STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185246	A. BUILDING _____ B. WING _____	03/10/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
ROCKCASTLE HEALTH AND REHABILITATION CENTER	371 WEST MAIN STREET BRODHEAD, KY 40409

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0773 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview, record review, and review of the facility policy it was determined the facility failed to ensure laboratory services were provided for one (1) of four (4) sampled residents as ordered by the physician (Resident #4). Resident #4 had a physician's order dated 01/12/2020, for staff to obtain a stool specimen to test the resident for [MEDICAL CONDITION] (C. Diff) (a highly contagious [MEDICAL CONDITION] process of the colon caused by the bacteria which results in diarrhea); however, staff failed to obtain a stool specimen until 01/16/2020. Review of a laboratory test dated 01/16/2020 revealed Resident #4 tested positive and was diagnosed with [REDACTED]. The findings include: Review of the facility's policy, Laboratory Diagnostic Testing/Reporting, revised 11/06/2019, revealed diagnostic tests and clinical labs would be obtained based on Physician/Nurse Practitioner's orders. The policy stated problems, refusals, or complications would be documented and the physician notified. Review of the facility's policy, [MEDICAL CONDITION], revised October 2018, revealed [MEDICAL CONDITION] infection was suspected in residents with acute, unexplained onset of diarrhea (three or more unformed stools within 24 hours). Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident was moderately cognitively impaired. Further review of the MDS revealed the resident required total assistance of one (1) staff member for toileting and bathing, and extensive assistance of two (2) staff members for bed mobility, transfers, and personal hygiene. No observations were made of Resident #4 because the resident was discharged from the facility on 02/02/2020. Review of a Stop and Watch Early Warning Tool dated 01/10/2020 at 7:40 AM revealed Resident #4 was complaining of loose stools and Licensed Practical Nurse (LPN) #1 was notified. Interview with LPN #1 on 03/10/2020 at 11:32 AM and 6:20 PM revealed she was notified by the Medical Records Nurse on 01/10/2020 that Resident #4 was complaining of having loose stools. She stated that Resident #4 had an order for [REDACTED].#4 had experienced multiple episodes of loose stool and his/her physician was notified and gave an order to obtain a stool specimen to test for [DIAGNOSES REDACTED]. Review of a Nursing Progress Note dated 01/12/2020 at 1:06 PM revealed orders received via the Advanced Practice Registered Nurse (APRN) to obtain a stool culture to check for [DIAGNOSES REDACTED] related to Resident #4 experiencing loose stools. Review of an APRN Progress Note dated 01/12/2020 revealed Resident #4 was assessed by the APRN for complaints of intermittent diarrhea. APRN #1 ordered a stool sample for testing of [DIAGNOSES REDACTED]. Review of bowel output for Resident #4 revealed staff documented that Resident #4 had a large bowel movement on 01/12/2020, 01/13/2020, 01/14/2020, and 01/15/2020. Review of a laboratory report dated 01/16/2020 revealed a stool specimen was collected on 01/16/2020 at 1:38 PM. The report stated that Resident #4 tested positive for [MEDICAL CONDITIONS] and the facility was notified on 01/16/2020 at 2:44 PM. Review of Physician Orders dated 01/16/2020 revealed Resident #4 was ordered [MEDICATION NAME] 500 milligrams (mg) by mouth four (4) times daily for ten (10) days, [MEDICATION NAME] 250 mg every six (6) hours for ten (10) days, and [MEDICATION NAME] 250 mg by mouth twice daily for 20 days. Further review of Resident #4's medical record revealed Resident #4 was placed in contact isolation on 01/16/2020, when the facility received the laboratory results stating Resident #4 tested positive for [DIAGNOSES REDACTED]. Interview with LPN #1 on 03/10/2020 at 3:53 PM and 6:20 PM revealed on 01/12/2020 Resident #4 was experiencing loose stools. She stated APRN #1 was in the facility and she alerted him that Resident #4 had numerous loose stools, and he gave an order to obtain a stool specimen to test for [DIAGNOSES REDACTED]. She stated she told staff that they were to obtain a stool specimen with Resident #4's next loose stool. Interview with APRN #1 on 03/10/2020 at 1:58 PM revealed he ordered a stool specimen on Resident #4 to check for [DIAGNOSES REDACTED] due to the resident experiencing numerous loose stools and because he/she had been receiving antibiotics for an extended period of time. He stated he expected staff to obtain a stool specimen with Resident #4's next loose stool. Interview with the Director of Nursing (DON) on 03/10/2020 at 6:26 PM revealed staff were to obtain a stool specimen when ordered as long as the resident was still having loose stools. She stated she felt that Resident #4 had formed stools for a few days and that was why a stool specimen was not obtained until 01/16/2020 even though it was ordered on [DATE]. Interview with the Administrator on 03/10/2020 at 6:52 PM revealed she was not sure why staff did not obtain a stool specimen from Resident #4 until 01/16/2020 even though it was ordered on [DATE]. She stated she thought that Resident #4 began having formed stools; therefore, a specimen would not be collected. She stated staff should have notified Resident #4's physician if they were not able to obtain a stool specimen within a couple of days of the order.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to maintain an effective infection prevention and control program to prevent the development and transmission of communicable diseases and infections for four (4) of four (4) sampled residents (Residents #1, #2, #3, and #4). During observation of incontinence care for Resident #1, staff contaminated supplies in the resident's room. Residents #2 and #3 had physician orders [REDACTED]. Resident #2 was diagnosed with [REDACTED]. The facility failed to obtain a lab test for [MEDICAL CONDITION] (C. Diff) (a highly contagious [MEDICAL CONDITION] process of the colon caused by the bacteria which results in diarrhea) as ordered for Resident #4 and failed to place the resident in isolation per facility policy. The findings include: Review of the facility's policy, [MEDICAL CONDITION], revised October 2018, revealed precautions would be taken while caring for residents with [MEDICAL CONDITION] to prevent transmission to others. The policy stated that residents with diarrhea and suspected [DIAGNOSES REDACTED] would be placed on contact precautions while awaiting laboratory results. Review of the facility's policy, [MEDICAL CONDITION] - Management of Recurrent Skin and Soft Tissue Infection, revised September 2017, revealed education would be performed for staff and residents about the need for personal hygiene and appropriate wound care that would include: keeping draining wounds covered with clean, dry bandages; and performing hand hygiene after touching an infected area or any item that was in contact with the wound. Review of the facility's policy, Isolation - Categories of Transmission-Based Precautions, revised October 2018, revealed transmission-based precautions would be initiated when a resident developed signs and symptoms of a transmissible infection; has a laboratory confirmed infection; and is at risk of transmitting the infection to other residents. The policy stated transmission-based precautions were determined by the specific pathogen and how it transmitted from resident to resident and used only when the spread of infection could not be reasonably prevented by less restrictive measures. Further review of the policy revealed that when a resident was placed on transmission-based precautions, appropriate notification was placed on the room entrance door so personnel and visitors were aware of the need for and type of Centers for Disease Control and Prevention

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 1) (CDC) precaution(s); instructions for use of Personal Protective Equipment (PPE); and/or instructions to see a nurse before entering the room. The policy stated that contact precautions would be implemented for residents known or suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces. Review of the CDC Implementation of Personal Protective Equipment (PPE) in Nursing Homes to Prevent Spread of Novel or Targeted [MEDICAL CONDITION] (MDROs), updated 07/26/2019, revealed residents on Contact Precautions should be restricted to their rooms except for medically necessary care and restricted from participation in group activities. 1. Review of Resident #1's medical record revealed the facility admitted the resident on 09/04/2017 with [DIAGNOSES REDACTED]. Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE], revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 12, indicating the resident was moderately impaired cognitively. The facility assessed the resident to require total assistance of two (2) or more staff persons for toileting. Review of Resident #1's comprehensive care plan for bowel elimination, initiated on 10/19/2018, revealed staff were to provide incontinence care after incontinence episode and as needed (PRN). Observation of incontinence care for Resident #1 on 03/09/2020 at 3:12 PM, revealed Resident #1 was incontinent of bowel and SRNA #6 provided incontinence care. SRNA #6 was observed to close Resident #1's incontinence wipes that were located on the bedside table with the soiled gloves she used to provide incontinence care. Interview with SRNA #6 on 03/10/2020 at 5:18 PM revealed she was trained to remove her gloves and wash her hands after performing incontinence care. She stated she was nervous and forgot to remove the soiled gloves and wash her hands prior to touching the incontinence wipes. Interview with the Director of Nursing on 03/10/2020 at 6:26 PM revealed staff were expected to remove gloves and wash their hands prior to touching items in the resident's room to avoid contamination. Interview with the Administrator on 03/10/2020 at 6:52 PM revealed she expected staff to remove soiled gloves and wash their hands after performing incontinence care and before touching items in resident rooms. She stated SRNA #6 should have discarded the incontinence wipes when she touched the package with soiled gloves. 2. Review of Resident #2's medical record revealed the facility admitted the resident on 10/26/2012 with [DIAGNOSES REDACTED]. Review of Resident #2's quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of seven (7), indicating the resident was severely cognitively impaired. Continued review of the MDS assessment revealed staff assessed the resident to be independent with supervision only when utilizing his/her wheelchair in the facility. Review of a Physician order [REDACTED].#2's chin with normal saline and mild soap, rinse and dry thoroughly, and place [MEDICATION NAME] in and around the wound, and to cover the wound with a gauze bandage or bandaid two (2) or three (3) times daily and as needed (PRN). Review of Resident #2's Microbiology Report dated 03/03/2020 revealed Resident #2 had a wound culture performed on a surgical wound to his/her chin. The report stated that on 03/06/2020 at 10:19 AM the facility received a faxed copy of the report stating that Resident #2 [MEDICAL CONDITION] of his/her chin surgical wound. Review of a Physician order [REDACTED].#2 due to a [DIAGNOSES REDACTED]. Review of Resident #2's Physician order [REDACTED].#2 was ordered [MEDICATION NAME] (an antibiotic) 100 milligrams (mg) two (2) times per day for ten (10) days on 03/09/2020, three (3) days after the culture was received at the facility. Review of Resident #2's comprehensive care plan for infection control dated 03/09/2020 revealed Resident #2 had an [MEDICAL CONDITION] infection of a surgical wound. Interventions listed included to administer antibiotic as directed, encourage clean hygiene techniques to avoid cross-contamination, and Personal Protective Equipment (PPE) as indicated. Review of Resident #2's Nurse Aide Care Plan dated (NAME)2020 revealed Resident #2 was on contact precautions. Observations throughout the day on 03/09/2020 of Resident #2's door revealed no signage to alert staff and visitors that Resident #2 was on transmission-based precautions until approximately 5:30 PM. Observations of Resident #2 on 03/09/2020 at 3:57 PM revealed the resident was sitting in his/her wheelchair in the dining room with a bandage to his/her chin dated 03/09/2020. Further observation revealed there was a brown substance on the upper left corner of the dressing and Resident #2 was observed with his/her hand on the dressing and also drinking a beverage in a cup on the table. At 4:21 PM Resident #2 was observed propelling himself/herself in his/her wheelchair, continuing to touch the dressing to his/her chin. Resident #2's cup was left on the table in the dining room where the resident sat earlier (so other residents could possibly touch and become infected). At 5:28 PM Resident #2 was observed in the dining room feeding himself/herself lunch, and the dressing to Resident #2's chin had been replaced with a clean dressing. Observation of wound care on 03/10/2020 at 10:46 PM revealed no concerns; however, Resident #2 had to be reminded by staff numerous times during the treatment to keep his/her hands away from the wound. Furthermore, Resident #2 referred to the surgical wound as a blister and had no recollection of past surgical procedures that were performed to his/her chin. Observations on 03/10/2020 at 10:35 AM revealed Resident #2 was sitting in his/her wheelchair in the dining room during church services. Resident #2 was observed with a bandage to his/her chin intact and clean. At 4:28 PM Resident #2 was observed sitting in the dining room with two (2) bandaids covering the wound on his/her chin. At 4:54 PM Resident #2 was observed sitting in the dining room and the top right corner of the bandaid was loose and Resident #2 continued to touch the bandaids on his/her chin. Interview with LPN #1 on 03/10/2020 at 11:32 AM revealed she provided care to Resident #2 on 03/06/2020. She stated that after she received the laboratory results for Resident #2, she contacted APRN #1 and reported the results to him. She stated he did not order any medications at that time. She stated the resident had just finished antibiotic treatment one (1) day earlier to the wound culture being performed and she contacted Physician #1's office because she did not receive any medication orders with the laboratory results that his office had faxed. She stated that she was told to continue the current treatment, which was for wound care. Interview with Physician #1 on 03/10/2020 at 12:00 PM revealed he performed surgery on Resident #2's chin to remove [MEDICAL CONDITION] area in December 2019. He stated the resident had another surgery because [MEDICAL CONDITION] had returned and when he assessed Resident #2 during a follow-up appointment on 03/03/2020, he performed a wound culture of Resident #2's chin. He stated the culture came back on 03/06/2020 and the wound culture was positive [MEDICAL CONDITION]. Physician #1 stated that Resident #1 should have begun antibiotic therapy on 03/06/2020 to treat the infection. Further interview with Physician #1 revealed that if Resident #2's wound was draining and the resident picked at the dressing and/or wound, he/she should not be allowed in common areas with other residents due to the potential of spreading the infection to others. He further stated he did not recall anyone from the facility contacting him on 03/06/2020 for medication orders. Interview with APRN #1 on 03/10/2020 at 1:58 PM revealed he denied being notified by facility staff on 03/06/2020 regarding treatment of [REDACTED]. He stated he expected staff to notify him for treatment orders when they received a [MEDICAL CONDITION] culture. APRN #1 stated facility staff should only allow Resident #2 in common areas with other residents if the wound to his/her chin was covered and free from drainage. Interviews with SRNA #1 on 03/09/2020 at 4:31 PM, SRNA #2 on 03/10/2020 at 12:34 PM, SRNA #4 on 03/10/2020 at 3:39 PM, and SRNA #6 on 03/10/2020 at 5:18 PM revealed Resident #2 picked at the dressing/wound on his/her chin often. They stated they attempted to educate Resident #2 not to pick at the dressing/wound but he/she had Dementia and could not be educated. They stated Resident #2 was on contact precautions [MEDICAL CONDITION] in the surgical wound on his/her chin. They further stated the resident propelled himself/herself in his/her wheelchair throughout the facility and often ate meals in the dining room. Interviews with LPN #1 on 03/10/2020 at 3:53 PM and LPN #2 on 03/10/2020 at 2:54 PM revealed Resident #2 was on contact precautions [MEDICAL CONDITION] in his/her chin surgical wound. They stated as long as the wound was covered and was not draining the resident could leave his/her room. They stated the resident picked at the bandage constantly and would be educated not to touch it; however, he/she had a [DIAGNOSES REDACTED]. They stated they did not know why Resident #2 did not have signage on his/her door addressing the transmission-based precautions. LPN #1 stated that Resident #2 removed his/her bandage twice in one (1) day, once in the dining room. She stated she took Resident #2 back to his/her room and covered the wound with a clean bandage. Interview with the DON on 03/10/2020 at 6:24 PM revealed the nurses were responsible for placing signage on the door of a resident on transmission-based precautions. She stated Resident #2 often removed the signage and placed it in random places and that someone should have noticed that Resident #2 did not have signage on his/her door indicating the resident was on transmission-based precautions. She stated that as long as Resident #2's wound was covered, he/she could be in common areas and attend activities in the facility. Further interview with the DON revealed Physician #1's office was contacted on 03/06/2020 when Resident #2's wound culture results were received. She stated that she was told that Physician #1 stated for Resident #2 to continue his/her current orders. Continued interview with the DON revealed on 03/09/2020 APRN #1 reviewed Resident #2's wound culture results and ordered [MEDICATION NAME] for 10 days to treat the infection. Interview with the Administrator on 03/10/2020 at 6:52 PM revealed during the morning white board meeting they reviewed physician orders, wound cultures, laboratory tests, and antibiotics to ensure that residents received the appropriate treatments. She stated the nurses were responsible for placing signage indicating that a resident was on transmission-based precautions. She stated on 03/06/2020 Resident #2's wound culture results were received as well as an order from Physician

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F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 2) #1 to continue Resident #2's current treatment orders. Continued interview revealed on 03/09/2020 APRN #1 ordered [MEDICATION NAME] for Resident #2 for 10 days to treat the infection to his/her chin. 3. Review of Resident #3's medical record revealed the facility admitted the resident on 01/10/2018, with [DIAGNOSES REDACTED]. Review of the quarterly MDS assessment dated [DATE], revealed the facility assessed the resident to have a BIMS score of four (4), indicating the resident was severely cognitively impaired. Review of a Physician order [REDACTED]. Review of a Laboratory Report dated 03/02/2020 revealed a culture was collected of Resident #3's left eye on 02/28/2020, and on 03/02/2020 the facility was notified that Resident #3 [MEDICAL CONDITION] in his/her left eye. Continued review of the report revealed APRN #1 was notified and orders were received to begin [MEDICATION NAME] (an antibiotic) 0.3 percent (%) ointment three (3) times per day in his/her left eye for seven (7) days. Review of a Physician order [REDACTED].#3 on contact precautions. Observations of Resident #3 throughout the day on 03/09/2020 revealed Resident #3 was in his/her room; however there was no signage on the resident's door to alert staff and visitors that Resident #2 was on transmission-based precautions. Review of Resident #3's comprehensive care plan for infection control dated 02/28/2020 revealed Resident #3 had infectious [MEDICAL CONDITION] and was placed on contact precautions as well as [MEDICATION NAME] eye ointment. Review of Resident #3's Nurse Aide Care Plan dated (NAME)2020 revealed Resident #3 was on contact precautions. Interview with the DON on 03/10/2020 at 6:24 PM and the Administrator on 03/10/2020 at 6:52 PM revealed Resident #3 should have had signage on his/her door alerting staff and visitors that the resident was in contact precautions. 4. Review of Resident #4's medical record revealed the resident was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Review of Resident #4's admission Minimum Data Set (MDS) assessment dated [DATE] revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of eleven (11), indicating the resident was moderately cognitively impaired. Further review of the MDS revealed the resident required total assistance of one (1) staff member for toileting and bathing, and extensive assistance of two (2) staff members for bed mobility, transfers, and personal hygiene. No observations were made of Resident #4 because the resident was discharged from the facility on 02/02/2020. Review of a Stop and Watch Early Warning Tool dated 01/10/2020 at 7:40 AM revealed Resident #4 was complaining of loose stools and Licensed Practical Nurse (LPN) #1 was notified. Interview with LPN #1 on 03/10/2020 at 11:32 AM and 6:20 PM revealed she was notified by the Medical Records Nurse on 01/10/2020 that Resident #4 was complaining of having loose stools. She stated that Resident #4 had an order for [REDACTED].#4 had experienced multiple episodes of loose stool and his/her physician was notified and gave an order to obtain a stool specimen to test for [DIAGNOSES REDACTED]. Review of a Nursing Progress Note dated 01/12/2020 at 1:06 PM revealed orders received via the Advanced Practice Registered Nurse (APRN) related to Resident #4 experiencing loose stools, to obtain a stool culture to check for [DIAGNOSES REDACTED]. Review of an APRN Progress Note dated 01/12/2020 revealed Resident #4 was assessed by the APRN for complaints of intermittent diarrhea. APRN #1 ordered a stool sample for testing of [DIAGNOSES REDACTED]. Review of bowel output for Resident #4 revealed staff documented that Resident #4 had a large bowel movement on 01/12/2020, 01/13/2020, 01/14/2020, and 01/15/2020. Review of a laboratory report dated 01/16/2020 revealed a stool specimen was collected on 01/16/2020 at 1:38 PM. The report stated that Resident #4 tested positive for [MEDICAL CONDITIONS] and the facility was notified on 01/16/2020 at 2:44 PM. Review of Physician order [REDACTED].#4 was ordered [MEDICATION NAME] 500 milligrams (mg) by mouth four (4) times daily for ten (10) days, [MEDICATION NAME] 250 mg every six (6) hours for ten (10) days, and [MEDICATION NAME] 250 mg by mouth twice daily for twenty (20) days. Further review of Resident #4's medical record revealed Resident #4 was placed in contact isolation on 01/16/2020, when the facility received the laboratory results stating Resident #4 tested positive for [DIAGNOSES REDACTED]. Interview with LPN #1 on 03/10/2020 at 3:53 PM and 6:20 PM revealed residents were placed on contact precautions when they were diagnosed with [REDACTED]. Interview with LPN #3 on 03/10/2020 at 5:30 PM revealed residents were placed on contact precautions when they were diagnosed with [REDACTED]. Interview with the DON on 03/10/2020 at 6:26 PM and the Administrator on 03/10/2020 at 6:52 PM revealed residents were expected to be placed on contact precautions if there was a suspicion that the resident could have [DIAGNOSES REDACTED]. They stated staff were not to wait until the diagnostic results were received to place a resident on contact precautions. They stated they performed rounds throughout the day, and they had not identified concerns with transmission-based precautions.