

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

PRINTED: 07/23/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  07/11/2013
NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143	
(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	INITIAL COMMENTS  A standard recertification survey was initiated on 07/09/13 and concluded on 07/11/13 and the Life Safety Code survey was conducted on 07/10/13 with deficiencies cited at the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to prevent Urinary Tract Infections for one (1) of fifteen (15) sampled residents. (Resident #5) The facility failed to determine the source of four (4) positive urine cultures reported from the laboratory on 12/18/12, 04/03/13, 05/10/13 and on 06/06/13.  The findings include:  The facility did not provide a policy regarding pericare or indwelling catheter care. The facility	F 315	Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements. <u>F315</u>  1. The Director of Nursing noted on 7/11/13 that the catheter and tubing for resident #5 were off the floor and in a dignity bag. An observation by the Director of Nursing on 7/31/13 noted that foley catheter care for resident # 5 was being performed by staff using proper infection control procedures including cleaning from front to back, away from the catheter. 2. The Director of Nursing, Assistant Director of Nursing or Unit Manager observed on 7/31/13 that catheter care was being provided to all residents who had a foley catheter placed and noted that foley catheter care was being provided with proper infection control	8/25/13

LABORATORY DIRECTOR'S, OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

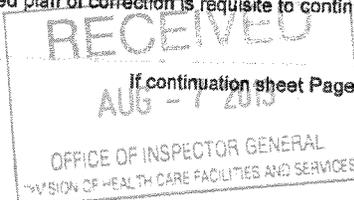
(X6) DATE

*Jackie Ramsey*

*NHA*

*1 8/5/13*

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.

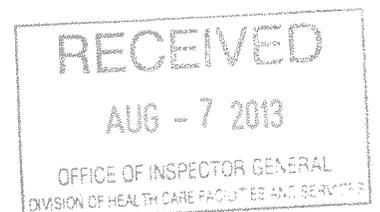


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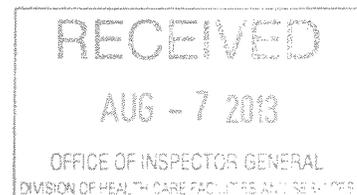
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F 315	<p>Continued From page 1</p> <p>utilized the Lippincott Manual of Nursing Practice as guidance for procedures.</p> <p>Review of the Lippincott Manual of Nursing Practice, Eight Edition, page 757, Management of the Patient with an Indwelling Catheter and Closed Drainage System was to maintain an unobstructed urine flow and to keep the bag off of the floor. Urine should not be allowed to collect in the tubing because a free flow of urine must be maintained to prevent infection.</p> <p>Observation of Resident #5, on 07/09/13 from 2:00 PM through 2:28 PM, while he/she sat in the Front Lobby revealed an indwelling catheter collection bag sat on the floor. On 07/09/13 at 3:15 PM, an observation of the resident at a table on the front porch area revealed the indwelling catheter bag lying on the catheter tubing on the floor.</p> <p>Observation of Resident #5, on 7/10/13 at 10:18 AM, revealed he/she sat near the bird cage in the lobby area and the indwelling catheter bag remained on the floor with the tubing under the bag.</p> <p>Observation of catheter care for Resident #5, on 07/11/13 at 1:57 PM, with Certified Nurse Aide (CNA) #2, revealed peri-rectal care was completed in a manner in which the wash cloth motion moved from the rectal area towards the urine catheter insertion site.</p> <p>Review of Resident #5's clinical record revealed the facility admitted the resident on 05/03/12 with diagnoses of Cerebral Vascular Accident, Cerebellar Ataxia, Hypertension, Diabetes</p>	F 315	<p>practices including wiping away form the catheter from front to back. An observation by the Director of Nursing on 7/11/13 noted that all residents who have a foley catheter placed had their catheter tubing off of the floor and in a dignity bag.</p> <p>3. All direct care staff will be re-educated on catheter care and assuring that foley catheter tubing is not on the floor and the urine bag is stored in a dignity bag. The re-education will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager. This education will be completed by 8/24/13, with no staff working after 8/24/13 without having received this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing, or Unit Manager will observe foley catheter care and foley catheter tubing placement five (5) times per week for twelve (12) weeks to ensure that foley catheter care is provided with proper infection control procedures including cleaning from front to back away from the catheter and that the tubing is not touching the floor and the urine bag is placed in the dignity bag. The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting, consisting of the Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until the team concludes that the issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>		



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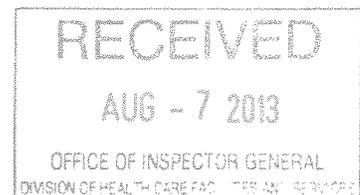
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F 315	<p>Continued From page 2</p> <p>Mellitus, Atherosclerosis, Renal Insufficiency, Neurogenic Bladder and Urinary Tract Infection. The facility obtained a urine specimen on 12/18/13 with a culture. The culture revealed Escherichia coli on 12/19/12. A second (2nd) urine specimen was obtained on 04/01/13 and revealed on 04/03/13 the organism identified was Escherichia coli. A third (3rd) urine specimen was obtained on 05/08/13 and revealed on 05/10/13 the culture identified Morganella morganii ssp morganii. The resident was admitted to the hospital on 06/04/13 with the diagnosis of Urinary Tract Infection. A fourth (4 th) urine specimen was obtained on 06/04/13 at the hospital and the culture revealed on 06/06/13 the organism was Morganella morganii ssp morganii.</p> <p>Interview with Certified Nurse Aide (CNA) #2, on 07/11/13 at 2:35 PM, revealed the urine collection bag should be kept off the floor and hung high enough on the wheelchair to keep them off the floor. She stated the urine collection bags and catheter tubing on the floor could be a cause for infections. She reported it was okay to wash down the resident's bottom towards the catheter. She then hesitated and said she should not have done that, she should have wiped away from the catheter.</p> <p>Interview with the Director of Nursing, on 07/11/13 at 2:45 PM, confirmed the peri-care was to wash away from the insertion site of the catheter. She stated the urine collection bags are placed in a dignity bag, which would protect the urine collection bag. She then stated the urine collection bag would get contaminated when the dignity bag was removed to drain the urine. She stated the tubing and the urine collection bag on</p>	F 315	



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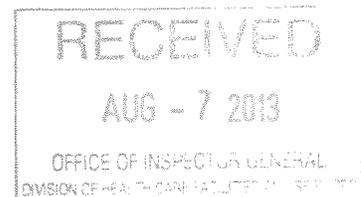
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F 315	Continued From page 3 the floor was a source for cross contamination. She confirmed the tubing should not be allowed on the floor or the bag to lay on top of the tubing in the floor.	F 315		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - 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 review of the facility's policy, it was determined the facility failed to ensure adequate disinfecting of the temperature probe for five (5) opportunities during the testing of food temperatures. In addition, one (1) of one (1) Cooks failed to ensure their hair was secured within the hairnet while taking food temperatures on the tray line.  The findings include:  Review of the facility's policy regarding Food Prep and Service/Distribution, not dated, revealed the policy interpretation and implementation identified the dietary staff shall wear hair restraints so the hair would not contact food.  Review of the Food Temperature Record utilized	F 371	<u>F371</u>  1. The Dietary Services Manager observed on 7/12/13 that all dietary staff had correctly applied their hairnet to cover all of hair and observed the temperature probe being disinfected between the testing of each food as required.  2. The Dietary Services Manager observed on 7/12/13 that all dietary staff had correctly applied their hairnet to cover all of hair and observed the temperature probe being disinfected between the testing of each food as required.  3. The Dietary Services Manager re-educated all Dietary employees on 7/9/13 related to the proper application and use of hairnets, to include covering all hair with hairnet. All dietary employees were also re-educated on 7/9/13 by the Dietary Services Manager regarding proper infection control procedure while testing food temperatures, to include disinfecting the thermometer probe between each food being tested.  4. The Dietary Services Manager will monitor proper use of hairnets and the proper procedure of testing food temperatures three (3) times per week for twelve (12) weeks. The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting, consisting of the Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until the	8/25/13



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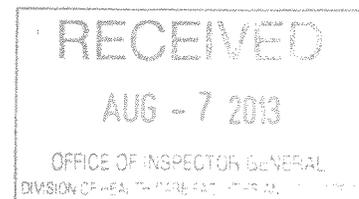
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F 371	<p>Continued From page 4</p> <p>to record food temperatures, revealed staff were to clean the temperature probe with alcohol swab between each item and list the food temperatures in ink.</p> <p>Observation, on 07/09/13 at 10:40 AM, revealed the Cook was at the tray line with her bangs and temple area of her hair line not contained within the hairnet utilized to secure her hair as she obtained food temperatures. The Cook did not disinfect the food temperature probe between each food as required. The Cook obtained the temperature for the bean and ham soup, then she removed the thermometer and placed it in the pureed carrots, then tested the sliced carrots, and then tested the pureed beans. The Cook dropped the thermometer and the dietary manager handed her a clean thermometer to continue to test the food temperatures. The Cook tested the temperature of the alternate meat, Swiss steak and then obtained the temperature of the peas and pearl onions without disinfecting the temperature probe. The Cook did not ensure the thermometer was disinfected in between each food item.</p> <p>Interview with the Cook, on 07/09/13 at 10:55 AM, revealed she was new to the facility and was not aware she was to disinfect the thermometer between each food. She stated she forgot to put her hairnet completely on when she had returned from her break, that all of her hair was to be contained in the hairnet.</p> <p>Interview with the Dietary Manager, on 07/09/13 at 11:45 AM, revealed the temperature probe was to be cleaned with the alcohol wipes between each food tested. She stated staff were to keep</p>	F 371	<p>team concludes that the issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance</p>	



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F 371	Continued From page 5 all of their hair covered with haimets.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH  The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.  A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.  The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Medication Shortages/Unavailable Medication, it was determined the facility failed to follow pharmacy procedures for two (2) of fifteen (15) sampled residents. (#4 and #8). The facility failed to follow procedures for re-ordering as needed pain medications for Resident #8. In addition, the facility failed to follow directions regarding "Do Not Crush" medications during the medication	F 425	<u>F425</u>  1. Resident #8's Hydrocodone was received by the facility on 7/9/2013. An audit of resident #8 medications by the Director of Nursing on 7/9/13 noted that all ordered medications were present in the facility. Resident #4 was assessed after receiving crushed medications with no abnormalities noted and doctor was notified on 7/10/13 of medications inappropriately crushed with no further orders being noted. On 7/10/13, the Director of Nursing observed resident #4 receiving medications, including the medications that could not be crushed, and noted none were crushed inappropriately.  2. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit all current residents' current medication orders to assure that all are present in the facility and available. This audit will be completed by 8/24/13. Any identified as not available will have physician notification and will be delivered stat by the pharmacy. The Director of Nursing and Assistant Director of Nursing will observe medication administration by 8/24/2013 to assure that no medications are given crushed that are not appropriate to be crushed. If any mediation is crushed that should not be crushed, the nurse will be stopped and the appropriate dose and appropriate form will be administered.  3. All licensed Nurses and Certified	8/25/13



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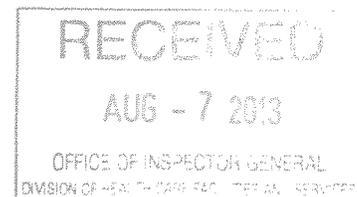
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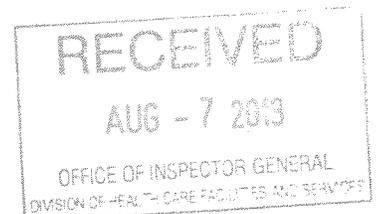
F 425	<p>Continued From page 6 pass observation, on 07/10/13, for Resident #4.</p> <p>The findings include:</p> <p>1. Review of the facility's policy regarding Medication Shortages/Unavailable Medications, revised on 05/01/10, revealed upon discovery that the facility had an inadequate supply of a medication, the facility should immediately initiate action to obtain the medication from the pharmacy. If a medication shortage was discovered after normal pharmacy hours a licensed facility nurse should obtain the medications from the emergency medication supply. If the ordered medication was not available, the nurse should call the Pharmacy's emergency answering service and request to speak with the Registered Pharmacist on duty to manage the plan of action. Actions may include emergency delivery; or use of an emergency (back up) Third Party Pharmacy.</p> <p>Interview with Resident #8, on 07/09/13 at 9:30 AM, revealed he/she had been waiting for his/her pain medication Hydrocodone, which he/she took periodically for pain, and stated they had reordered it last night. The resident stated he/she needed the medication and appeared anxious. LPN #2 was observed to enter the room, and gave Resident #8 Tylenol for pain, and Xanax for anxiety. LPN #2 told the resident the Hydrocodone had been ordered, and the Tylenol and Xanax should help until it arrived. In addition, the LPN stated the resident had been assessed for pain, and the Pharmacy called to check on the status of the medication, which had just been changed to deliver STAT or immediately, instead of routine.</p>	F 425	<p>Medication Assistants will be re-educated on medication ordering, refill, pulling refill labels, stat delivery and not crushing extended release medications by 8/24/13. This re-education will be completed by the Director of Nursing, Assistant Director of Nursing or Unit Manager with no licensed Nurses or Certified Medication Assistants working past 8/24/13 without having received this re-education.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will audit ten (10) resident's medications and physician orders per week for twelve (12) weeks to assure that medications are re-ordered timely. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe medication pass weekly for twelve (12) weeks to assure medications that are not intended to be crushed are not crushed. The results of the audits will be reviewed at the monthly Quality Assurance Committee meeting, consisting of Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until the team concludes that the issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	
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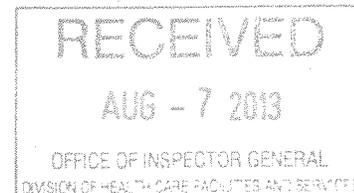
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F 425	Continued From page 7  Further observations at 1:00 PM, 2:00 PM, and 3:30 PM, revealed the resident was involved in activities and stated he/she was feeling better; however, the medication had not arrived.  Interview with LPN #1, on 07/10/13 at 4:00 PM, revealed the medication should be ordered when there are 5 or 6 tablets left. The LPN stated the procedure was to pull the tab, and fax to pharmacy, which usually took 1-2 days to return. If the medication was in the Emergency Drug Kit (EDK), they would give it, and call the Pharmacy and have them send the medication routinely. In resident #8's case, the medication was a narcotic, and the dosage of the Hydrocodone was not listed in the EDK. Also, there would have to be a new prescription ordered by the physician in order to use a different dosage from the EDK.  Interview with the Director of Nursing (DON), on 07/11/13 at 1:00 PM, revealed when there are 1-2 tablets left, there was a pull tab that was put on a form and faxed to pharmacy, and stated if the night shift knows there was only one tablet left, they should call the pharmacy. If they are having trouble getting the medication, they should call DON. The DON stated if the medication was a narcotic and was in the EDK, the staff should have called and verified the dose to be given. The DON stated she did not know if there was a back up pharmacy, because she was new to the position. The DON stated Resident #8 was given the medication when it arrived from pharmacy around 4:15 PM on 07/09/13. Review of the Medication Administration Record (MAR) revealed the medication was given at 5:00 PM, seven and a half (7.5) hours after the Tylenol was	F 425			



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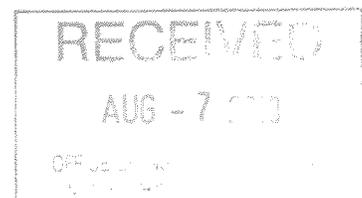
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NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143	
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F 425	<p>Continued From page 8 administered</p> <p>Interview with the Pharmacist, on 07/11/13 at 2:25 PM, revealed the resident had a prescription for Hydrocodone and stated, on 07/09/13, an order had been placed for reorder, which was filled at 3:15 PM, on 07/09/13, and delivered at 4:15 PM. The Pharmacist stated that unless indicated as STAT, the medication would be sent with the normal delivery, and would have been sent around midnight of that day. The Pharmacist also stated that any medication should be estimated before three days of the last dose and ordered at that time. The Pharmacist stated that this was not the case here, and revealed if the facility called and ordered the medication STAT, it would have been delivered within 3-4 hours. The medication Hydrocodone was not ordered to be sent STAT until 2:30 PM, on 7/9/13.</p> <p>2. Review of the facility's policy for Long Term Care Facilities Receiving Pharmacy Products and Services from Pharmacy with a revision date of 05/01/10, revealed the facility staff should crush oral medications only in accordance with Pharmacy guidelines as set forth in Appendix 16: Oral Dosage Forms that Should Not Be Crushed and/or facility policy. The Oral Dosage Forms that Should Not Be Crushed identified Isosorbide SR as a do not crush medication.</p> <p>Review of the Physician Orders for Resident #4, revealed it was documented on the order, May crush medications and open capsules if appropriate and not contraindicated.</p> <p>Observation during the medication pass, on 07/10/13 at 7:20 AM, revealed LPN #1 crushed</p>	F 425	



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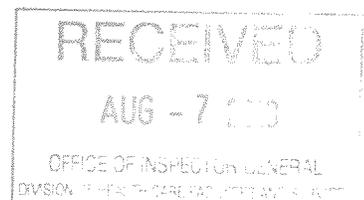
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F 425	<p>Continued From page 9</p> <p>one tablet of Isosorbide ER (extended release) 60 mg. and mixed it in pudding prior to administration for Resident #4.</p> <p>Telephone interview with the Pharmacist, on 07/10/13 at 9:40 AM, revealed Isosorbide MN ER 60 mg. tablet was recommended to be given with food; however, the tablets were not to be crushed or chewed, and it was not a good idea.</p> <p>Interview with LPN #1, on 07/10/13 at 12:35 PM, revealed Resident #4 would spit the medications out unless they were crushed. She stated she did not realize the Isosorbide was an extended release tablet. She stated she should not have crushed the tablet. She stated she had not notified the physician of the patient refusing to take the medications whole and had not requested an order for the Isosorbide to be in a liquid form.</p> <p>Interview with the Director of Nursing, on 07/11/13 at 1:15 PM, revealed extended release tablets identified on the Do Not Crush list were not to be crushed or if capsules were not to be opened prior to administration.</p>	F 425	<p><u>F441</u></p> <ol style="list-style-type: none"> <li>The Director of Nursing observed proper hand hygiene procedures during medication pass for residents #4 and #9 on 7/11/13. The Director of Nursing observed the foley catheter drainage bag and tubing of resident #5 up off floor and in a dignity bag on 7/10/13.</li> <li>The Director of Nursing, Assistant Director of Nursing or Unit Manager observed the foley catheter drainage bag and tubing of all residents with foley catheters having catheter drainage bag and tubing up off floor and drainage bags in a dignity bag on 7/10/13. The Director of Nursing, Assistant Director of Nursing or Unit Manager observed proper hand hygiene procedures during medication pass for all residents on 7/30/2013 and 7/31/2013.</li> <li>All nursing staff will be re-educated on proper infection control procedures regarding positioning of foley catheter bags and tubing by 8/24/13. All nurses and certified medication aides will be re-educated on proper hand hygiene during medication pass by 8/24/13. This re-education will be provided by the Director of Nursing, Assistant Director of Nursing or Unit Manager, with no nursing staff working after 8/24/2013 without having received this re-education.</li> <li>The Director of Nursing, Assistant Director of</li> </ol>
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>	F 441	<p>8/25/13</p>



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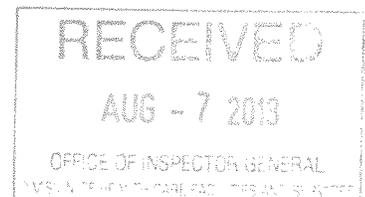
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F 441	<p>Continued From page 10</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents 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> <p>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, it was determined the facility failed to follow their hand hygiene procedures for two (2) of fifteen (15) sampled residents, (Resident #4 and #9). The staff did not practice hand hygiene during medication pass for Resident #4 and Resident #9. In addition, the facility failed to ensure the indwelling catheter collection bag and tubing was</p>	F 441	<p>Nursing or Unit Manager will observe medication administration for proper hand hygiene weekly for twelve (12) weeks. The Director of Nursing, Assistant Director of Nursing or Unit Manager will observe residents with foley catheters five (5) times per week for twelve (12) weeks to ensure catheter bags and tubing are off floor according to proper infection control guidelines. The results of the audits will be reviewed monthly by the Quality Assurance Committee, consisting of the Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until the team concludes that the issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.</p>	



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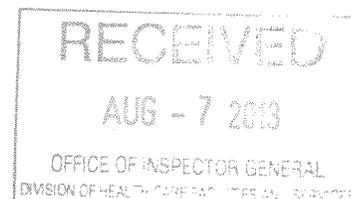
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F 441	<p>Continued From page 11</p> <p>not allowed to drag the floor for one (1) of fifteen (15) sampled residents. (Resident #5).</p> <p>The findings include:</p> <p>1. The facility did not provide a policy regarding indwelling catheter and closed drainage systems. However, the facility utilized the Lippincott Manual as a guidance to staff.</p> <p>Review of the Lippincott Manual of Nursing Practice, Eight Edition, page 757, Management of the Patient with an Indwelling Catheter and Closed Drainage System stated to keep the drainage bag off of the floor.</p> <p>Observation of Resident #5, on 07/09/13 at 2:00 PM through 2:28 PM, while the resident sat in the Front Lobby revealed the indwelling catheter collection bag sat on the floor. Continued observations, on 07/09/13 at 3:15 PM, of the resident revealed he/she sat at a table on the front porch with the indwelling catheter bag attached to the wheelchair with the tubing attached to the urine collection bag lying on the floor with the drainage bag on top of the tubing.</p> <p>Observation of Resident #5, on 7/10/13 at 10:18 AM, revealed the resident sat near the bird cage in the lobby area with the indwelling catheter bag lying on the tubing that was lying on the floor.</p> <p>Review of Resident #5's clinical record revealed the facility admitted the resident on 05/03/12 with diagnoses of Renal Insufficiency, Neurogenic Bladder and Urinary Tract Infection.</p> <p>Interview, on 07/11/13 at 2:35 PM, with CNA #2</p>	F 441		



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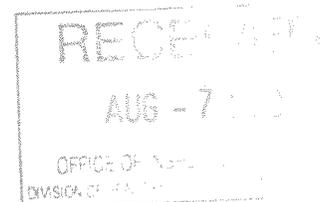
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F 441	<p>Continued From page 12</p> <p>revealed the urine collection bags and catheter tubing in the floor could be a cause for infections and the urine collection bag should be kept off the floor and hung high enough on the wheelchair so the tubing and bag do not touch the floor.</p> <p>Interview, with the Director of Nursing, on 07/11/13 at 2:45 PM, reported the urine collection bags are placed in a dignity bag, which would protect the urine collection bag. She did report the urine collection bag would get contaminated when the dignity bag was removed to drain the urine. She confirmed the tubing should not be allowed in the floor or the bag to lay on top of the tubing in the floor. She stated the tubing and the urine collection bag on the floor was a source for cross contamination.</p> <p>2. Review of the facility's policy regarding General Dose Preparation and Medication Administration revealed prior to preparing or administering medications, authorized and competent facility staff should follow the facility's infection control policy regarding handwashing.</p> <p>Review of the Hand Hygiene policy, revealed the facility would follow the Centers for Disease Control (CDC) guidelines for hand hygiene. The center would use standard precautions to include handwashing whether or not gloves were worn, for blood/body fluids, secretions, excretions or contaminated items, when gloves were removed, between resident contact, between tasks and procedures on the same resident to prevent cross contamination of different body sites.</p> <p>Observation during the medication pass on</p>	F 441		



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F 441	<p>Continued From page 13</p> <p>07/10/13 at 7:17 AM, revealed LPN #1 failed to wash or disinfect her hands after administration of medications for Resident #9. LPN#1 began to prepare the medications for Resident #4 without disinfecting her hands. She opened several medications for Resident #4 and dropped Resident #4's Lisinopril on the floor. She picked the tablet off of the floor and threw it away; then replaced the pill with another one. She failed to disinfect her hands after retrieving the medication from the floor. LPN #1 continued to open two more pills, crushed them and mixed them in pudding for administration to Resident #4. LPN #1 did not disinfect her hands prior to administering the medications to Resident #4.</p> <p>Interview with LPN #1, on 07/10/13 at 12:35 PM, revealed she was to disinfect her hands before and after contact with each resident. She could not explain why she did not disinfect or wash her hands as required.</p> <p>Interview with the Director of Nursing, on 07/11/13 at 1:45 PM, revealed staff were to wash/disinfect their hands between every resident contact. She stated the floor was dirty and the nurse should have washed or disinfected her hands after disposing the dropped medication.</p>	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967, 1991</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (000)</p> <p>SMOKE COMPARTMENTS: Four (4) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system; hydraulically designed.</p> <p>GENERATOR: Type II, 55 KW generator; fuel source is propane gas; installed new in 2009.</p> <p>A standard Life Safety Code survey was conducted on 07/10/13. Hardinsburg Nursing and Rehabilitation was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty three (63) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings that follow demonstrate</p>	K 000	<p>Submission of this plan of correction is not a legal admission that a deficiency exists or that this statement of deficiency was correctly cited, and is also not to be construed as an admission of interest against the facility, the Administrator or any employees, agents, or other individuals who draft or may be discussed in this response and plan of correction. In addition, preparation of this plan of correction does not constitute an admission or agreement of any kind by the facility of the truth of any facts alleged or see the correctness of any allegation by the survey agency. Accordingly, the facility has prepared and submitted this plan of correction prior to the resolution of any appeal which may be filed solely because of the requirements under state and federal law that mandate submission of a plan of correction within (10) days of the survey as a condition to participate in Title 18, and Title 19 programs. The submission of the plan of correction within this timeframe should in no way be construed or considered as an agreement with the allegations of noncompliance or admissions by the facility. This plan of correction constitutes a written allegation of submission of substantial compliance with Federal Medicare Requirements.</p> <p><b>K018</b></p> <ol style="list-style-type: none"> <li>1. Fire resistant strips to prevent gaps in corridor doors will be installed by 8/24/13 to door frames of rooms 10, 13, 19, 20, 24 by the Maintenance Director.</li> <li>2. All interior corridor doors will be checked to ensure there is no gap and are resistant to the passage of smoke. Any identified will be corrected by 8/24/2013.</li> <li>3. The Maintenance Director will be re-educated by the Administrator</li> </ol>	8/25/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Cheri Ramsey*

TITLE

NHA

(X9) DATE

8/5/13

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.

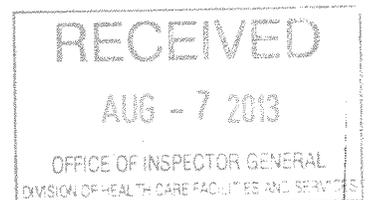
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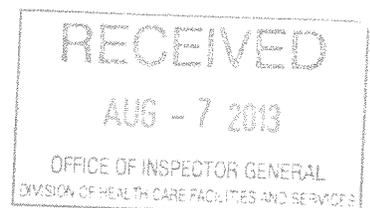
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)  Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	by 8/24/2013 regarding the need for all interior corridor doors to be without gaps that would not resist passage of smoke.	
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1½ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure doors protecting corridor openings were constructed to resist the passage of smoke in accordance with NFPA standards. The deficiency had the	K 018	4. The Maintenance Director will audit all interior corridor doors to assure they prevent the passage of smoke. This audit will be completed on a monthly basis. The results of the audits will be reviewed monthly by the Quality Assurance Committee, consisting of Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until team concludes issue is resolved. If at any time concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.	8/25/13



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K 018	<p>Continued From page 2</p> <p>potential to affect two (2) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty three (63) beds with a census of fifty three (53) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/10/13 between 10:40 AM and 3:00 PM, with the Administrator in Training revealed the corridor doors to room's #10, 13, 19, 20, and 24 had a greater than one half inch gap from the door stop and would not resist the passage of smoke.</p> <p>Interview, on 07/10/13 between 10:40 AM and 3:00 PM, with the Administrator in Training revealed he was not aware the doors would not resist the passage of smoke.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>18.3.6.3.1* Doors protecting corridor openings shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>18.3.6.3.2</p>	K 018		



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**K 018** Continued From page 3  
Doors shall be provided with positive latching hardware. Roller latches shall be prohibited. Exception: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  
18.3.6.3.3\*  
Hold-open devices that release when the door is pushed or pulled shall be permitted.

K 018

**K025**

1. One half inch drywall will be installed on the attic smoke barriers on the lobby side of the East Hall and West hall so that both sides have appropriate smoke barrier. This will be completed by the Maintenance Director by 8/24/13.
2. All smoke barriers in the attic will be examined by the Maintenance Director to ensure that both sides of the barrier will have drywall installed by 8/24/13. Any identified concerns will be corrected by 8/24/2013.
3. The Maintenance Director will re-educated by 8/24/2013 by the Administrator on the NFPA code for smoke barriers including the need for both sides of smoke barriers in the attic to have drywall installed.
4. The Maintenance Director will audit all smoke barriers on a monthly for three (3) months to assure all smoke barriers provide at least one half hour fire resistance rating. The results of the audits will be reviewed monthly by the Quality Assurance Committee, consisting of Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until the team concludes that the issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent

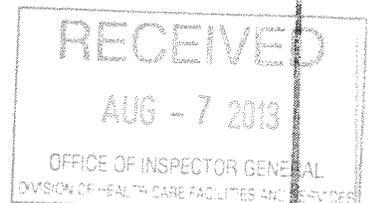
8/25/13

**K 025**  
SS=E  
NFPA 101 LIFE SAFETY CODE STANDARD  
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems.  
19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025

This STANDARD is not met as evidenced by:  
Based on observations and interview, it was determined the facility failed to maintain smoke barriers in accordance with NFPA standards. The deficiency had the potential to affect three (3) of four (4) smoke compartments, residents, staff and visitors. The facility is certified for sixty three (63) beds with a census of fifty three (53) on the day of the survey.

The findings include:



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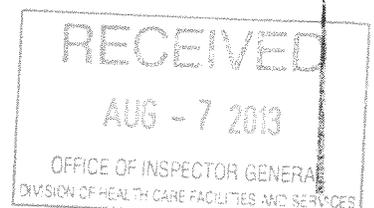
PRINTED: 07/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185302	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  07/10/2013
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NAME OF PROVIDER OR SUPPLIER  HARDINBURG NURSING AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 101 FAIRGROUNDS ROAD HARDINBURG, KY 40143
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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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K 025	Continued From page 4  Observation, on 07/10/13 at 10:30 AM, with the Administrator in Training revealed the smoke barriers located in the attic on the lobby side of the East Hall and the West Hall only had one layer of half inch drywall installed on one side of the smoke barrier leaving the framing studs exposed on the opposite side of the smoke barrier.  Interview, on 07/10/13 at 10:30 AM, with the Administrator in Training revealed he was not aware the smoke barriers only had drywall on one side of the framing.  Reference: NFPA 101 (2000 Edition).  Reference: NFPA 101 (2000 edition) 19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour. Exception No. 1: Where an atrium is used, smoke barriers shall be permitted to terminate at an atrium wall constructed in accordance with Exception No. 2 to 8.2.5.6(1). Not less than two separate smoke compartments shall be provided on each floor. Exception No. 2*: Dampers shall not be required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems where an approved, supervised automatic sprinkler system in accordance with 19.3.5.3 has been provided for smoke compartments adjacent to the smoke barrier.  8.3 SMOKE BARRIERS	K 025	upon the root cause to ensure ongoing compliance.	
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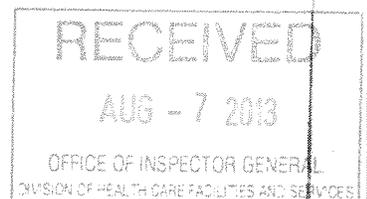
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K 025	Continued From page 5 8.3.1* General. Where required by Chapters 12 through 42, smoke barriers shall be provided to subdivide building spaces for the purpose of restricting the movement of smoke. 8.3.2* Continuity. Smoke barriers required by this Code shall be continuous from an outside wall to an outside wall, from a floor to a floor, or from a smoke barrier to a smoke barrier or a combination thereof. Such barriers shall be continuous through all concealed spaces, such as those found above a ceiling, including interstitial spaces. Exception: A smoke barrier required for an occupied space below an interstitial space shall not be required to extend through the interstitial space, provided that the construction assembly forming the bottom of the interstitial space provides resistance to the passage of smoke equal to that provided by the smoke barrier.  18.3.7* Subdivision of Building Spaces. 18.3.7.1 Buildings containing health care facilities shall be subdivided by smoke barriers as follows: (1) To divide every story used by inpatients for sleeping or treatment into not less than two smoke compartments (2) To divide every story having an occupant load of 50 or more persons, regardless of use, into not less than two smoke compartments (3) To limit the size of each smoke compartment required by (1) and (2) to an area not exceeding 22,500 ft <sup>2</sup> (2100 m <sup>2</sup> ) Exception: The area of an atrium separated in accordance with 8.2.5.6 shall not be limited in	K 025			

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K 025	Continued From page 6 size. (4) To limit the travel distance from any point to reach a door in the required smoke barrier to a distance not exceeding 200 ft (60 m). Exception No. 1: Stories that do not contain a health care occupancy, located totally above the health care occupancy. Exception No. 2: Areas that do not contain a health care occupancy and that are separated from the health care occupancy by a fire barrier complying with 7.2.4.3. Exception No. 3: Stories that do not contain health care occupancies and that are more than one story below the health care occupancy. Exception No. 4: Open-air parking structures protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.  8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed	K 025			



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K 025 Continued From page 7 for the specific purpose.  
(c) Where designs take transmission of vibration into consideration, any vibration isolation shall  
1. Be made on either side of the smoke barrier, or  
2. Be made by an approved device designed for the specific purpose.

K 025

K029  
1. Door stops were removed from Janitor's closet, kitchen and dry storage room doors by Maintenance Director on 7/30/13. An observation by the Administrator on 8/1/13 noted that the doors to the Janitor's closet, kitchen and the dry storage room to be closed and not propped open.

8/25/13

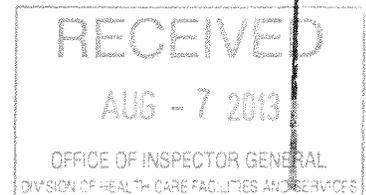
19.3.7.3 Any required smoke barrier shall be constructed in accordance with Section 8.3 and shall have a fire resistance rating of not less than 1/2 hour.

K 029 SS=D NFPA 101 LIFE SAFETY CODE STANDARD  
One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1

K 029

2. All interior doors will be checked by the Maintenance Director and the Administrator by 8/24/13 to ensure that no other doors had door stops on them. None were noted.  
3. All staff will be re-educated regarding inappropriate use of door stops or anything that would hold an interior door open by 8/24/13 by the Administrator or Maintenance Director.  
4. The Maintenance Director will audit interior doors weekly for twelve (12) weeks to assure no interior door is propped open. The results of the audits will be reviewed at least monthly by the Quality Assurance Committee, consisting of Administrator, Director of Nursing, Maintenance Director, Environmental Services Director, and by the Medical Director at least quarterly, until team concludes issue is resolved. If at anytime concerns are identified, the Quality Assurance Committee will convene to analyze and implement further measures dependent upon the root cause to ensure ongoing compliance.

This STANDARD is not met as evidenced by:  
Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiency had the potential to affect two (2) of four (4) smoke compartments, patients, staff and visitors. The facility is certified for sixty three (63) beds with a census of fifty three (53) on the day



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K 029	<p>Continued From page 8 of the survey. The facility failed to maintain self-closing doors protecting hazardous areas.</p> <p>The findings include:</p> <p>Observation, on 07/10/13 between 10:40 AM and 3:00 PM, with the Administrator in Training revealed unapproved door stops being used to hold open the doors to the Janitor Closet by Therapy, the Kitchen, and the Dry Storage Room. The doors are required to be self-closing and were equipped with a self-closing device.</p> <p>Interview, on 07/10/13 between 10:40 AM and 3:00 PM, with the Administrator in Training revealed he was not aware staff used the door stops on these doors.</p> <p>8.4.1.3 Doors in barriers required to have a fire resistance rating shall have a 3/4-hour fire protection rating and shall be self-closing or automatic-closing in accordance with 7.2.1.8.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated</p>	K 029		

