STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185164	A. BUILDING _____ B. WING _____	**08/22/2018**

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARBOURVILLE HEALTH AND REHABILITATION CENTER	**65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0657 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on interview, record review, and review of facility policy it was determined the facility failed to revise the plan of care for one (1) of four (4) sampled residents (Resident #1). On 06/22/18, Resident #1 had an appointment with an orthopedic surgeon for follow-up after tibia/fibula (lower leg bones) and metatarsal (toes) fractures. The orthopedic surgeon prescribed a walker boot for Resident #1 to be worn at all times, except for bathing and daily skin checks. The facility failed to revise the resident's care plan with the physician's orders [REDACTED].#1's skin daily. On 07/19/18, Resident #1 was transferred to the hospital due to unresponsiveness. When hospital staff removed the walker boot, Resident #1's right lower leg/foot had severe wet gangrene (Gangrene refers to the death of body tissue due to either a lack of blood flow or a serious bacterial infection. Chances for developing gangrene are higher if you have an underlying condition that can damage your blood vessels and affect blood flow, such as diabetes) that required the resident's leg to be amputated below the knee. The facility's failure to ensure resident care plans were revised has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/09/18 and determined to exist on 06/22/18 at 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F657 J) and 42 CFR 483.25 Quality of Care (F684 J). The facility was notified of the Immediate Jeopardy on 08/09/18. An acceptable Allegation of Compliance was received on 08/17/18, which alleged removal of the Immediate Jeopardy on 08/15/18. The State Survey Agency determined the Immediate Jeopardy was removed as alleged on 08/15/18, prior to exit on 08/22/18, which lowered the scope and severity to D level at 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) and 42 CFR 483.25 Quality of Care (F684), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's Care Plan Policy & Protocol, revised (MONTH) (YEAR), revealed the facility should develop a comprehensive care plan for each resident that included measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that were identified in the comprehensive assessment. Further review revealed the care plan would be periodically reviewed and revised by the interdisciplinary team after each assessment and on an as needed basis. According to the policy, the care plan would be updated as indicated with changes in condition and physician orders. Review of Resident #1's medical record revealed the facility admitted the resident on 04/06/12, with [DIAGNOSES REDACTED]. Review of a Significant Change Minimum Data Set (MDS) assessment, dated 06/24/18, revealed the facility assessed the resident's Brief Interview for Mental Status (BIMS) score to be fifteen (15), indicating the resident was cognitively intact and interviewable. Further review of the MDS assessment revealed the resident required extensive assistance with bed mobility and total assistance with transfers. Review of Resident #1's care plan, revised 06/08/18, revealed the resident had right tibia, fibula, and first and second toe fractures. Further review of the care plan revealed the facility implemented interventions that included notifying the physician of any complications, observing for [MEDICAL CONDITION] (swelling), and observing for skin breakdown. Review of an Orthopedic Consult for Resident #1 dated 06/22/18, revealed the orthopedic surgeon ordered a walker boot for the resident to be worn, except for skin checks and bathing once a day briefly. Continued review of Resident #1's care plan revealed the facility revised the care plan on 06/25/18 to include interventions of Consulting with ortho (orthopedic physician) and To wear walker boot at all times. (MONTH) remove for shower and bathing briefly. There was no documented evidence the facility revised the care plan to include the physician's orders [REDACTED]. In addition, the care plan stated the resident refused to remove the boot at times during bathing. However, there was no documented evidence the facility revised the care plan with interventions to address the alleged refusal. Interview with Licensed Practical Nurse (LPN) #7 on 08/08/18 at 1:30 PM, revealed she called the orthopedic office on 06/22/18, and notified the physician (Physician #1) that the facility only conducted weekly skin assessments. According to LPN #7, the orthopedic physician stated the facility could change the order and conduct only weekly skin assessments for Resident #1, per the facility's policy. However, interview with Physician #1 on 08/09/18 at 8:34 AM, revealed the orthopedic recommendations were to remove the resident's walking boot daily for skin checks and bathing. Physician #1 stated he would not have recommended only checking the resident's foot/leg weekly. Observation and interview with Resident #1 on 08/08/18 at 3:00 PM at Hospital #2 revealed the resident stated the walking boot was only removed one time while at the facility. The resident stated he never refused to allow staff to remove the walking boot. Further review revealed the resident stated he/she requested that the walking boot be removed. However, nurse aides had told him/her that they were not allowed to remove the boot, and that a nurse had to remove the boot. Interviews on 08/07/18 with State Registered Nurse Aide (SRNA) #2 at 3:39 PM, Registered Nurse (RN) #1 at 4:28 PM, LPN #2 at 4:37 PM, SRNA #3 at 5:02 PM, LPN #3 at 5:08 PM, RN #2 at 5:30 PM, LPN #4 at 5:35 PM, SRNA #4 at 5:40 PM, SRNA #5 at 6:02 PM, and SRNA #6 at 6:19 PM, and on 08/08/18 with LPN #5 at 11:58 AM, LPN #6 at 12:35 PM, LPN #7 at 12:43 PM, and RN #3 at 4:12 PM revealed Resident #1's walking boot was not removed and the resident's skin was not assessed from 07/14/18 to 07/19/18. Review of the facility's nurse's note, dated 07/19/18 at 1:45 AM, revealed Resident #1 had a decreased level of consciousness and was transferred to the Emergency Department for evaluation. Review of Resident #1's record from Hospital #1, dated 07/19/18, revealed after the resident's walking boot was removed upon arrival to the hospital, the resident's right lower extremity had extremely severe wet gangrene from midleg down wards and pulses in the right foot were not palpable. Resident #1 was transferred to Hospital #2 for surgical consultation regarding the gangrene. Review of Resident #1's medical record from Hospital #2, dated 07/20/18, revealed the resident was assessed to have a gangrenous right lower extremity from the ankle area down. Review of the Wound Care Team Consult, dated 07/20/18, revealed the resident's right foot was noted to be swollen, blisters present on foot and toes, skin rolls off with touch and bloody drainage was noted. Further review of the record dated 07/20/18, revealed the resident had a below-the-knee amputation of the right lower extremity. Interview with the facility's Administrator and Director of Nursing on 08/09/18 at 6:53 PM, revealed the nursing staff was to revise the plan of care for each resident with any changes to care, and staff were expected to follow physician orders

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 0657 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 1) [REDACTED]. Interview with Physician #2 on 08/08/18 at 3:35 PM, revealed he was Resident #1's surgeon at Hospital #2 and had removed the resident's leg from the knee down. The Physician stated the resident's leg smelled, it was discolored, and it was a dead foot and could not be saved. The Physician stated that in his medical opinion, the walking boot should have been removed at least every 24-48 hours, and by not removing the boot it created a wet environment that promoted a bacterial infection. The Physician further stated that given the resident's history of diabetes, hypertension, and immobility, the walking boot should have been removed daily. ****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 plan was developed for the IJ abatement. 2. On 08/11/18, skin assessments were initiated for all residents with removable orthopedic devices and completed by 08/14/18. The skin assessments were conducted by the DON, Clinical Coordinators, Staff Development Coordinator, and the MDS/Medicare Coordinators, and documented on the facility Skin Assessment form. 3. Care plan reviews were initiated on 08/11/18 for all residents with removable orthotic devices to ensure the care plan was up-to-date and interventions were in place and being followed. The care plan reviews were completed by the MDS and Medicare Coordinators and a Corporate Nurse Consultant. 4. Skin assessments were initiated on 08/12/18 and completed on 08/14/18 on every resident in the facility to ensure skin integrity alterations were addressed, physician orders [REDACTED]. The assessments were completed by the DON, Clinical Coordinator, and Staff Development and MDS/Medicare Coordinators. 5. On 08/13/18, a Quality Assurance (QA) meeting was conducted with the Administrator, DON, Clinical Coordinators, MDS/Medicare Coordinators, Staff Development Coordinator, Corporate Consultant Staff Members, and the Medical Director to discuss the plan for IJ removal, review the status of education, and review audits. 6. On 08/09/18, a protocol was developed by the Corporate Nurse 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 F684 (Quality of Care). 8. On 08/11/18, Corporate Consultants provided education to the Clinical Coordinators, Staff Development Coordinator, and the MDS/Medicare Coordinators on the importance of ensuring orders were being followed, accurately transcribed to the appropriate document, and care plan implementation. A post-test was given to verify comprehension of the information. 9. On 08/11/18, facility nurses were in-serviced by the Corporate Nurse Consultants and Nurse Coordinator regarding the Protocol for Use of a Removable Orthotic Device. The protocol instructed nurses to place a monitoring statement on the Treatment Administration Record when an order was received for a removable device. The resident's skin will be monitored on a daily basis when the device is removed or more frequently based upon the physician's orders [REDACTED]. The nurses were also administered a post-test to ensure comprehension of the information. All nurses were to be re-educated prior to providing resident care. Information was posted at the time clock to alert staff of the in-service. 10. Facility nurse aides were in-serviced on 08/13/18, by the Corporate Nurse Consultants and the Nurse Coordinator regarding observation and reporting changes in condition. The observations should include showers, baths, and routine care, as well as following the Kardex (information provided to nurse aides on how to care for a resident). A post-test was given to evaluate comprehension of the information. The nurse aides were not permitted to work until they had received the education. 11. Quality Assurance (QA) meetings will be conducted with Corporate Consultant Staff Members weekly, until substantial compliance is achieved. 12. To ensure retention, education will be completed by QA Committee Members, including the Staff Development Coordinator, MDS/Medicare Coordinators, and Clinical Coordinators, by conducting ongoing post-testing with three (3) nurses and three (3) nurse aides per unit on a daily basis for one week, then weekly for one (1) month. Any concerns will be reported immediately to the Administrator and Director of Nursing (DON). The Staff Development Coordinator will bring all results to the weekly QA meetings for review and discussion. 13. The QA Committee members, including the MDS/Medicare Coordinators and Clinical Coordinators, audited four (4) charts per unit per day for one week, then weekly for four weeks, and then monthly for one quarter to ensure physician orders [REDACTED]. The MDS and Medicare Coordinators and Clinical Coordinators observed care provided to four (4) residents, related to skin assessments and the monitoring of skin under the removable orthotic devices and care plan implementation. Any concerns were reported immediately to the Administrator and DON. The results of the audits were reported to the Administrator and discussed in the QA meeting. ****The State Agency determined Immediate Jeopardy was removed on 08/15/18 as alleged based on the following: 1. Review of the Quality Assurance (QA) meeting roster revealed a meeting was conducted on 08/09/18 with department heads including the Administrator, Director of Nursing (DON), Clinical Coordinators, Minimum Data Set (MDS) Coordinators, and the Staff Development Coordinator. Interviews on 08/22/18 with the Unit Coordinator at 3:06 PM, Minimum Data Set (MDS) Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, Director of Nursing (DON) at 3:35, and Administrator at 3:45 PM revealed a QA meeting was conducted on 08/09/18 regarding the IJ (Immediate Jeopardy) notification and plan for IJ removal. 2. Review of the facility's Skin Assessment forms, dated 08/11/18 through 08/14/18, revealed skin assessments had been completed on facility residents with removable orthotic devices. Interviews on 08/22/18, with the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, and DON at 3:35 PM confirmed the skin assessments had been completed and no concerns were identified. 3. Review of resident care plans for Resident #4, Resident A, Resident B, and Resident C revealed the facility had reviewed and revised the care plans for residents with removable orthotic devices between 08/11/18 and 08/14/18. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM and the MDS Coordinator at 3:15 PM revealed all resident care plans were reviewed to ensure care plans were up-to-date and interventions were being followed appropriately for residents with removable orthotic devices. 4. Review of the facility's Skin Assessment forms, dated 08/12/18 through 08/14/18, revealed skin assessments were completed on all residents in the facility. Interviews on 08/22/18 with the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, and the DON at 3:35 PM confirmed that skin assessments were completed on all facility residents. Further interview revealed physician orders [REDACTED]. Care plans were reviewed to ensure interventions were being followed, and notification verifications were completed to ensure resident physician and representatives were aware of status and orders. 5. Review of the QA meeting roster, dated 08/13/18, revealed a meeting was conducted with the Administrator, DON, Unit Coordinator, MDS Coordinator, Staff Development Coordinator, Corporate Nurse Consultant, and Medical Director. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and the Administrator at 3:45 PM revealed a QA meeting was held on 08/13/18 to discuss facility progress with the IJ removal and plan. 6. Review of the facility in-service and roster, dated 08/11/18, revealed the Administrator and DON received education from the Corporate Nurse Consultant regarding regulations F656 and F684. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, DON at 3:35 PM, and Administrator at 3:45 PM revealed an in-service was given by the Corporate Nurse Consultant on 08/11/18 related to regulations F656 and F684. 7. Review of the QA Committee minutes and roster, dated 08/09/18, revealed the Protocol for Use of a Removable Orthotic Device was adopted by the QA Committee. Review of a facility in-service and roster, dated 08/11/18, revealed an in-service was conducted by the Corporate Nurse Consultant regarding the Protocol for Use of a Removable Orthotic Device; in attendance was the Administrator, DON, Unit Coordinator, Staff Development Coordinator, and the MDS Coordinator. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and Administrator at 3:45 PM revealed an in-service was conducted

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F 0657 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 2) regarding the Protocol for Use of a Removable Orthotic Device. A post-test given to evaluate comprehension. 8. Review of the in-service and roster, dated 08/11/18, revealed an in-service was conducted by the Corporate Nurse 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 at 3:15 PM, and Staff Development Coordinator at 3:25 PM confirmed the in-service had been conducted and post-tests were given to evaluate comprehension. 9. Review of the in-service and roster, dated 08/11/18, revealed facility nurses received an in-service related to the facility's Protocol for Use of a Removable Orthotic Device. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM and Unit Coordinator at 3:06 PM revealed they in-serviced facility nursing staff on the protocol. Review of the Treatment Administration Records (TARs) revealed a monitoring statement which included the frequency of when to remove and assess the skin underneath the orthotic device per physician order. Further interview revealed nursing staff received education regarding accurate transcription of physician orders, care plan implementation, and skin assessments underneath a removable device. Interviews on 08/22/18 with RN #3 at 2:41 PM, RN #4 at 2:45 PM, and LPN #8 at 2:52 PM, revealed they had received the education and taken a post-test. 10. Review of an in-service roster, dated 08/13/18, revealed facility nurse aides were provided education by the Corporate Nurse Consultants and Unit Coordinators regarding observation and reporting of changes in resident condition and following the resident Kardex when providing care. Interviews on 08/22/18, with the facility Corporate Nurse Consultant at 2:55 PM and Unit Coordinator at 3:06 PM confirmed the in-service had been given to all facility nurse aides prior to resident care. Interviews on 08/22/18 with SRNA #7 at 2:30 PM, SRNA #8 at 2:35 PM, and SRNA #9 at 2:40 PM, revealed in-services were provided prior to returning to resident care and post-tests were given. 11. Review of QA Committee meeting rosters, dated 08/09/18, 08/13/18, and 08/20/18, revealed QA meetings were held at a minimum weekly with Corporate Consultant Staff Members in attendance. Interviews with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and the Administrator at 3:45 PM confirmed QA meetings had been conducted at least weekly. 12. Review of the facility's QA audits, dated 08/11/18 through 08/22/18, revealed post-tests were given to three (3) nurse aides and three (3) nurses per unit on a daily basis for one (1) week, and then weekly for all shifts regarding in-service education comprehension. Interviews 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, RN #4 at 2:45 PM, LPN #8 at 2:52 PM, the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, and the Staff Development Coordinator at 3:25 PM, confirmed post-tests were conducted daily. Further interview with the Unit Coordinator, MDS Coordinator, and Staff Development Coordinator revealed the audits would continue weekly for one (1) month and then monthly for one (1) quarter. Interview with the Staff Development Coordinator on 08/22/18 at 3:35 PM revealed any concerns were reported immediately to the Administrator and the results of the audits were taken to the weekly QA meetings for review and discussion. 13. Review of the facility's QA audits, dated 08/11/18 through 08/22/18, revealed four (4) resident medical records were audited per day for one (1) week and then weekly and skin care observations were conducted on the residents who were reviewed. Interview with the Unit Coordinator at 3:06 PM and MDS Coordinator at 3:15 PM revealed four (4) resident medical records were reviewed daily for one (1) week and then weekly for the accuracy of transcription of physician orders, care plan implementation, and removal of orthotic devices per physician orders. Further interview revealed skin care observations were completed on the residents with removable orthotic devices to ensure monitoring and care plan 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.
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** > Based on observation, interview, record review, and review of facility policies, it was determined the facility failed to ensure necessary care and services were provided for one (1) of four (4) sampled residents (Resident #1). Review of Resident #1's medical record revealed the resident sustained [REDACTED]. Review of the orthopedic orders, dated 06/22/18, revealed the walking boot was to be removed daily for bathing and skin checks. However, interview with facility staff and the resident revealed the facility failed to remove Resident #1's walking boot and assess the resident's foot/leg from 07/15/18 through 07/19/18, until the resident was sent to the Emergency Department due to a decrease in consciousness. The hospital assessed the resident to have extremely severe wet gangrene from midleg down wards on 07/09/18 upon arrival to the hospital (Gangrene refers to the death of body tissue due to either a lack of blood flow or a serious bacterial infection. Chances for developing gangrene are higher if you have an underlying condition that can damage your blood vessels and affect blood flow, such as diabetes.). The resident was then sent to a secondary hospital where the resident required a below-the-knee amputation of the right leg. The facility's failure to ensure care and services were provided has caused or is likely to cause serious injury, harm, impairment, or death to a resident. Immediate Jeopardy was identified on 08/09/18, and determined to exist on 06/22/18 at 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) and 42 CFR 483.25 Quality of Care (F684). The facility was notified of the Immediate Jeopardy on 08/09/18. An acceptable Allegation of Compliance was received on 08/17/18, which alleged removal of the Immediate Jeopardy on 08/15/18. The State Survey Agency determined the Immediate Jeopardy was removed on 08/15/18, prior to exit on 08/22/18, which lowered the scope and severity to D level at 42 CFR 483.21 Comprehensive Person-Centered Care Plans (F656) and 42 CFR 483.25 Quality of Care (f684), while the facility monitors the effectiveness of systemic changes and quality assurance activities. The findings include: Review of the facility's policy titled 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. Interview with the Administrator on 08/08/18 at 1:40 PM revealed the facility did not have a policy related to orthotic devices. 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. Review of x-ray reports, dated 06/08/18, revealed Resident #1 sustained a spiral [MEDICAL CONDITION] right tibia and right 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 interviewable. Further review of the MDS assessment revealed the resident required extensive assistance of staff for bed mobility and total assistance of two or more staff members for transfers. Review of Resident #1's care plan, revised 06/08/18, revealed the facility identified that the resident had a fracture to the right tibia and fibula, and first and second metatarsals. The facility's goal was for the resident to have no complications through the next review on 09/13/18. The facility developed interventions 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

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 3) state that the resident refused to have the boot removed at times during baths, but implemented no interventions to address the refusal. Review of an Orthopedic Consult, dated 06/22/18, revealed the orthopedic surgeon prescribed a walker boot for Resident #1 to wear at all times, with the exception that the boot should be removed for skin checks and bathing once a day briefly. However, review of Physician Orders, dated 06/22/18, revealed LPN #7 rewrote the orthopedic order as walker boot to be worn at all times, may remove for showers and bathing briefly, and the order did not address the frequency for skin assessments. Interview with Licensed Practical Nurse (LPN # 7) on 08/08/18 at 1:30 PM, revealed she wrote the order regarding Resident #1's care after the orthopedic consultation. The LPN stated she called the orthopedic office on 06/22/18, and notified the physician (Physician #1) that the facility only conducted weekly skin assessments. According to LPN #7, the orthopedic physician stated the facility could change the order and conduct weekly skin assessments for Resident #1 per the facility's policy. However, interview with Physician #1 on 08/09/18 at 8:34 AM, revealed the orthopedic recommendations were to remove the resident's walking boot daily for skin checks and bathing. The interview revealed the physician was not aware of a clarification order written by the facility to only assess the resident's skin weekly. Physician #1 stated he would not have recommended weekly skin checks. The physician stated the walking boot should have been removed daily for skin checks as ordered. Review of Resident #1's medical record revealed the facility conducted assessments of Resident #1's skin weekly on 06/26/18, 06/28/18, 07/05/18, and 07/12/18, not daily as prescribed by the resident's orthopedic physician. Review of the resident's Skin Integrity Assessment, dated 07/12/18, revealed the resident's skin was warm and dry with adequate turgor and hydration, and no new issues were noted. Interviews on 08/06/18 with LPN #1 at 2:55 PM and State Registered Nurse Aide (SRNA) #1 at 3:02 PM revealed they assisted Resident #1 with a bath on 07/14/18, at which time the resident's walker boot was removed and no skin concerns were identified. Interviews on 08/07/18 with SRNA #2 at 3:39 PM, Registered Nurse (RN) #1 at 4:28 PM, LPN #2 at 4:37 PM, SRNA #3 at 5:02 PM, LPN #3 at 5:08 PM, RN #2 at 5:30 PM, LPN #4 at 5:35 PM, SRNA #4 at 5:40 PM, SRNA #5 at 6:02 PM, and SRNA #6 at 6:19 PM, and on 08/08/18 with LPN #5 at 11:58 AM, LPN #6 at 12:35 PM, LPN #7 at 12:43 PM, and RN #3 at 4:12 PM revealed they had cared for Resident #1 at some time from 07/14/18 through 07/19/18. The staff stated the resident's walking boot was not removed to assess the resident's skin after the resident received a bath during the day shift on 07/14/18. Interviews on 08/07/18 with SRNA #5 at 6:02 PM and SRNA #6 at 6:19 PM revealed that during care on 07/16-17/18, Resident #1 smelled bad and the staff questioned the resident about bathing. Interview with SRNA #4 on 08/07/18 at 5:40 PM revealed the resident's toes appeared bruised and swollen on 07/18/18. Observation and interview with Resident # 1 on 08/08/18 at 3:00 PM at Hospital #2 revealed the walking boot was only removed one time while at the facility. The resident stated he/she requested that the walking boot be removed; however, nurse aides had told him/her that they were not allowed to remove the boot. The SRNAs stated that a nurse had to remove the boot. Further interview revealed the resident could smell his/her leg and reported it to nursing staff; however, the resident stated a nurse did not remove the boot to assess the resident. Further interview revealed facility nurse aides also smelled the foul odor because they told the resident he/she was going to lose his/her leg because it smelled so bad. Continued review of Resident #1's medical record revealed on 07/19/18 at 1:45 AM, LPN #5 found Resident #1 with a decreased level of consciousness, responding to sternal rub (the application of pain with the knuckles of a closed fist to the center chest of a patient who is not alert and does not respond to verbal stimuli). Resident #1 was transferred to the Emergency Department (ED) of Hospital #1 for evaluation. Review of Resident #1's hospital medical record dated 07/19/18, from Hospital #1 revealed after the resident's walking boot was removed, the resident's right lower extremity was observed to have extremely severe wet gangrene from midleg down wards and the resident's pulses were not palpable on the right foot. Further review revealed the resident was sent to a secondary hospital for a surgical consultation regarding the gangrene. Review of Resident #1's medical record from Hospital #2, dated 07/20/18, revealed the resident was assessed to have a gangrenous right lower extremity from the ankle area down. Review of the Wound Care Team Consult, dated 07/20/18, revealed the resident's right foot was noted to be swollen, blisters present on foot and toes, skin rolls off with touch and bloody drainage was noted. Further review of the record, dated 07/20/18, revealed the resident had a below-the-knee amputation of the right lower extremity. Interview with Physician #2 on 08/08/18 at 3:35 PM, revealed he was Resident #1's surgeon at Hospital #2 and had removed the resident's leg from the knee down. The Physician stated the resident's leg smelled, it was discolored, and it was a dead foot that could not be saved. Further interview revealed the resident was noted to have two ulcers on the back of the calf. The Physician stated that in his medical opinion, the walking boot should have been removed at least every 24-48 hours. He stated that by not removing the boot it created a wet environment that promoted a bacterial infection. The Physician further stated that given the resident's history of being bedbound, and having diabetes and hypertension, the walking boot should have been removed daily. Interview with the facility's Administrator and Director of Nursing on 08/09/18 at 6:53 PM revealed that although the facility did not have a specific policy related to the removal of orthotic devices, the nursing staff was expected to follow physician orders. The Administrator and Director of Nursing stated that it was their expectation that any area of potential skin breakdown would be inspected each shift, at a minimum, and the area would be kept clean and dry. ****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 plan was developed for the IJ abatement. 2. On 08/11/18, skin assessments were initiated for all residents with removable orthopedic devices and completed by 08/14/18. The skin assessments were conducted by the DON, Clinical Coordinators, Staff Development Coordinator, and the MDS/Medicare Coordinators, and documented on the facility Skin Assessment form. 3. Care plan reviews were initiated on 08/11/18 for all residents with removable orthotic devices to ensure the care plan was up-to-date and interventions were in place and being followed. The care plan reviews were completed by the MDS and Medicare Coordinators and a Corporate Nurse Consultant. 4. Skin assessments were initiated on 08/12/18 and completed on 08/14/18 on every resident in the facility to ensure skin integrity alterations were addressed, physician orders [REDACTED]. The assessments were completed by the DON, Clinical Coordinator, and Staff Development and MDS/Medicare Coordinators. 5. On 08/13/18, a Quality Assurance (QA) meeting was conducted with the Administrator, DON, Clinical Coordinators, MDS/Medicare Coordinators, Staff Development Coordinator, Corporate Consultant Staff Members, and the Medical Director to discuss the plan for IJ removal, review the status of education, and review audits. 6. On 08/09/18, a protocol was developed by the Corporate Nurse 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 F684 (Quality of Care). 8. On 08/11/18, Corporate Consultants provided education to the Clinical Coordinators, Staff Development Coordinator, and the MDS/Medicare Coordinators on the importance of ensuring orders were being followed, accurately transcribed to the appropriate document, and care plan implementation. A post-test was given to verify comprehension of the information. 9. On 08/11/18, facility nurses were in-serviced by the Corporate Nurse Consultants and Nurse Coordinator regarding the Protocol for Use of a Removable Orthotic Device. The protocol instructed nurses to place a monitoring statement on the Treatment Administration Record when an order was received for a removable device. The resident's skin will be monitored on a daily basis when the device is removed or more frequently based upon the physician's orders [REDACTED]. The nurses were also administered a post-test to ensure comprehension of the information. All nurses were to be re-educated prior to providing resident care. Information was posted at the time clock to alert staff of the in-service. 10. Facility nurse aides were in-serviced on 08/13/18, by the Corporate Nurse Consultants and the Nurse Coordinator

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	185164	A. BUILDING _____ B. WING _____	08/22/2018

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
BARBOURVILLE HEALTH AND REHABILITATION CENTER	65 MINTON HICKORY FARM ROAD BARBOURVILLE, KY 40906

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 4) regarding observation and reporting changes in condition. The observations should include showers, baths, and routine care, as well as following the Kardex (information provided to nurse aides on how to care for a resident). A post-test was given to evaluate comprehension of the information. The nurse aides were not permitted to work until they had received the education. 11. Quality Assurance (QA) meetings will be conducted with Corporate Consultant Staff Members weekly, until substantial compliance is achieved. 12. To ensure retention, education will be completed by QA Committee Members, including the Staff Development Coordinator, MDS/Medicare Coordinators, and Clinical Coordinators, by conducting ongoing post-testing with three (3) nurses and three (3) nurse aides per unit on a daily basis for one week, then weekly for one (1) month. Any concerns will be reported immediately to the Administrator and Director of Nursing (DON). The Staff Development Coordinator will bring all results to the weekly QA meetings for review and discussion. 13. The QA Committee members, including the MDS/Medicare Coordinators and Clinical Coordinators, audited four (4) charts per unit per day for one week, then weekly for four weeks, and then monthly for one quarter to ensure physician orders [REDACTED]. The MDS and Medicare Coordinators and Clinical Coordinators observed care provided to four (4) residents, related to skin assessments and the monitoring of skin under the removable orthotic devices and care plan implementation. Any concerns were reported immediately to the Administrator and DON. The results of the audits were reported to the Administrator and discussed in the QA meeting. ****The State Agency determined Immediate Jeopardy was removed on 08/15/18 as alleged based on the following: 1. Review of the Quality Assurance (QA) meeting roster revealed a meeting was conducted on 08/09/18 with department heads including the Administrator, Director of Nursing (DON), Clinical Coordinators, Minimum Data Set (MDS) Coordinators, and the Staff Development Coordinator. Interviews on 08/22/18 with the Unit Coordinator at 3:06 PM, Minimum Data Set (MDS) Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, Director of Nursing (DON) at 3:35, and Administrator at 3:45 PM revealed a QA meeting was conducted on 08/09/18 regarding the IJ (Immediate Jeopardy) notification and plan for IJ removal. 2. Review of the facility's Skin Assessment forms, dated 08/11/18 through 08/14/18, revealed skin assessments had been completed on facility residents with removable orthotic devices. Interviews on 08/22/18, with the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, and DON at 3:35 PM confirmed the skin assessments had been completed and no concerns were identified. 3. Review of resident care plans for Resident #4, Resident A, Resident B, and Resident C revealed the facility had reviewed and revised the care plans for residents with removable orthotic devices between 08/11/18 and 08/14/18. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM and the MDS Coordinator at 3:15 PM revealed all resident care plans were reviewed to ensure care plans were up-to-date and interventions were being followed appropriately for residents with removable orthotic devices. 4. Review of the facility's Skin Assessment forms, dated 08/12/18 through 08/14/18, revealed skin assessments were completed on all residents in the facility. Interviews on 08/22/18 with the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, and the DON at 3:35 PM confirmed that skin assessments were completed on all facility residents. Further interview revealed physician orders [REDACTED]. Care plans were reviewed to ensure interventions were being followed, and notification verifications were completed to ensure resident physician and representatives were aware of status and orders. 5. Review of the QA meeting roster, dated 08/13/18, revealed a meeting was conducted with the Administrator, DON, Unit Coordinator, MDS Coordinator, Staff Development Coordinator, Corporate Nurse Consultant, and Medical Director. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and the Administrator at 3:45 PM revealed a QA meeting was held on 08/13/18 to discuss facility progress with the IJ removal and plan. 6. Review of the facility in-service and roster, dated 08/11/18, revealed the Administrator and DON received education from the Corporate Nurse Consultant regarding regulations F656 and F684. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, DON at 3:35 PM, and Administrator at 3:45 PM revealed an in-service was given by the Corporate Nurse Consultant on 08/11/18 related to regulations F656 and F684. 7. Review of the QA Committee minutes and roster, dated 08/09/18, revealed the Protocol for Use of a Removable Orthotic Device was adopted by the QA Committee. Review of a facility in-service and roster, dated 08/11/18, revealed an in-service was conducted by the Corporate Nurse Consultant regarding the Protocol for Use of a Removable Orthotic Device; in attendance was the Administrator, DON, Unit Coordinator, Staff Development Coordinator, and the MDS Coordinator. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and Administrator at 3:45 PM revealed an in-service was conducted regarding the Protocol for Use of a Removable Orthotic Device. A post-test given to evaluate comprehension. 8. Review of the in-service and roster, dated 08/11/18, revealed an in-service was conducted by the Corporate Nurse 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 at 3:15 PM, and Staff Development Coordinator at 3:25 PM confirmed the in-service had been conducted and post-tests were given to evaluate comprehension. 9. Review of the in-service and roster, dated 08/11/18, revealed facility nurses received an in-service related to the facility's Protocol for Use of a Removable Orthotic Device. Interviews on 08/22/18 with the Corporate Nurse Consultant at 2:55 PM and Unit Coordinator at 3:06 PM revealed they in-serviced facility nursing staff on the protocol. Review of the Treatment Administration Records (TARs) revealed a monitoring statement which included the frequency of when to remove and assess the skin underneath the orthotic device per physician order. Further interview revealed nursing staff received education regarding accurate transcription of physician orders, care plan implementation, and skin assessments underneath a removable device. Interviews on 08/22/18 with RN #3 at 2:41 PM, RN #4 at 2:45 PM, and LPN #8 at 2:52 PM, revealed they had received the education and taken a post-test. 10. Review of an in-service roster, dated 08/13/18, revealed facility nurse aides were provided education by the Corporate Nurse Consultants and Unit Coordinators regarding observation and reporting of changes in resident condition and following the resident Kardex when providing care. Interviews on 08/22/18, with the facility Corporate Nurse Consultant at 2:55 PM and Unit Coordinator at 3:06 PM confirmed the in-service had been given to all facility nurse aides prior to resident care. Interviews on 08/22/18 with SRNA #7 at 2:30 PM, SRNA #8 at 2:35 PM, and SRNA #9 at 2:40 PM, revealed in-services were provided prior to returning to resident care and post-tests were given. 11. Review of QA Committee meeting rosters, dated 08/09/18, 08/13/18, and 08/20/18, revealed QA meetings were held at a minimum weekly with Corporate Consultant Staff Members in attendance. Interviews with the Corporate Nurse Consultant at 2:55 PM, Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, Staff Development Coordinator at 3:25 PM, DON at 3:35 PM, and the Administrator at 3:45 PM confirmed QA meetings had been conducted at least weekly. 12. Review of the facility's QA audits, dated 08/11/18 through 08/22/18, revealed post-tests were given to three (3) nurse aides and three (3) nurses per unit on a daily basis for one (1) week, and then weekly for all shifts regarding in-service education comprehension. Interviews 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, RN #4 at 2:45 PM, LPN #8 at 2:52 PM, the Unit Coordinator at 3:06 PM, MDS Coordinator at 3:15 PM, and the Staff Development Coordinator at 3:25 PM, confirmed post-tests were conducted daily. Further interview with the Unit Coordinator, MDS Coordinator, and Staff Development Coordinator revealed the audits would continue weekly for one (1) month and then monthly for one (1) quarter. Interview with the Staff Development Coordinator on 08/22/18 at 3:35 PM revealed any concerns were reported immediately to the Administrator and the results of the audits were taken to the weekly QA meetings for review and discussion. 13. Review of the facility's QA audits, dated 08/11/18 through 08/22/18, revealed four (4) resident medical records were audited per day for one (1) week and then weekly and skin care observations were conducted on the residents who were reviewed. Interview with the Unit Coordinator at 3:06 PM and MDS Coordinator at 3:15 PM revealed four (4) resident medical records were reviewed daily for one (1) week and then weekly for the accuracy of transcription of physician orders, care plan implementation, and removal of orthotic devices per physician orders. Further interview revealed skin care observations were completed on the residents with removable orthotic devices to ensure monitoring and care plan

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F 0684 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(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.