

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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
--	---

(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	INITIAL COMMENTS A standard health and Life Safety Code survey was conducted on 07/13/10 through 07/15/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other-facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated	F 225	In order to satisfy the requirements of this regulation that all injuries of unknown source are reported immediately (by shift end) Administrator, as well as, other officials in accordance with State law, our Home has established a policy whereby injuries of unknown origin i.e. 1) the source of which has not been observed by any person & which cannot be explained by the Resident & 2) the injury is suspicious due to its' extent, location, the number of injuries observed over one particular point in time or the incidence of injuries over time. Such injuries are to be thoroughly investigated & reported to the Administrator by shift end. If the nature of the injury indicates possible abuse, neglect or are of unknown origin the D.O.N. or Administrator notify the O.I.G. & the Adult Protective Services immediately (no more than 1 hour after discovery of the injury). A thorough investigation will be conducted by the D.O.N. or Administrator which will include interviews	8/10/10

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

Ms. Mary Fisher Administrator 8/10/10

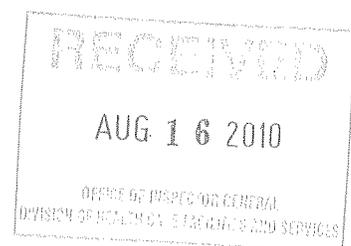
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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.

AUG 16 2010
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR		STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217	
(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)
F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide evidence of an investigation for Resident #5 regarding injury of unknown origin and failed to report it to the Office of Inspector General (OIG) and Adult Protective Services (APS).</p> <p>The findings include:</p> <p>Record review of Resident #5, accident/incident report dated 06/16/10 at 8:45pm, revealed Certified Nursing Assistant (CNA) #1 found purple bruising and a small amount of blood on the underside of the second, fourth and fifth toes while assisting Resident #5 to bed. Resident #5 was up in Geri-chair all day. The family was pushing Resident #5 around the facility all evening. Record review of Resident #5's careplan revealed a fracture to third, fourth and fifth toes of the right foot and was related to an unknown cause - possible fall, injury.</p> <p>Interview with CNA #12 on 07/15/10 at 2:12pm revealed the CNA remembered putting Resident #5 to bed and finding bruises on the right toes of the foot. The CNA stated she immediately notified Licensed Practical Nurse (LPN) #1 of her findings. The Assistant Director of Nursing (ADON) and LPN #1 went to Resident #5's room</p>	F 225	<p>of staff caring for or observing the Resident during the relevant time period, interviews of the Resident, family visitors, etc. & review of personnel files of those who cared for the Resident during the relevant time. Any staff member suspected of abuse, neglect, etc. will be immediately suspended to protect the Resident & others. If an employee is found to be guilty of abuse, neglect, etc. which caused the injury, that person will be terminated immediately. The final investigation will be reported the Office of the Inspector General & Adult Protective Services within 5 days of the incident or sooner, as required by regulations.</p> <p>Resident #5 was directly affected by our failure to investigate her injury of unknown origin. Subsequently we questioned family and staff but have not been able to find the cause of the injury. Her foot has been x-rayed & cared for as directed by her physician & is healing well.</p> <p>We now know & understand that all injuries of unknown origin must be thoroughly investigated, documented, and reported as required.</p> <p>To be sure these procedures as indicated for F-225 & F-226 are known & consistently followed</p>



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

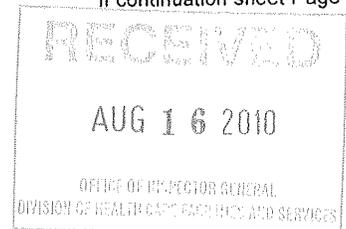
PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
--	---

(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
--------------------	--	---------------	---	----------------------

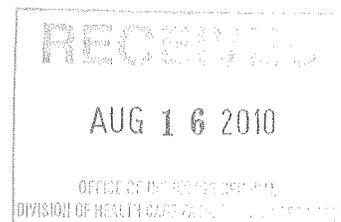
F 225	<p>Continued From page 2</p> <p>to assess the foot. Both ADON and LPN tried to come up with their own conclusions as to what could have happened to the resident's foot. The CNA stated that no family members came to her that day to report any injuries and the resident did not complain of any pain. The CNA further stated that when she received report that evening from first shift staff, nothing was reported.</p> <p>Interview with CNA #7 on 07/15/10 at 1:20pm revealed the third shift CNA's usually do morning care for Resident #5 and 6:30am starts the 7-3 shift. The CNA further stated that she remembers family coming in after lunch, the day of the incident, to be with Resident #5. No complaints were expressed by the family. The CNA stated that she did not remember the resident hitting his/her foot or anyone stepping on the foot. If anything had occurred she would have reported the incident immediately. The CNA further stated that she does not remember any staff questioning her about day of the incident.</p> <p>Interview with CNA #13 on 07/15/10 at 2:22pm revealed that the eleven to seven (11-7) shift gave showers to Resident #5. The CNA stated that she did not see any bruising or bumps to the feet that morning. The Director of Nursing (DON) or ADON did not ask any questions about the day of the incident.</p> <p>Interview with LPN #1 on 07/14/10 at 3:30pm revealed that Resident #5 had on soft canvas shoes the day of the incident. When the resident's foot was assessed by LPN #1 she found tears on the base, and the underside of the toes. The resident did not complain of pain, but complained of pain when the toes were touched. The LPN further stated that part of her</p>	F 225	<p>the D.O.N. will in-service all nursing staff on the importance of thoroughly investigating, documenting, & reporting as required, all injuries of unknown origin as explained above. The required documentation will be faxed to your office.</p>	
-------	--	-------	--	--



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

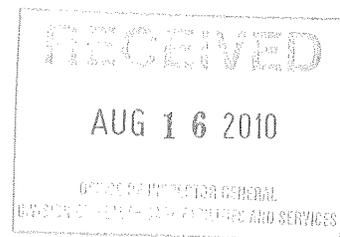
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
(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 225	Continued From page 3 assessment was to ask all the evening CNA's if they knew what had happened and to call the family. The CNA's were not questioned the day of the incident and only one family member was called. No causes could be ascertained on how the incident occurred. Interview with the DON on 07/14/10 at 3:00pm revealed that she and the Administrator monitor and investigate incidents and accidents. The DON did not know that OIG and APS were to be called for incidences of unknown origin involving residents. The DON further stated that she assumed the incident was the families fault because they had Resident #5 all afternoon. No family members or staff were interviewed. The DON further agreed with the care plan that the fracture to the toes was of unknown origin. Interview with the Administrator on 07/14/10 at 6:15pm revealed that she did not investigate incidents or accidents but investigated complaints. The Administrator further stated that she did not know injuries of unknown origin were reportable and that the DON and she should have investigated further. The facility had no policy on reporting incidents of unknown origin.	F 225			
F 226 SS=C	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced	F 226	In order to fulfill the require-ment that facilities develop & implement a policy regarding injuries of unknown origin, our Home developed a policy (see also #225) defining such inju-ries as 1) those whose source was not observed or cannot be	8/20/10	



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

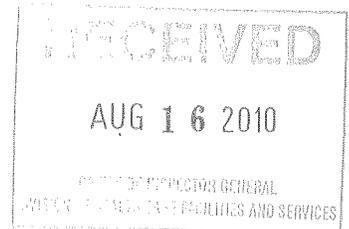
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217	
(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 226	Continued From page 4 by: Based on interview and record review it was determined the facility failed to develop and implement a policy regarding injury of unknown origin. The findings include: Interview with the Director of Nursing (DON) on 07/14/10 at 3:00pm revealed that she and the Administrator monitor and investigate incidents and accidents. The DON did not know that the Office of Inspector General (OIG) and Adult Protective Services (APS) were to be called for resident injury incidents of unknown origin and they could not provide a policy regarding incidents with injury of unknown origin. Interview with the Administrator on 07/14/10 at 6:15pm revealed that she did not investigate incidents or accidents but investigated complaints. The Administrator further stated that she did not know injuries of unknown origin were reportable.	F 226	explained or 2) the injury is suspicious due to its extent, location, number of injuries at one point in time or over a period of time. Such injuries will be thoroughly investigated by the D.O.N. or A.D.O.N. & by shift end reported to the Administrator. If the injury indicates possible abuse, neglect, etc. it will be reported to the OIG & APS by the D.O.N. or Administrator immediately or within one hour. The Resident's physician, family, guardian, or responsible party will be contacted & all investigations & notifications will be documented. An incident report will also be completed. Any suspected person will be suspended while the investigation is underway & anyone found huiltly of abuse, neglect, etc. will be immediately terminated. The final investigation will be sent to the OIG & APS within 5 days.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	In order to protect our Residents from possible contamination & to fulfill this requirement regarding sanitary conditions our entire dietary staff was (see next page)	



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

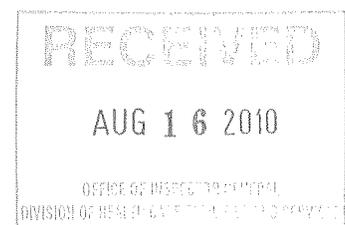
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
(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 371	Continued From page 5 by: Based on record review, interview and observations it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Food items were retained past expiration dates, held too long in the storage and some without labels. Equipment was noted with food particles and lime buildup. Spice containers had the lids left open. Staff with facial hair were not covered and hair coverings were not worn appropriately. There was no evidence of a system to rotate stock. The findings include: Observations on 07/13/10 at 7:55am revealed the cook and dietary manager with hair coverings on and large amounts of hair hanging out of the hair coverings. In addition, a male dietary employee had uncovered facial hair. A small can opener had a buildup of a dark thick substance on the blade, a can was opened and emptied into a pan and the can opener washed afterwards. The refrigerator had two containers of peaches opened and without dates. Two juice containers used for breakfast were opened and had no label or date. In the refrigerator were two cakes marked managers special with sell by dates of 07/02/10, one chocolate cake dated 06/26/10, and Artisan Rolls dated 07/09/10. The freezer had a frozen egg product with an expiration date of 02/04 and dated as opened 06/08/10. The dry storage area contained sugar cookies dated 06/24/10 and Variety cookies dated 06/26/10. Continued observations revealed four (4) spice containers: Ground White Pepper; Ground Nutmeg; Poultry Seasoning; and Garlic Powder with the lids open and continued to remain open on 07/14/10 and 07/15/10.	F 371	instructed by the Dietary Manager on 7/17/10 on the importance of wearing a hairnet which effectively covers all hair whenever they are working in the kitchen, pantry, or dining rooms. The proper way of wearing a hairnet was demonstrated & all dietary staff received a copy of the revised policy on 7/20. The male members of our dietary staff were also instructed by the D.M. that personnel must be either clean shaven or wear a facial mask which completely covers all facial hair. The correct way of wearing the mask was demonstrated. The masks are on hand & will be given to staff as needed. A copy of the Facial Mask policy was also distributed. The Dietary Manager & the Sister Supervisor will be responsible for observing all dietary staff for their compliance to both the above mentioned policies. In order to insure the practices are sustained, they will be the topic for the Dietary QA project for both Aug. & Sept. 2010. In order to protect all our Residents from illness & to fulfill the same requirement all our staff cooks & cooks' helpers were instructed to wash & sanitize the blades of all can openers after each use & to visually check the cleanliness of the blade before each use. A check list has been provided for each cook shift to be initiated to		



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

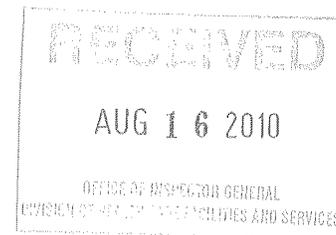
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217	
(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 371	Continued From page 6 Observations of the tray line on 07/13/10 at 12:10pm revealed milk cartons on the serving line with temperatures of 43 and 47 degrees. Two tubs of peeled potatoes soaking in a water bath did not have a lid to cover and protect the food. Observations on 07/15/10 at 2:10pm revealed a tub of peeled potatoes soaking in water bath sitting in the refrigerator dated 07/13/10. Observations of the dish washing room on 07/15/10 at 2:51pm revealed the dish washing machine across the top had a heavy build up of a reddish brown thick crusted matter and loose particles lying across the top of the dishwasher. In addition, a utility cart holding clean dishes had brown loose particles and dried brown streams running down the legs of the cart. Interview with the Dietary Cook on 07/15/10 at 2:10pm revealed the potatoes in the water bath were left out too long for over three (3) hours with no lid to protect the food. The potatoes should have been thrown away. Interview with the Dietary Manager (DM) on 07/15/10 at 2:25pm revealed the milk should not have been left on the serving line at 47 degrees, the milk should have been maintained at 41 degrees or less and milk with temperatures above 41 degrees should have been thrown in the garbage. The DM further stated that the hair nets will not stay on or cover the entire amount of hair. The facility further does not have any coverings for facial hair and have never provided any as she was not aware the facial hair had to be covered. The DM indicated she was not aware how long the spices had been left opened and it was an	F 371	indicate their compliance. The D.M. will be responsible for checking this daily. In order to safeguard the health of our Residents & to fulfill the above requirement our entire dietary staff was instructed by the D.M. on 7/19 regarding the proper way to place left over food which has not been prepared or brought to the dining rooms in a suitable container. These are to be labeled, dated, covered, & stored according to HACCP guidelines & according to proper cooling techniques. A labeling gun is being used to stamp the current date when items are received & stored. Staff has been instructed to remove all expired items from the storage areas & refrigerators so they can be disposed of. It will be the responsibility of the Dietary Manage & the Sister Supervisor to inspect these areas daily for compliance. To insure compliance is sustained the D. M. will take this topic for her QA project for the final quarter of this year. In fulfillment of this same requirement all dietary personnel were informed of the need to close the lids on all condiments & other food items so as to preserve their freshness & avoid contamination. The D.M. is responsible for	



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
(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 371	<p>Continued From page 7</p> <p>infection control issue with possible bug infestation as there were no barriers to prevent it. In addition, the frozen egg product was only good for three days after opened otherwise it should have been discarded. Egg products left too long are a source of salmonella and could cause the residents to get sick. The dry storage area utilizes a first in - first out system to rotate food items. However she could not identify which stock were first in or first out.</p> <p>Interview with Dietary Staff #14 on 07/15/10 at 2:51pm revealed the utility cart did not belong to the dietary department. The cart was being used to place clean dishes, cookware and spatulas on for transport. The dietary staff stated a dirty cart should not be used for clean dishes. In addition, he wears a hair net; however, he does not have anything to cover his moustache.</p> <p>Interview with the DM on 07/15/10 at 2:51pm revealed the substance on the dishwasher was a buildup of lime and is a concern for coming in contact with the clean dishes and a potential for infection control concerns.</p> <p>Interview with Dietary Staff #15 on 07/15/10 at 2:45pm revealed the dietary staff are to keep all hair covered with a hair nets when in the dining room or the kitchen and indicated it was hard to keep all of the hair under the hair net.</p> <p>Review of the facility's policy on Food and Supply Storage revealed stock on hand is pulled to the front and new is placed in the back. The old stock is marked with a black X to insure it is used first.</p> <p>Interview with the DM on 07/15/10 at 2:51pm</p>	F 371	<p>examining such food items bi-weekly to insure this policy is being followed.</p> <p>In order to avoid the possibility of having milk with temperatures above 41 degrees on the serving buffet line, we no longer store milk in the reach in refrigerator in the pantry. Instead all milk is kept in the walk in kitchen refrigerator until serving time. Staff have been instructed to submerge milk containers in ice. They have also been instructed to take the temperature of the milk before placing it in the serving buffet, & also during the meal service to assure the proper temperature. The D.M. & Sister Supervisor will monitor to be sure staff are in compliance.</p> <p>Dietary staff will be informed of our revised policy for raw potatoes. These are to be covered while being peeled, placed in a container half full of water & ice to insure a temperature below 41 degrees. The temperature is to be taken each half hour & ice added if needed. Containers are to be covered, labeled, dated & put in the refrigerator but discarded if not used in 3 days. The D.M. will in -service staff on these procedures & frequently check to be sure they are followed.</p> <p>The lime buildup on our dish</p>		



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

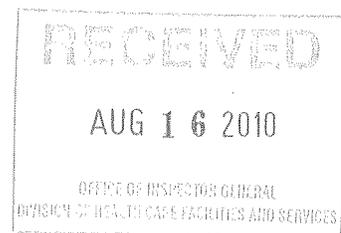
PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/15/2010
--	--	--	--

NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
--	---

(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 371	Continued From page 8 revealed the dietary department has never placed a black X on the stock to identify the stock that should be used first. Review of the facility's policy on Food Labeling revealed all food containers should be labeled and dated and disposed of after three days. Review of the facility's policy on Hairnet Wearing revealed hair nets are worn to prevent hair from falling into Residents' food during meal preparation and service.	F 371	machine was removed on 7/15. To be sure this does not happen again an in-service on proper cleaning & de-liming techniques, as well as, proper floor cleaning procedures was held on 7/22. Staff were shown how to dismantle & clean the machine at the end of each shift & reminded to de-lime it twice weekly. The exterior & interior however, are to be cleaned daily. The D.M. & Supervisor are responsible for checking bi-weekly to insure these procedures are followed. In order to prevent the growth of bacteria & to protect our Residents dietary staff will be instructed to follow the following procedures for our carts: Carts are to be thoroughly washed & sanitized after each use; clean dishes are never to be placed on dirty carts & vice versa & to be covered in transport. The D.M. & Supervisor will monitor daily for compliance. Our Home has begun a revised food storage plan using the "First In, First Out" method & to insure that items are stored according to HACCP guidelines. A labeling gun is used to stamp the date of reception & storage. New items are put behind old stock, right side up, with label in front. Dented & damaged items are separated & returned, & expired items are discarded. The D.M. will in-service staff & monitor bi-weekly for compliance.	
-------	---	-------	---	--



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

PRINTED: 07/27/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185260	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/15/2010
NAME OF PROVIDER OR SUPPLIER LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
(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 371	Continued From page 8 revealed the dietary department has never placed a black X on the stock to identify the stock that should be used first. Review of the facility's policy on Food Labeling revealed all food containers should be labeled and dated and disposed of after three days. Review of the facility's policy on Hairnet Wearing revealed hair nets are worn to prevent hair from falling into Residents' food during meal preparation and service.	F 371	Copies of checklists, in-service, etc. will be given to the Administrator for approval. Administrator will observe & verify by means of consultation with the D.M. & Sister Supervisor that the above measures are being complied with. Failure in this regard will lead to disciplinary measures. Our Dietary Manager has left on vacation, however her in-services will be completed by 8/10/10. The required documentation will be faxed to your office.		

