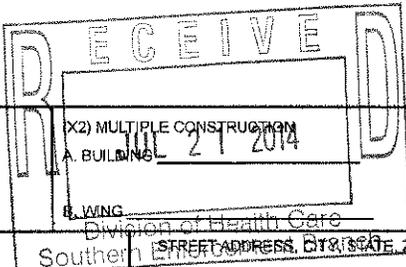


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/16/2014
FORM APPROVED
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185337	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING Division of Health Care Southern District	(X3) DATE SURVEY COMPLETED C 07/01/2014
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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 441 SS=D	<p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p>	F 441	<p>Lee County Care and Rehabilitation does not believe and does not admit that any deficiencies existed, before, during or after the survey. The Facility reserves the right to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Bush TITLE: NHA (X6) DATE: 7/21/14

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

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NAME OF PROVIDER OR SUPPLIER LEE COUNTY CARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 246 EAST MAIN STREET BEATTYVILLE, KY 41311	
(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 441	<p>Continued From page 1</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policy it was determine the facility failed to maintain an effective infection control program to help prevent the development and transmission of disease and infection for two (2) of three (3) sampled residents and three (3) unsampled residents (Resident #2 and unsampled Resident A). Observation of the medication pass on 07/01/14 at 11:30 AM revealed Registered Nurse (RN) #1 failed to sanitize the glucose meter before and after use for Resident #2; and before proceeding to use the same glucose meter to test Resident A's blood glucose level.</p> <p>The findings include: A review of the facility policy, "Glucometer-Cleaning of Equipment in Personal Contact," dated December 2010, revealed the glucose meter exterior surfaces was cleaned after each resident use with either an EPA-registered detergent/germicide wipe or a 10 percent bleach solution.</p> <p>Observation of the medication pass on 07/01/14 at 11:30 AM revealed RN #1 performed a blood glucose test on Resident #2 with the blood glucose monitor without cleaning the machine first. After the blood glucose test was completed RN #1 cleaned the glucose meter using soap and</p>	F 441	<p>F441</p> <ol style="list-style-type: none"> 1. RN#1 was re-educated verbally and a competency was completed on July 1, 2014 by the Staff Development Coordinator upon notification by the surveyor that she had not completed a correct cleaning of the glucometer (use of a bleach wipe) after completing a blood sugar check for resident #2 and A. The nurse had not followed the infection control policy when providing care to residents in an effort to prevent cross-contamination and/or the spread of infections. Please note resident #2 or A did not have any adverse effect from said practice. 2. All resident's requiring staff to assist with direct contact has the potential for the spread of infection. The Director of Nursing, Staff Development Coordinator, or Unit Managers will observe direct care staff 	

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F 441	<p>Continued From page 2</p> <p>water. RN #1 was then observed to take the same glucose meter and begin to perform a blood glucose level on Resident A, without cleaning the meter with a 10 percent bleach solution on 07/01/14 at 11:40 AM.</p> <p>Interview with RN #1 on 07/01/14 at 11:45 AM revealed bleach wipes were normally located on the medication carts but the cart being used did not have any. RN #1 said when there were no wipes on the cart it was acceptable to clean the blood glucose meters with either soap and water, alcohol-based wipes, or a bleach wipe.</p> <p>Interview with the Director of Nursing (DON) on 07/01/14 at 3:30 PM revealed the facility had an in-service in June 2014 about cleaning the glucose meters but RN #1 had been on leave at the time. The DON also said the facility had not in-serviced RN #1 regarding the cleaning of glucose meters since he/she returned two days earlier. Interview with the DON on 07/01/14 at 4:42 PM revealed the nurses should be cleaning the glucose meters before and after each resident use with facility approved micro-kill/bleach wipes. The DON stated random observations were made of staff administering medications, including blood glucose monitoring, at least once a week and no problems had been identified.</p>	F 441	<p>providing care to residents to ensure the infection control policy is followed during care. Any issues identified will be addressed immediately.</p>		

Managers will complete observations of Licensed Nurses completing Blood Glucose levels daily x 4 weeks, weekly x 4 weeks, 5 observations monthly x 2 months to ensure the infection control policy is being followed.

The Director of Nursing, Staff Development Coordinator, and Unit Managers will complete observations of direct care staff daily x 4 weeks, weekly x 4 weeks, 5 observations monthly x 2 months to ensure the infection control policy is being followed.

Findings of the above stated audits will be discussed in the Quality Assurance meeting monthly for three months for recommendations and further follow up as indicated. Members of the Quality Assurance Committee are: Medical Director, Administrator, Director of Nursing, Unit Managers, Social Services

3. Education for all licensed staff was started on July 1, 2014 by the Director of Nursing and Staff Development Coordinator. The education will be completed by July 25, 2014 for all staff. Education provided contains the policy for direct care of residents to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. Emphasis was placed on the correct cleaning of glucose monitors before and after use.

Competencies were started on July 1, 2014 for all licensed staff by the Staff Development Coordinator for to ensure the infection control program is being followed.

4. The Director of Nursing, Staff Development Coordinator, and Unit

Director, Dietary Manager,
Human Resource Director,
Maintenance Director, and
Quality of Life Director.

5. Date of compliance 7-31-14.