STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185269	A. Building B. Wing	02/07/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Crittenden County Health & Rehabilitation Center	201 Watson Street Marion, KY 42064

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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on observation, interview, record review, and facility policy review, the facility failed to implement multiple interventions on the comprehensive person-centered care plan for one (Resident (R) 37) of two sampled residents reviewed for wound care. Interventions regarding treatment orders, infection control measures, and odor control were not implemented in accordance with the resident's care plan. The findings include: Review of the facility policy, Resident Assessment Comprehensive Care Plans, updated 05/24/2022, revealed the facility must implement a comprehensive person-centered care plan for each resident. The intent stated, Each resident will have a person-centered comprehensive care plan developed and implemented to meet his other preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs. Review of the facility policy, Comprehensive Care Plans, effective 11/28/2017, revealed, the services provided or arranged by the facility, as outlined by the comprehensive care plan must meet professional standards of quality. Under procedure, it revealed, professional standards of quality means that care and services are provided according to accepted standards of clinical practice. Review of the face sheet revealed R37 was admitted to the facility on [DATE] with diagnoses which included fistula of intestine-enterocolic and colocutaneous, and a colostomy related to megacolon/abdominal surgery. A. Review of the Comprehensive Care Plan, dated 05/09/2023, with a problem of ostomy related to megacolon and abdominal surgery, revealed ostomy care will be managed appropriately. Approaches included enhanced barrier precautions (EBP) during high contact resident care activities. On 02/06/2025 at 2:40 PM, observation revealed Licensed Practical Nurse (LPN) 1 failed to wear a gown (part of the facility's required EBP) while providing wound care (a high contact resident care activity) to R37. (Refer to F880). (continued on next page)

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.

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

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with LPN1 on 02/07/2025 at 2:33 PM, he stated he did not take the time to put on a gown (as an EBP) prior to providing care; however, he continued, he should have taken the time. LPN1 stated the Comprehensive Care Plan was used to tell everyone how to care for all the resident sand confirmed he was not following the care plan as written. B. Review of the Comprehensive Care Plan, dated 09/04/2024, revealed the resident had a problem of an open area to the left buttock, which was verified by a medical doctor as a chronic fistula wound. Review of the Comprehensive Care Plan, dated 05/23/2024, revealed the resident also had a problem of an open area to the right buttock. Both care plan problems included a goal to heal skin and prevent infection. Care Plan approaches to meet these goals included for staff to deliver prescribed treatment. Review of the physician-prescribed treatment orders, dated 02/01/2025, revealed an order for wound care, with a start date of 01/18/2025, which included cleansing the buttock wounds with Dial soap and water, as well as the application of Neosporin ointment (triple antibiotic ointment) 3.5 milligrams, to the wounds. An observation on 02/06/2025 at 2:40 PM during wound care revealed LPN1 failed to follow the care plan by delivering the prescribed treatment. LPN1 cleansed the resident's wounds with Dakin's solution, instead of with Dial soap and water. Further observation of the treatment revealed LPN1 failed to apply Neosporin ointment, and instead applied a topical lotion (Dermacil). During an interview with LPN1 on 02/07/2025 at 2:33 PM, he acknowledged that he had not provided the prescribed treatment in accordance with the care plan. (Refer to F684.) C. Review of the Comprehensive Care Plan, dated 07/19/2023, revealed the resident has odor problems related to the ostomy and fistula. The goal was for the resident's room to have a pleasant odor. An approach was that the resident would have a scented plug-in in his room at his request. An observation on 02/06/2025 at 2:40 PM, revealed LPN1 preparing to provide ostomy and wound care During this observation, it was noted that the resident did not have a scented plug-in in his room to control odors. A strong foul odor was noted in the resident's room and could also be smelled throughout his hall and the surrounding halls. An interview with Housekeeper 1 on 02/06/2025 at 10:38 AM revealed that housekeeping staff cleaned R37's room each day while the resident went out to smoke, and no one had mentioned that they needed to obtain a plug in to control the odor in the resident's room. During an interview with the Director of Nursing (DON) on 02/07/2024 at 2:58 PM, she stated she expected all staff to follow the Comprehensive Care Plans as written. She stated the care plans should be person centered, developed, and implemented to meet the resident's preferences and goals, and address the resident's medical, physical, mental, and psychosocial needs.

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(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 - Minimal harm or potential for actual harm 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** 37031 Based on observation, interview, and record review, the facility failed to provide non-pressure wound care in accordance with the resident's care plan and physician orders for one (Resident (R) 37) of two sampled residents reviewed for wounds. The findings include: Review of R37's face sheet revealed the resident was admitted to the facility on [DATE] with diagnoses which included a fistula of intestine-enterocolic and colocutaneous, and a colostomy related to megacolon/abdominal surgery. Review of the Comprehensive Care Plan, dated 09/04/2024, revealed the resident had a problem of an open area to the left buttock which was verified by the medical doctor as a chronic fistula wound. Review of the Comprehensive Care Plan, dated 05/23/2024, also revealed the resident had an open area to the right buttock. The care plan goal for each wound was to heal skin and prevent infection. An approach to meet this goal was for staff to deliver prescribed treatment. Review of physician orders, dated 02/01/2025, revealed an order for wound care, with a start date of 01/18/2025. The prescribed treatment included: Neosporin ointment (triple antibiotic ointment) 3.5 milligrams, 1 application topical. Special Instructions: buttock wounds, cleanse with Dial soap and water, pat dry. Apply Neosporin to wounds along with lidocaine, cover with gauze island dressing every shift and as needed if soiled or dislodged. During an observation of ostomy care and skin assessment on 02/06/2025 at 2:40 PM, Licensed Practical Nurse (LPN) 1 failed to follow physician orders. LPN1 was observed to cleanse the resident's buttock wounds with Dakin's solution, rather than Dial soap and water as ordered. LPN1 then applied a topical skin lotion (Dermacil), instead of using the physician-ordered triple antibiotic ointment (Neosporin). Interview with LPN1, on 02/07/2025 at 2:33 PM, revealed he was the charge nurse on the floor and that wound care was completed by whichever nurse was working the floor that day. Interview with LPN1 revealed that he was aware that the physician's order called for cleansing the wound with Dial soap and water. However, he failed to follow the order because he thought the Dakin's solution would do a good job of cleaning the wound. Further interview revealed he was also aware that the orders called for applying Neosporin; however, he thought by using the skin lotion, it would help the resident's excoriated skin at the fistula/ostomy sites. LPN1 confirmed he was not following the physician orders as written. An interview with the Director of Nursing (DON) on 02/07/2025 at 2:58 PM revealed her expectation was that nursing staff follow physician orders and provide quality of care per professional standards. During an interview with the Administrator, on 02/07/2025 at 3:30 PM, she stated she expected all nursing staff to follow physician orders as written and to provide quality of care with wound care.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 50991 Based on observation, interview, and review of facility policy, the facility failed to store, prepare, distribute, and serve food in accordance with professional standards for food service safety. Food items in the walk-in freezer were not labeled or dated. Staff failed to completely cover their hair while in the kitchen. Staff failed to cover prepared food on the warming table. A cold food was not at the proper temperature for serving. These failures had the potential to affect all 61 of the facility's residents who consumed food from the kitchen. The findings include: 1. Review of the facility's policy titled, Storage Procedures, dated 08/2023, revealed, Food shall be properly stored to preserve flavor, nutritive value, and appearance. Per policy review, all foods in the freezer were to be wrapped in moisture proof wrapping or placed in suitable containers, to prevent freezer burn. In addition, they were to be labeled and dated with use by dates clearly marked. Observation of the walk-in freezer, at 12:11 PM on 02/04/2025, revealed five chicken patties, six hamburger steaks, five chicken fritters, and five chicken cordon bleu were not labeled or dated. Interview with the Dietary Manager, on 02/04/2025 at 12:15 PM, revealed that all left over foods should be labeled and dated before putting into the freezer. She further stated that it could cause residents to become sick if they eat something outdated. 2. Review of the facility's policy titled, Food Temperature Records/Controls, dated 08/2023, revealed, Cold foods should be 41 degrees or less when the temperature is taken in the kitchen, at the time of service. Additionally, per the policy, prepared perishables such as salads, puddings, milk, etc., should be stored in a refrigerator and covered until use. At 11:32 AM on 02/04/2025, observation revealed that various foods were prepared for lunch and were placed on the hot bar, waiting to be plated. Observation of this area revealed that all the foods were covered with plastic, with the exception of two large containers of chicken pot pie. This food remained uncovered until 11:37 AM when [NAME] 2 entered the kitchen and covered the containers of chicken pot pie. After covering the food, [NAME] 2 was observed to take the temperatures of all foods that were to be served for the lunch, with the exception of the mayonnaise-based coleslaw that was being served as a substitute for the scheduled salad. After [NAME] 2 indicated that the foods were ready to be served, the survey team asked [NAME] 2 to check the temperature of the coleslaw. This food, which was supposed to be served cold, measured 57 degrees. After surveyor intervention, the coleslaw was not used for lunch and a substitute was served. Interview with [NAME] 2, on 02/04/2025 at 12:07 PM, revealed she forgot to cover the chicken pot pie before she left the kitchen for a few minutes She added that she had prepared the coleslaw that morning and left the filled containers out, next to the stove, because she was going to serve the coleslaw for lunch. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Interview with the Dietary Manager, on 02/04/2025 at 12:15 PM, revealed that food should be covered before leaving it on the warmer. She states that germs or flies could get into the food and cause sickness for the residents. She stated she did not know why the cook left the food uncovered before leaving the kitchen. 3. Review of the facility's policy titled, Dietary Dress Code, dated 08/23, revealed, All dietary service employees will wear clean and safe apparel. Per policy review, hair nets or hair restraints were to be worn, and hair should be completely under the hair restraint with no bangs protruding from any side of one's scalp. An initial tour of the kitchen on 02/04/2025 at 11:31 AM, with the Dietary Manager revealed that food was being prepared for the lunch meal. Observation at this time revealed that the Dietary Manager's hair was pulled back in a bun. The Dietary Manager was wearing a hairnet; however, it only covered the bun portion of her hair and the rest of her hair was uncovered. Additional observation of the Dietary Manager on 02/05/2025 at 1:30 PM, again revealed that only the back portion of her hair was covered. Interview with the Dietary Manager, on 02/05/2025 at 1:30 PM, revealed that she had trouble with her hair covering not staying on/slipping back and the facility was trying to order a different type of hairnet that would hopefully cover all her hair. In interview with the Administrator of the facility on 02/07/2025 at 5:15 PM, she stated her expectation was that all of her staff followed policies. She stated that, If staff do not wear their hairnets properly, hairs could get in the food and that would not be good. The Administrator added that she expected the dietary staff to label and date all leftover foods in the freezer, saying that it could make the residents ill if they ate things that were freezer burnt or outdated. Further interview with the Administrator revealed that she expected foods to be covered and be served at the correct temperature. She stated serving coleslaw at a temperature of 57 degrees was not acceptable and could cause residents to become sick.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37031 Based on observation, interview, record review, and policy review, the facility failed to maintain an infection prevention and control program designed to prevent the development and transmission of communicable diseases and infections for one (Resident (R) 37) of two residents reviewed for wound care. Facility staff failed to perform hand hygiene as indicated before, during, and after ostomy and wound care. Staff failed to use enhanced barrier precautions (EBP) designed to reduce transmission of multidrug-resistant organisms even though the resident had wounds that required EBP. Treatment supplies, including scissors and ointment, were handled in a manner that did not prevent the spread of infection. In addition, hand hygiene was not monitored by supervisory staff as planned as part of the facility's surveillance/monitoring activities. The findings included: Review of the facility policy, Infection Control Program, reviewed 01/2025 revealed the purposed of the infection control program in the nursing facility was to minimize the effects of infections on residents and employees, and to educate the staff. The Infection Control Manual, reviewed 01/2025, revealed staff will wash hands before donning gloves for resident care, during care when soiled, between glove changes, and after care is completed before leaving the resident's room. Review of the policy for Isolation-Categories of Transmission-Based Precautions, updated 10/2023 and reviewed 01/2025, revealed EBP for close contact resident care included the use of gloves, a gown, and eye protection if there was a risk of splashing fluids. Review of the policy, Monitoring Infection Control Practices, dated 01/2022, revealed the facility's infection control preventionist will conduct routine monitoring and surveillance to determine compliance with infection control policies and practices. Review of the face sheet revealed R37 was admitted to the facility on [DATE] with diagnoses which included a fistula of intestine-enterocolic and colocutaneous, and a colostomy related to megacolon/abdominal surgery. Observation on 02/06/2025 at 10:09 AM revealed a sign on the right side of the door to R37's room, which noted the resident was on EBP. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an observation of ostomy care and a wound assessment for R37 on 02/06/2025 at 2:40 PM, Licensed Practical Nurse (LPN) 1 failed to use all required EBP during ostomy care to the lower abdomen and wound care to the left and right buttock. LPN1 did not don a gown prior to completing ostomy and wound care. In addition, LPN1 failed to wash his hands prior to, during, and after ostomy care and wound care. Each time he removed his gloves, he did not wash his hands prior to donning another pair of gloves. During ostomy care, he took a topical lotion for external use and used a dirty gloved finger to place the lotion on and around an excoriated area of the resident's fistula/ostomy. LPN1 further took a pair of scissors from his pocket using his dirty gloves and cut out an area of the ostomy wafer before securing it around the fistula and the ostomy. He then used his dirty scissors to cut another wafer to fit on the left side of the abdomen. After placing the new ostomy bags to the abdomen, LPN1 was requested to assess the wounds to the resident's buttocks. Without washing his hands after ostomy care, LPN1 proceeded to don another pair of gloves. He began care of the wounds on the resident's bilateral buttocks by cleansing the areas with Dakin's solution, which was not the ordered care (Refer to F684.) However, LPN1 did not clean all of the dried stool from the wounds before he applied a treatment and dressing. After the procedures were completed, LPN 1 removed his gloves, placed them in a red bag along with the contaminated ostomy bags, and left the open red bag, which had a foul odor at the resident's bedside. LPN1 proceeded to leave the room and go to the nurses' station. He did not perform hand hygiene before he then went into the medication room. During an interview with LPN1 on 02/07/2025 at 2:33 PM, he stated he had a bad habit of not washing his hands. LPN1 added that, There are bad outcomes, from not performing hand hygiene as he could pass bad pathogens back and forth between residents. LPN1 also stated he was aware that R37 was on enhanced barriers due to his ostomy and wounds; however, he confirmed that he failed to put on a gown prior to providing care. He also stated he should have tied up the red bagged contaminated dressing and removed it from the resident's room. During an interview with the Infection Control (IC) Nurse on 02/06/2024 at 3:10 PM, she stated she received her IC certificate in 05/2024. She stated she had not watched LPN1 do wound care. The IC Nurse added that she is supposed to do hand hygiene evaluations two times a week. However, the IC Nurse continued, she could not currently watch all staff for hand hygiene practices as she is working the floor. She stated she expected LPN1, and all staff, to use good hand hygiene practices, use the required personal protective equipment including gowns, and remove all contaminated trash from the room after care, per infection control policy. An interview with the Director of Nursing (DON), on 02/07/2025 at 2:58 PM, revealed her expectation was for nursing staff to follow the infection control policy as written, use good hand hygiene, and use the personal protective equipment provided. During an interview with the Administrator on 02/07/2025 at 3:30 PM, she stated she expected all nursing staff to follow facility policies regarding good infection control practices, which included hand hygiene and removing soiled ostomy bags and dressing. She stated she expected staff to remove the soiled items from the room and replace a clean bag to the trash can.