the Clinical Service Manager or designee to observe a medication pass and glucometer use for proper infection control and hand hygiene procedures.		

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F 441	<p>Continued From page 16</p> <p>Review of the Handwashing policy (no date) revealed all staff was responsible to wash their hands to control the spread of microorganisms. The policy revealed handwashing must be performed at "certain times" and at any time the staff deemed necessary; however, the policy did not provide examples of specific times for staff to perform handwashing.</p> <p>A review of the facility policies titled Water and Ice Pass Water Pitchers, dated 11/02/10, and the policy for ice machines and ice storage containers (undated) revealed all personnel should wash hands, use a clean designated scoop to obtain ice, and to hold the ice scoop only by the handle.</p> <p>1. Review of the medical record revealed the facility readmitted Resident #19 on 05/16/12, with diagnoses to include Aspiration Bronchitis, Hypoxia, History of tobacco abuse, and Diabetes Mellitus.</p> <p>A review of the admission physician's orders revealed facility staff was to perform fingerstick blood glucose checks for Resident #19 twice a day.</p> <p>Observations of Resident #19 on 05/16/12, at 4:50 PM, revealed Registered Nurse (RN) #3 performed a fingerstick blood glucose check on Resident #19. RN #3 was observed to obtain the glucometer from the nurses' station and to put on gloves. The RN was observed to obtain a blood specimen from Resident #19, processed the blood specimen in the glucometer, and returned the glucometer to the nurses' station. However, RN #3 failed to cleanse/sanitize the glucometer</p>	F 441	<p>Monitoring</p> <p>All reviews and audits will be submitted to the QAA Committee for their review, recommendations, and follow-up. Infection Control will be reviewed at every monthly QAA Committee Meeting.</p> <p>Completion Date: June 20, 2012.</p>	06/20/12	

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F 441	<p>Continued From page 17</p> <p>before and after processing the resident's blood specimen. No further fingerstick blood sugars were scheduled to be obtained at that time.</p> <p>Interview with RN #3 on 05/16/12, at 5:20 PM, revealed the glucometer was cleaned by the night shift nurse. The RN stated night shift was the only nurses responsible to clean/sanitize the glucometer machines. RN #3 stated she never cleans/sanitizes the glucometer between residents. RN #3 further stated she had been employed at the facility for approximately two years and had not been instructed to clean/sanitize the glucometer machine before and after each resident use.</p> <p>Interview with the Director of Nurses (DON) on 05/17/12, at 1:30 PM, revealed all licensed nurses had been trained on proper cleaning/sanitizing of the glucometer machines. The DON stated a card with directions for cleaning/sanitizing the glucometer machine was kept on the glucometer tray. The DON stated RN #3 had been trained when employed regarding the policies/procedures related to proper cleaning/sanitizing of the glucometer, but the facility had not maintained a training record at that time to validate staff training. The DON stated she was not aware staff had not cleaned/sanitized the glucometer appropriately.</p> <p>2. During observation on 05/17/12, at 9:26 AM, of a medication pass, LPN #1 was observed to administer medication tablets by mouth to Resident #20 and failed to wash her hands after the administration. LPN #1 then prepared Resident #21's medication, administered the medication tablets and an inhaler to Resident</p>	F 441			

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F 441	<p>Continued From page 18</p> <p>#21, and failed to wash her hands after the administration.</p> <p>Interview on 05/17/12, at 9:53 AM, with LPN #1 revealed she had been trained on the facility's policy related to proper handwashing when she began employment at the facility approximately one month ago. LPN #1 stated she knew she should have washed her hands between each resident; she acknowledged she had forgotten to wash her hands between each resident's medication administration.</p> <p>3. Observation of an ice pass conducted for unsampled Residents A and B on 05/16/12, at 9:35 AM, revealed Certified Nurse Aide (CNA) #2 obtained ice from an ice cooler located in the hallway with an ice scoop, placed the ice scoop in the cooler with the handle in contact with the ice, left the cooler lid open, entered the resident's room, and placed the ice pitcher on unsampled Resident A's overbed table. CNA #2 then took the water pitcher for unsampled Resident B, filled the water pitcher with ice, placed the scoop inside the cooler with the handle in contact with the ice, left the cooler lid open, and entered the resident's room and placed the water pitcher on the resident's overbed table.</p> <p>An interview conducted with CNA #2 on 05/16/12, at 9:38 AM, revealed the CNA had been in-serviced regarding infection control in April 2012. However, the CNA acknowledged she failed to identify the potential for the ice in the ice cooler to become cross-contaminated when she obtained the water pitcher of unsampled Resident A, filled the pitcher with ice by means of an ice scoop, returned the ice scoop to the ice cooler,</p>	F 441			

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F 441	Continued From page 19 placed the filled ice cooler on unsampled Resident A's table before obtaining the ice pitcher from the table of unsampled Resident B and without washing hands, and repeating the process for unsampled Resident B. In addition, the CNA failed to identify the potential of cross-contamination of the ice when the lid of the cooler was left open and unattended in a common area, i.e., the hallway. An interview conducted with the Director of Nursing (DON) on 05/17/12, at 2:05 PM, revealed CNA #2 had been in-serviced regarding infection control procedures and that the ice scoop was required to be placed in the holder on the side of the cooler and not left in the ice cooler. Additional interview revealed no formal audits of the ice pass had been conducted and there had not been any concerns brought to the DON's attention related to infection control practices during the distribution of ice to residents. A review of the infection control in-service post-test completed by CNA #2 on 04/26/12, revealed no evidence the passing of ice to residents was addressed in the in-service.	F 441			
F 460 SS=C	483.70(d)(1)(iv)-(v) BEDROOMS ASSURE FULL VISUAL PRIVACY Bedrooms must be designed or equipped to assure full visual privacy for each resident. In facilities initially certified after March 31, 1992, except in private rooms, each bed must have ceiling suspended curtains, which extend around the bed to provide total visual privacy in combination with adjacent walls and curtains.	F 460	<u>F 460 (C) BEDROOMS ASSURE FULL VISUAL PRIVACY</u> <i>Residents Found to Have Been Affected</i> Staff have been in-serviced and instructed to close door before providing care to maintain resident's privacy and that care		

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F 460	<p>Continued From page 20</p> <p>This REQUIREMENT is not met as evidenced by: The facility failed to ensure full visual privacy for residents in the facility that resided in semi-private rooms. Observations revealed the facility's semi-private rooms had a privacy curtain that only provided privacy between the residents in bed A and bed B but failed to ensure full visual privacy was provided for the resident in bed A when the door to the room was opened.</p> <p>The findings include:</p> <p>A review of the facility policy titled Dignity (undated) revealed staff was required to provide privacy when providing resident care by ensuring curtains were drawn, doors were closed, and window shades were down.</p> <p>Observations of Resident #18 conducted on 05/17/12, at 6:10 AM, revealed the resident requested privacy to use a bedside commode and staff closed the door to the room and closed the curtain between bed A and bed B. However, Licensed Practical Nurse (LPN) #2 was observed to open the door and enter the room to assess the resident in bed B and as a result the resident in bed A was in full view of anyone in the hallway outside of the room when the door to the room was opened because the curtain did not enclose the entire area around the resident's bed.</p> <p>An interview conducted with LPN #2 on 05/17/12, at 6:15 AM, revealed staff provided privacy to the resident in bed A by closing the resident's door and not allowing anyone into the room. However, the LPN acknowledged privacy could not be</p>	F 460	<p>will be provided in privacy for both residents who reside in a semi-private room. Privacy curtains and hanging tracks have been ordered and will be installed as soon as available in order to comply with F 460.</p> <p><i>Identification of Other Residents with the Potential to be Affected</i> All semi-private resident rooms have the potential to be affected by F 460. See Systemic Changes for compliance for all residents.</p> <p><i>Systemic Changes</i> New cubicle curtains and new cubicle tracks were ordered on June 8, 2012 with delivery anticipated on July 15, 2012. Installation will begin immediately when these items arrive and installation is anticipated to be completed by July 31, 2012.</p> <p><i>Monitoring</i> The Administrator will monitor the installation of privacy curtains and cubicle tracks. The CQI Managers will monitor privacy by completing daily CQI rounds and walk-throughs to assure compliance with F 460.</p> <p>Completion Date: June 20, 2012</p>	06/20/12	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 05/17/2012
NAME OF PROVIDER OR SUPPLIER OWSLEY COUNTY HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE HIGHWAY 11, P O BOX 250 BOONEVILLE, KY 41314		
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F 460	Continued From page 21 maintained for the resident in bed A if staff or someone had to enter the room to check on a resident or provide care to the resident in bed B. Observations conducted during the environmental tour on 05/17/12, at 12:40 PM, revealed all facility rooms did not have a privacy curtain that extended around the beds in resident rooms and did not provide full visual privacy when a person had to enter the resident's room. An interview conducted with Resident #10 on 05/17/12, at 9:40 AM, revealed the resident used bedside urinary equipment and staff provided privacy to the resident by closing the resident's door and closing the privacy curtain between bed A and bed B. However, Resident #10 stated privacy was not maintained when staff entered the room to check on the resident located in bed B. An interview conducted with the Director of Nursing (DON) on 05/17/12, revealed the DON was not aware of the privacy issue related to the curtains and was not aware of any concerns related to resident privacy.	F 460			
F 505 SS=D	483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS The facility must promptly notify the attending physician of the findings. This REQUIREMENT is not met as evidenced by: --Amended-- Based on interview, record review, and review of	F 505	<u>F 505 (D) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</u> <i>Residents Found to Have Been Affected</i> The physician of resident # 9 has been notified. No change in treatment plan was made at this time.		

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F 505	<p>Continued From page 22</p> <p>the facility's policy/procedure, it was determined the facility failed to promptly notify the attending physician of laboratory findings for one resident (Resident #9) in a sample of twenty-three residents. A urinalysis was ordered on 05/07/12, with the initial abnormal results faxed to the physician on 05/08/12. The urine culture results were received on 05/10/12; however, there was no evidence these results were faxed to the physician and an order for antibiotic therapy was not received until the physician was notified of the results by phone on 05/14/12, a timeframe of four days after the facility received the results of the urine culture.</p> <p>The findings include:</p> <p>Review of the Laboratory Policy and Procedure (no dated) revealed abnormal test results received by the licensed nurse will be telephoned to the patient's physician immediately and the nurse will initial and date the lab report indicating the physician notification.</p> <p>A record review revealed Resident #9 was admitted to the facility on 09/21/09, with diagnoses to include hypertension, diabetes, coronary artery disease, CVA, and hypothyroidism. A review of the quarterly Minimum Data Set (MDS), dated 04/25/12, revealed the facility assessed the resident to be severely cognitively impaired and also revealed Resident #9 had an indwelling catheter.</p> <p>A review of physician's orders dated 05/07/12, revealed Resident #9's physician requested laboratory tests, including a urinalysis and a culture and sensitivity of the resident's urine.</p>	F 505	<p>Identification of Other Residents with the Potential to be Affected An audit was completed to review all lab orders in the last 30 days to ensure proper physician notification and follow up was completed. Audit was performed by the Unit Managers and reviewed by the DON. Audits completed by 6/12/12.</p> <p>Systemic Changes An in-service was conducted for all licensed nurses regarding the lab process, including writing the lab on the 24 hour report and the lab calendar for follow up. In-service was conducted by the Clinical Systems Manager and DON on 5/31/12 and 5/31/12. A copy of this process was placed in the lab book for future reference. A post-test was completed following the in-service.</p> <p>Monitoring Lab orders are monitored daily in the morning Interdisciplinary Team (IDT) meeting by the Unit Managers for notification and follow up. In the absence of a Unit Manager, the DON is responsible for follow up. The Clinical Systems Manager will complete a Quality Assurance audit on labs weekly. The results of these audits</p>		

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F 505	Continued From page 23 A review of the initial urinalysis results, dated 05/07/12, revealed the abnormal results were faxed to Resident #9's physician on 05/08/12, at 3:45 AM, by staff. However, it could not be determined by a review of documentation that the report of an abnormal urinalysis culture dated 05/10/12, had been faxed to the resident's physician until 05/14/12. Based on documentation, on 05/14/12, Resident #9's physician was notified of the results of the urine culture and sensitivity tests and the physician ordered antibiotics to treat the resident's urinary tract infection (UTI). Interview on 05/17/12, at 7:32 AM, with Unit Manager (UM) #2 revealed staff had failed to write the physician's order for the urine culture and sensitivity on the calendar maintained at the nurses' station as was the facility practice and as a result the tests and results were overlooked by the UM. The interview also revealed even when lab results are faxed to a physician the results should always be followed up with a phone call if the physician does not fax back new orders or acknowledgement of the fax.	F 505	and reviews will be submitted to the Quality Assurance Committee for further review and recommendations as needed. Completion Date: June 20, 2012	05/20/12	
F 520 SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520	<u>F 520 (E) QAA</u> <u>COMMITTEE-</u> <u>MEMBERS/MEET</u> <u>QUARTERLY/PLANS</u> <i>Residents Found to Have Been Affected</i> Residents #19, #20, and #21 were assessed by a licensed nurse for signs and symptoms of infection, no signs and symptoms were identified. The nursing staff involved have been counseled and re-educated.		

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F 520	<p>Continued From page 24</p> <p>committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure the quality assessment and assurance committee was effective in identifying and correcting quality deficiencies related to the infection control program. There was no evidence the facility had an effective system to monitor staff performance to ensure fingerstick blood glucose levels were obtained under sanitary conditions, to ensure staff followed appropriate handwashing techniques during medication administration, and to ensure appropriate infection control techniques were performed when staff passed ice/water to residents. Observations revealed staff failed to clean/sanitize the glucometer machine prior to or after obtaining a blood specimen to check Resident #19's blood sugar level, failed to</p>	F 520	<p><i>Identification of Other Residents with the Potential to be Affected</i> All residents have the potential to be affected by F 520. See Systemic Changes below for compliance.</p> <p><i>Systemic Changes</i> The nurse management team has been in-serviced on the Infection Control Monitoring Process, including skills and knowledge validation, tracking and trending infections and staff education based on the CDC guidelines by the Nurse Consultant on 5/16/12. The policy and procedure for passing ice and water to residents has been updated to reflect specific times that employees are to perform hand hygiene. An in-service was conducted for all nursing staff regarding infection control and prevention practices by the Clinical Systems Manager</p>	

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F 520	<p>Continued From page 25</p> <p>perform appropriate handwashing techniques during medication administration for Residents #20 and #21 on 05/17/12, and failed to follow appropriate infection control techniques while passing ice to two unsampled residents (Residents A and B) on 05/16/12. (Refer to F441).</p> <p>The findings include:</p> <p>A review of the Quality Assurance (QA) policy (no date) revealed the Quality Assurance Program (QAP) was to ensure that the delivery of care and services to enhance the lives of the residents was provided. The policy stated the QA Committee was responsible to identify and address quality issues and implement corrective action plans as necessary. The policy stated the QA Committee would be responsible to monitor areas which could negatively affect quality of care and service provided to the residents and would develop/implement plans of action to correct any identified quality deficiencies.</p> <p>1. RN #3 was observed on 05/16/12, at 4:50 PM, to perform a fingerstick blood glucose level on Resident #19 without cleaning/sanitizing the glucometer before and after processing the blood specimen in the glucometer. The RN stated she had not received training related to the appropriate cleaning/sanitizing of the glucometer and had not been instructed to clean/sanitize the glucometer between each resident use.</p> <p>Interview conducted with the QA Coordinator (QAC) on 05/17/12, at 3:30 PM, revealed no audits had been conducted to determine if staff was following established protocols for</p>	F 520	<p>and DON on 5/17/12 and 5/31/12. A specific focus was placed on ice pass and hand washing. All licensed and certified nursing staff were in-serviced on infection control practices with medication administration and medical equipment, including the glucometer. In-services were completed by the Clinical Systems Manager and the DON on 5/16/12 and 5/31/12. A post-test was completed following the in-service.</p> <p>Clinical Services Manager or designee will continue to monitor by completing skills validation checks on all nursing employees to ensure comprehension and competency on infection control practices during ice pass, medication administration, and glucometer use and cleaning. Audits will be completed by 6/18/2012 Ongoing audits will be performed weekly on each unit by the Clinical Service Manager by observing staff passing ice and water to ensure infection control policies are followed.</p>		

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F 520	<p>Continued From page 26</p> <p>cleaning/sanitizing the glucometer. The QAC stated she had not conducted observations of staff to determine if staff was following the appropriate procedures for cleaning/disinfecting the glucometer. The QAC stated she had not considered doing an audit or observation since she believed staff had knowledge of the appropriate techniques to clean/sanitize the glucometer machine.</p> <p>2. LPN #1 was observed on 05/17/12, at 9:26 AM, to administer medications to Residents #20 and #21 without performing appropriate handwashing techniques between residents. LPN #1 stated she had received training regarding proper handwashing, but forgot to wash her hands between medication administration for Residents #20 and #21.</p> <p>Interview conducted on 05/17/12, at 3:00 PM, with the Infection Control Nurse, Director of Nursing (DON), and the Quality Assurance Coordinator (QAC) revealed the facility did not have a formal audit system to ensure that facility staff utilized appropriate infection control techniques that included proper handwashing and no evidence was provided that the facility had conducted any handwashing audits to evaluate staff handwashing performance/skills.</p> <p>3. CNA #2 was observed to pass ice on 05/16/12, at 9:35 AM, to unsampled Residents A and B; however, the CNA failed to use appropriate infection control techniques during the ice pass, by allowing the scoop handle to come in contact with the ice and leaving the cooler lid open. CNA #2 stated that he had been trained regarding infection control techniques.</p>	F 520	<p>Audits will be performed weekly on each unit by the Clinical Service Manager to observe a medication pass and glucometer use for proper infection control and hand hygiene procedures. The RN Nurse Consultant will review in-services and completed skills validation for content and completion</p> <p>Monitoring The results of these audits and observations will be submitted to the Quality Assurance Committee for further review and recommendations as needed.</p> <p>Completion Date: June 20, 2012</p>	06/20/12	

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F 520	Continued From page 27 However, he stated he could not remember if the training included the passing of ice to residents. An interview conducted with the Infection Control Nurse, Director of Nursing (DON), and the Quality Assurance Coordinator (QAC) on 05/17/12, at 3:00 PM, revealed the facility did not have a formal audit system to ensure that facility staff utilized appropriate infection control techniques, and no evidence was provided of any audits of CNA #2 regarding the passing of ice to residents.	F 520			

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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>Building: 01</p> <p>Survey under: NFPA 101 (2000 Edition)</p> <p>Plan approval: 1980, 1999</p> <p>Facility type: SNF/NF</p> <p>Type of structure: One story, Type V (unprotected)</p> <p>Smoke Compartments: 6</p> <p>Fire Alarm: Complete fire alarm smoke detectors in corridors and dining room, heat detectors in kitchen and laundry room.</p> <p>Sprinkler System: Complete sprinkler system (dry).</p> <p>Generator: Type 2 generator powered by diesel installed 2011.</p> <p>A standard Life Safety Code survey was conducted on 05/16/12. Owsley County Health Care Center was found to be in compliance with the requirements for participation in Medicare and Medicaid. The census on the day of the survey was 72. The facility is licensed for 91 beds.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.