

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

PRINTED: 12/16/2014  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185340	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  C 12/03/2014
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NAME OF PROVIDER OR SUPPLIER  GLASGOW HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 220 WESTWOOD ST. GLASGOW, KY 42141
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F 000	INITIAL COMMENTS  An Abbreviated Survey Investigating Complaint #KY22513 was conducted on 12/03/14 to determine the facility's compliance with Federal requirements. #KY22513 was unsubstantiated with an unrelated deficiency cited at a Scope and Severity of an "E".	F 000	The Preparation and execution of this Plan of Correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in this Statement of Deficiency. This Plan of Correction is prepared and executed solely because it is required by Federal and State law.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if 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	F 441	<u>F441</u>  1. Residents #5, #7, & #8, were monitored for 72 hours to determine if the deficient practice resulted in any negative outcomes. There were no negative outcomes noted for any of these three residents. Resident #8 had her bag placed in a dignity bag upon her return to the facility.  2. Twenty four hour reports and all MD orders for past 30 days reviewed by Jamie Maynard, Director of Nursing on 12/15/2014 to determine if there have been any noted infections or signs of infections that may be attributed to poor hand hygiene or infection control practices. None were noted. All residents with catheters were checked to ensure that they have dignity bags on and available. This was completed on 12/3/2014 by Jamie Maynard, Director of Nursing.	1/10/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Jason [Signature]* TITLE: Administrator (X6) DATE: 12/26/14

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

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F 441	<p>Continued From page 1 professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy and procedures it was determined the facility failed to maintain an infection control program for three (3) of eight (8) sampled residents (Resident #5, #7, and #8). The facility failed to perform hand hygiene while providing care for Resident #5 and #8 and failed to prevent a urinary catheter bag from touching the floor and outdoor sidewalk for Resident #7. Additionally, a staff member failed to wash hands after touching a trash bag in the trash can and prior to delivering a meal tray and removing a cup lid and plate cover for a resident.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure titled, "Hand Hygiene", last revised 11/01/12, revealed all personnel shall follow the hand washing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. Further review revealed hand hygiene is the primary means of preventing the transmission of infection and staff was expected to wash their hands with soap and water before and after assisting a resident with toileting. Additionally, hand hygiene was expected after handling soiled or used linens, soiled equipment and after</p>	F 441	<p><u>F441 (cont.)</u></p> <p>3. The following will be completed to ensure that the deficient practice does not reoccur. The facility will perform retraining which will be completed by 1/09/15 on infection control, including hand washing and glove use and will perform checkoffs on all the SRNAs with no SRNA working after 1/09/2015 without having the retraining and checkoffs completed. All newly hired Nursing Assistants will be trained in infection control during orientation. The ADON, Infection Control Coordinator or designee will perform random infection control audits 5 (five) times a week for 6 (six) weeks. The results of these audits will be given to the CQI committee for any modifications of this plan of correction. The audits will include hand washing, glove use, tray delivery, and dignity bugs at a minimum.</p> <p>4. The CQI committee will review all retraining and audits and will make recommendations to the Administrator for appropriate followup, modifications, or retraining. The CQI committee will meet at least quarterly, including the Medical Director, Administrator, Director of Nursing, Social Services, Dietary Manager, and Maintenance.</p> <p>5. Date of Completion: January 10, 2015</p>	1/10/15

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F 441	<p>Continued From page 2 removing gloves.</p> <p>1. An observation on 12/03/14 at 2:50 PM, revealed Certified Nursing Assistant (CNA) #6 performed peri-care for Resident #5. Further observation revealed CNA #6 wiped Resident #5 from front to back with gloved hands. When the peri care was completed, with the same gloves, CNA #6 placed blankets on Resident #5, placed the call light on his/her chest and placed the bedside table next to his/her bed. Further observation revealed CNA #6 placed Resident #6's wheelchair and walker to the corner of his/her room, picked up a pillow, gathered up the soiled linen, and trash and left Resident #6's room. With the same gloves, CNA #6 went out into the hallway, placed the soiled linen and trash onto the linen cart. CNA #6 wheeled the linen cart to the soiled laundry room and entered the soiled laundry room three (3) times to place the soiled linens in the linen room. After placing the soiled linens in the laundry room, CNA #6 removed the trash, exited the door to the dumpster, discarded the trash to the dumpsite, and removed gloves. CNA #6 entered the building through the kitchen and went back to the nurses' station. CNA #6 was not observed to change gloves or wash his hands after performing the peri care.</p> <p>Interview with CNA #6 on 12/03/14 at 3:12 PM, revealed he normally washed his hands before and after performing peri care per the facility's policy and procedures. He stated he must have just forgotten and was nervous. He stated this was important to prevent the spread of germs</p> <p>Interview with the Director of Nursing, (DON) on 12/03/14 at 3:17 PM revealed that all staff should</p>	F 441			

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F 441	<p>Continued From page 3</p> <p>wash hands before and after performing peri care and after handling soiled linen and biohazard waste.</p> <p>Interview with the Administrator on 12/03/14 at 4:45 PM, revealed he expected the staff the follow the training on peri care and to follow the policy and procedures as it relates and to always utilize good judgment.</p> <p>2. Review of the World Health Organization Guidelines on Hand Hygiene in Healthcare: A Summary dated 2009. Section 8 (six), page 17 (seventeen), revealed documentation to include, "when wearing gloves, change or remove gloves during patient care if moving from a contaminated body site to another body site within the same patient or environment."</p> <p>Review of an In-service record, dated 11/17/14, located at the nurses station revealed a sign in sheet and photocopied booklet titled, "What you should know About Infection Control", 2011 edition. The booklet revealed: "Hand Hygiene is the Most Important Measure in infection control". Hand hygiene was expected after touching blood and other body substances even if gloves were worn.</p> <p>Observation, on 12/03/14 at 3:30 PM, revealed Resident #7 who had been incontinent of urine, was provided incontinent care by three (3) Certified Nurses Aides (CNAs) #3, #4, and #5. CNA #4 washed his/her hands and applied gloves prior to providing perineal care; however, further observation revealed CNA #4 placed a clean pad and brief, repositioned Resident #7 in the bed and repositioned the bed covers prior to removing gloves and washing his/her hands.</p>	F 441		

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F 441	<p>Continued From page 4</p> <p>Interview with CNA #4, on 12/03/14 at 3:45 PM, revealed she normally removes her gloves and washes hands prior to exiting the room and that she did not know she should remove gloves after cleansing perineal and rectal area unless stool was visible.</p> <p>Interview with the Administrator, on 12/03/14 at 4:45 PM, revealed he expected staff to follow proper training on incontinent and perineal care, to follow policy and procedure as it relates and to use good nursing judgment if "those things are not specifically outlined".</p> <p>3. Observation, on 12/3/14 at 8:45 AM, during the breakfast meal service revealed CNA#1 to empty the contents of a tray into the trash with her left hand touching the trash bag in the trash bin. Additional observation revealed CNA#1 did not sanitize her hands, then delivered the resident's tray to his/her table and removed the plastic covers off of the drink and the top cover over the meal and silverware. CNA#1 then went over to the sink in the Restorative Dining area and stated "we are officially out of soap" and rinsed her hands with water and then dried them and used the foam hand sanitizer on the wall.</p> <p>Interview with the Administrator, on 12/03/14 at 4:40 PM, revealed staff were required to wash or sanitize their hands between residents during meal service and his expectation would be for staff to wash their hands if they touched a trash bag in the trash can to ensure infection control and prevent contamination when they provide services to residents.</p> <p>4. Review of "Indwelling Urinary Catheter Use in</p>	F 441			

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F 441	<p>Continued From page 5</p> <p>the Long-Term Care Setting" dated 4/16/14, revealed documentation to include urine drainage bags are to be positioned below the bladder utilizing gravity to facilitate drainage. Bags must never touch the floor to prevent contamination that can be a potential source for external biofilm formation.</p> <p>Record review revealed the facility admitted Resident #8 on 04/30/14 with diagnoses to include Diabetes Mellitus Type II, Chronic Kidney Disease, Pressure Ulcer, Cellulitis, Congestive Heart Failure, Hypertension, Anemia, Rheumatoid Arthritis, History of Colonic Malignancy, and Gastro esophageal Reflux Disease. Review of the Quarterly Minimum Data Set (MDS) assessment, dated 10/25/14, revealed the facility assessed the resident cognitively intake with a BIMS score of "15" (fifteen) and required total assistance with all activities of daily living. He/she had an indwelling urinary catheter related to hydronephrosis and Resident #8 transfers to dialysis three days per week.</p> <p>Review of the comprehensive care plan revised 11/05/14, revealed documentation to include Resident #8 was at risk for infection related to indwelling catheter and staff were to observe for proper placement of tubing when repositioning, transferring and ambulating and a urinary catheter leg strap should be in place at all times. Review of the medical record, dated 11/21/14, revealed Resident #8 was diagnosed with a urinary tract infection, and the culture and sensitivity revealed gram negative bacilli, Rocaphin 1 (one) gram injection was given intra-muscularly on 11/23/14, a urinary leg strap was ordered.</p>	F 441			

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F 441	<p>Continued From page 6</p> <p>Observation, on 12/03/14 at 11:30 AM, revealed Resident #8 sitting in a wheelchair, and the urinary catheter drainage bag without a dignity bag was anchored beneath the wheelchair seat and dragged on the floor from room 117A to the entranceway of the facility. Further observation revealed the urinary drainage bag was dragged on the outdoor sidewalk to the transport vehicle.</p> <p>Interview with the DON, on 12/03/14 at 5:30 PM, revealed she expected staff to place catheter drainage bag inside dignity bag and the bag should not drag the ground. The DON stated there was a dignity bag on Resident #8's wheelchair and she was "unsure why they did not put the catheter drainage bag inside the dignity bag prior to transport to dialysis".</p> <p>Interview with the Administrator, on 12/03/14 at 5:05 PM, revealed staff should place urinary catheter drainage bag inside a dignity bag and the bag should be clipped so the bag is lower than the bladder but not dragging the ground.</p>	F 441			