

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

PRINTED: 05/19/20  
FORM APPROVAL  
OMB NO. 0938-03

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185287</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>R</b> <b>05/19/2014</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HARRODSBURG HEALTH &amp; REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>853 LEXINGTON ROAD</b> <b>HARRODSBURG, KY 40330</b>
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{F 000} INITIAL COMMENTS

An offsite revisit was conducted and based on the acceptable Plan of Correction (POC) the facility was deemed to be in compliance as alleged on 05/09/14.

{F 000}

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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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  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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F 000 INITIAL COMMENTS

Amended

A Recertification Survey was initiated on 04/22/14 and concluded on 04/24/14. Deficiencies were cited with the highest Scope and Severity of a "D".

F 225 SS=D 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS

The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.

The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported

F 000 This Plan of Correction is the center's credible allegation of compliance.

Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

F 225 F225 5/9/2014

A written investigation was completed related to Resident #8 and the allegation of abuse was unsubstantiated.

The staff members were counseled and reeducated related to the failure to implement the abuse policy and procedure regarding immediate suspension of staff, notification to the direct supervisor and initiating an investigation completed by 5/1/2014.

Abuse education and investigation tools which includes a staff suspension investigation form were placed at each facility nurses station accessible to staff. The education was completed by 5/9/2014.

The facility will implement the policy and procedure for abuse for all future allegations of any type of abuse.

All facility staff will be inserviced on the location of the abuse education and tools and the abuse policy and procedure, to include immediate reporting, suspension of staff, notification to the appropriate state agencies and initiating and conducting a

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Sharon Peterson</i>	TITLE Administrator	(X6) DATE 5-12-2014
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F 225	<p>Continued From page 1</p> <p>to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure all allegations of abuse were reported immediately to the Administrator of the facility and to other officials in accordance with State law and failed to investigate allegations to prevent further potential abuse for one (1) of twenty-one (21) sampled residents ( Resident #8 ).</p> <p>Resident #8 reported an allegation of verbal abuse to staff on 04/19/14; however, the facility's Administrator was not notified of the allegation until 04/21/14, allowing the alleged perpetrator, Licensed Practical Nurse (LPN) #2, to work after Resident #8's report, caring for residents.</p> <p>The findings include:</p> <p>Review of the facility's policy, titled, "Abuse, Neglect and Misappropriation", revised March 2013, revealed verbal, sexual, physical, and mental abuse of residents were prohibited. The policy stated all allegations of abuse would be investigated and reported to the appropriate agencies. Continued review of the policy revealed the Administrator or designee would make all reasonable efforts to investigate and</p>	F 225	<p>thorough, written investigation completed by 5/9/2014.</p> <p>Education on the abuse policy and procedure for reporting will be repeated by Staff Development Coordinator and/or designee in three months. New hires will be educated on the abuse policy and procedures during orientation.</p> <p>All alert and oriented residents with a BIMS of 8 or greater were interviewed on 4/21/2014 and 4/25/2014 by the Social Service Director related to abuse and care issues regarding staff.</p> <p>Each week the Social Service Director and/or Activity Director and/or designee will randomly interview a minimum of 10 alert and oriented residents related to abuse and care issues regarding staff for 3 months.</p> <p>The Activity Director and/or designee will discuss in resident council any concerns the residents have related to abuse and care issues regarding staff for 3 months.</p> <p>The ED and/or designee will monitor and investigation concerns and track, trend and report all interview identified concerns to the QA meeting for three months and then quarterly thereafter. The committee will implement any changes needed to sustain compliance.</p>	

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F 225 Continued From page 2  
address alleged reports, concerns and grievances. The policy indicated all allegations of abuse were to be reported to the Charge Nurse, who would immediately report the allegation to the Administrator, Director of Nursing (DON), and/or Abuse Coordinator. Policy review revealed the Charge Nurse was to ensure the suspected perpetrator was immediately removed from resident care areas. Review of the policy revealed the person(s) who observed the incident would immediately report it and provide a written statement that included the name of the resident, date and time the incident occurred, where it occurred, staff involved and a description of what occurred. Continued review revealed investigations were to be kept confidential.

Review of Resident #8's medical record revealed the facility admitted the resident on 04/06/11, with diagnosis which included Schizophrenia and Diabetes Mellitus, Type Two. Review of the Quarterly Minimum Data Set (MDS) Assessment revealed the facility assessed Resident #8 to have a Brief Interview for Mental Status (BIMS) score of thirteen (13), indicating the resident was cognitively intact. Review of a Nurse's Note, dated 04/19/14 at 7:00 PM, revealed it stated Resident #8 was heard screaming from the middle hallway. The Note documented Resident #8 had stated, "you people" were not "going to drive me crazy" and the one (1) nurse "was not going to talk to me like I'm stupid." Continued review of the Note revealed Resident #8 was "so angry", he/she was "shaking" at the desk. According to the Note, staff called the Emergency Medical Services (EMS) to have Resident #8 transported to the Emergency Room (ER). Further review of the Nurse's Notes revealed the facility was contacted by the ER Nurse on

F 225 Criminal Records Checks (CRC) and Nurse Aide Abuse Registry Checks (NAARCs) have been conducted for all identified states in which the identified employees have lived and/or worked. An audit of all active employees has been conducted to ensure that CRCs and NAARCs have been conducted for all identified states in which the employee has lived and/or worked was completed by 5/9/2014.

All potential hires will have a CRC and a NAARC conducted for all identified states in which the employee has lived and/or worked.

The ED and/or designee will audit all new hire personnel records monthly for three months.

The ED and/or designee will report the findings of the audits in the QA meeting monthly for three months and as needed thereafter.

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F 225 Continued From page 3

04/20/14 at 11:30 PM, who reported Resident #8 was being sent back to the facility due to the resident being quiet with no behaviors during his/her time there. Review of the Social Service (SS) Notes, dated 4/20/14 at 11:20, with no specification between AM or PM, revealed a "male nurse" informed Resident #8 he was having a private conversation when the resident was attempting to say something to the staff member. Review of the SS Note revealed the male nurse was "hateful" and Resident #8 had stated, "I thought he was my friend." The SS Note revealed Resident #8 appeared to have hurt feelings as a result of this and had possibly responded with "verbal aggression."

Interview with Resident #8 on 04/22/14 at 4:40 PM, revealed Licensed Practical Nurse (LPN) #2 was talking to the Quality of Life Assistant on 04/19/14. Resident #8 reported he/she was going to ask the Quality of Life Assistant a question when LPN #2 stated to him/her, "this is a private conversation, you're not wanted here." Resident #8 stated he/she left after the comment was made and went and sat down in a chair. According to Resident #8, the more he/she thought about the statement made by LPN #2, the more he/she felt "awful" about it. Resident #8 stated the thought of the statement built up inside of him/her until he/she voiced concern later that night. Resident #8 stated he/she told the "head nurse" about the incident; however, could not remember her name. He/She stated he told the "head nurse", LPN #2 had treated him/her "like a dog". Resident #8 reported he/she did not know why he/she was sent out to the hospital. Resident #8 LPN #2 was allowed to work the next day.

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| Interview with the Quality of Life Assistant on 04/23/14 at 9:40 AM, revealed she was talking to LPN #2, sometime on 04/19/14, regarding storage of some of the residents' candy they had received earlier that day. She reported her back was to Resident #8 and, LPN #2 noticed the resident listening to their conversation. The Quality of Life Assistant stated LPN #2 informed Resident #8, "we're having a private conversation, if you don't mind." She reported the resident did not seem to be upset at the time.

| Interview with LPN #2 on 04/23/14, at 8:19 PM, revealed he was discussing resident care with another nurse and Resident #8 was standing between the two (2) of them. He stated he told Resident #8, "this is a private conversation". LPN #2 stated that was all he said to the resident and Resident #8 stood there for another two (2) or three (3) seconds before he/she left. He reported the resident did not say anything to him. According to LPN #2, he had worked his shift 04/20/14.

| Interview with Certified Nursing Assistant (CNA) #10 on 04/23/14 at 7:50 PM, revealed she was passing out snacks on the night of 04/19/14, when she heard Resident #8 "yell" at LPN #3 that LPN #2 had talked to him/her "like a dog". She stated Resident #8's statement would be defined as verbal abuse of the resident by LPN #2. CNA #10 stated it should have been investigated. CNA #10 indicated she should have reported this incident to the Charge Nurse and/or her Supervisor; however, had not.

| Interview with the Assistant Director of Nursing (ADON) on 04/24/14 at 11:43 AM, revealed she had witnessed the incident, on 04/19/14. She

F 225

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F 225	Continued From page 5 stated LPN #2 stated to the resident, "this was a private conversation, can you move on". The ADON stated Resident #8 was calm during the day; however, later that evening, the resident started yelling and was hitting the nurse's desk and stated, he/she "was not going to be talked to like" he/she "was stupid." She reported Resident #8 mentioned LPN #2 by name and the nurse had already left work for the evening. The ADON stated the amount of "rage" Resident #8 had appeared as though it had built up for some time. She reported Resident #8 was "shaking", but was able to calm down. According to the ADON, she sent Resident #8 to the hospital between the hours of 10:30 PM and 11:00 PM on 04/19/14. She stated she had gone home for the evening, and Resident #8 returned to the facility sometime during the morning of 04/20/14. She reported LPN #2 worked on 04/20/14, as his schedule was to work weekends. The ADON stated she did not report the incident because at the time, she had not viewed Resident #8's statements as verbal abuse by LPN #2; however, now after looking back on the incident and how the resident felt, it probably should have been reported as per the policy.  Interview with LPN #3 on 04/24/14 at 1:37 PM, revealed the night of 04/19/14, Resident #8 told her LPN #2 was not going to treat him/her "like that" and indicated the resident stated the LPN treated him/her "like a dog". She reported Resident #8 was normally happy and she had never seen him/her "go off". LPN #3 stated Resident #8 was yelling and this behavior had not lasted very long. She reported Resident #8 went to his/her room and cried. According to LPN #3, she felt the facility should have started an investigation, and thought an investigation was	F 225			

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F 225 Continued From page 6  
started since the ADON had witnessed the incident. She stated the ADON would be the person she reported the incident to and indicated she had not felt this necessary as the ADON was witness to the incident.

Interview with the SS Director on 04/24/14 at 3:23 PM, revealed she had received a text from the Administrator on 04/20/14, which stated Resident #8 had experienced an "explosive reaction" to staff and there needed to be an updated care plan. She reported when she talked to Resident #8 on 04/20/14, regarding the incident which occurred on 04/19/14, the resident reported he/she was at the nurse's station waiting to talk to the Quality of Life Assistant and LPN #2. The SS Director stated Resident #8 told her LPN #2 stated to him/her, "we are having a private conversation, go on". She reported Resident #8 had indicated to her this had hurt his/her feelings. According to the SS Director, she was at the facility to assess Resident #8 for his/her behavior, and did not probe any further regarding Resident #8's statement to her. She reported at the time she did not think the incident described by Resident #8 was abuse, and staff did not tell her about the alleged verbal abuse. She reported she had limited information regarding this incident.

Interview with the ER Nurse on 04/24/14 at 3:15 PM, revealed Resident #8 was calm and had not exhibited any behaviors when he/she arrived at the hospital ER. She reported she asked Resident #8 open ended questions to find out if the resident knew why he/she was at the hospital. The ER Nurse stated Resident #8 told her, LPN #2 said to him/her, "what do you want, this is a private conversation, go down the hallway". She

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F 225 | Continued From page 7  
 | reported she did not report Resident #8's statement to the facility because by law the hospital was expected to report the incident to State Agencies. She indicated she contacted the Ombudsman and Adult Protective Services (APS).  
 | Interview with the Administrator on 04/24/14 at 2:25 PM, revealed she heard about the Resident #8's behavior from the ADON, who told her the resident was upset over a nurse and had an outburst at the nurse's station because of this. She reported she thought she was dealing with Resident #8's behavior, therefore, asked the SS Director to inquire about the resident's behavior. The Administrator stated the SS Director talked to Resident #8 on 04/20/14. Continued interview with the Administrator revealed when speaking with the ADON later, she had reported the hospital contacted the Ombudsman, who had come to the facility on 04/20/14, to speak with Resident #8. She reported she called the hospital, and received a return call on 04/21/14 at 9:30 AM. The Administrator stated she was informed Resident #8 told hospital staff he/she was verbally abused by LPN #2. She reported she immediately initiated her investigation into the alleged verbal abuse and stated the alleged perpetrator, LPN #2 was suspended immediately. The Administrator stated it was her expectation staff would immediately report any alleged abuse to her. She stated Resident #8's statement, "LPN #2 treats me like a dog", should have been reported to her, the DON, or to the staff person's direct Supervisor. She indicated LPN #2 should have been suspended pending the investigation, and if there was truth to the allegation, there would have been potential for harm.

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F 280 Continued From page 8  
F 280 483.20(d)(3), 483.10(k)(2) RIGHT TO  
SS=D PARTICIPATE PLANNING CARE-REVISE CP

The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.

A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to ensure the Comprehensive Care Plan was revised for one (1) of twenty-one (21) sampled residents (Resident #4).

Observation of a skin assessment on 04/22/14, revealed the resident had an abrasion to the right buttock and redness to the scrotum which had a treatment ordered; however, there was no Care Plan related to the areas of skin breakdown. In

F 280 *This Plan of Correction is the center's credible allegation of compliance.*  
F 280 *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

F280 5/9/2014  
The UM updated and revised Resident #4 care plan on 4/25/2014.

An audit was conducted on all current care plans to ensure that the care plan reflected the current needs of every resident in the facility. This was completed by 5/9/2014 by the Unit Managers, Case Managers, DNS and MDS Coordinator.

New orders will be checked Monday through Friday by Unit Managers and/or designee to ensure the care plans are revised accordingly to reflect current resident needs. All new admission and readmission charts will be reviewed and revised and updated as necessary within 24 hours by Unit Managers and/or designee.

A random audit of 50% of the monthly new admissions and/or readmission charts will be conducted by the DNS and/or designee monthly for three months.

An education was implemented by the Staff Development Coordinator for all licensed staff, IDT team and therapy on

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  04/24/2014
NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330		
(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 280	<p>Continued From page 9</p> <p>addition, during the skin assessment two (2) new Stage I areas were identified including a Stage I Pressure Ulcer to the right hip and a Stage I Pressure Ulcer to the right outer foot; however, as of 04/24/14, the Care Plan had not been revised related to these new areas of skin breakdown.</p> <p>Also, Resident #4's Care Plan included interventions for fall mats and a sensor alarm; however, interviews revealed the resident no longer needed/ or utilized these devices.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Using the Care Plan", revised 2006, revealed changes in the resident's condition were to be reported to the Minimum Data Set (MDS) Coordinator so a review of the resident's assessment and Care Plan could be made. Further review revealed documentation must be consistent with the resident's Care Plan.</p> <p>Review of the facility's policy titled, "Care Plans-Comprehensive", revised October 2010, revealed each residents' Comprehensive Care Plan was designed to incorporate identified problem areas, incorporate risk factors associated with identified problems, aid in preventing or reducing declines in the resident's functional status and/or functional level, and reflect treatment goals, timetables and objectives in measurable outcomes.</p> <p>1. Review of Resident #4's medical record revealed diagnoses which included Dementia, Arthritis, Psychotic Disorder, and Pressure Ulcers. Review of the Quarterly MDS Assessment dated 03/24/14, revealed the facility</p>	F 280	<p>revising and following care plans. The education was completed by 5/9/2014.</p> <p>Education for all licensed staff, IDT team and therapy on revising and following care plans will be repeated in three months by the Staff Development Coordinator.</p> <p>The DNS/ED and/or designee will bring any concerns to the QA meeting for three months. The committee will implement any changes needed to sustain compliance.</p>	

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F 280	<p>Continued From page 10</p> <p>assessed the resident as having both short and long term memory loss and as having a Stage 2 Pressure Ulcer. Review of the Physician's Orders dated 04/15/14 revealed orders for Silvadene to the abrasion on the right buttocks and scrotum every shift, and Silvadene to the left inner ankle every day. Review of the Comprehensive Care Plan, dated 03/19/14, revealed Resident #4 had a problem of an abrasion to the left ankle, with a goal stating there would be no signs/symptoms of infection. Continued review of the Comprehensive Care Plan revealed a Care Plan initiated on 03/19/14, which stated the resident had a problem of excoriation to the coccyx related to incontinence, with a goal stating Resident #4 would be free of skin breakdown.</p> <p>Observation on 04/22/14 from 4:45 PM until 5:45 PM, of Resident #4's skin assessment, performed by Licensed Practical Nurse (LPN) #1/Unit Manager (UM) of the unit the resident resided on, revealed Resident #4 had an abrasion to the left inner ankle which measured one (1) centimeter (cm) by (x) one (1) cm, and an area to the right buttock the nurse described as an abrasion which measured 1 cm x 1 cm, and a reddened scrotum. Continued observation of the skin assessment revealed Resident #4 had an area on the right hip measuring 2 cm x 1.8 cm which the nurse described as a Stage I Pressure Ulcer area with surrounding scar tissue which was blanchable. In addition, observation revealed Resident #4 had an area to the right outer foot which measured 1 cm x 0.2 cm the nurse described as a Stage I Pressure Ulcer area. Interview with LPN #1/UM, at the time of the observation, revealed she was unaware Resident #4 had a Stage I Pressure Ulcer area to the right buttock. She stated she felt it might just have been scar tissue and she</p>	F 280			

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F 280	Continued From page 11 would have the Director of Nursing (DON), who was wound certified, assess the area. She further stated she was also unaware the resident had a Stage I Pressure Ulcer area to the right outer foot.  Interview with the DON on 04/23/14 at 10:00 AM, revealed she had assessed the area on the resident's right hip and it was scar tissue with a small Stage I Pressure Ulcer area inside the scar tissue which measured 0.6 cm x 0.8 cm.  Further record review of the Physician's Orders revealed there was no orders for the Stage I areas to the right hip and right outer foot until 04/22/14, after the areas were identified.  Further review of the Comprehensive Plan of Care on 04/22/14, revealed there was no documented evidence of a Care Plan related to the areas which were previously identified prior to the skin assessment on 04/22/14, which included the abrasion to the right buttock and redness to the scrotum. Additionally, review of the Comprehensive Care Plan on 04/24/14, revealed there was no documented evidence the Care Plan had been revised to include the areas identified on 04/22/14, which included the Stage I Pressure Ulcer areas to the right hip and right outer foot.  Interview on 04/24/14 at 2:00 PM with MDS Coordinator #1, revealed the MDS nurses only developed and revised residents' Comprehensive Care Plans for the Initial, Quarterly, Annual or Significant Change MDS Assessments. MDS Coordinator #1 stated the floor nurses were responsible for revising the Care Plans otherwise.	F 280			

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F 280	Continued From page 12 Interview on 04/24/14 at 3:15 PM with LPN #1/UM, revealed all nurses were to revise the care plans as Physician's Orders were received. She stated Resident #4's Comprehensive Care Plan should have been revised by the nurse who transcribed the orders to the Treatment Administration Record (TAR), to include the abrasion to the right buttock and the redness to the scrotum at the time the orders were received on 04/15/14, and/or by the nurse who first discovered the skin breakdown. Further interview revealed she had first identified the Stage I Pressure Ulcer areas on the right hip and right outer foot on 04/22/14, and had obtained Physician's Orders for treatment. She stated she should have updated Resident #4's Comprehensive Care Plan related to these areas on 04/22/14.  2. Further review of Resident #4's Quarterly MDS Assessment dated 03/24/14, revealed the resident had no falls noted. Review of the Comprehensive Care Plan dated 03/28/14, revealed a problem stating the resident had an actual fall and had rolled out of the bed. The goal for this problem stated the resident would not have another fall and the new Care Plan fall interventions initiated 03/28/14, included bed bolsters and floor mats. Further review of the Care Plan dated 10/09/12, revealed a problem stating the resident was at risk for falls, with an goal stating the resident would be free from falls, and interventions which included a sensor alarm to the bed.  Observation of Resident #4 on 04/22/14 at 3:20 PM and 3:50 PM, revealed the resident lying on the bed on his/her back with the head of the bed up approximately thirty (30) degrees and bolsters	F 280			

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F 280	<p>Continued From page 13</p> <p>were noted beside him/her on the bed bilaterally. However, observation revealed no sensor alarm or floor mats observed.</p> <p>Review of the Physician's Orders dated 03/28/14 revealed orders for bilateral bed bolsters and floor mats related to a recent fall. Review of the Physician's Orders dated 04/18/14, revealed an order to discontinue the bed sensor alarms. However, further review of the Physician's Orders revealed no documented evidence of Physician's orders to discontinue the floor mats.</p> <p>Interview on 04/24/14 at 3:15 PM with LPN #1/UM, revealed Resident #4 had experienced a big decline over the past month and had been hospitalized related to a Urinary Tract Infection (UTI), and also had a Gastrostomy Tube (g-tube) placed. She stated now the resident was not as mobile, so the fall mats and bed sensor alarms were no longer needed and were not being used. Continued interview with LPN #1/UM revealed the Resident #4's Physician's Orders dated 04/18/14, revealed orders to discontinue the bed sensor alarm and the Comprehensive Care Plan should have been revised to discontinue the bed sensor alarm by the nurse who transcribed the Physician's Order. She stated Resident #4 had returned from the hospital on 04/18/14, with new Admission Orders, and the fall mats were not listed as an order when he/she returned. LPN #1/UM stated the nurse who re-admitted the resident on 04/18/14, should have revised the Comprehensive Care Plan according to the Physician's Orders, as there was no longer an order for the fall mats. LPN #1/UM indicated there was an Interdisciplinary Team (IDT) Meeting, which took place a week after a resident was admitted or re-admitted, to ensure the</p>	F 280		

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F 280 Continued From page 14  
Comprehensive Care Plans were accurate and the meeting for Resident #4 was due 04/25/14.

Interview on 04/24/14 at 4:30 PM with the DON, revealed as nurses obtained Physician's Orders, they were to update/revise the Comprehensive Care Plans. She stated the next morning, Unit Managers were to review all Physician's Orders for the previous day, and ensure the care plans had been updated according to the Physician's Orders. The DON stated Resident #4's Comprehensive Care Plan should have been updated to include the areas of skin breakdown, and the floor mats and sensor pad should have been discontinued from the care plan. The DON further stated, due to new ownership the facility was in the process of transitioning from computer to paperwork for the medical records. According to the DON, this had contributed to the Comprehensive Care Plans not being updated, as staff were adjusting to the new system of writing in the record, instead of documenting on the computer.

F 280

F 282 SS=D 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure services were provided in accordance with each resident's

F 282 *This Plan of Correction is the center's credible allegation of compliance.*

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

F282 Resident #17 was provided with the appropriate ordered utensils at the time of service on 4/22/2014. A department manager was assigned to check the resident's tray card to the resident's tray for 72 hours.

5/9/2014

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F 282	Continued From page 15 written plan of care for one (1) of twenty-one (21) sampled residents (Resident #17) as evidence by failure to ensure the resident received the built-up utensils he/she was care planned to have with each meal to increase his/her independence with self-feeding.  The findings include:  Review of the facility's policy titled, "Comprehensive Care Plan", revised October 2010, revealed the Comprehensive Care Plan would be used in developing the resident's daily care routines and was to be available to staff who provided the care and services to the resident. Additionally, review of the policy revealed the Nurse Supervisor used the Comprehensive Care Plan to complete the Certified Nursing Assistants (CNA's) daily/weekly assignment sheets.  Review of Resident #17's medical record revealed the facility admitted the resident on 04/10/14, with diagnoses which included End Stage Lung Cancer, Depression, Arthritis, Anxiety and Chronic Obstructive Pulmonary Disease (COPD). Review of the Comprehensive Care Plan dated 04/16/14, revealed Resident #17 had a Care Plan problem listed which indicated the resident had difficulty self feeding secondary to decreased range of motion and weakness. Continued review of this Care Plan problem revealed the interventions included Resident #17 was to utilize built-up utensils to increase his/her independence with self-feeding.  Observation on 04/22/14 at 11:19 of Resident #17, revealed the resident's meal ticket indicated he/she was supposed to have built-up utensils as he/she was care planned to have; however, no	F 282	An audit was immediately implemented on 4/22/2014 for department managers to audit the tray card to the resident's tray every meal at the point of service for 72 hours and any issue was immediately addressed.  An audit was immediately implemented on 4/22/2014 comparing the tray cards to the MD ordered special diets and utensils in the dining room and hall trays for all residents by the Department Managers.  A care plan audit was conducted comparing the resident care needs to the care plan by department managers and/or designated staff. This audit was completed by 5/9/2014.  A completed audit was conducted comparing the tray card to the MD orders and resident care plan by the Dietary Manager. This audit was completed by 5/9/2014.  A random audit of 10 trays per week for accuracy will be conducted by the department managers for accuracy for three months.  A random audit of 10 residents per week will be conducted in regards to following of the care plan by checking the chart to the SRNA assignment sheet and observation of care will be completed for three months.	

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F 282	<p>Continued From page 16</p> <p>built-up utensils were observed as present and available for use by the resident. Interview with Resident #17, at the time of this observation, revealed the resident stated he/she did "need" built-up utensils and normally had them.</p> <p>Interview with the Unit Coordinator on 04/24/14 at 4:16 PM, revealed the purpose of the Comprehensive Care Plan was for nurses and CNA's to be able to meet each residents' needs, mentally, medically and physically. The Unit Coordinator stated staff were educated on any changes of a resident's Care Plan, had access to view Care Plans at any time, and should be aware of a resident's dietary needs if care planned. The Unit Coordinator indicated staff should have ensure Resident #17 had the built-up utensils as per the Care Plan.</p> <p>Interview with the Director of Nursing (DON) on 04/24/14 at 5:30 PM, revealed the purpose of the Comprehensive Care Plan was to help guide staff with each residents' care. She stated to ensure residents' had the equipment necessary for meals, the process should begin with Dietary staff checking the tray and meal card to ensure any special utensils or other required equipment was on the tray. The DON stated the meal tray should be double checked by the persons passing out them out to ensure all required items were present on the tray. According to the DON, nurses were responsible for ensuring CNA's were following the interventions put in place on the care plan. She indicated Resident #17 should have had the built-up utensils available on his/her meal tray as per the Care Plan.</p>	F 282	<p>An education was implemented by the Staff Development on following care plan according to their particular discipline for dietary, nursing staff, activities, therapy and social services. The education was completed by 5/9/2014.</p> <p>Education on following care plan according to their particular discipline for dietary, nursing staff, activities, therapy and social services will be repeated in three months by the Staff Development Coordinator.</p> <p>The DNS/ED and/or designee will bring any concerns to the QA meeting for three months. The committee will implement any changes needed to sustain compliance.</p>	
F 367 SS=D	483.35(e) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		

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F 367 Continued From page 17

Therapeutic diets must be prescribed by the attending physician.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure residents received and consumed foods in the appropriate form as prescribed by the Physician for one (1) of twenty-one (21) sampled residents (Resident #14). Resident #14 was ordered a mechanical soft diet related to difficulty with chewing/swallowing food; however, observation of the resident's lunch meal served on 04/22/14 at 11:10 AM, revealed the resident received a whole piece of chicken breast.

The findings include:  
Review of the facility's policy titled, "Therapeutic Diets", undated, revealed therapeutic diets were to be prepared and served as ordered by the attending Physician. Further review of the policy revealed each resident's tray had a tray card which included the resident's name and diet ordered.

Review of Resident #14's medical record revealed the facility admitted the resident on 11/27/10, with diagnoses which included Alzheimer's Disease, Anxiety, and Gastroesophageal Reflux Disease (GERD). Review of the Annual Minimum Data Set (MDS) Assessment, dated 03/27/14, revealed the facility had assessed Resident #14 to be severely cognitively impaired. Continued record review

F 367

*This Plan of Correction is the center's credible allegation of compliance.*

*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

F367

Resident #14 was provided with the correct therapeutic diet on 4/22/2014. The resident was assessed by licensed nurse and no adverse outcome was noted. The resident was referred to therapy for follow up assessment of appropriate diet and alert charting conducted for 72 hours.

An audit was immediately implemented on 4/22/2014 for department managers to audit the tray card to the resident's tray every meal at the point of service for 72 hours and any issue was immediately addressed.

A audit was immediately implemented on 4/22/2014 comparing the tray cards to the MD ordered special diets and utensils for all residents in the dining room and hall trays by the Department Managers.

A completed audit was conducted comparing the tray card to the MD orders and resident care plan by the Dietary Manager. This audit was completed by 5/9/2014.

5/9/2014

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F 367 Continued From page 18  
revealed Resident #14's April 2014 monthly Physician's Orders included a diet order for mechanical soft food texture dated 09/05/12. Review of Resident #14's Comprehensive Care Plan, revealed a Care Plan dated 03/01/13, which was revised on 03/28/14, which indicated the resident was at risk for nutritional decline related to difficulty chewing with an intervention to provide his/her meals per the mechanical soft diet.

Observation of the lunch meal service on 04/22/14 at 11:10 AM, revealed Resident #14's meal card noted a mechanical soft diet. However, observation revealed Resident #14 was served a piece of chicken breast on his/her meal tray, which was not mechanical soft texture.

Interview, on 04/22/14 at 11:36 AM, with Speech Therapist (ST) #1 revealed based on the diet order Resident #14 was to be served ground meat to meet the mechanical soft texture ordered. ST #1 stated however, the resident had been served a chicken breast which was regular in texture (a whole piece). The ST stated she was not familiar with Resident #14, but a mechanical soft diet would normally be ordered if a resident had problems with chewing or swallowing.

Interview, on 04/24/14 at 2:00 PM, with the Dietary Manager (DM) revealed the dietary aide "in the middle" during the meal tray line was to check meal trays for accuracy; however, had missed the tray check to ensure Resident #14 received mechanical soft chicken.

Interview, on 04/24/14 with Certified Nursing Assistant (CNA) #5 at 2:09 PM and with CNA #6

F 367 A random audit of 20 trays per week will be completed on the tray card accuracy comparing to the resident's tray by the Dietary Manager and/or designee for three months.

A random audit of 10 trays per week will be completed on the tray card accuracy in the dining room and hall comparing to the resident's tray by the Department Manager and/or designee for three months

An education was implemented by the Staff Development on following tray cards and comparing to resident's meal tray for dietary, nursing staff, department managers and social services. The education was completed by 5/9/2014.

Education on following tray cards and comparing to resident's meal tray for dietary, nursing staff, department managers and social services will be repeated by the Staff Development Coordinator and/or designee in three months.

The DNS/ED and/or designee will bring any concerns to the QA meeting for three months. The committee will implement any changes needed to sustain compliance.

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVE COMPLETED  04/24/2014
NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330	

(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) COMPLETE DATE
F 367	<p>Continued From page 19</p> <p>at 2:26 PM, revealed when serving trays staff were supposed to look at the meal ticket to ensure the meal served matched the meal ticket. CNA #5 and #6 stated if a resident were on a mechanical soft diet and the tray had a whole piece of chicken they would not serve the chicken and would take the tray back to the kitchen for correction. CNA #5 stated mechanical soft diets were served to make sure the residents were able to chew the food and not get choked.</p> <p>Interview, on 04/24/14 at 3:52 PM, with the Dietician revealed residents were put on mechanical soft diets if they had difficulty chewing food. The Dietician revealed the mechanical soft diet allowed residents not to work as hard chewing food. The Dietician stated if a resident was no a mechanical soft diet he/she should not be served a whole piece of chicken. According to the Dietician, whoever served the meal tray should have checked to ensure Resident #14 was getting the appropriate diet.</p> <p>Interview, on 04/24/14 at 4:16 PM, with Licensed Practical Nurse (LPN)/Unit Manager (UM) #2 revealed Resident #14 was on a mechanical soft diet. LPN/UM #2 revealed when the tray was prepared and being served to Resident #14, staff should have ensured the resident had a mechanical soft diet. She stated Resident #14 should not have been served the whole chicken breast and, indicated the resident should have received the diet ordered.</p> <p>Interview, on 04/24/14 at 5:26 PM, with the Director of Nursing (DON) revealed Resident #14 had a Physician's Order for a mechanical soft diet and should not have been served a whole chicken breast. She stated dietary staff should</p>	F 367		

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NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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F 367 Continued From page 20  
have ensured the tray matched what was on the tray card. The DON stated this should have been checked at the point of service also, to ensure Resident #14 was served the correct diet ordered.

F 369 483.35(g) ASSISTIVE DEVICES - EATING SS=D EQUIPMENT/UTENSILS

The facility must provide special eating equipment and utensils for residents who need them.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure special eating utensils were provided for residents who need them for one (1) of twenty-one (21) sampled residents (Resident #17). Observation on 04/22/14 revealed Resident #17 had not received built-up utensils with his/her lunch meal as ordered and as listed on the meal card.

The findings include:  
Review of the facility's policy titled, "Adaptive Self-Feeding Devices", undated, revealed the Dietary Department was responsible for ensuring placement of the adaptive self-help feeding device on resident's trays as needed.

Observation on 04/22/14 at 11:19 AM, of the lunch meal service revealed Resident #17 received his/her meal tray. Continued observation revealed the meal card indicated Resident #17 was to have received built-up utensils on the meal tray. However, further

F 367 *This Plan of Correction is the center's credible allegation of compliance.*

F 369 *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*

F369 5/9/2014  
Resident #17 was provided with the appropriate ordered assisted devices/utensils at the time of service on 4/22/2014. A department manager was assigned to check her tray card to the resident's tray every meal for 72 hours and any issue would be immediately addressed.

An audit was immediately implemented on 4/22/2014 for department managers to audit the tray cards to the resident's tray every meal at the point of service for 72 hours and any issue was immediately addressed.

An audit was immediately implemented on 4/22/2014 comparing the tray cards to the MD ordered special diets and assisted devices/utensils by the Department Managers in the dining room and the hall trays.

A care plan audit was conducted comparing the resident care needs to the care plan by department managers and/or designated staff. This audit was completed by 5/9/2014.

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NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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F 369 | Continued From page 21  
 observation revealed no built-up utensils were present on Resident #17's meal tray available for the resident's use. Interview with Resident #17 on 04/22/14 at 11:21 AM, during the observation, revealed the resident stated he/she was supposed to receive built-up utensils with her lunch tray.  
 Review of Resident #17's medical record revealed the facility admitted the resident 04/10/14, with diagnoses which included Gastroesophageal Reflux Disease (GERD), Arthritis, and End Stage Lung Cancer. Review of Resident #17's Physician's Orders revealed a telephone order dated 04/16/14, which stated the resident was to utilize built-up utensils to increase his/her independence with self-feeding. Review of Resident #17's Comprehensive Care Plan, dated 04/16/14, revealed the resident was to utilize built-up utensils to increase independence with self-feeding.  
 Interview with the Dietary Manager on 04/24/14 at 2:00 PM, revealed the large (built up) utensils were missed on the tray line by the dietary aide who checked the meal trays for accuracy. The Dietary Manager stated before the meal tray was served to Resident #17, the Certified Nursing Assistants (CNA's) should checked the meal card to ensure the utensils were present on the tray.  
 Interview with the Unit Manager on 04/24/14 at 1:31 PM, revealed dietary cards had changed recently; however, was no excuse in not providing the built-up utensils on Resident #17's meal tray. An additional interview, at 4:16 PM, with the Unit Manager, revealed the Comprehensive Care Plan indicated the built-up utensils and staff should have been aware of this as they had access to

F 369 | A completed audit was conducted comparing the tray card to the MD orders and resident care plan by the Dietary Manager. This audit was completed by 5/9/2014.  
 A random audit of 10 trays per week for accuracy of the tray card to the resident tray will be conducted by the department managers for accuracy for three months.  
 An education was implemented by the Staff Development on following care plan according to their particular discipline for dietary, nursing staff, activities, therapy and social services. The education was completed by 5/9/2014.  
 Education on following care plan according to their particular discipline for dietary, nursing staff, activities, therapy and social services will be repeated by the Staff Development Coordinator and/or designee in three months.  
 The DNS/ED and/or designee will bring any concerns to the QA meeting for three months. The committee will implement any changes needed to sustain compliance.

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NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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F 369 | Continued From page 22  
the Care Plan. The Unit Manager indicated Resident #17 should have received the built-up utensil as ordered.  
  
Interview with the Director of Nursing (DON) on 04/24/14 at 5:30 PM, revealed the facility's process for ensuring resident's received the items necessary on their trays began with Dietary staff who were to check the tray and meal card to ensure residents received what they required on the trays, such as, special utensils. The DON stated staff passing the trays should then double check to ensure all required items were present on the tray. She indicated the built-up utensils should have been on Resident #17's meal tray as ordered.

F 369 |

F 441 | 483.65 INFECTION CONTROL, PREVENT SS=D 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

F 441 | *This Plan of Correction is the center's credible allegation of compliance.*  
  
*Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*  
  
F441  
Resident #4 was assessed and documented that no adverse effects resulted from the deficiency for 72 hours.  
  
Department Managers will randomly observe 10 staff members weekly during the dining room meal service and UM, DNS, SDC will observe 10 staff members twice weekly entering and exiting rooms in precautions for compliance with infection control for three months.

5/9/2014

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F 441 Continued From page 23  
prevent the spread of infection, the facility must isolate the resident.  
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.  
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens  
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to 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 for one (1) of twenty-one (21) sampled residents (Resident #4).

Observation of incontinence care and of a skin assessment for Resident #4, who was in contact isolation precautions (precaution for germs spread by touching where everyone entering who might touch the resident or objects in the room should wear a gown and gloves), revealed the nurse used poor infection control techniques. In addition, the Certified Nursing Assistant (CNA) assisting with turning and repositioning of the

F 441 All staff will be educated on hand washing and education on the types of precautions and the protocol for each. Education was implemented on Infection Control in regards to providing assistance to residents during dining by the Staff Development Coordinator was completed by 5/9/2014.

Education on hand washing and education on the types of precautions and the protocol for each will be repeated by the Staff Development Coordinator and/or designee in three months. New hires will also be educated on Infection Control policy and procedures.

The DNS/ED and/or designee will bring any concerns to the QA meeting for three months. The committee will implement any changes needed to sustain compliance.

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F 441	Continued From page 24 resident removed her personal protective equipment (PPE), and exited the room without washing her hands.  Also, observation of the dinner meal service in the dining room revealed a CNA observed using the same hand, at times, to feed two (2) residents without sanitizing in between the feeding of the residents. Additionally, the CNA failed to sanitize her hands after she touched one resident's wheelchair, touched her face, hair and glasses, and touched both residents during the meal.  The findings include:  1. Review of the facility's policy titled, "Multidrug Resistant Organisms", dated August 2012, revealed contact precautions would be implemented for residents known or suspected to be infected with microorganisms which could be transmitted by direct contact with the resident; or indirect contact with environmental services; or resident care items in the resident's environment. Further review revealed while caring for a resident with contact precautions staff should change their gloves after having contact with infective material (fecal material and wound drainage) and remove the gloves and perform hand hygiene before leaving the room.  Review of Resident #4's medical record revealed diagnoses which included Alzheimer's Disease and a Extended Spectrum Betalactamase (ESBL) UTI. Review of the Quarterly Minimum Data Set (MDS) Assessment dated 03/24/14, revealed the facility assessed Resident #4 as having both short term and long term memory loss and as requiring total assistance with all Activities of Daily Living (ADL's).	F 441			

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NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 863 LEXINGTON ROAD HARRODSBURG, KY 40330
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F 441	Continued From page 25  Review of the Physician's Orders dated 04/15/14, revealed orders for Zosyn (an antibiotic) 3.375 grams intravenous (IV) every six (6) hours for eight (8) days. Review of the Physician's Orders dated 04/18/14, revealed orders to continue contact precautions until IV antibiotics were finished related to the ESBL.  Observation on 04/22/14 from 4:45 PM until 5:45 PM, of Resident #4's skin assessment and incontinence care revealed Licensed Practical Nurse (LPN) #1 assessed and touched the resident's scrotum, then went to the sink, turned on the sink faucet and wet wash cloths and towels while wearing the soiled gloves. LPN #1 returned to Resident #4 assisted with turning the resident on his/her side and provided incontinence care by wiping stool from the rectal area. Continued observation revealed LPN #1 returned to the sink wearing the same soiled gloves, turned on the sink to wet more towels and wash cloths, returned to resident and again wiped stool from the resident's rectum and buttocks. Observation revealed the LPN, while still wearing the same soiled gloves, removed Resident #4's Multipodus (specialized boots to prevent skin breakdown and corrects foot misalignments) boots, assessed the resident's feet, legs, and hips, then removed the soiled gloves and washed her hands.  Also, observation during the skin assessment and incontinence care revealed CNA #9, assisted LPN #1 with turning and repositioning the resident, while the nurse performed the skin assessment and incontinence care. The CNA was observed to remove her PPE which were gloves and a gown, during the observation and	F 441		

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F 441 | Continued From page 26  
 exited the room without washing her hands.

Interview on 04/23/14 at 9:45 AM with CNA #9, revealed she was asked to assist with Resident #4's skin assessment yesterday, 04/22/14. CNA #9 stated she usually worked in the business office; however, occasionally got pulled to the floor to provide resident care. The CNA stated she had exited the room after removing her PPE and had not washed her hands, but stated she knew she should have washed her hands prior to leaving the room as she had been trained on contact precautions in the past. She indicated she must have been nervous.

Interview on 04/23/14 at 9:50 AM with LPN #1, revealed she had training in the past related to hand washing, and glove usage. LPN #1 stated she should have removed her gloves after touching the resident's scrotum and prior to turning on the faucet. She stated she then should have washed her hands prior to wetting the wash cloths and towels. The LPN reported she should have removed the soiled gloves and washed her hands after providing incontinence care, prior to continuing with the skin assessment, and removing the resident's Multipodus boots.

Interview on 04/24/14 at 4:30 PM with the Director of Nursing (DON), revealed the nurse should have removed her gloves before touching the faucet after she had assessed Resident #4's scrotum. The DON stated LPN #1 should have also washed her hands after providing incontinence care and prior to continuing the skin assessment. The DON indicated the CNA should have removed her PPE, and washed her hands prior to exiting the room to prevent the spread of infection. She stated the facility provided yearly

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F 441	<p>Continued From page 27</p> <p>competencies related to infection control procedures such as hand washing and glove usage.</p> <p>2. Review of the facility's policy titled, "Handwashing", effective date December 2010, revealed staff and residents were to wash their hands as necessary to prevent the spread of infections or germs. Continued review of the policy revealed appropriate times for staff to wash their hands included before and after caring for each resident, and before handling a resident's food or food tray.</p> <p>Interview with the DON on 04/24/14 at 5:26 PM, revealed she expected staff, if they were feeding two (2) residents, to sanitize their hands if they touched the residents, residents' wheelchairs, or their body before continuing to feed the residents.</p> <p>Observation on 04/22/14 at 5:45 PM, of the dinner meal service in the dining room, revealed CNA #7 assisting two (2) residents with feeding their meals. Observation revealed CNA #7 using the same hand, at times, to feed both residents without sanitizing in between providing the assistance. In addition, observation revealed the CNA failed to sanitize her hands after she touched one resident's wheelchair, touched her face, hair, and glasses, and touched both residents' upper bodies at times during the meal.</p> <p>Interview with CNA #7 on 04/22/14 at 6:17 PM, revealed staff were not supposed to touch residents and then feed them. The CNA stated it was not ideal to touch your face, hair, and glasses and then continue to feed residents. CNA #7 indicated she had received infection control training, but it had not been in relation to</p>	F 441		

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F 441	Continued From page 28 assisting residents with their meals.  Interview with the Activities Assistant/CNA on 04/24/14 at 1:54 PM, revealed staff were trained on infection control techniques for feeding two (2) residents at the same time. She stated staff were supposed to use separate arms to feed each resident or sanitize their hands after feeding one (1) resident and before feeding the other resident. The Activities Assistant/CNA stated staff should sanitize their hands if they touched the residents or their hair, face, or glasses before continuing with feeding residents because otherwise, they could pass germs.  Interview with CNA #6 on 04/24/14 at 2:26 PM, revealed when feeding two (2) residents staff were to use separate hands or sanitize their hands between residents. CNA #6 revealed staff were not supposed to touch residents or themselves when feeding, but if they did they were supposed to sanitize their hands prior to beginning feeding again. The CNA further stated this was because of infection control as it could transfer germs from one resident to another, or from yourself to another resident.  Interview with the Infection Control Nurse on 04/24/14 at 7:01 PM, revealed the facility had a competency check off upon hire and annually related to infection control and assisting two (2) residents with meal service. She stated after touching a resident, or glasses, hair, or face staff were to cleanse their hands because of the potential for cross contamination. She further stated anytime staff touched anything which was potentially contaminated they should sanitize their hands.	F 441		
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F 441	Continued From page 29 Interview with the DON on 04/24/14 at 5:26 PM, revealed to ensure proper infection control, when staff were feeding two (2) different residents, they were to either use separate hands, one for each resident, or sanitize their hands when going from one resident to another. She stated by not doing this, there was the potential for infection control issues related to cross contamination.	F 441		

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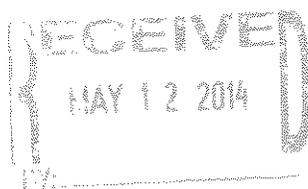
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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185287	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING  B. WING _____	(X3) DATE SURVEY COMPLETED  04/23/2014
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NAME OF PROVIDER OR SUPPLIER  HARRODSBURG HEALTH & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 853 LEXINGTON ROAD HARRODSBURG, KY 40330
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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 000	INITIAL COMMENTS  CFR : 42 CFR 483.70(a)  Building: 01  Plan Approval: 12/01/75  SURVEY UNDER: NFPA 101 (2000 Edition)  FACILITY TYPE: SNF/NF  TYPE OF STRUCTURE: One (1) Story, Type V (000) Unprotected  SMOKE COMPARTMENTS: Five (5)  COMPLETE SUPERVISED AUTOMATIC FIRE ALARM SYSTEM (original installed)  FULLY SPRINKLERED, SUPERVISED (DRY SYSTEM) updated 2005  EMERGENCY POWER: Type II Diesel installed in 2000  A Life Safety Code Survey was initiated and concluded on 04/23/14. The facility was in compliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire).	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* ADMINISTRATOR TITLE: ADMINISTRATOR (X6) DATE: 5-12-2014

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.