

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

RECEIVED 08/05/2011
HOSPITAL APPROVED
OMB NO. 0938-0391

AUG 15 2011

07/28/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185405	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/28/2011
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NAME OF PROVIDER OR SUPPLIER EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 441 SS=D	<p>483.65 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 -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens</p>	F 441	<p>Clarification of the disinfectant product and process to be used for disinfection of the glucose monitoring device between residents was done with Ephraim McDowell Regional Medical Center Infection Prevention Coordinator and Laboratory Director 07/28/11 by the Nursing Home Administrator. Staff on duty 07/28/11 was immediately educated regarding the correct disinfectant (10% Bleach) & the procedure when performing glucose monitoring of residents.</p> <p>Revised policy changes were communicated to the designated Laboratory Certified Trainer by the Laboratory Director. The Laboratory Medical Director & Laboratory Director revised the policy using the manufacturer's recommendations for 10% bleach solution as referenced by CDC. Each staff member provided a return demonstration of their competency in this procedure by a laboratory certified trained trainer. This is evidenced by the attached Glucose Monitoring Device Competency Tool for Disinfection</p>	08/19/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Judy A. Morgan</i>	TITLE <i>RN Director/Nursing Home Administrator</i>	(X6) DATE <i>08/12/11</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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NAME OF PROVIDER OR SUPPLIER EPHRAIM MCDOWELL REGIONAL MEDICAL CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 217 SOUTH THIRD STREET DANVILLE, KY 40422	
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F 441	Continued From page 1 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, review of facility policy/procedures, review of manufacturer's recommendations, and review of Centers for Disease Control and Prevention (CDC) guidelines, it was determined the facility failed to have an effective Infection Control Program in place to provide a safe environment to prevent the development and transmission of disease and infection. The facility failed to ensure resident multi-use blood glucose monitoring devices were disinfected between each resident in accordance with manufacturer's directions, facility policy/procedures, and CDC guidelines for two of ten sampled residents (Resident #1 and Resident #6). On 07/27/11, Registered Nurse (RN) #2 and SRNA (State Registered Nurse Aide) #7 were observed performing blood glucose monitoring via fingerstick for Resident #6 and Resident #1. Staff failed to disinfect the blood glucose monitoring device between each resident in accordance with facility policy/procedures and manufacturer's directions for use. It was further determined the facility failed to provide evidence the facility's infection control program was effective in ensuring the competency of RN #2 and SRNA #7 in the proper technique to disinfect glucose monitoring devices as recommended by CDC guidelines and manufacturer's guidelines. The facility policy/procedures did not instruct staff	F 441	Refer to ATTACHMENT A. At 1400 on 07/28/11, the causal agent of the deficient practice was determined to be unclear policy about the product to be used for disinfection of of glucose monitoring device. The following were used to determine the cause: Infection Prevention Coordinator, Infection Prevention Specialist RN, Laboratory Director, Laboratory Education Preceptor, Director/Nursing Home Administrator, and staff RN. The analysis identified the need for Blood Glucose Monitoring Policy revision by Laboratory Director & input of Pathologist Medical Director, Laboratory Education Preceptor, Chief Nursing Officer & Staff RN with Target Date of completion of revision by 07/28/11 (completion 07/28/11 @1545). Action Plan: Immediate education of the revised Blood Glucose Monitoring Policy to begin with existing Transitional Care Unit staff on duty by the Certified Trained Trainer. Additionally, the Practice/process of Glucose Monitoring was identified by the analysis as an outcome of the unclear policy. Immediate competency with return demonstration of the process of disinfecting glucose meters between patients	

Jan-Jabgonen

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F 441	Continued From page 2 of the recommended disinfectant to use or directions for use of the disinfectant. In addition, RN #2 failed to change gloves as required during wound care for Resident #1 on 07/27/11. The findings include: 1. According to the Centers for Disease Control (CDC) guidelines, updated 03/23/11, "Whenever possible, blood glucose meters should be assigned to an individual person and not be shared. If blood glucose meters must be shared, the device should be cleaned and disinfected after every use, per manufacturer's instructions, to prevent carry-over of blood and infectious agents. If the manufacturer does not specify how the device should be cleaned and disinfected then it should not be shared." The facility's policy/procedure for "Point of Care Testing" (dated as revised February 2011) revealed repeatedly used point-of-care devices, such as blood glucose meters, if used for multiple patients, must be cleaned and disinfected after each use according to manufacturer's instructions. The facility had an additional policy/procedure for "Blood Glucose Monitoring" (dated as revised and approved March 2009) that stated staff was required to clean the outside of the meter with a cloth dampened with a 10% bleach solution. The policy/procedure further stated the meters could be cleaned with water or 10% bleach as needed. According to the manufacturer's directions for use for disinfection of the SureStep Flexx Meter used by the facility, the outside of the meter should be cleaned with a cloth dampened with a 10%	F 441	by the Certified Trainer 07/28/11, began @ 1845. Residents with glucose monitoring checks were potentially impacted or at risk by the deficient practice. There were (4) residents. Upon notification by the survey team 07/28/11, practice change began by 1400 and verification of policy revisions and practice with the revised competency components by 07/28/11 @ 1845. Staff categories involved in the deficient practice include RN, LPN and PCT(SRNA) (Patient Care Technicians). The deficient practice will be prevented from recurring to these residents & other future residents who require glucose monitoring through the following actions: 1) The Glucose Monitor policy was revised 07/28/11 to clarify the product to be used for disinfection by the Laboratory Director, Pathologist Laboratory Director, Laboratory Education Preceptor, Chief Nursing Officer, Director/ Nursing Home Administrator, and Staff RN. Policy Revisions: a) Clarification of training & retraining by identifying the who & I means of training/		

Jul - J. Morgan, RN

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F 441	<p>Continued From page 3</p> <p>bleach solution. A 30% CaviCide was included as an effective disinfectant for use on the SureStep Flexx Meter. The facility had CaviWipes XL available for use which were pre-saturated with CaviCide. The CaviWipes XL instructions for use as a disinfectant revealed the surface to be disinfected should be precleaned with one CaviWipes XL towelette. A second CaviWipes XL towelette should be used to thoroughly wet the surface. The surface should remain visibly wet for three minutes at room temperature for effectiveness.</p> <p>During observation of medication pass on 07/27/11, at 3:55 PM, RN #2 performed a blood glucose test on Resident #6. Resident #6 had been admitted to the facility with diagnoses that included cecal abscess, perforated sigmoid colon, and diabetes mellitus Type II. RN #2 disinfected the blood glucose meter with alcohol wipes after use. RN #2 gave the blood glucose meter to SRNA #7 who performed a blood glucose test on Resident #1. Resident #1 had been admitted to the facility with diagnoses of a right hip fracture and end stage renal disease requiring hemodialysis. Resident #1 was on contact isolation related to a history of MRSA (Methicillin Resistant Staph Aureus). SRNA #7 used a CaviWipes XL to clean the blood glucose monitor. However, the SRNA wiped the surface of the blood glucose meter with only one CaviWipes XL towelette and placed the meter back into storage at the nursing station.</p> <p>An interview conducted on 07/27/11, at 4:00 PM, with RN #2 revealed it was acceptable to clean the blood glucose meter with alcohol wipes. According to RN #2, night shift personnel perform</p>	F 441	<p>retraining.</p> <p>b)Quality control lock-out statement</p> <p>c)Disinfection using 10% Bleach/Dispatch between patients clarification on multiple patient use. (previously read "cleaning").</p> <p>d)Addition of 10% Bleach/Dispatch wipes to equipment needed to perform procedure.</p> <p>e)Changes statement of "must" be disinfected between patients & minimal dwell time with 10% Bleach.</p> <p>f)Changes regarding when the test strip holder is cleaned & situations requiring additional cleaning per manufacturer's recommendations.</p> <p>Refer to ATTACHMENT B1,2,3.</p> <p>2. The Care Learning Product used for staff education (Electronic & paper learning module on Life Scan Glucose Monitoring) was revised by the Laboratory Director & the Pathologist Medical Director of both CLIA & Point of Care Testing to specifically note the disinfecting product & the process. Refer to ATTACHMENT C.</p> <p>3. All Transitional Care Unit Staff who perform glucose testing were required to have inservice/re-education training that included the following components:</p>	

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F 441	<p>Continued From page 4</p> <p>a "big cleaning" at night. RN #2 was unaware of what constituted a "big cleaning," only that it was conducted by night shift personnel.</p> <p>An interview with SRNA #7 on 07/27/11, at 4:05 PM, revealed staff was to use CaviWipes XL to clean the glucose meter if the resident was on contact isolation but if the resident was not on isolation it was acceptable to use alcohol wipes. SRNA #7 was unaware of the CaviWipes XL manufacturer's directions to use two wipes for disinfection.</p> <p>Interview on 07/27/11, at 4:45 PM, with RN #4 revealed the RN stated staff was required to clean the glucose testing monitors after each resident use with a CaviWipes XL towelette. RN #4 was unaware of the manufacturer's recommendations to use two CaviWipes XL towelettes to ensure disinfection of the monitor. According to RN #4, it was acceptable to use alcohol wipes to clean the glucose testing monitors, but the RN always used the CaviWipes XL.</p> <p>Interview with SRNA #6 on 07/27/11, at 4:48 PM, revealed staff was required to use the CaviWipes XL to clean the exterior of the glucose testing monitors after each resident use. SRNA #6 was unaware of the manufacturer's recommendations to use two CaviWipes XL towelettes to ensure disinfection of the monitor.</p> <p>Interview with SRNA #9 on 07/27/11, at 5:10 PM, revealed staff was required to use a CaviWipes XL towelette to clean the exterior of the glucose monitors after resident use. SRNA #7 was unaware of the manufacturer's recommendations</p>	F 441	<p>*Completion of Care Learning Module prior to performing glucose monitoring procedures, with documentation of completion. The house supervisor on duty monitored to assure that there were sufficient numbers of Transitional Care Unit staff who had completed the re-education and re-competency checks to provide glucose monitoring procedures. Content was revised on paper 07/28/11 for immediate resolution for staff. Submission of revised changes to the Computerized Care Learning product located in West Virginia was completed 07/29/11 @ 1045 to be available 08/01/11 or sooner. Paper versions of the learning module that addressed disinfection of blood glucose monitors were in use 07/28/11 by 1845. All Transitional Care Unit Computerized Care Learning & Competencies for re-education/retraining were completed 08/09/11.</p> <p>Refer to ATTACHMENT D1.</p> <p>There is no outside agency staffing for the Transitional Care Unit. The one RN from EMRMC internal Float Pool, occupying a temporary position for the RN on FMLA, was also re-educated.</p> <p>Refer to ATTACHMENT D2.</p> <p>*Return demonstration by the staff member of proper competency in</p>		

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F 441	<p>Continued From page 5</p> <p>to use two CaviWipes XL towelettes to ensure disinfection of the monitor.</p> <p>An interview on 07/28/11, at 11:55 AM, with the facility Laboratory Director revealed the Director had completed the revision of the policy/procedure for "Point of Care Testing" in February 2011. According to the Laboratory Director, the individual facility units were notified of the policy change and each unit should have verified the implementation of the policy change. The Laboratory Director stated the policy had always stated the exterior of the blood glucose meter was to be disinfected with 10% bleach and the revision had only concerned frequency.</p> <p>An interview was conducted on 07/28/11, at 11:40 AM, with the interim Unit Supervisor. The Unit Supervisor stated staff was required to complete an annual online competency. According to the Unit Supervisor, the disinfection of the blood glucose meters was included in the online training. The Unit Supervisor produced a copy of the online training content which stated staff was to disinfect the glucose testing meters with a 10% bleach solution. The Unit Supervisor stated there was no follow-up observation of staff competency.</p> <p>An interview on 07/28/11, at 3:45 PM, with the facility Administrator revealed staff was not monitored for implementation of policy/procedures on the unit. According to the Administrator, staff received instruction on disinfection of the blood glucose meter during orientation and any follow-up instruction concentrated on competency in the use of the controls for the meters, and not disinfection.</p>	F 441	<p>glucometer disinfection prior to performing glucose monitoring procedures with sign off by the staff member and co-signature of the certified trainer that staff member is competent was completed 08/09/11.</p> <p>The re-education/training ensured that all staff who perform glucose monitoring have a clear understanding of the policy & procedure. Training began 07/28/11 & was completed by all Transitional Care Unit Staff who perform blood glucose monitoring by 08/09/11. This ensures a clear understanding of the policy & procedure & demonstrated competency. The RN who was on FMLA did complete the educational process 08/02/11 as well as the demonstrated competency. To ensure that the practice will not recur, any staff hired after this completion of the re-education/training of glucose monitoring will receive the same re-education/training by a certified laboratory trainer, including demonstrating competency prior to performing blood glucose monitoring. Annual competency verification is revised to reflect/correct the practice issues as well as verifying the psychomotor and cognitive skills associated with glucose monitoring disinfection</p>	

Jan-Judithson RN

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F 441	<p>Continued From page 6</p> <p>2. Review of the facility's policy/procedure for Asepsis (dated as revised October 2009) revealed medical asepsis (clean technique) included hand hygiene, barrier technique to reduce microbial transmission, and no-touch dressing technique to avoid contamination of supplies and glove usage either sterile or clean. A review of the facility's policy/procedure for Standard Precautions (Universal) and Transmission-Based Precautions (dated as revised October 2009) revealed gloves must be removed and hands washed after gloves are soiled with a specific body fluid of the same patient.</p> <p>Observations on 07/27/11, at 9:20 AM, of wound care and skin assessment of Resident #1 revealed RN #2 donned gloves, removed the soiled dressing from the resident's sacral area, cleaned the wound with normal saline-soaked gauze, and applied the clean dressing. The RN did not change her gloves or perform hand hygiene after removing the soiled dressing or after cleansing the resident's wound.</p> <p>Interview with RN #2 on 07/27/11, at 9:42 AM, revealed she did not change her gloves or perform hand hygiene during any part of the wound care process. According to RN #2, she only touched the tape on the old dressing and did not need to change gloves or perform hand hygiene.</p> <p>Interview on 07/27/11, at 10:10 AM, with the facility Infection Control Nurse revealed staff was required to change gloves and perform hand hygiene after removing the old wound dressing</p>	F 441	<p>procedures.</p> <p>Refer to Attachments E1,2.</p> <p>No staff members were permitted to perform glucose monitoring until competencies were completed. The House Supervisor assured that there were sufficient numbers of Transitional Care Unit re-trained staff to perform glucose monitoring. A "G" was placed on the time sheet besides the name of those that had been retrained until all were retrained. There is no outside agency staffing for the Transitional Care Unit.</p> <p>Refer to Attachment F1,2,3,4.</p> <p>A list of Transitional Care Unit Associates was used as a tool to track completion of glucometer competency.</p> <p>Refer to Attachment G1,2.</p> <p>5. Process changes to aid in the consistency of the process of always using the 10% bleach to disinfect the glucose meters between patients include documentation in the electronic medical record intervention, "Glucose Monitoring". This was revised 07/28/11 by the Nursing Information Services Director & the Certified trainer to include confirmation of the use of the actual disinfectant/10% bleach</p>	

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F 441	Continued From page 7 and before applying the new dressing. Review of the training record for RN #2 dated October 2010 revealed the RN had received instruction on wound care via a poster presentation that the RN viewed. There was no evidence of an evaluator of the RN's proficiency to perform the task.	F 441	and confirmation by a second on-duty staff person that this process did occur. Transitional Care Unit staff understand that they must document the disinfectant agent used as well as have the second staff person on duty, confirm the use of the disinfectant. Meditech Assessment Documentation titled, "Blood Glucose/FS/Verification TCU Set". To prevent the deficient practice from recurring, monitoring of the 2nd verification process will be done by the Director/Administrator weekly for at least 21 days & communicated to the Performance Improvement Team for analysis and assurance of continued compliance. (August 16, 2011 @ 12N). The committee will determine any further monitoring and the duration of monitoring. This committee includes the Medical Staff Director, Director/Nursing Home Administrator, the MDS coordinator, Social Worker, Registered Dietician, Certified Activity Coordinator, Registered Physical Therapist, Occupational Therapist, Nurse Preceptor and Transitional Care Unit Nursing Staff. Refer to Attachment H1,2. Refer to Attachment I. The monitoring/tracking system		

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K 000	<p>INITIAL COMMENTS</p> <p>TYPE OF STRUCTURE: 1994 Six-story protected frame Type I(332) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on 07/27/11, for compliance with Title 42, Code of Federal Regulations, §483.70(a). The facility was found to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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