Department of Veterans Affairs State Veterans Home Survey Report

This survey report and the information contained herein, which resulted from the State Veterans Home Unannounced On-Site or Announced Virtual Survey is a Summary Statement of Deficiencies. (Each Deficiency Must be Preceded by Full Regulatory or LSC Identifying Information.) Title 38 CFR Part 51 Federal Regulations for SVHs.

General Information:

Facility Name: Joseph Ballard Western KY Veterans Center

Location: 926 Veterans Drive, Hanson, KY, 42413

Onsite / Virtual: Virtual

Dates of Survey: 4/18/22-4/21/22

NH / DOM / ADHC: NH

Survey Class: Annual

Total Available Beds: 156

Census on First Day of Survey: 54

Deficiency	Findings
	Initial Comments: A VA Annual survey was conducted from April 18, 2022, through April 21, 2022, at Joseph Ballard Western KY Veterans Center. The facility was not in compliance with Title 38 CFR Part 51 Federal Requirements for State Veterans Homes.
§51.190(b) Preventing spread of infection (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility management must isolate the resident. (2) The facility management must prohibit employees with a communicable disease or infected skin lesions from engaging in any contact with residents or their environment that would transmit the disease. (3) The facility management must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.	Based on observation, interviews, record review, and policy review, the facility failed to ensure proper infection control was maintained during catheter care for one (1) resident, Resident #1, of one (1) sampled residents reviewed for catheters, to prevent cross contamination, which could cause a potential Urinary Tract Infection (UTI) due to fecal contamination. The findings include: Review of the facility's policy titled, "Using Gloves" reviewed 4/19/22, revealed, "Gloves are not a substitute for hand hygiene-if your task requires gloves, perform hand hygiene before donning gloves, before touching the patient or the patient environment and change gloves and perform hand hygiene during patient care, if gloves become damaged; gloves become visibly soiled with blood or body fluids following a task and moving from work on a soiled body site to a clean body site on

Level of Harm – No Actual Harm, with potential for more than minimal harm. Residents Affected – Few	the same patient or if another clinical indication for hand hygiene occurs." Resident #1 was admitted to the facility in 2019 with diagnoses that included Urinary Retention and Neurogenic Bladder. Review of Resident #1's Order Summary Report indicated to cleanse supra pubic catheter site with normal saline and apply 4x4 split gauze daily and when needed (PRN). Review of Resident #1's medical record, indicated on [DATE], resident #1 had a urine culture, which revealed positive for UTI, with Escherichia coli (E. Coli) and Gram-Negative Bacilli. On 4/19/22 at 12:30 p.m. Eastern Standard Time (EST), Licensed Nurse A and Certified Nurse Aide A were observed performing catheter care for Resident #1. Licensed Nurse A gathered all necessary supplies and placed them on a clean field on Resident #1's overbed table. Both Licensed Nurse A and Certified Nurse A donned (put on) gloves, then Licensed Nurse A unfastened Resident #1's incontinence pad, which they tucked between the resident's legs. Licensed Nurse A changed their gloves and donned sterile gloves, then cleaned resident #1's pubic area and catheter tubing without any issues. However, Licensed Nurse A, after completing Resident #1's catheter care, did not change their gloves and they were observed going into Resident #1's built-in cabinet and to get a clean incontinence pad, peri-spray, clean draw sheet, and package of wipes. After Licensed Nurse A obtained these items, they rolled Resident #1 toward Certified Nurse Aide A, and proceeded to clean Resident #1's bowel movement (BM) off their bottom, wiping in the correct direction and changing the direction of each wipe. When Licensed Nurse A finished cleaning Resident #1's BM, they rolled a new draw sheet and incontinence pad under the resident. They bunched up the soiled incontinence pad and dirty draw sheet under the resident without changing their gloves. During this time, Licensed Nurse A kept touching Resident #1's right arm, which they would keep moving beside them. Licensed Nurse A then rolled Resident #1 back towards them, and Certified Nurse Aide A pulled out the bunched up, soiled incontinence pad and dirty draw sheet from under Resident #1. Certified Nurse Aide A then handed the bunched up soiled items to Licensed Nurse A, who took them with their right gloved hand and placed them into a plastic bag, which was located behind them. Neither Licensed Nurse A nor Certified Nurse Aide A changed their gloves at this point, but Licensed Nurse A continued to assist Certified Nurse Aide A by

	holding Resident #1's shoulder and knee areas. At this time, Certified Nurse Aide A handed Licensed Nurse A a BM soiled wipe, which Licensed Nurse A took with their right gloved hand, and threw into the trashcan, which was located behind them. Certified Nurse Aide A and Licensed Nurse A then assisted Resident #1 to their back were Licensed Nurse A fastened their incontinence pad and put their right sock back on their foot, without either of them changing gloves. Resident #1 was observed to roll themself back over to their left side, facing the wall, when Licensed Nurse A was observed adjusting their sheet and placing a blue blanket over them. At this point, Licensed Nurse A removed their gloves and performed hand hygiene with hand sanitizer which was in their right-side, pants pocket. Certified Nurse Aide A came from around the left side of Resident #1's bed, started gathering dirty bags and placing the package of wipes back into Resident #1's built-in cabinet, all without changing their gloves. Then Certified Nurse Aide A removed their gloves and left the room, without performing hand hygiene. Licensed Nurse A gathered up all left-over items from Resident #1's overbed table and pushed the overbed table under the window and performed hand hygiene by using hand sanitizer. In an interview with Administrative Nurse A on 4/20/22 at 12:30 p.m. EST, they stated that they had just done a hand hygiene in-service with a return demonstration during the annual emergency meeting a few months ago. They stated this in-service did not include glove changing. They indicated the staff knew when to change gloves and wash hands; however, they confirmed that the gloves should have been changed when going from a dirty area to a clean area, and that handwashing should be completed after contact with anything soiled. Review of the "In-Service sign-in sheets" dated 3/21/22, 3/23/22 and 3/24/22 indicated there was no evidence that Licensed Nurse A and Certified Nurse Aide A attended this in-service. However, inside License Nurse A's signature space it indicated "tested," without Licensed Nurse A's signature. There was no educational material attached. Attempted phone interview with staff development staff on 4/20/22 at 10:42 a.m., 11:02 a.m., and 2:00 p.m. EST, all without any answer and/or voicemail capability.