DEPARTMENT OF HEALTH CENTERS FOR MEDICARE &				FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/22/2018
CORRECTION	185164			
NAME OF PROVIDER OF SUI		STREET	ADDRESS, CITY, STA	TE, ZIP
BARBOURVILLE HEALTH	AND REHABILITATION CENT		ΓΟΝ HICKORY FARM URVILLE, KY 40906	I ROAD
For information on the nursing	home's plan to correct this deficient	y, please contact the nursing home or the s	state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DOR LSC IDENTIFYING INFORM	EFICIENCIES (EACH DEFICIENCY MU MATION)	JST BE PRECEDED BY	FULL REGULATORY
F 0657		within 7 days of the comprehensive asses by a team of health professionals.	sment; and	
Level of harm - Immediate jeopardy	**NOTE- TERMS IN BRACKET Based on interview, record review	S HAVE BEEN EDITED TO PROTECT (, and review of facility policy it was determ	nined the facility failed to	revise the plan of
Residents Affected - Few	care for one (1) of four (4) sample orthopedic surgeon for follow-up surgeon prescribed a walker boot facility failed to revise the resider Resident #1 was transferred to the #1's right lower leg/foot had seves blood flow or a serious bacterial i that can damage your blood vesse amputated below the knee. The facility's failure to ensure resi impairment, or death to a resident CFR 483.21 Comprehensive Pers notified of the Immediate Jeopard An acceptable Allegation of Comg 108/15/18. The State Survey Agen 08/22/18, which lowered the scop and 42 CFR 483.25 Quality of Ca assurance activities. The findings include: Review of the facility's Care Plan comprehensive care plan for each nursing, mental, and psychosocial care plan would be periodically reneeded basis. According to the porders. Review of Resident #1's medical review of a Significant Change N resident's Brief Interview for Mer intact and interviewable. Further imobility and total assistance with Review of Resident #1's care plan fractures. Further review of the caphysician of any complications, on Review of an Orthopedic Consult the resident to be worn, except for Consulting with ortho (orthope briefly. There was no documented naddition, the care plan stated th documented evidence the facility's poli However, interview with Physician Resident #1, per the facility's poli However, interview with Physician resident's walking boot daily for sthe resident's foot/leg weekly. Observation and interview with Reboot was only re	d residents (Resident #1). On 06/22/18, Re after tibia/fibula (lower leg bones) and met for Resident #1 to be worn at all times, exc t's care plan with the physician's orders [R hospital due to unresponsiveness. When he wet gangrene (Gangrene refers to the deanfection. Chances for developing gangrene is and affect blood flow, such as diabetes) dent care plans were revised has caused or Immediate Jeopardy was identified on 08. on-Centred Care Plans (F657 J) and 42 CI you on 08/09/18. diance was received on 08/17/18, which all ye determined the Immediate Jeopardy was et and severity to D level at 42 CFR 483.21 re (F684), while the facility monitors the elevation of the compact of the compact with the facility and the comprehensive wed and revised by the interdisciplinary licy, the care plan would be updated as independent of the MDS assessment, date tall Status (BIMS) score to be fifteen (15), eview of the MDS assessment revealed the transfers. revised 06/08/18, revealed the resident have plan revealed the facility implemented it skin checks and bathing once a day briefly care plan revealed the facility revised the care plan erevealed the facility revised the care plan erevised the care plan with interventions to Nurse (LPN) #7 on 08/08/18 at 1:30 PM, rean (Physician #1) that the facility only constated the facility could change the order a stated the facility could change the order as the order of the order	esident #1 had an appoint tatarsal (toes) fractures. The perforbathing and daily EDACTED] #1's skin dailospital staff removed the ath of body tissue due to evant the state of	ment with an he orthopedic skin checks. The lly. On 07/19/18, walker boot, Resident either a lack of a underlying condition s leg to be injury, harm, exist on 06/22/18 at 42 et (F684 J). The facility was nediate Jeopardy on 18/15/18, prior to exit on Centered Care Plans (F656) changes and quality are should develop a a resident's medical, er review revealed the ent and on an as modition and physician DIAGNOSES REDACTED]. facility assessed the as cognitively ive assistance with bed irst and second toe dinotifying the for skin breakdown. Hered a walker boot for include interventions ove for shower and bathing sorders [REDACTED]. Ever, there was not all. hopedic office on sments. According to skin assessments for ions were to remove the moved. However, nurse the boot. Style of the stated the walking aff to remove the moved. However, nurse the boot. Style at 12:43 PM, and RN #3 at 2d from 07/14/18 to 1 level of the boot was removed upon iddleg down wards and sultation regarding sessessed to have a lt, dated 07/20/18, revealed
		uistrator and Director of Nursing on 08/09/ resident with any changes to care, and staf		

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.

FORM CMS-2567(02-99) Previous Versions Obsolete If continuation sheet Page 1 of 6 Event ID: YL1O11 Facility ID: 185164

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUC	TION	(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		08/22/2018
CORRECTION	NUMBER			00/22/2010
NAME OF BROWINGS OF CH	185164		CTREET ADDRESS CITY OF	ATE ZID
NAME OF PROVIDER OF SU BARBOURVILLE HEALTH	AND REHABILITATION CENT	TER	STREET ADDRESS, CITY, STA 65 MINTON HICKORY FARM BARBOURVILLE, KY 40906	
For information on the nursing	home's plan to correct this deficien	cy, please contact the nursing hor	me or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFOR		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
F 0657	(continued from page 1) [REDACTED].			
Level of harm - Immediate jeopardy	Interview with Physician #2 on 08 resident's leg from the knee down	 The Physician stated the resident 	was Resident #1's surgeon at Hospi nt's leg smelled, it was discolored, cal opinion, the walking boot shou	and it was a dead
Residents Affected - Few	least every 24-48 hours, and by n	ot removing the boot it created a n the resident's history of diabete	wet environment that promoted a s, hypertension, and immobility, the	bacterial infection. The
	****The facility alleged the following was implemented to remove Immediate Jeopardy on 08/15/18: 1. On 08/09/18, a department head meeting, including the facility's Administrator, Director of Nursing (DON), Clinical Coordinators, Minimum Data Set (MDS) Coordinators, and the Staff Development Coordinator was held to review the Immediate			
	Jeopardy (IJ) notification and a pi 2. On 08/11/18, skin assessments	lan was developed for the IJ abat were initiated for all residents wi		nd completed by
	was up-to-date and interventions	d on 08/11/18 for all residents wi were in place and being followed	n Assessment form. th removable orthotic devices to end. The care plan reviews were compared to the compared t	nsure the care plan pleted by the MDS and
		on 08/12/18 and completed on 0	08/14/18 on every resident in the fa	
	Coordinator, and Staff Developm 5. On 08/13/18, a Quality Assuran	ent and MDS/Medicare Coordina ace (QA) meeting was conducted	 D]. The assessments were completed ators. with the Administrator, DON, Clipporate Consultant Staff Members 	nical Coordinators,
	discuss the plan for IJ removal, re 6. On 08/09/18, a protocol was de	eview the status of education, and veloped by the Corporate Nurse	l review audits. Consultants, Use of a Removable (Orthotic Device, and adopted
	by the Quality Assurance (QA) Committee. The Corporate Nurse in-serviced the Administrator, DON, Clinical Coordinators, Staff Development Coordinator, and MDS/Medicare Coordinators on the Protocol for the facility's protocol, Use of a Removable Orthotic Device, on 08/11/18, and a post-test was completed to ensure comprehension. 7. The Administrator and DON were re-educated by the Corporate Nurse Consultant on 08/11/18, regarding the regulatory intent			
	of F656 (Resident Care Plan) and 8. On 08/11/18, Corporate Consul	F684 (Quality of Care). tants provided education to the C	Clinical Coordinators, Staff Develo	pment Coordinator, and
	9. On 08/11/18, facility nurses we Protocol for Use of a Removable	re in-serviced by the Corporate N Orthotic Device. The protocol in	was given to verify comprehension Jurse Consultants and Nurse Coord structed nurses to place a monitori	dinator regarding the ing statement on the
	a daily basis when the device is re also administered a post-test to er	emoved or more frequently based asure comprehension of the information	a removable device. The resident's I upon the physician's orders [RED mation. All nurses were to be re-ec	OACTED]. The nurses were
	regarding observation and reporti as well as following the Kardex (erviced on 08/13/18, by the Corporng changes in condition. The obsinformation provided to nurse aid	to alert start of the in-service. orate Nurse Consultants and the Nuservations should include showers, des on how to care for a resident). re not permitted to work until they	baths, and routine care, A post-test was given
	education. 11. Quality Assurance (QA) meeti		orate Consultant Staff Members w	
	MDS/Medicare Coordinators, and (3) nurse aides per unit on a daily immediately to the Administrator	d Clinical Coordinators, by condu- basis for one week, then weekly and Director of Nursing (DON).	nittee Members, including the Staf acting ongoing post-testing with th for one (1) month. Any concerns The Staff Development Coordina	ree (3) nurses and three will be reported
	unit per day for one week, then w [REDACTED]. The MDS and M	including the MDS/Medicare Coreekly for four weeks, and then medicare Coordinators and Clinica	oordinators and Clinical Coordinat nonthly for one quarter to ensure pl Il Coordinators observed care provenovable orthotic devices and care	hysician orders ided to four (4) residents,
	Any concerns were reported imm Administrator and discussed in th	ediately to the Administrator and the QA meeting.	DON. The results of the audits we will yed on 08/15/18 as alleged based o	ere reported to the
	Review of the Quality Assurance including the Administrator, Dire Staff Development Coordinator. I Coordinator at 3:15 PM, Staff Development Coordinator.	ce (QA) meeting roster revealed a actor of Nursing (DON), Clinical Interviews on 08/22/18 with the Uselopment Coordinator at 3:25 P	a meeting was conducted on 08/09. Coordinators, Minimum Data Set Unit Coordinator at 3:06 PM, Mini Wh, Director of Nursing (DON) at ding the IJ (Immediate Jeopardy)	/18 with department heads (MDS) Coordinators, and the mum Data Set (MDS) 3:35, and Administrator at
	completed on facility residents with PM, MDS Coordinator at 3:15 PM	ith removable orthotic devices. In M, Staff Development Coordinate	through 08/14/18, revealed skin as nterviews on 08/22/18, with the Ur or at 3:25 PM, and DON at 3:35 PM	nit Coordinator at 3:06
	and revised the care plans for resi 08/22/18 with the Corporate Nurs	or Resident #4, Resident A, Residents with removable orthotic dese Consultant at 2:55 PM and the	dent B, and Resident C revealed the evices between 08/11/18 and 08/14 MDS Coordinator at 3:15 PM revealed appropria	/18. Interviews on ealed all resident care plans
	on all residents in the facility. Into Staff Development Coordinator a	erviews on 08/22/18 with the Unit 3:25 PM, and the DON at 3:35	through 08/14/18, revealed skin as it Coordinator at 3:06 PM, MDS C PM confirmed that skin assessmer	Coordinator at 3:15 PM, ats were completed on all
	interventions were being follower representatives were aware of sta 5. Review of the QA meeting rost	d, and notification verifications was and orders. er, dated 08/13/18, revealed a me	DACTED]. Care plans were reviewere completed to ensure resident parting was conducted with the Adn	physician and ninistrator, DON, Unit
	on 08/22/18 with the Corporate N Development Coordinator at 3:25 08/13/18 to discuss facility progra	Jurse Consultant at 2:55 PM, Unit PM, DON at 3:35 PM, and the Aless with the IJ removal and plan.		oordinator at 3:15 PM, Staff a QA meeting was held on
	the Corporate Nurse Consultant r	egarding regulations F656 and F6 :35 PM, and Administrator at 3:4	aled the Administrator and DON r 684. Interviews on 08/22/18 with the 45 PM revealed an in-service was g	he Corporate Nurse
	7. Review of the QA Committee r Device was adopted by the QA C was conducted by the Corporate 1 attendance was the Administrator on 08/22/18 with the Corporate N	ninutes and roster, dated 08/09/1: ommittee. Review of a facility in Nurse Consultant regarding the P , DON, Unit Coordinator, Staff I Jurse Consultant at 2:55 PM, Uni	8, revealed the Protocol for Use of 1-service and roster, dated 08/11/18 rotocol for Use of a Removable Or Development Coordinator, and the t Coordinator at 3:06 PM, MDS C ninistrator at 3:45 PM revealed an	8, revealed an in-service rthotic Device; in MDS Coordinator. Interviews oordinator at 3:15 PM, Staff
i	į.			

			OMB NO. 0936-0391
STATEMENT OF	(X1) PROVIDER / SUPPLIER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
DEFICIENCIES	/ CLIA	A. BUILDING	COMPLETED
AND PLAN OF CORRECTION	IDENNTIFICATION NUMBER	B. WING	08/22/2018
CORRECTION			
	185164		
NAME OF PROVIDER STREET ADDRESS, CITY, STATE, ZIP			
BARBOURVILLE HEALTH	AND REHABILITATION CEN		ORY FARM ROAD
E i C d d i	1 1 1	BARBOURVILLE,	
	1 .	cy, please contact the nursing home or the state survey	<u> </u>
(X4) ID PREFIX TAG	OR LSC IDENTIFYING INFOR	DEFICIENCIES (EACH DEFICIENCY MUST BE PR MATION)	ECEDED BY FULL REGULATORY
F 0657	(continued from page 2)		
1 0037		a Removable Orthotic Device. A post-test given to eva	aluate comprehension.
Level of harm - Immediate		ster, dated 08/11/18, revealed an in-service was conductive for the state of the st	
jeopardy	Consultant regarding following physician orders, accurate transcription of orders, and implementation of resident care plans. Interviews on 08/22/18, with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator		
Residents Affected - Few	at 3:15 PM, and Staff Developme	ent Coordinator at 3:25 PM confirmed the in-service ha	
	given to evaluate comprehension	ster, dated 08/11/18, revealed facility nurses received a	on in compice related to the
		emovable Orthotic Device. Interviews on 08/22/18 with	
	2:55 PM and Unit Coordinator at	3:06 PM revealed they in-serviced facility nursing staf	ff on the protocol. Review of the
		ls (TARs) revealed a monitoring statement which inclu hotic device per physician order. Further interview rev	
	education regarding accurate tran	scription of physician orders, care plan implementation	n, and skin assessments underneath a
		08/22/18 with RN #3 at 2:41 PM, RN #4 at 2:45 PM, a	and LPN #8 at 2:52 PM, revealed they had
	received the education and taken 10. Review of an in-service roster	a post-test. , dated 08/13/18, revealed facility nurse aides were pro	wided education by the Corporate
	Nurse Consultants and Unit Coor	dinators regarding observation and reporting of change	es in resident condition and following
	and Unit Coordinator at 3:06 PM	ng care. Interviews on 08/22/18, with the facility Corp. confirmed the in-service had been given to all facility	orate Nurse Consultant at 2:55 PM
	Interviews on 08/22/18 with SRN	IA #7 at 2:30 PM, SRNA #8 at 2:35 PM, and SRNA #9	
	provided prior to returning to res	ident care and post-tests were given. eting rosters, dated 08/09/18, 08/13/18, and 08/20/18, r	
		Consultant Staff Members in attendance. Interviews w	
	2:55 PM, Unit Coordinator at 3:0	6 PM, MDS Coordinator at 3:15 PM, Staff Developme	ent Coordinator at 3:25 PM, DON at 3:35 PM,
		I confirmed QA meetings had been conducted at least valits, dated 08/11/18 through 08/22/18, revealed post-te	
	aides and three (3) nurses per uni	t on a daily basis for one (1) week, and then weekly for	r all shifts regarding in-service
	education comprehension. Interv	iews with SRNA #7 at 2:30 PM, SRNA #8 at 2:35 PM,	SRNA #9 at 2:40 PM, RN #3 at 2:41 PM,
	#4 at 2:45 PM, LPN #8 at 2:52 P.	M, the Unit Coordinator at 3:06 PM, MDS Coordinator	
		ed post-tests were conducted daily. Further interview went Coordinator revealed the audits would continue we	
		th the Staff Development Coordinator on 08/22/18 at 3::	
		inistrator and the results of the audits were taken to the	weekly QA meetings for review and
	discussion. 13. Review of the facility's QA au	dits, dated 08/11/18 through 08/22/18, revealed four (4	1) resident medical records were
	audited per day for one (1) week	and then weekly and skin care observations were condu	ucted on the residents who were
		t Coordinator at 3:06 PM and MDS Coordinator at 3:15 one (1) week and then weekly for the accuracy of transc	
	plan implementation, and remova	d of orthotic devices per physician orders. Further inter	view revealed skin care
		the residents with removable orthotic devices to ensure appropriately. Further interview revealed any concerns	
	and Administrator. Interviews on	08/22/18 with the DON at 3:35 PM and Administrator	at 3:45 PM revealed any concerns were
	addressed immediately including	staff re-education and physician notification. Further in	
	audits were taken to the weekly (A meetings for review and discussion.	
F 0684	Provide appropriate treatment	and care according to orders, resident's preferences	and
	goals.	•	
Level of harm - Immediate jeopardy		TS HAVE BEEN EDITED TO PROTECT CONFIDEN record review, and review of facility policies, it was de	
Jeopardy		es were provided for one (1) of four (4) sampled resider	
Residents Affected - Few		record revealed the resident sustained [REDACTED]. I	
		oot was to be removed daily for bathing and skin check e facility failed to remove Resident #1's walking boot as	
	from 07/15/18 through 07/19/18,	until the resident was sent to the Emergency Departme	ent due to a decrease in consciousness.
		to have extremely severe wet gangrene from midleg do he death of body tissue due to either a lack of blood flo	
	infection. Chances for developing	g gangrene are higher if you have an underlying conditi	ion that can damage your blood
	vessels and affect blood flow, sucrequired a below-the-knee amput	ch as diabetes.). The resident was then sent to a secondary	ary hospital where the resident
	The facility's failure to ensure car	e and services were provided has caused or is likely to	
	impairment, or death to a residen	t. Immediate Jeopardy was identified on 08/09/18, and	determined to exist on 06/22/18 at
	notified of the Immediate Jeopard	Person-Centered Care Plans (F656) and 42 CFR 483.25 dy on 08/09/18.	Quanty of Care (F684). The facility was
	An acceptable Allegation of Com	pliance was received on 08/17/18, which alleged remove	val of the Immediate Jeopardy on
	08/15/18. The State Survey Ager	cy determined the Immediate Jeopardy was removed o erity to D level at 42 CFR 483.21 Comprehensive Perso	on 08/15/18, prior to exit on 08/22/18,
	483.25 Quality of Care (f684), w	hile the facility monitors the effectiveness of systemic	
	activities. The findings include:		
		ed Skin Ulcers, not dated, revealed nursing measures to	prevent pressure sores were to
	be in place for all residents. Further review revealed the measures to prevent pressure ulcers included: inspection of potential sites of breakdown at least once during each nursing shift; keep the resident's skin clean and dry; and provide adequate exposure of skin to air.		
		on 08/08/18 at 1:40 PM revealed the facility did not have	ve a policy related to orthotic
devices. Review of Resident #1's medical record revealed the facility initially adm			nt on 04/06/12. Resident #1 had
	Review of Resident #1's medical record revealed the facility initially admitted the resident on 04/06/12. Resident #1 had [DIAGNOSES REDACTED]. Review of a Nurse's Note dated 06/08/18, revealed Resident #1 ran into a door, while self-propelling a mechanical wheelchair, striking his/her right foot. Further review revealed the resident was transferred to the Emergency Department		
(ED) for evaluation.			
		/08/18, revealed Resident #1 sustained a spiral [MEDIO	
	fibula (bones in the lower leg), and impact fractures of the right first and second metatarsals (toes). Review of the Hospital History and Physical revealed the resident had a right leg splint placed, with physician orders [REDACTED]. Review of a Significant Change Minimum Data Set (MDS), dated [DATE], revealed the facility assessed Resident #1 to have a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact and		
		the MDS assessment revealed the resident required extended	
	mobility and total assistance of ty	vo or more staff members for transfers.	
	the right tibia and fibula and fire	, revised 06/08/18, revealed the facility identified that t and second metatarsals. The facility's goal was for the	tne resident had a fracture to
	complications through the next re	eview on 09/13/18. The facility developed interventions	s included observing the resident's
	skin for breakdown. The facility revised the care plan on 06/25/18 with an intervention for the resident to wear a walker boot at all times, but the boot may be removed briefly for showers. The facility also revised the care plan on 06/25/18, to		
	ooot at an anies, but the boot Illa	, oc removed orieny for showers. The facility also levi	asea are care plan on 00/23/10, to

Facility ID: 185164

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCT A. BUILDING B. WING	TION	(X3) DATE SURVEY COMPLETED 08/22/2018
	185164		·	
NAME OF PROVIDER OF SUF BARBOURVILLE HEALTH A	PPLIER AND REHABILITATION CENT	TER	STREET ADDRESS, CITY, STA 65 MINTON HICKORY FARN BARBOURVILLE, KY 40906	
	nome's plan to correct this deficience			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		ENCY MUST BE PRECEDED BY	Y FULL REGULATORY
F 0684	(continued from page 3) state that the resident refused to h	ove the best removed at times du	ring boths, but implemented no in	torrontions to address
Level of harm - Immediate	the refusal.		-	
jeopardy	Review of an Orthopedic Consult, wear at all times, with the excepti	on that the boot should be remove	ed for skin checks and bathing one	ce a day briefly.
Residents Affected - Few	However, review of Physician Or at all times, may remove for show Interview with Licensed Practical #1's care after the orthopedic cons physician (Physician #1) that the l physician stated the facility could policy.	rers and bathing briefly, and the o Nurse (LPN # 7) on 08/08/18 at 1 sultation. The LPN stated she callifacility only conducted weekly sk change the order and conduct we	rder did not address the frequency :30 PM, revealed she wrote the or ed the orthopedic office on 06/22/ in assessments. According to LPN ekly skin assessments for Resider	of for skin assessments. rder regarding Resident 118, and notified the #7, the orthopedic tt #1 per the facility's
	However, interview with Physician resident's walking boot daily for s clarification order written by the f have recommended weekly skin c as ordered.	kin checks and bathing. The inter acility to only assess the resident	view revealed the physician was a 's skin weekly. Physician #1 stated	not aware of a I he would not
	Review of Resident #1's medical r 06/28/18, 07/05/18, and 07/12/18, Review of the resident's Skin Integ adequate turgor and hydration, an	not daily as prescribed by the resgrity Assessment, dated 07/12/18,	sident's orthopedic physician.	,
	Interviews on 08/06/18 with LPN Resident #1 with a bath on 07/14/identified.	#1 at 2:55 PM and State Registere 18, at which time the resident's w	alker boot was removed and no sk	kin concerns were
	Interviews on 08/07/18 with SRNA LPN #3 at 5:08 PM, RN #2 at 5:3 and	0 PM, LPN #4 at 5:35 PM, SRNA	A #4 at 5:40 PM, SRNA #5 at 6:02	2 PM, and SRNA #6 at 6:19 PM
	on 08/08/18 with LPN #5 at 11:58 for Resident #1 at some time from	n 07/14/18 through 07/19/18. The	staff stated the resident's walking	
	to assess the resident's skin after t Interviews on 08/07/18 with SRNA	A #5 at 6:02 PM and SRNA #6 at	6:19 PM revealed that during care	
	smelled bad and the staff question resident's toes appeared bruised an	nd swollen on 07/18/18.		
	Observation and interview with Re one time while at the facility. The	resident stated he/she requested t	that the walking boot be removed;	however, nurse aides
	had told him/her that they were no Further interview revealed the res	ident could smell his/her leg and	reported it to nursing staff; however	er, the resident
	stated a nurse did not remove the the foul odor because they told the	e resident he/she was going to los	e his/her leg because it smelled so	bad.
	Continued review of Resident #1's level of consciousness, responding	g to sternal rub (the application of	f pain with the knuckles of a close	d fist to the center
	chest of a patient who is not alert Department (ED) of Hospital #1 f	or evaluation.	· ·	<u> </u>
	Review of Resident #1's hospital n was removed, the resident's right and the resident's pulses were not hospital for a surgical consultation	lower extremity was observed to l palpable on the right foot. Furthe	have extremely severe wet gangre	ne from midleg down wards
	Review of Resident #1's medical regangrenous right lower extremity the resident's right foot was noted drainage was noted. Further review	ecord from Hospital #2, dated 07/ from the ankle area down. Review to be swollen, blisters present on	w of the Wound Care Team Const foot and toes, skin rolls off with t	alt, dated 07/20/18, revealed touch and bloody
	the right lower extremity. Interview with Physician #2 on 08			1
	resident's leg from the knee down foot that could not be saved. Furth The Physician stated that in his m stated that by not removing the be further stated that given the reside	. The Physician stated the residenter interview revealed the residented opinion, the walking boot it created a wet environment the	t's leg smelled, it was discolored, t was noted to have two ulcers on should have been removed at least nat promoted a bacterial infection.	and it was a dead the back of the calf. every 24-48 hours. He The Physician
	should have been removed daily. Interview with the facility's Admir	nistrator and Director of Nursing	on 08/09/18 at 6:53 PM revealed t	hat although the
	facility did not have a specific pol follow physician orders. The Adm potential skin breakdown would b ****The facility alleged the follow	ninistrator and Director of Nursing the inspected each shift, at a minim	g stated that it was their expectation, and the area would be kept co	on that any area of lean and dry.
	1. On 08/09/18, a department head Coordinators, Minimum Data Set Jeopardy (IJ) notification and a pl	meeting, including the facility's (MDS) Coordinators, and the Sta an was developed for the IJ abate	Administrator, Director of Nursin iff Development Coordinator was ment.	g (DON), Clinical held to review the Immediate
	2. On 08/11/18, skin assessments w 08/14/18. The skin assessments w MDS/Medicare Coordinators, and	ere conducted by the DON, Clini I documented on the facility Skin	cal Coordinators, Staff Developm Assessment form.	ent Coordinator, and the
	 Care plan reviews were initiated was up-to-date and interventions of Medicare Coordinators and a Corp 4. Skin assessments were initiated 	were in place and being followed. porate Nurse Consultant.	The care plan reviews were comp	pleted by the MDS and
	integrity alterations were addresse Coordinator, and Staff Developme 5. On 08/13/18, a Quality Assuran	ed, physician orders [REDACTEI ent and MDS/Medicare Coordinal	D]. The assessments were complet tors.	ed by the DON, Clinical
	MDS/Medicare Coordinators, Sta discuss the plan for IJ removal, re 6. On 08/09/18, a protocol was dev	ff Development Coordinator, Cor view the status of education, and	porate Consultant Staff Members, review audits.	, and the Medical Director to
	by the Quality Assurance (QA) Constaff Development Coordinator, a Removable Orthotic Device, on 0.7. The Administrator and DON we	ommittee. The Corporate Nurse in and MDS/Medicare Coordinators 8/11/18, and a post-test was compare re-educated by the Corporate I	n-serviced the Administrator, DOl on the Protocol for the facility's poleted to ensure comprehension.	N, Clinical Coordinators, rotocol, Use of a
	of F656 (Resident Care Plan) and 8. On 08/11/18, Corporate Consult the MDS/Medicare Coordinators appropriate document, and care pl	tants provided education to the Cl on the importance of ensuring ord	lers were being followed, accurate	ly transcribed to the
	9. On 08/11/18, facility nurses wer Protocol for Use of a Removable Treatment Administration Record a daily basis when the device is re also administered a post-test to en	re in-serviced by the Corporate N Orthotic Device. The protocol ins when an order was received for a smoved or more frequently based sure comprehension of the inform	urse Consultants and Nurse Coord tructed nurses to place a monitori a removable device. The resident's upon the physician's orders [RED nation. All nurses were to be re-ed	linator regarding the ng statement on the s skin will be monitored on ACTED]. The nurses were
	providing resident care. Informati 10. Facility nurse aides were in-ser			rse Coordinator

Facility ID: 185164

STATEMENT OF	(X1) PROVIDER / SUPPLIER	(N2) MEETILEE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
DEFICIENCIES AND PLAN OF	/ CLIA IDENNTIFICATION	A. BUILDING B. WING		08/22/2018
CORRECTION	NUMBER 185164			
NAME OF PROVIDER OF SUF			STREET ADDRESS, CITY, STA	TE, ZIP
BARBOURVILLE HEALTH A	AND REHABILITATION CENT		65 MINTON HICKORY FARM BARBOURVILLE, KY 40906	I ROAD
For information on the nursing h	ome's plan to correct this deficience	cy, please contact the nursing hom	e or the state survey agency.	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF D OR LSC IDENTIFYING INFORM		NCY MUST BE PRECEDED BY	FULL REGULATORY
F 0684	(continued from page 4) regarding observation and reporting	ng abangas in condition. The abso	ryations should include showers	haths, and routing care
Level of harm - Immediate jeopardy	as well as following the Kardex (i to evaluate comprehension of the education.	nformation provided to nurse aide	es on how to care for a resident). A	A post-test was given
Residents Affected - Few	11. Quality Assurance (QA) meeti	ngs will be conducted with Corpor	rate Consultant Staff Members we	eekly, until substantial
Residents Affected - Few	11. Quality Assurance (QA) meeti compliance is achieved. 12. To ensure retention, education MDS/Medicare Coordinators, and (3) nurse aides per unit on a daily immediately to the Administrator the weekly QA meetings for revie 13. The QA Committee members, unit per day for one week, then w [REDACTED]. The MDS and Merelated to skin assessments and the Any concerns were reported immediately and the Administrator and discussed in the ****The State Agency determined. Review of the Quality Assurancincluding the Administrator, Dires Staff Development Coordinator, I Coordinator at 3:15 PM, Staff De 3:45 PM revealed a QA meeting v removal. 2. Review of the facility's Skin As completed on facility residents wi PM, MDS Coordinator at 3:15 PM, Staff De 3:42/18 with the Corporate Nurs were reviewed to ensure care plans for and revised the care plans for resident of the proper of the facility's Skin As on all residents in the facility. Inte Staff Development Coordinator at 3:45 PM review of the facility's Skin As on all residents. Further interviewent of the facility is skin As on all residents. Further interviewent interventions were being followed representatives were aware of stafs. Review of the QA meeting rosts.	will be completed by QA Commit Clinical Coordinators, by conduct basis for one week, then weekly fand Director of Nursing (DON). It was and discussion. including the MDS/Medicare Cocekly for four weeks, and then modicare Coordinators and Clinical et a monitoring of skin under the renediately to the Administrator and I et QA meeting. Immediate Jeopardy was remove to (QA) meeting (DON), Clinical Conterviews on 08/22/18 with the Unvelopment Coordinator at 3:25 PN was conducted on 08/09/18 regards sessment forms, dated 08/11/18 the thremovable orthotic devices. Into M, Staff Development Coordinator rns were identified. or Resident #4, Resident A, Resided dents with removable orthotic devices consultant at 2:55 PM and the N is were up-to-date and intervention sessment forms, dated 08/12/18 the rviews on 08/22/18 with the Unit 3:25 PM, and the DON at 3:35 PM, and the DON at 3:35 PM, and the DON at 3:35 PM, and notification verifications we us and orders. ev, dated 08/13/18, revealed a meet taff Development Coordinator, Cordinator, Cordi	ttee Members, including the Staff titing ongoing post-testing with throof one (1) month. Any concerns with Staff Development Coordinate or Staff Development Coordinate or Staff Development Coordinate or Staff Development Coordinators and Clinical Coordinators observed care provincy of the Coordinators observed care provincy of the audits were done of the Staff of the Audits were done of the Staff of the Audits were done of the Staff of the Audits were observed on Staff of the Audits of	Development Coordinator, ree (3) nurses and three will be reported or will bring all results to ors, audited four (4) charts per ysician orders ded to four (4) residents, plan implementation. re reported to the at the following: 18 with department heads MDS) Coordinators, and the num Data Set (MDS) 2:35, and Administrator at otification and plan for IJ residents had been it Coordinator at 3:06 at confirmed the skin assessment of acility had reviewed at the resident care plans lely for residents with resident care plans lely for residents with resident care plans level to ensure the skin assessment of acility had reviewed at 3:15 PM, to were completed or all yed to ensure hysician and inistrator, DON, Unit edical Director. Interviews
	on 08/22/18 with the Corporate N Development Coordinator at 3:25 08/13/18 to discuss facility progre 6. Review of the facility in-service the Corporate Nurse Consultant re Consultant at 2:55 PM, DON at 3 Consultant on 08/11/18 related to 7. Review of the QA Committee n Device was adopted by the QA Cwas conducted by the Corporate N attendance was the Administrator on 08/22/18 with the Corporate N Development Coordinator at 3:25 regarding the Protocol for Use of 8. Review of the in-service and ros Consultant regarding following pl plans. Interviews on 08/22/18, with at 3:15 PM, and Staff Developme given to evaluate comprehension. 9. Review of the in-service and ros facility's Protocol for Use of a Reiziby Service and ros facility's Protocol for Use of a Reiziby Protocol for Use	PM, DON at 3:35 PM, and the Adsess with the IJ removal and plan. and roster, dated 08/11/18, reveal egarding regulations F656 and F68:35 PM, and Administrator at 3:45 regulations F656 and F684. annutes and roster, dated 08/09/18, promittee. Review of a facility insures consultant regarding the Proposition of the pro	dministrator at 3:45 PM revealed led the Administrator and DON re 34. Interviews on 08/22/18 with the PM revealed an in-service was generous and roster, dated 08/11/18 of box of a Removable Or evelopment Coordinator, and the 1 Coordinator at 3:45 PM revealed an inpost-test given to evaluate comprenence was conducted by the Cotion of orders, and implementation at 2:55 PM, Unit Coordinator at at 2:55 PM, Unit Coordinator at at 2:55 PM, Unit Coordinator at 1 did in-service was conducted by the Cotion of orders, and implementation at 2:55 PM, Unit Coordinator at need the in-service had been condulity nurses received an in-service laws on 08/22/18 with the Corporal facility nursing staff on the prote tatement which included the frequenther interview revealed nursing plan implementation, and skin as RN #4 at 2:45 PM, and LPN #8 at nurse aides were provided education on the provided education.	a QA meeting was held on exceived education from the Corporate Nurse iven by the Corporate Nurse as Removable Orthotic, revealed an in-service thotic Device; in MDS Coordinator. Interviews soordinator at 3:15 PM, Staff in-service was conducted thension. Or prorate Nurse in of resident care 3:06 PM, MDS Coordinator cted and post-tests were related to the ten Nurse Consultant at ocol. Review of the encry of when to remove and staff received sessments underneath a 12:52 PM, revealed they had ion by the Corporate
	Nurse Consultants and Unit Coort the resident Kardex when providin and Unit Coordinator at 3:06 PM Interviews on 08/22/18 with SRN provided prior to returning to resil 11. Review of QA Committee medinimum weekly with Corporate 2:55 PM, Unit Coordinator at 3:04 and the Administrator at 3:45 PM 12. Review of the facility's QA audides and three (3) nurses per unit education comprehension. Intervient RN #4 at 2:45 PM, LPN #8 at 2:52 PM Coordinator at 3:25 PM, confirme Coordinator, and Staff Developm for one (1) quarter. Interview with reported immediately to the Admidiscussion. 13. Review of the facility's QA audidied per day for one (1) week a cudited per day for one (1) week a reviewed. Interview with the Unit records were reviewed daily for oplan implementation, and remova observations were completed on the staff of the staff	dinators regarding observation and g care. Interviews on 08/22/18, w confirmed the in-service had been A #7 at 2:30 PM, SRNA #8 at 2:3 dent care and post-tests were givered by the consultant Staff Members in atter 5 PM, MDS Coordinator at 3:15 P confirmed QA meetings had been dits, dated 08/11/18 through 08/22 on a daily basis for one (1) week, ews with SRNA #7 at 2:30 PM, SI M, the Unit Coordinator at 3:06 PM distributed by the Staff Development Coordinator in the Staff Development Coordination in the Staff Development Coordination in the Staff Development Coordination and the results of the auditis, dated 08/11/18 through 08/22 and then weekly and skin care obsection (1) week and then weekly for the orthotic devices per physician	I reporting of changes in resident with the facility Corporate Nurse Cigiven to all facility nurse aides p 5 PM, and SRNA #9 at 2:40 PM, n. 33/18, and 08/20/18, revealed QA I addance. Interviews with the Corpo M, Staff Development Coordinate I conducted at least weekly. 1/18, revealed post-tests were give and then weekly for all shifts regRNA #8 at 2:35 PM, SRNA #9 at M, MDS Coordinator at 3:15 PM, Further interview with the Unit 0 s would continue weekly for one tor on 08/22/18 at 3:35 PM revealed its were taken to the weekly QA 1/218, revealed four (4) resident me ervations were conducted on the I S Coordinator at 3:15 PM revealed heaccuracy of transcription of ph orders. Further interview revealed orders. Further interview revealed orders. Further interview revealed orders. Further interview revealed	condition and following Consultant at 2:55 PM rior to resident care. revealed in-services were meetings were held at a brate Nurse Consultant at or at 3:25 PM, DON at 3:35 PM on to three (3) nurse parding in-service 2:40 PM, RN #3 at 2:41 PM, and the Staff Development Coordinator, MDS (1) month and then monthly ed any concerns were meetings for review and dical records were residents who were d four (4) resident medical ysician orders, care d skin care

Facility ID: 185164

FORM CMS-2567(02-99) Previous Versions Obsolete DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED:1/31/2019 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING 08/22/2018 185164 NAME OF PROVIDER OF SUPPLIER STREET ADDRESS, CITY, STATE, ZIP 65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906 BARBOURVILLE HEALTH AND REHABILITATION CENTER For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG F 0684 (continued... from page 5) interventions were implemented appropriately. Further interview revealed any concerns were reported immediately to the DON and Administrator. Interviews on 08/22/18 with the DON at 3:35 PM and Administrator at 3:45 PM revealed any concerns were addressed immediately including staff re-education and physician notification. Further interview revealed results of the audits were taken to the weekly QA meetings for review and discussion. Level of harm - Immediate jeopardy Residents Affected - Few

FORM CMS-2567(02-99) Event ID: YL1011 Facility ID: 185164
Previous Versions Obsolete