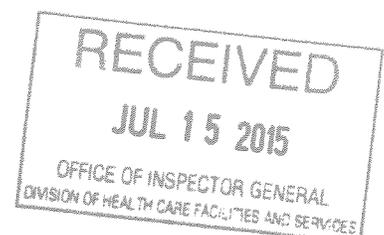


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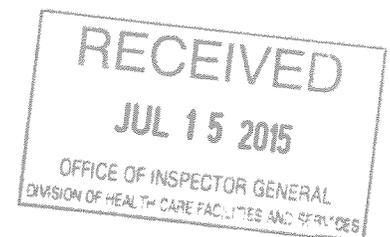
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2015
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F 318	Continued From page 36 stated she did not know why Residents #4 and #11 were not on the master list in the Restorative Binder. She stated the Restorative Program was not what she wanted it to be, and they had been working on improvements since March, 2015. She stated the risk to the residents was a decline in function. 4. Observation, on 06/09/15 at 3:11 PM, revealed Resident #13 was laying in bed awake. The resident did not have a splint on the left hand. Observation at 4:00 PM, revealed the resident was sitting in a wheelchair in the hallway by the nurses' station with a splint on the left hand. Observation, on 06/10/15 at 8:23 AM, revealed the resident was sitting up in a wheelchair in the main dining room with a plastic half tray attached to the wheelchair. The resident was not wearing a splint to the left hand. At 9:15 AM, observation revealed the resident was in bed without the splint applied. Review of the clinical record revealed Resident #13 had resided at the facility since 07/26/13. The facility re-admitted the resident on 05/02/15, after a short hospitalization. Review of the most current diagnoses included Cerebrovascular Accident (CVA) Osteoarthritis, Dementia, and Muscle Weakness. Review of the physician orders, dated 02/19/15, revealed the resident's splint to the left hand was to be applied after breakfast and removed before dinner for a total of six (6) hours. Review of the Physical Therapist Evaluation, conducted on 05/05/15, revealed the therapist assessed the resident to have a contracture to the left hand. The resident received range of	F 318			



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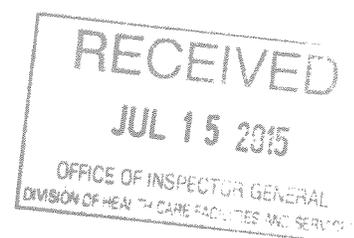
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F 318	<p>Continued From page 37</p> <p>motion (ROM) exercises to the left upper extremities to reduce joint stiffness, improve circulation, and decrease risk of contracture to the left hand. The discharge note, dated 05/07/15, revealed the resident was discharged to a Restorative Nursing Program.</p> <p>Review of the Restorative Nursing Record, dated June 2015, revealed goals of prevention of contractures by applying a splint to the left hand before breakfast and remove after lunch for a total of six (6) hours a day. The staff was instructed to check skin integrity and limb alignment before, during, and after application of the splint.</p> <p>Review of the comprehensive care plan, revised on 09/10/14, revealed staff were to apply the splint to the left upper extremity before breakfast and remove after lunch for a total of six (6) hours/day.</p> <p>Review of the Kardex for Resident #13, dated 09/27/14, revealed a section titled Restorative Nursing Program. Further review revealed passive ROM exercises, Splint assistance, and transfer was checked. However, no additional information was provided.</p> <p>Review of the Treatment Administration Record (TAR) for June 2015, revealed the splint to the left hand was to be applied after breakfast and removed before dinner for a total of six (6) hours. The start date was noted to be 02/20/15.</p> <p>Interview with CNA #9, on 06/10/15 at 3:45 PM, revealed the left hand splint are taken off sometime after supper or at bedtime. He then stated the splint could only be removed by</p>	F 318			



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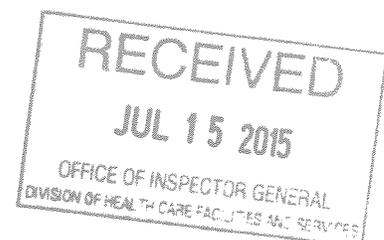
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F 318	<p>Continued From page 38 therapy or a nurse.</p> <p>Interview with LPN #5, on 06/10/15 at 3:50 PM, revealed the splint to the left hand was to be removed before dinner. She followed the TAR. However, there was no wearing schedule noted on the TAR, just a place for the nurse's initials. Continued interview revealed the nurse was not aware of the discrepancy between the TAR and the Restorative Record.</p> <p>5. Review of the clinical record revealed the facility admitted Resident #10 on 02/05/09. Review of the current diagnoses included Fracture of the Lower Leg, CVA, Dementia, Osteoporosis, Anemia, and Hypertension.</p> <p>Review of the Physical Therapy notes, dated 03/27/15, revealed the resident was to have physical therapy for a knee immobilizer and ROM. The resident received physical therapy five (5) times a week for thirty (30) days. The treatment plan included therapeutic activities, neuromuscular reeducation, therapeutic exercise and orthotics. The resident was discharged on 05/07/15 with the maximum potential met. Review of the discharge summary revealed the resident utilized a smaller knee immobilizer and there was no signs or symptoms of any pressure areas. The resident tolerated ROM to the bilateral lower extremities except on the right knee secondary to a fracture. Caregivers were educated by physical therapy on 05/07/15 on the proper rolling pattern for the resident and the resident was referred to the Restorative Nursing Program. Review of the Occupational Therapy notes, dated 05/18/15, revealed the resident was to receive occupation therapy five (5) times a week for thirty (30) days for</p>	F 318			



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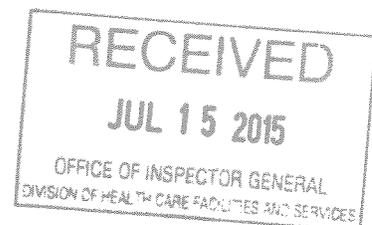
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F 318	<p>Continued From page 39</p> <p>therapeutic exercises and self care/Activities of Daily living (DAL). Review of the discharge summary, dated 05/29/15, revealed the resident was to participate in the Restorative Nursing Program.</p> <p>Review of the therapist's restorative referral, dated 04/22/15, revealed the resident was to receive PROM and application of a knee immobilizer. The right knee was not to receive ROM. The goals for the resident was to maintain the current level of ROM to bilateral lower extremity and to not develop any further contractures to the lower extremity. The treatment program consisted of passive ROM to bilateral lower extremities with ten (10) repetitions six (6) to seven (7) days a week. The knee immobilizer should be worn at all times.</p> <p>Review of the May 2015 and June 2015 Restorative Nursing Record revealed a goal of passive ROM to the bilateral upper extremities and the left lower extremity, 10 repetitions each, six to seven days a week. The May 2015 record revealed eleven (11) days out of the thirty-one (31) days in May the resident received the restorative service for ten minutes. Four days (4) had been documented as receiving twenty (20) minutes of restorative. Review of the June 2015 record revealed two days of restorative nursing for ten minutes had been completed out of the eight days available in June.</p> <p>Observation of Resident #10, on 06/10/15 at 8:15 AM, revealed he/she was in bed receiving a bed bath. CNA #2 and #3 stated they were going to get the resident up after they finished with morning care. Observation revealed the resident did not have an immobilizer on the right knee.</p>	F 318			



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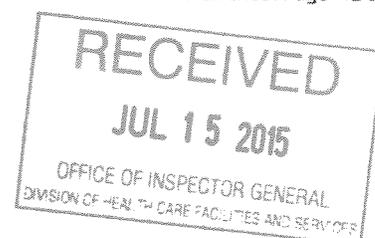
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F 318	<p>Continued From page 40</p> <p>The immobilizer was observed in the resident's wheelchair in the room. Observation revealed no restorative nursing was provided during care.</p> <p>Interview with CNA #3, on 06/10/15 at 10:25 AM, revealed if the resident was supposed to receive restorative ROM it would be in the restorative book. CNA #3 stated Resident #10 received restorative when she would rub his/her hands four to five times and lift the resident feet up to five times for each leg. CNA #3 revealed the resident had an immobilizer on his/her knee, but that was about two months ago and it was not used any longer. CNA #3 revealed the CNA's do the restorative and if there were any changes it would be in the restorative book. The CNA's were supposed to record the minutes in the book and report to the nurse if the restorative was not done. The nurses were supposed to record the minutes in the book or put a zero if not done.</p> <p>Interview with CNA #2, on 06/10/15 at 10:20 AM, revealed she was not aware Resident #10 needed an immobilizer.</p> <p>Interview with Resident #10 family member, on 06/09/15 at 3:10 PM, revealed the resident had used a knee immobilizer on the right leg, but the facility had not put the immobilizer on for awhile and they did not know why.</p> <p>Observation on, 06/10/15 at 3:15 PM, revealed the knee immobilizer was lying in the wheelchair.</p> <p>Review of the comprehensive care plan, 05/08/14 and revised on 01/07/15 with a target date of 07/12/15, revealed a care plan for restorative nursing had not been initiated. Review of the current CNA Kardex revealed restorative nursing</p>	F 318			



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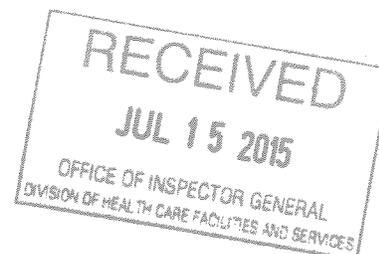
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F 318	<p>Continued From page 41 section was blank.</p> <p>Review of the May 2015 Treatment Administration Record (TAR) revealed the immobilizer had been put on hold for forty eight hours except for positioning and transfers on 05/02/15 thru 05/04/15. Review of the rest of May and the June TAR revealed the application of the knee immobilizer had not been carried over.</p> <p>Interview with the DON, on 06/10/15 at 9:30 AM, revealed Resident #10 was to have a knee immobilizer during transfers and when rolling him/her in bed. The DON stated she did not know why the staff did not use it when transferring the resident.</p> <p>Interview with the MDS Coordinator, on 06/10/15 at 1:00 PM, revealed if a resident had a specific restorative program then they should have a specific care plan for that. She stated the MDS Coordinator, the DON, or the Assistant Director of Nursing (ADON) could initiate the care plan. She said the restorative program was a work in progress.</p> <p>Interview with the DON, on 06/10/15 at 9:30 AM, revealed she was in the process of revamping the restorative program and had started retraining and reeducating the staff on restorative nursing. She stated quality rounds were done to see if anyone would benefit from restorative.</p> <p>6. Review of Resident #2's clinical record revealed the facility admitted the resident on 01/07/15 with diagnoses of Acute Respiratory Failure Following Trauma and Surgery, Cerebral Vascular Accident, Muscle Weakness, and Dysphagia. The clinical record revealed the</p>	F 318			



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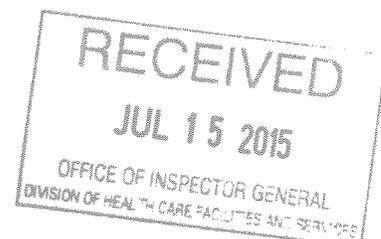
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F 318	Continued From page 42 resident had received physical therapy at the facility from 03/27/15 through 05/07/15. The resident also received Occupational Therapy and Speech Therapy at the facility. Interview with the Physical Therapist, on 06/10/15 at 11:45 AM, revealed Resident #2 was supposed to have a restorative program, but it was developed to be utilized in the resident's personal home. She stated sometime in April 2015, a family member was supposed to come to the facility for training and they never came. Another appointment was made and the family member again did not show. Several weeks went by and the family member never came for the training or returned to take the resident home. On 05/07/15, therapy evaluated the resident and the resident was placed back on their case load. However, for an extended period of time, the resident did not receive restorative services. Further interview with the physical therapist, on 06/10/15 at 11:55 AM, revealed a transition from therapy services to restorative would require a referral from therapy with services needed to be provided by restorative nursing. The therapist would put the referral in the DON's mail tray and she would develop the restorative schedule. The therapist stated she did not normally follow up with nursing to ensure the restorative services were being done, unless there were questions.	F 318			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to	F 323			



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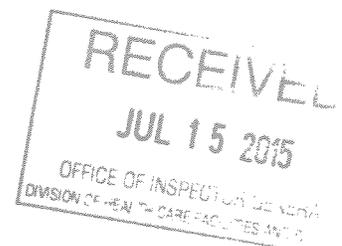
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F 323	Continued From page 43 prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure the residents' environment was free from accident hazards in regard to leaving tools and chemicals in the courtyard unattended, bio-hazard material not properly stored and secured, and monitoring the metal ash box to ensure paper products were not placed in the container. The findings include: Review of the facility's Waste Management policy, effective date 09/01/04, revealed regulated waste included sharps (needles, blades, glass) and to reduce the risk of contamination and maintain appropriate handling and disposal of all waste. The policy stated the facility would maintain a safe, secure, and clean holding area for the regulated waste and restrict to employees only. Review of the facility's Smoking Policy, revised 04/01/15, revealed safety designed metal containers with self-closing covers would be used to empty ashtrays. The containers would be located in the designated smoking area. Review of the smoking assessments for the eight (8) residents who smoked revealed all eight (8) residents were assessed to be safe smoking	F 323	F 323 Free of Accidents Hazardous/Supervision/Devises 1. The tools including long handled shovels, hedge trimmers, a putty knife, and wooden bench with a broken seat slat, spray bottle of Spray Master, and can of True Fuel were removed from the courtyard upon discovery by the Maintenance Director. The shed designated to store biohazard waste was immediately locked by the Maintenance Director. On 6-10-15 the trash can was moved away from the smoking area in the courtyard and the administrator placed a sign on it stating "Trash Only" and posted a sign on the red metal trash can stating "No trash---cigarettes only." 2. All residents of the facility have the potential to be affected. The Maintenance Director and Administrator completed rounds on 6-11-15 to check the trash can and cigarette can for appropriate items in each can, the courtyard to ensure no equipment is left in the area, storage shed for bio-hazardous waste is locked and all furniture is in good repair with corrective action if indicated. 3. The Administrator provided re-education on 6-12-15 with all staff regarding need to follow smoking	6-15-15	



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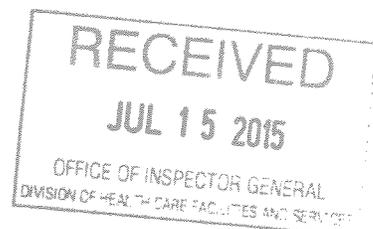
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F 323	<p>Continued From page 44 without supervision because they had no cognition impairment.</p> <p>Review of the Material Safety Data Sheet (MSDS) for the True Fuel, no date, revealed the product was a pre-blended gas and oil product for 2 cycle gas engine machinery.</p> <p>1. Observation of the courtyard during tour of the facility, on 06/07/15 at 2:52 PM, revealed two (2) long handled shovels, hedge trimmers, a putty knife, quart spray bottle of Spray Master (no label), and a can of True Fuel beside the privacy fence in the back of the courtyard. In addition, there was a wooden bench with a broken seat slat. Observation of the door leading to the courtyard revealed no code was required to exit through the doors. When you pushed, the doors opened. Continued observation of the courtyard revealed the back gate had a lock.</p> <p>Interview with the Maintenance Director, on 06/07/15 at 4:45 PM, revealed he had been working in the courtyard on Friday and he had forgotten and left the tools and chemical outside. He stated the tools were his own personal tools.</p> <p>2. Continued observation during tour of the grounds, on 06/17/15 at 4:45 PM, revealed a wooden storage barn/building in the back of the property. The pad lock was on the outside of the door but the doors were not locked. The Maintenance Director opened the doors to the storage building that revealed four (4) red sharps containers placed unsecured on top of six (6) large red totes with bio-hazard symbol on the front of the totes. One (1) red plastic bio-hazard bag was observed on top of a red bio-hazard</p>	F 323	<p>regulations, use of appropriate container for cigarette ashes, locking of storage shed, and preventing accident hazards by leaving tools and chemicals unattended in the courtyard, and proper storage of biohazards materials. A post-test was given by the Administrator to validate understanding. Staff not available during this timeframe will be provided re-education including post-test upon return to work.</p> <p>4. The Maintenance Director will conduct rounds 2 times a day to check trash can and cigarette can for contents, the courtyard for equipment left in the areas, and furniture in good repair and report results of these audits daily to the Administrator with corrective action if indicated. The Administrator will track the results of the audits weekly for 3 months and then bi-weekly for 3 months. Areas of concern will be corrected when identified.</p> <p>The Administrator will submit a summary of the findings of the audits to the Monthly Performance Improvement Committee consisting of Administrator, DON, Medical Director, Social Service Director, Activity Director, Maintenance Director, Housekeeping Supervisor and Medical Records for any additional follow-up and/or in-servicing needs until the issue is resolved.</p>		



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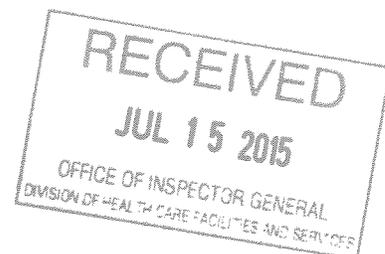
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F 323	Continued From page 45 trash receptacle located inside the unsecured storage building. There was no staff in the immediate area during the observation. Interview with the Maintenance Director, on 06/07/05 at 4:50 PM, revealed he forgot to lock the storage building after he had removed something from the building earlier. He stated he had been calling the bio-hazard disposal company since 04/27/15, but no pick up to date. However, there was no documented evidence of the calls. He stated the storage building that contained the bio-hazard material/sharps are normally locked and he failed to lock the doors back earlier. 3. Observation, 06/07/15 at 3:06 PM, revealed a large trash can inside the courtyard near the smoking area. Observation inside the trash can revealed multiple cigarette butts laying on top of the trash. Interview with the Maintenance Director at the time of the observation, revealed this was an ongoing problem. Observation of the designated smoking area, on 06/10/15 at 10:15 AM, revealed a red metal ash container in the area. Further observation revealed paper trash (two empty cigarette packs) inside the can. Interview with the Maintenance Director at the time of the observation revealed he had emptied the ash can earlier. He stated it was an ongoing problem with residents and staff placing paper trash into the ash can if a trash can was not available. The Maintenance Director stated there was no scheduled times he checked the smoking area and he did not document any of his findings.	F 323			
F 372	483.35(i)(3) DISPOSE GARBAGE & REFUSE	F 372			



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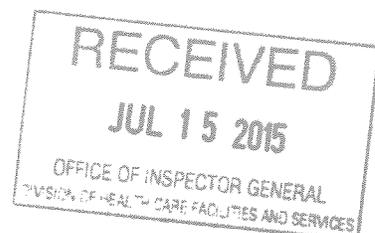
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/10/2015
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
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F 372 SS=F	<p>Continued From page 46 PROPERLY</p> <p>The facility must dispose of garbage and refuse properly.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to properly dispose of garbage for one (1) of one (1) dumpsters with garbage overflowing onto the ground.</p> <p>The finding include:</p> <p>Interview with the Administrator, on 06/08/15 at 9:22 AM, revealed there was no policy for disposal of garbage.</p> <p>Observation, on 06/07/15 at 2:14 PM, revealed the facility had one dumpster located in front of the building, to the right. Observation revealed the dumpster's lid was opened with six (6) white trash bags overflowing above the top of the dumpster. There were three (3) bags of garbage sitting on top of a cardboard box on the ground.</p> <p>Interview with Maintenance Director, on 06/07/15 at 4:28 PM, revealed the garbage pick up days needed to be changed to prevent the buildup of garbage on the weekends. He stated the front containment door in front of the dumpster was broke.</p> <p>Interview with the Administrator, on 06/08/15 at 9:22 AM, revealed there was only one dumpster and the garbage was scheduled for pick up Monday-Friday. She stated the weekend managers should monitor the dumpster and staff</p>	F 372	<p>F 372 Dispose Garbage & Refuse</p> <ol style="list-style-type: none"> On 6-7-15 the 6 trash bags on top of the dumpster and the 3 cardboard boxes on the ground and bags sitting on top of the dumpster were removed from the property and disposed. All residents of the facility have the potential to be affected. On 6-8-15 the Administrator and Maintenance Director made routine rounds throughout the shifts to ensure the dumpster was not overflowing and lids remain closed with corrective action if indicated. On 6-8-15 the Administrator also contacted the company responsible for garbage pick-up and changed the pick-up time and type of dumpster. The dumpster was replaced with one with a side door to make it easier to dispose of the garbage bags. By 7-10-15 the staff will be re-educated on proper disposal of garbage by the Administrator. A post-test was given by the Administrator to validate understanding. Staff not available during this timeframe will be provided re-education including post-test upon return to work. 	7-17-15	



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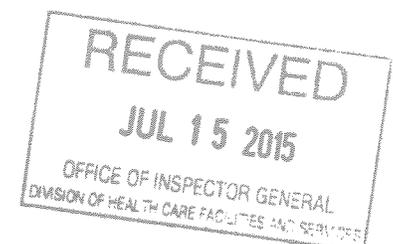
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F 372	Continued From page 47 should look at the dumpster when arriving to work and leaving. She stated there was no scheduled monitoring of the dumpster and no specific staff assigned to that task. She stated staff had placed several boxes that had not been broken down into the dumpster on 06/07/15 that left little room for the garbage. She stated the staff should have broken the boxes down and placed the garbage into the dumpster and not left it overflowing with spillage onto the ground.	F 372	4. The Maintenance Director will report results of daily audits to the Administrator and corrective action if indicated. The Administrator submit a summary of the finding of the audits to the Monthly Performance Improvement Committee consisting of the Administrator, DON, Medical Director, Social Service	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (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 must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.	F 441	Director, Activity Director, Maintenance Director, Housekeeping Supervisor and Medical Records for any additional follow-up and/or in-servicing needs until the issue is resolved. F 441 Infection Control, Prevent Spread, Linens 1. Resident 3: On 6-10-15 contact precautions was discontinued for resident #3. Staff involved in the care of the resident were provided re-education by the DON on 6-10-15 regarding use of PPE when a resident is in contact isolation. Resident 5: On 6-10-15 a stop sign was placed on the door by the DON upon discovery.	7-17-15



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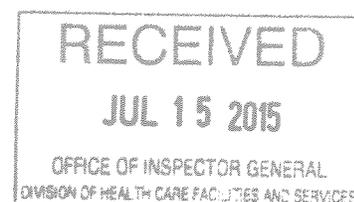
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F 441	<p>Continued From page 48</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to consistently implement and follow their infection control program in regards to contact precautions for two (2) of the fifteen (15) sampled residents, Residents #3 and #5.</p> <p>The findings include: Review of the facility's policy regarding Contact Precautions, dated 10/01/13, revealed contact precautions would be used in addition to standard precautions when caring for a patient who was colonized or infected with epidemiological important microorganisms that could be transmitted by direct contact (hand or skin to skin) or indirect contact with environmental surfaces in patient care environment. State regulations would be followed when applicable. The purpose of the policy was to reduce the risk of transmission of epidemiological important microorganisms by direct or indirect contact.</p>	F 441	<p>2. All residents of the facility have the potential to be affected. On 6-11-15 all other residents who are on antibiotics and labs were reviewed by the DON to ensure proper isolation procedures were implemented, followed and had appropriate signage on the door if indicated.</p> <p>3. The DON will re-educate all staff on the center's isolation/infection control policy and procedure; specifically to contact precautions including use of appropriate signage and using of PPE if indicated, and providing staff information when giving shift to shift reports by 7-16-15. A post-test was given by the DON or Assistant Director of Nursing to validate understanding. Staff not available during this timeframe will be provided reeducation including posttest upon return to work.</p> <p>4. The DON or Assistant Director of Nursing, or Shift Nurse supervisor will review labs and follow-up to ensure the set up procedure was properly executed and observe staff is following necessary precautions with corrective action if indicated, daily across all shifts times 2 weeks then 3 times per week times 2 weeks then as determined by the monthly Performance Improvement Committee. DON or Assistant Director of Nursing will review results of the audits with the Administrator daily.</p>		



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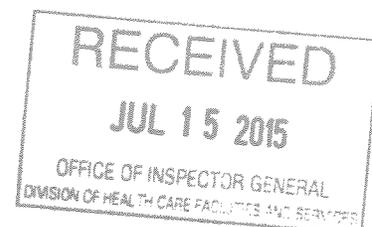
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F 441	<p>Continued From page 49</p> <p>Continued review of the policy revealed specific steps to follow: place resident in a private room, if possible; place a Stop sign (please see nurse before entering room) on the door; instruct staff on Personal Protective Equipment (PPE); staff to use barrier precautions when entering the room; dedicate personal care equipment when available; do not restrict patient to his/her room; and clean and disinfect frequently touched surfaces daily.</p> <p>Review of the Infection Control: Nursing Principles and Practices post test given to facility nurses dated May 2014, revealed information given to the nursing staff was types of isolation, the use of PPE and the staffs' role in infection control and contact precautions.</p> <p>1. Review of Resident #3's clinical record revealed the facility admitted the resident on 11/21/13 with a readmission date of 04/09/14 with diagnoses of Dementia with Behavioral Disturbances, Difficulty Walking, Muscle Weakness, Bipolar Disorder, Narcolepsy, Closed Fracture of the Clavicle, and Gastritis.</p> <p>Review of lab reports, dated 03/31/15 and 05/21/15, revealed findings of a Urinary Tract Infections (UTIs) with an organism that required contact precaution to prevent transmission according to the facility's policy. Review of the lab report dated 06/05/15, revealed a UTI without the need for contact precaution.</p> <p>Observation, on 06/07/15 at 4:40 PM, of Resident #3's room, revealed an isolation encasement hanging on the door to the resident's room. No sign was posted on the door and no biohazard</p>	F 441	<p>The DON will submit a summary of the findings of the audits to the monthly Performance Improvement Committee consisting of Administrator, DON, Medical Director, Social Service Director, Activity Director, Maintenance Director, Housekeeping Supervisor and Medical Records for any additional follow up and/or in-servicing needs until the issue is resolved.</p>		



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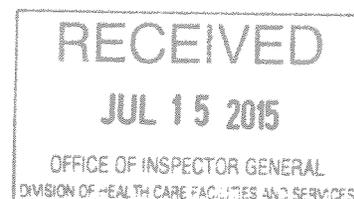
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F 441	<p>Continued From page 50 waste receptacles were observed.</p> <p>Observation, on 06/08/15 at 8:30 AM, of Resident #3's room revealed an isolation encasement that held PPE hanging on the door entering the room. Two (2) red biohazard waste receptacles had been placed outside the resident's room and no sign posted on the door or door frame to see the nurse prior to entering the room.</p> <p>Observation, on 06/08/15 at 12:08 PM, revealed Certified Nursing Assistant (CNA) #8 entered Resident #3's room to deliver his/her lunch tray without donning PPE. CNA #8 stated she was not aware Resident #3 was in contact precautions. CNA #8 stated the purpose of wearing PPE was to reduce cross contamination.</p> <p>Observation, on 06/09/15 at 9:30 AM, of Resident #3's room revealed an isolation encasement hanging on the door. Two red biohazard waste receptacles were present in the hallway, outside of the resident's room and a stop sign was now posted on the resident's door.</p> <p>Observation, on 06/10/15 at 9:00 AM, of Resident #3's room, revealed no PPE or signage was noted.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 06/07/15 at 4:50 PM, revealed the isolation encasement hanging over the door and a sign posted would indicate a resident was in precaution, but she was not sure if Resident #3 was in precaution at this time.</p> <p>Interview with LPN #2, on 06/08/15 at 8:45 AM, revealed Resident #3 should be in contact precaution and have a sign on the door stating to</p>	F 441			



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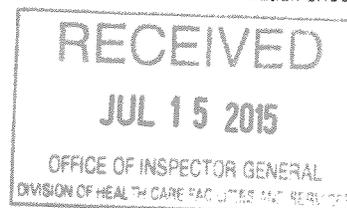
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F 441	<p>Continued From page 51</p> <p>see the nurse prior to entering the room. LPN #2 stated it was reported in shift report that Resident #3 was in contact precaution.</p> <p>Interview with CNA #7, on 06/08/15 at 9:45 AM, revealed Resident #3 had not been in isolation, but agreed an isolation encasement hanging on the door and two red biohazard receptacles on the outside of the room would indicate Resident #3 was in some type of precaution. CNA #7 stated sometime the facility forgot to remove the PPE when a Resident was out of contact precautions.</p> <p>Interview with CNA #3, on 06/08/15 at 10:00 AM, revealed she received information in shift report that Resident #3 was in contact precautions. If there was no signage, the staff would still use the PPE, just in case and then go find out from the nurse if the resident was in precaution or not.</p> <p>Interview with the Director of Nursing on 06/09/15 at 10:50 AM, revealed Resident #3 should not be in contact precautions and all items would be removed today. She could not state why the policy had not been followed. In addition, she revealed the resident had been in contact precautions in May 2015 and the staff was confused if PPE was to be worn or not.</p> <p>2. Review of Resident #5's clinical record revealed the facility admitted the resident on 06/05/15 with diagnoses of Clostridium difficile (C-Diff), Colitis, Chronic Pain, Mental Status Changes, Severe Malnutrition and Seizure-like Activity.</p> <p>Review of the initial care plan, dated 06/07/15,</p>	F 441			



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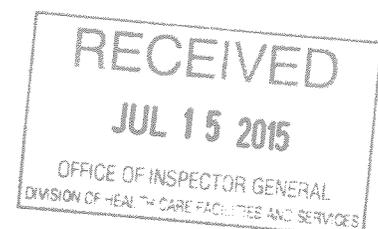
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F 441	<p>Continued From page 52</p> <p>revealed the resident had C-diff. One intervention was for the resident to be in contact isolation. Review of the CNA Kardex revealed the contact isolation was not on the form.</p> <p>Observation, on 06/07/15 at 2:30 PM, of Resident #5, revealed he/she was laying in bed on their right side. The door to the resident's room had an encasement that contained gloves, masks, and gowns. The inside of the room had two red containers in the room.</p> <p>Interview with the CNA #2, on 06/07/15 at 3:20 PM, revealed she was not sure if Resident #5 was in isolation or not because usually there would be a sign that said, "see nurse". She further stated normally there would be isolation supplies on the door and a red container for linens. She continued to say just because there were supplies on the door, doesn't necessarily mean the resident was in isolation.</p> <p>Interview with LPN #1, on 06/07/15 at 5:20 PM, revealed Resident #5 was in isolation for C-diff. She stated sometimes they would put a stop sign on the door that said, see the nurse and at other times there was no sign. The nurse stated a visitor might not know if the resident was in isolation if the stop sign was not displayed. The nurses and the staff know if the encasement was on the door then the resident was in isolation.</p> <p>Observation, on 06/09/15 at 10:15 AM, revealed a visitor was in the resident's room and had placed a gown on. The visitor was observed coming out of the resident's room with the isolation gown applied and walking down the hall to the next room. The nurse requested the visitor to go back into the room and take the isolation gown off.</p>	F 441			



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F 441	Continued From page 53 The family member was overheard saying he/she had forgotten to remove the gown when he/she went out of the room. Interview with the Registered Nurse (RN) #1, on 06/09/15 at 10:35 AM, revealed the visitor leaving Resident #5's room without removing the isolation gown posed an infection control risk because C-diff could be transmitted by contact with the organism. A stop sign should be placed at the door to let the visitors know that isolation precautions were being utilized. She stated the stop signs worked. Interview with the DON on 06/10/15 at 9:10 AM, revealed the stop sign should have been placed on the door to let the staff, visitors, and contract housekeeping services know so they would use the PPE. The DON stated any staff member could place the stop sign on the door.	F 441			



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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) stories, Type V Protected. Offices are located on the partial second floor.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments on the ground floor.</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, 100KW generator. Fuel source is diesel; Upgraded in 1999.</p> <p>A Recertification Life Safety Code Survey (utilizing the 2786S Short Form) was conducted on 06/09/15. The facility was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</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			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

07/09/2015

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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K 000	Continued From page 1 Fire).	K 000			
K 038 SS=E	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit doors equipped with fifteen (15) second delayed egress hardware were maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has sixty-two (62) certified beds and the census was fifty-nine (59) on the day of the survey. The findings include: Observation, on 06/09/15 at 12:22 PM, with the Maintenance Supervisor revealed the South-West exit door located in the South Hall, was equipped with fifteen (15) second delayed egress hardware, but did not open within fifteen (15)	K 038			

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K 038	<p>Continued From page 2</p> <p>seconds when tested. The exit door would open upon activation of the Fire Alarm System.</p> <p>Interview, on 06/09/15 at 12:24 PM, with the Maintenance Supervisor revealed he was not aware of the South-West exit door, equipped with fifteen (15) second delayed egress hardware was malfunctioning.</p> <p>The census of fifty-nine (59) was verified by the Administrator on 06/09/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/09/15.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met.</p> <p>(a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors</p>	K 038			

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NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
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K 038	<p>Continued From page 3 of an approved, supervised automatic fire detection system in accordance with Section 9.6.</p> <p>(b) The doors shall unlock upon loss of power controlling the lock or locking mechanism.</p> <p>(c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted.</p> <p>(d) *On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS</p> <p>7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access</p>	K 038			

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K 038	Continued From page 4 and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. 7.5.2.2* Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over exit doors or located to conceal or obscure any exit. Mirrors shall not be placed on exit doors. Mirrors shall not be placed in or adjacent to any exit in such a manner as to confuse the direction of exit. Exception: Curtains shall be permitted across means of egress openings in tent walls if the following criteria are met: (a) They are distinctly marked in contrast to the tent wall so as to be recognizable as means of egress. (b) They are installed across an opening that is at least 6 ft (1.8 m) in width. (c) They are hung from slide rings or equivalent hardware so as to be readily moved to the side to create an unobstructed opening in the tent wall of the minimum width required for door openings.	K 038			
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 072			

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K 072	<p>Continued From page 5</p> <p>Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access to egress the building in the event of an emergency in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of five (5) smoke compartments, residents, staff and visitors. The facility has sixty-two (62) certified beds and the census was fifty-nine (59) on the day of the survey. The facility failed to ensure the means of egress were free of all obstructions or impediments for exiting the building in the event of an emergency.</p> <p>The findings include:</p> <p>1. Observation, on 06/09/15 at 12:38 PM, with the Maintenance Supervisor revealed two (2) med carts and one (1) treatment cart were permanently located within the egress path located within the South Hall exit route.</p> <p>Interview, on 06/09/15 at 12:40 PM, with the Maintenance Supervisor and Assistant Director of Nursing revealed they were unaware of the items located within the South Hall were an impediment in egressing the building in the event of an emergency and the facility was lacking in</p>	K 072			

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K 072	<p>Continued From page 6 adequate storage space.</p> <p>2. Observation, on 06/09/15 at 1:38 PM, with the Maintenance Supervisor revealed two (2) med carts and one (1) treatment cart were permanently located within the egress path located within the North Hall exit route.</p> <p>Interview, on 06/09/15 at 1:40 PM, with the Maintenance Supervisor revealed he was unaware of the items located within the North Hall were an impediment in egressing the building in the event of an emergency and the facility was lacking in adequate storage space.</p> <p>The census of fifty-nine (59) was verified by the Administrator on 06/09/15. The findings were acknowledged by the Administrator and verified by the Maintenance Supervisor at the exit interview on 06/09/15.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p> <p>7.3.2* Measurement of Means of Egress. The width of means of egress shall be measured in the clear at the narrowest point of the exit component under consideration.</p> <p>Exception: Projections not more than 31/2 in. (8.9 cm) on each side shall be permitted at 38 in. (96 cm) and below.</p> <p>Reference: S&C-12-21-LSC</p>	K 072			

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