

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/09/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 03/28/2012	
NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000 F 280 SS=D	<p>INITIAL COMMENTS</p> <p>A standard health survey was conducted from 03/26/12 through 03/28/12 and a Life Safety Code survey was conducted on 03/27/12. Deficiencies were cited with the highest scope and severity of an "D" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and record reviews, it was determined the facility failed to update the care plan to include pressure ulcer</p>	F 000 F 280	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p>F280</p> <p>1. The Care Plan was updated by the Director of Nurses on 3/28/2012 for resident #6 to reflect potential for skin breakdown related to immobility and cognitive impairment.</p> <p>2. A Care Plan audit was completed on current residents on 4/4/12 by the Director of Nurses to determine that Care Plans are updated. No other concerns identified.</p>	

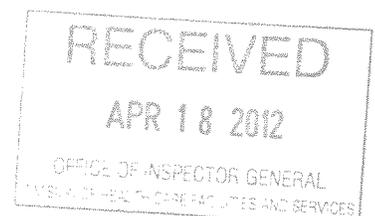
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *x Deane Garrett* TITLE *x Administrator* (X8) DATE *x 4/16/2012*

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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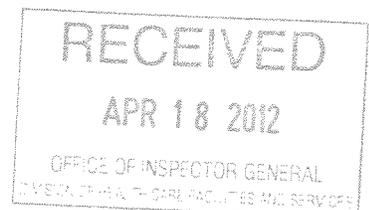
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F 280	<p>Continued From page 1 prevention for one (1) of fifteen (15) sampled residents (Resident #6).</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plan-Interdisciplinary, effective date 01/08, item #5 stated, the Interdisciplinary team (IDT) reviews each care plan quarterly with updates as necessary.</p> <p>Observation, on 03/27/12 at 10:30 AM, of the skin assessment for Resident #6 revealed a pink area at the coccyx that was blanchable. A dark brown spot, slightly reddened, was observed on the outer side of the right foot at the bony area of the fifth toe.</p> <p>Review of the most recent RAI Assessment revealed a significant change assessment dated November 17, 2011. The facility assessed Resident #6 as having pressure areas. A care plan update for the prevention of pressure ulcers was not added to the care plan.</p> <p>Interview, on 03/28/12 at 4:05 PM, with the Unit Manager revealed, the Minimum Data Set (MDS) nurse and the Director of Nursing (DON) were responsible for initiating and developing care plans for issues triggered through the Minimum Data Set (MDS) assessments.</p> <p>Interview with DON, on 03/28/12 at 4:30PM, revealed that care plans are initiated and/or updated upon admission, annually, and quarterly by the MDS nurse. The DON stated, Resident #6 triggered for pressure ulcers on the significant change assessment dated November, 17, 2011.</p>	F 280	<p>3. The Director of Nurses was re-educated on the Care Plan process by the Regional Director of Clinical Services on 3/28/12. The MDS Coordinator was re-educated on 4/4/12 by the Director of Nurses related to the Care Plan process. Licensed nurses will be reeducated on Care Plan process by the Director of Nurses by 4/15/2012.</p> <p>4. The Director of Nurses will conduct an audit weekly of 5 resident Care Plans for 4 weeks and then monthly times 2 months to determine that Care Plans are updated as indicated. The Director of Nurses will submit findings to the Performance Improvement Committee monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 4/16/2012</p>	



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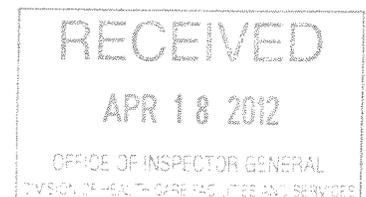
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F 280	Continued From page 2	F 280		
F 431 SS=D	<p>She further stated, she did not know how the care plan update for pressure ulcers was missed.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p>	F 431	<p>F431</p> <ol style="list-style-type: none"> 1. On 3/28/2012 both opened vials of insulin found without dates were destroyed by the licensed nurse and replaced at no cost to the resident. New vials opened and dated on 3/29/2012 by licensed nurse. 2. An audit of the medication carts was completed by the Unit Manager on 4/4/2012 to determine that all multidose medications were dated when opened. No other concerns were identified. 3. Licensed nursing staff have been re- educated on the Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles to include dating insulin and other multidose vials when opened by the Director of Nurses as of 04/13/2012. 4. The Unit Manager will audit medication carts to determine that medications are dated when open as appropriate weekly for four weeks then monthly times 2 months. The Director of Nurses will submit the findings to the Performance Improvement Committee monthly times 3 months for review and further recommendations. 5. Date of compliance 4/16/2012 	



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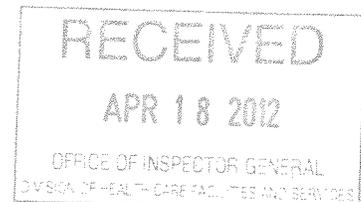
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F 431	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to date two containers of insulin when they were opened on one (1) of two (2) med carts. The findings include: Review of the facility's policy Storage and Expiration Dating of Medications, Biologicals, Syringes and Needles, revised 08/09/11, item #5 stated once any medication or biological package is opened, facility staff should follow manufacturer/supplier guidelines with respect to expiration dates for open medications. Facility staff should record the date opened on the medication container when the medication has a shortened expiration date once opened. Observation, on 03/28/12 at 10:20 AM, on the North Hall medication cart revealed, two (2) opened vials of insulin and their storage containers were not dated. Interview, on 03/28/12 at 11:23 AM, with LPN #2 revealed as long as the insulin was used within twenty-eight (28) days of opening, it is ok. She further stated, she was not sure of what the policy said about dating medications when they are opened. Interview, on 03/28/12 at 4:05 PM, with the North Unit Manager revealed staff members who pass medications were instructed to date the storage container on the day a multi-use vial or bottle was opened.	F 431		



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F 431	Continued From page 4 Interview, on 03/28/12 at 4:30 PM, with the DON revealed when medication containers, vials or bottles are opened they are dated because some solutions/medications effectiveness diminishes after a period of time. The DON further stated, she had an auditing tool for medication cart reviews to ensure multi-use vials and bottles had dates when they were opened and also, to ensure expired medications were returned to pharmacy.	F 431		



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) story, Type V Protected. Offices are located on the second floor.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel. Upgraded in 1999.</p> <p>A standard Life Safety Code survey was conducted on 03/27/12. Klondike Care and Rehabilitation Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for sixty-two (62) beds and the census was fifty-nine (59) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>x Diane Harrett</i>	TITLE <i>x Administrator</i>	(X6) DATE <i>x 4/16/2012</i>
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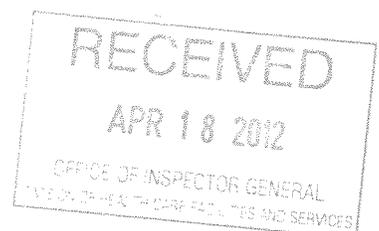
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K 000	Continued From page 1 Fire)	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiencies had the potential to affect two (2) of five (5) smoke compartments, residents, staff and visitors. The facility is licensed for sixty-two (62) beds and the census was fifty-nine (59) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/27/12 at 9:25 AM, with the Maintenance Director revealed the door to the</p>	K 029	<p>“This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency.”</p> <p>K 029</p> <p>1. No residents were identified. Facility Maintenance Director repaired the Dry Storage Room door located in the kitchen on 3/29/12 to close and latch. The opening in the Central Supply Room wall was sealed on 3/28/2012 by the Facility Maintenance Director.</p> <p>2. On 3/29/12 Maintenance Director inspected other fire walls and doors to determine compliance with NFPA 101 Life Safety Code Standard. No other areas were identified.</p>	



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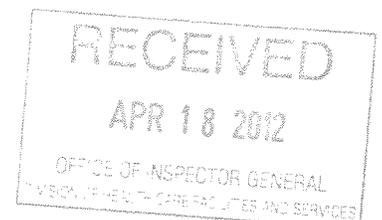
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K 029	<p>Continued From page 2</p> <p>Dry Storage Room located in the Kitchen, was held open and would not completely close and latch when tested. The door closer was not functioning properly.</p> <p>Interview, on 03/27/12 at 9:25 AM, with the Maintenance Director revealed he was not aware the Dry Storage Room was considered a hazardous storage area and required to be separated from other areas by smoke resisting partitions and doors with self closing devices.</p> <p>Observation, on 03/27/12 at 9:48 AM, with the Maintenance Director revealed a wall in the Central Supply Storage Room had been penetrated as a result of recently replacing the mixing valve piping. The opening in the wall had not been sealed and would not resist the passage of smoke in the event of a fire.</p> <p>Interview, on 03/27/12 at 9:48 AM, with the Maintenance Director revealed he was not aware that the penetrated wall had not been sealed since the new piping work had been completed.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in</p>	K 029	<p>3. The Maintenance Director was re-educated on maintenance of dry storage areas and smoke compartments in accordance with NFPA standards by the Administrator on 4/10/2012. Kitchen staff, Dietary Manager and Maintenance Director was re-educated on keeping the Dry Storage Room door closed by the Administrator on 4/10/2012.</p> <p>4. Maintenance Director will audit fire walls and door closures on weekly rounds to determine compliance with NFPA standards weekly x12 weeks. Findings will be submitted to the Performance Improvement Committee monthly times 3 months for further review and recommendation.</p> <p>5. Date of compliance 4/16/2012</p>	
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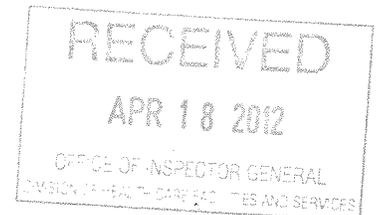
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K 029	Continued From page 3 accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was	K 147		



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NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 4</p> <p>determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, residents, staff, and visitors. The facility is licensed for sixty-two (62) beds and the census was fifty-nine (59) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 03/27/12 at 9:27 AM, with the Maintenance Director revealed the electrical panels located in the Kitchen had carts stored in front of them prohibiting easy access to the panels.</p> <p>Interview, on 03/27/12 at 9:27 AM, with the Maintenance Director revealed he was not aware of the storage in front of the electrical panels.</p> <p>Reference: NFPA 99 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>K 147</p> <ol style="list-style-type: none"> On 3/27/2012 food storage bin located in front of the electrical panel located in the kitchen was removed by the Dietary Manager. No residents were identified. The Maintenance Director inspected other electrical panels to determine proper clearance of stored items on 3/27/2012. No other concerns identified. The Maintenance Director, Dietary Manager and kitchen staff were re-educated on maintaining electrical panels free of objects within 3 feet in accordance with NFPA standards by the Administrator on 4/10/2012. The Maintenance Director will review electrical panels for proper clearance during weekly rounds x12 weeks. The Maintenance Director will submit summary of findings to the Performance Improvement Committee monthly times 3 months for further review and recommendations. Date of compliance 4/16/2012 	

