

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

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

10/14/2011

NAME OF PROVIDER OR SUPPLIER

FOUR COURTS AT CHEROKEE PARK

STREET ADDRESS, CITY, STATE, ZIP CODE  
2100 MILLVALE RD.  
LOUISVILLE, KY 40205

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
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PROVIDER'S PLAN OF CORRECTION  
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DATE

F 000

INITIAL COMMENTS

F 000

Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.

F 166  
SS=D

An amended statement of deficiencies was issued on 11/03/11.  
483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES

F 166

F166  
Resident #18 no longer resides in facility.

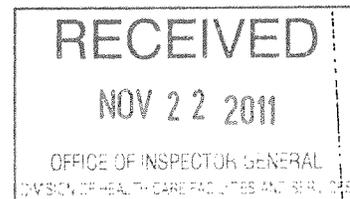
A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

An audit of all grievances filed over the last six months was conducted by the Administrator/designee. The Administrator/designee verified the notification to resident/family of any grievances filed since 4/14/11.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, review of complaint/grievance reports, and facility policy, it was determined the facility failed to notify one (1) of nineteen (19) sampled residents/family regarding the outcome of a verbal abuse allegation lodged against a facility staff member.

The finding includes:

Review of facility policy Investigating a Resident Grievance or Complaint, revised February 2009, revealed all grievances and/or complaints would be investigated by appropriate facility staff and



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

*Kelly Thompson* *K Thompson (with addendum)*

TITLE  
*Administrator* *Administrator* 11/18/11 11/2/11 (X6) DATE

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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Continued From page 1  
 recorded on the grievance/complaint log. Item # 5  
 under procedure; The resident or person acting  
 on behalf of the resident will be informed of the  
 findings upon completion of the investigation, as  
 well as any corrective actions.

Record review confirmed an allegation of verbal  
 abuse was reported on 08/18/11. The  
 investigation was assigned to Practical Nurse  
 (LPN) # 2 on the same day. Reviewed of the  
 report revealed the allegation was made by  
 Resident #18 and his/her son. Further review of  
 the complaint/grievance form revealed the  
 allegation had a resolution date of 09/30/11 and  
 indicated the resident and the Certified Nurse  
 Aide (CNA) had "worked it out". There was no  
 evidence provided by the facility to indicate the  
 resident's son was notified of the outcome per the  
 facility policy.

Interview, on 10/14/11 at 11:30 AM, with Resident  
 #18's son by telephone confirmed he was not  
 notified of the outcome of the complaint he and  
 the resident lodged on 08/18/11.

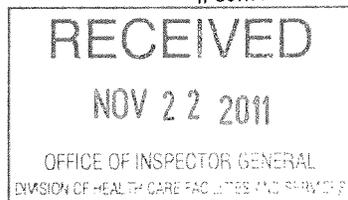
Interview, on 10/14/11 at 11:45 AM, Social  
 Service Director (SSD) explained she had not  
 followed up with Resident #18's family listed on  
 the complaint/grievance report form completed on  
 08/18/11. She stated she knew policy on  
 Grievances and knew the outcome should have  
 been discussed with the family.

Interview with the Administrator, on 10/12/11 at  
 3:50 PM, revealed the SSD was responsible for  
 management of the grievance/complaint policy

F 166

The grievance/complaint  
 investigation report must be  
 complete within 3 working days.  
 The resident or person acting on  
 behalf of the resident will be  
 informed by the  
 Administrator/designee of the  
 findings upon completion of the  
 investigation, as well as any  
 corrective actions.

All staff were re-educated by the  
 Administrator/designee on the  
 policy regarding Investigating a  
 Resident Grievance or Complaint  
 by 11/28/11. Residents or  
 person acting on behalf of the  
 resident were given the policy  
 regarding Investigating a  
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 as well by 11/28/11.



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F 166 Continued From page 2  
and was responsible for follow-up with Resident  
#18's family notification.  
F 225 483.13(c)(1)(ii)-(iii), (c)(2) - (4)  
SS=F INVESTIGATE/REPORT  
ALLEGATIONS/INDIVIDUALS

F 166

F 225

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 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

The Social Services Director /designee will conduct a monthly audit of all grievances or complaints noted on the monthly grievance log and will verify notification of the resident and/or resident representative of the outcome of the complaint. 100% of grievances will be audited each month to ensure the notification section is complete. Of those 10% will receive a follow call or visit to ensure completion/satisfaction.

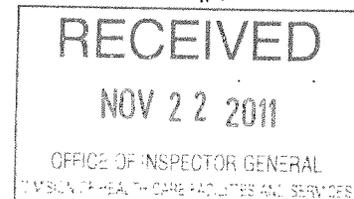
Findings of audits will be forwarded to quality assurance team for review x 3 months and at the discretion of the quality assurance team thereafter.

**F166 Addendum:**

- Designee to Administrator is Administrator in Training or Social Services Director to audit all grievances filed over the last six months.
- Designee to Administrator for grievance notification is the department manager investigating the grievance.
- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.

11/28/11

11-28-11



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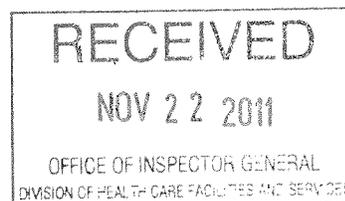
F 225

Continued From page 3  
appropriate corrective action must be taken.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review, incident report reviews, complaint reports, and facility policy, it was determined the facility failed to ensure all alleged violations involving mistreatment, neglect or abuse were reported immediately to officials in accordance with State laws through established procedures. In addition, the facility failed to ensure all alleged violations were investigated thoroughly and failed to prevent further potential abuse while the investigation was in progress for three (3) of nineteen (19) sampled residents (Resident #6, #18 and #19). The facility failed to follow policies and procedures for Prevention of Abuse, Neglect, and Misappropriation of Property, dated April 2009. The facility failed to thoroughly investigate an allegation of a missing cell phone and charger reported by Resident #6 on 08/19/11. The facility failed to thoroughly search for the missing items, failed to interview employees, and failed to notify the appropriate state agencies regarding the missing phone and charger. The facility failed to thoroughly investigate an allegation of verbal abuse reported by Resident #18 on 08/08/11. The resident reported a Certified Nurse Aide (CNA) used "demeaning" language and attitude and failed to respect the resident's privacy. The facility failed to protect residents by allowing the CNA to continue providing direct resident care pending an investigation of the allegation and failed to investigate the incident to determine exactly what "demeaning" language and attitude

F 225

F225  
Resident #6's grievance/investigation was re-opened, reported to the appropriate agencies and thoroughly investigated as much as possible. There was no alleged perpetrator identified and the phone and charger was reimbursed per the resident representative's preference. Resident #18's allegation of verbal abuse was re-opened, reported to the appropriate agencies and the alleged perpetrator identified was suspended immediately pending investigation and later terminated. Resident #19's allegation of "rough" care was re-opened, reported to the appropriate agencies and the alleged perpetrator identified was suspended immediately pending investigation and later terminated.



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F 225 Continued From page 4  
meant as reported by the resident. The facility failed to investigate an allegation of a CNA handling Resident #19's sore leg "rough" during the resident's shower on 09/08/11. The facility failed to protect residents from further abuse by allowing the CNA to continue to provide direct resident care pending an investigation. The CNA denied the allegation and no further investigation into the incident occurred.

Substandard Quality of Care was identified on 10/13/11 at 42 CFR 483.13 (c)(2)(3) and (4), Resident Behavior and Facility Practices, F225 and F226 at a S/S of an "F".

The findings include:

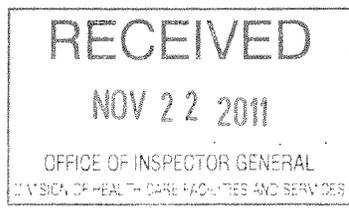
Refer to F226.

Record review of the facility policy on Prevention of Abuse, Neglect, and Misappropriation of Resident's Property found in the Nursing Services Policy and Procedure Manual (Revised April 2009) stated within the policy "It is the intent of this facility to immediately report and thoroughly investigate allegations of mistreatment, neglect, abuse, misappropriation of resident's property or any injury of unknown origin". The policy revealed under the heading Investigation, a thorough investigation would be initiated immediately for all alleged incidents of abuse involving staff members, residents, family, and/or visitors who have potential knowledge of the incident or its circumstances. The policy states the Administrator/designee will make all reasonable efforts to investigate and address

F 225

100% of residents or responsible parties if cognitively impaired were interviewed to ensure that the facility did not have any allegations of abuse/neglect/misappropriation that were not thoroughly investigated and reported.

Corporate Social Services Director re-educated Administrator on the abuse policy with emphasis on reporting, protection, investigation, and prevention as well as abuse coordinator responsibilities. All staff were re-educated on the abuse policy and procedure by the Administrator/designee with emphasis on reporting, protection, investigation and prevention as well as the change in abuse coordinator. The abuse coordinator in the facility was changed from the



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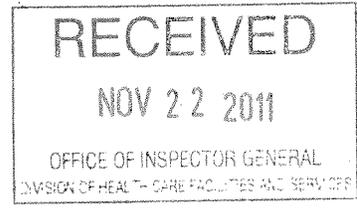
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F 225	<p>Continued From page 5</p> <p>alleged reports, concerns, and grievances presented to them. Staff are trained to report any oral or written reports of abuse, mistreatment, or misappropriation of property. The resident will receive measures to ensure his/her immediate safety and well-being following the incident and during the investigation process. Employees accused of participating in alleged abuse will be immediately suspended until the findings of the investigation have been reviewed by the Administrator, Director of Nursing and Human Resources.</p> <p>Interview with the Administrator, on 10/12/11 at 3:50 PM, revealed the facility Social Services Director (SSD) was responsible for monitoring and supervising, processing and the review of the grievance/complaint and abuse investigations and procedure. She stated the SSD received all complaints during business hours, logged in the complaints, reviewed them for possible abuse, assigned the complaints to the appropriate Department Manager for investigation, received the investigation results back from the Department Manager, noted if the resident was satisfied with the action taken by the facility, and logged in the results. She stated complaints reported after business hours were managed by the nursing supervisors on each shift then turned over to the SSD for investigation.</p> <p>Interview with the Social Services Director (SSD), on 10/13/11 at 8:50 AM, revealed she was responsible for ensuring residents were protected from abuse and that allegations of abuse were investigated and reported. She stated complaints</p>	F 225	<p>Social Services Director to the Administrator during the survey.</p> <p>The Social Services Director /designee will conduct a monthly audit of all grievances or complaints noted on the monthly grievance log to ensure allegations of abuse were not reported incorrectly and report findings to the monthly quality assurance meeting. The Social Services Director/designee will further audit any allegation of abuse monthly to ensure proper reporting, protection and investigation and report findings to the monthly quality assurance meeting. The Social Services Director/designee will conduct weekly interviews with residents or responsible parties per the quarterly/annual MDS calendar to ensure that the facility did not have any allegations of abuse/neglect/misappropriation that were not thoroughly investigated and reported and will report findings to the monthly quality assurance</p>	
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 were received from residents, families, and employees of the facility. She indicated the staff ensured she received the complaints as soon as they were lodged. She read the complaint and entered the information into a log, determined the appropriate Department Manager (DM) and forwarded the complaint to that DM, the DM was responsible to investigate the complaint and return the complaint form to the SSD. She revealed the nursing supervisors received the complaints after hours and on the weekends and forwarded them to her. The DMs were allowed five (5) days to investigate and return the results to her for review.

1. Review of the record for Resident #18 revealed the facility admitted Resident #18 on 08/18/11 with diagnoses of Gout and Muscle Weakness. Review of the facility's complaint report, dated 08/18/11, for Resident #18 revealed the resident and a family member reported an allegation of verbal abuse by a Certified Nurse Aide (CNA) who used a demeaning voice and attitude and did not respect the resident's privacy on 08/18/11. The resident stated trust was lost in the employee and the resident preferred not to have this employee provide care again. The facility documented proper behavior and dignity as part of the complaint. Further documentation revealed the resident and the employee had "worked it out".

Interview with Licensed Practical Nurse (LPN) #2, on 10/13/11 at 2:26 PM, revealed the resident was irate on 08/18/11 in the morning related to an incident which occurred during the night when the resident experienced an incontinent episode.

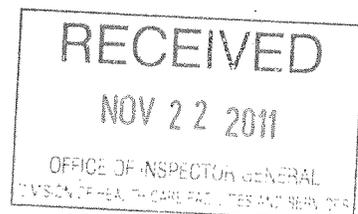
F 225

meeting. All audit results will be reviewed by the Quality Assurance team x 3 months and at the team's discretion thereafter.

11/20/11

**F225 Addendum:**

- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11. The Administrator will be the abuse coordinator which involves allegations of abuse being reported to the administrator immediately and the administrator being responsible for the overall investigation, protection of the resident and agency reporting process. Social Services will be auditing the reporting, protection and investigation process of the Administrator. The Medical Director will review all allegations of abuse and reports of abuse during the Quality Assurance meetings.
- Administrator re-educated to the abuse policy and abuse coordinator responsibilities by the Corporate Social Services Director on 11/18/11.



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The resident expressed that the staff were talking out in the hallway and the resident felt the incontinent incident was a private matter and staff discussed the incident in the hall where other residents could hear. She stated the resident was distressed and told LPN #2 that the staff involved was not to provide future care for the resident. She revealed the resident felt the staff were disrespectful.

Interview with the family member of Resident #18, on 10/14/11 at 11:30 AM, revealed the family member reported the abuse allegation, on 08/18/11, to staff after the resident verbalized being very upset. The facility completed an admission Minimum Data Set (MDS) assessment on 09/15/11 for Resident #18 which revealed the resident was alert and oriented and had a Brief Interview for Mental Status (BIM) score of "15" (score of 13-15 indicated the resident was cognitively intact)

There was no evidence documented that the facility took action to protect Resident #18 or other residents from further abuse nor was there documentation that an investigation was conducted to determine if abuse occurred.

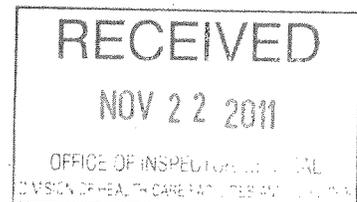
2. Resident #19 was admitted to the facility on 02/01/08 with diagnoses to include Congestive Heart Failure (CHF), Anxiety Disorder and Depression.

Record review of the Complaint Report, dated 09/08/11, revealed Resident #19 stated a CNA was rough while showering him/her and hurt

F 225

- Social Services Director will conduct weekly audits of all grievances or complaints as well as any allegation of abuse. However, weekly interviews with residents/responsible parties will be assigned out to different department managers to conduct correlating to the MDS schedule as part of a Corporate QA program called Abaqis. The Social Services Director will coordinate interviews to ensure completion and will review the results.
- QA team will first review the effectiveness and compliance on December 6, 2011 and will review weekly x 1 month, bi-weekly x 1 month after and at the QA team's discretion thereafter.

11-28-11



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 his/her left leg. A statement was obtained from  
 the CNA involved who denied the allegation. It  
 was revealed the CNA was educated to "be  
 gentle with residents" due to skin integrity. There  
 was no evidence provided by the facility to  
 document the CNA was removed from direct  
 resident care or suspended to ensure the resident  
 was protected from further abuse pending an  
 investigation, to report the alleged physical  
 abuse, or to investigate the allegation.

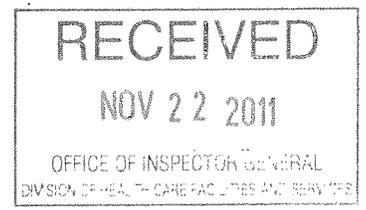
Attempts to interview Resident #19 on 10/14/11  
 were not successful as the resident expressed  
 concerns the CNA might lose her job.

Interview with the SSD, on 10/13/11 at 8:50 AM,  
 revealed Resident #19 did accuse the CNA of  
 being rough during the resident's shower;  
 however, she felt abuse had not occurred related  
 to how well she knew this resident and the  
 resident's behavior. She stated she should have  
 insisted on nursing investigations being  
 completed.

Interview with Assistant Director of Nursing  
 (ADON) #2, on 10/13/11 at 10:10 AM, revealed  
 she received the allegation of physical abuse and  
 provided a copy of the allegation to the SSD on  
 Resident #19. She stated she talked with the  
 resident and obtained a statement from the  
 employee. She indicated she was not familiar  
 with abuse and believed the facility had  
 completed the incorrect form possibly causing the  
 breakdown in recognizing possible abuse.

Interview, on 10/14/11 at 9:15 AM, with ADON #2

F 225



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

PRINTED: 11/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/14/2011
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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(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
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F 225

Continued From page 9 revealed she had not been educated on the process of an abuse investigation after a report of alleged abuse was received.

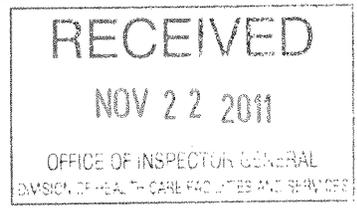
3. Review of the record for Resident #6 revealed the facility admitted the resident on 01/19/11 with diagnoses of Right Mastectomy, Hypertension, Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease. The facility completed a significant change MDS on 06/27/11 which revealed the resident had a BIM score of "7" and was not interviewable.

Record review of the Resident/Visitor/Grievance/Complaint Form filled out on 06/19/11 revealed the daughter of Resident #6 reported a cell phone and charger missing from the room of Resident #6. The missing phone and charger were not reported to the state agency. The form revealed Social Services and the daughter searched the room and did not locate the phone. There was no evidence of any further investigation completed by the facility. The resident stated the Social Services Director notified Resident #6 that the items could not be found. The administrator signed off on the form on 07/01/11 with the corrective action being the daughter was going to buy the resident a new phone which was placed at a value of forty (40) dollars.

Interview, on 10/14/11 at 9:15 AM, with ADON #2 revealed she had not been educated on the process of conducting an investigation.

Continued interview with the SSD revealed she

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

PRINTED: 11/03/2011  
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STATEMENT OF DEFICIENCIES  
 AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
 IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

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(X3) DATE SURVEY  
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LOUISVILLE, KY 40205

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(X5)  
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Continued From page 10  
 was responsible to monitor and supervise the  
 process; however, she did not review the  
 complaints for possible abuse before assigning  
 them to a DM. She stated she knew the  
 residents and felt they would tell her specifically if  
 they were abused. She indicated she was aware  
 the DMs were not thoroughly investigating  
 complaints and were returning them with little  
 information; however, she stated she did not  
 believe anyone working at the facility would abuse  
 the residents.

F 225

Continued interview with the Administrator  
 revealed she was not aware of any abuse  
 occurring in the facility and staff was trained to  
 notify the Director of Nursing (DON) and the  
 Administrator if abuse occurred.

F 226  
 SS=F

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  
 by:  
 Based on observation, interview, clinical record  
 review, review of completed  
 Resident/Visitor/Grievance/Complaint Forms and  
 review of facility policies it was determined the  
 facility failed to implement their policies related to  
 abuse and the thorough investigation of incidents  
 of alleged physical, verbal and mental abuse and  
 misappropriation of property, reporting to the  
 state agencies and ensuring resident protection  
 from further abuse pending investigations for

F226

F 226

Resident #6's  
 grievance/investigation was re-  
 opened, reported to the  
 appropriate agencies and  
 thoroughly investigated as much  
 as possible. There was no alleged  
 perpetrator identified and the  
 phone and charger was  
 reimbursed per the resident  
 representative's preference.  
 Resident #18's allegation of  
 verbal abuse was re-opened,  
 reported to the appropriate  
 agencies and the alleged  
 perpetrator identified was  
 suspended immediately pending  
 investigation and later

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

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F 226

Continued From page 11  
three (3) of nineteen (19) sampled residents  
(Resident #6, #18, #19). Resident #6 reported a  
missing cell phone and charger, on 06/19/11, to  
facility staff. The facility searched the resident's  
room; however, there was no documentation to  
show the facility searched other areas or that the  
facility reported the missing property to the  
appropriate state agencies per the facility policy.  
Resident #18 reported to facility staff, on  
08/18/11, that a facility Certified Nurse Aide  
(CNA) talked loudly about the resident in the  
hallway after the resident experienced an  
incontinent episode. There was no  
documentation from the facility that the resident  
was protected pending an investigation. The  
facility documented Resident #18's complaint and  
that the CNA denied the complaint. There was no  
further documentation from the facility that an  
investigation was completed per the facility policy.  
Resident #19 complained to facility staff, on  
09/08/11, that a facility CNA handled a sore leg  
roughly during the resident's shower.

Substandard Quality of Care was identified on  
10/13/11 at 42 CFR 483.13 (c)(2)(3) and (4),  
Resident Behavior and Facility Practices, F225  
and F226 at a S/S of an "F".

The findings include:

Refer to F225.

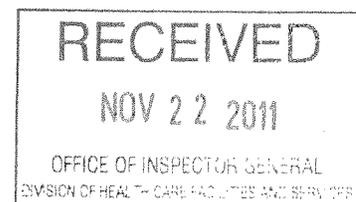
Record review of the facility policy on Prevention  
of Abuse, Neglect, and Misappropriation of  
Resident's Property found in the Nursing Services  
Policy and Procedure Manual (Revised April  
2009) stated within the policy "It is the intent of  
this facility to immediately report and thoroughly

F 226

terminated. Resident #19's  
allegation of "rough" care was re-  
opened, reported to the  
appropriate agencies and the  
alleged perpetrator identified  
was suspended immediately  
pending investigation and later  
terminated.

100% of residents or responsible  
parties if cognitively impaired  
were interviewed to ensure that  
the facility did not have any  
allegations of  
abuse/neglect/misappropriation  
that were not thoroughly  
investigated and reported.

Corporate Social Services  
Director re-educated  
Administrator by 11/28/11 on  
the abuse policy with emphasis  
on reporting, protection,  
investigation, and prevention as



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

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Continued From page 12  
 investigate allegations of mistreatment, neglect,  
 abuse, misappropriation of resident's property or  
 any injury of unknown origin". The policy  
 revealed under the heading Investigation, a  
 thorough investigation would be initiated  
 immediately for all alleged incidents of abuse  
 involving staff members, residents, family, and/or  
 visitors who have potential knowledge of the  
 incident or its circumstances. In addition, under  
 the same heading the policy states the  
 Administrator/designee will make all reasonable  
 efforts to investigate and address alleged reports,  
 concerns, and grievances presented to them.  
 Staff are trained to report any oral or written  
 reports of abuse, mistreatment, or  
 misappropriation of property. The resident will  
 receive measures to ensure his/her immediate  
 safety and well-being following the incident and  
 during the investigation process. Employees  
 accused of participating in alleged abuse will be  
 immediately suspended until the findings of the  
 investigation have been reviewed by the  
 Administrator, Director of Nursing and Human  
 Resources.

Interview with the Administrator, on 10/12/11 at  
 3:50 PM, revealed the facility Social Services  
 Director (SSD) was responsible for monitoring,  
 supervising, and implementing the facility policies  
 for abuse prevention. She stated the SSD  
 received all complaints during business hours,  
 logged in the complaints, reviewed them for  
 possible abuse, assigned the complaints to the  
 appropriate Department Manager for  
 investigation, received the investigation results  
 back from the Department Manager, noted if the  
 resident was satisfied with the action taken by the  
 facility, and logged in the results. She stated

F 226

well as abuse coordinator  
 responsibilities. All staff were re-  
 educated by 11/28/11 on the  
 abuse policy and procedure by  
 the Administrator/designee with  
 emphasis on reporting,  
 protection, investigation and  
 prevention as well as the change  
 in abuse coordinator. The re-  
 education of the Administrator  
 and all staff utilized a pre and  
 post test to ensure staff  
 understanding and ability to  
 implement the policy. The abuse  
 coordinator in the facility was  
 changed from the Social Services  
 Director to the Administrator  
 during the survey. The Social  
 Services Director will continue to  
 provide abuse training upon hire  
 and at least annually utilizing the  
 company provided abuse  
 training materials and a pre and  
 post test to ensure staff  
 understanding and ability to  
 implement the policy.

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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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PRINTED: 11/03/2011  
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OMB NO. 0938-0391

37. IDENTIFICATION OF DEFICIENCIES AND PLAN OF CORRECTION

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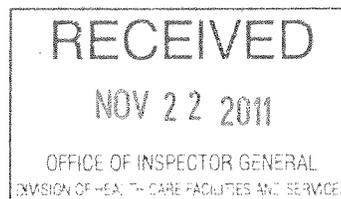
F 226

Continued From page 13  
complaints reported after business hours were managed by the nursing supervisors on each shift then turned over to the SSD for investigation. She stated she was not aware of any abuse occurring in the facility and staff were trained to notify the Director of Nursing (DON) and the Administrator if abuse occurred.

Interview with the Social Services Director (SSD), on 10/13/11 at 8:50 AM, revealed she was responsible for ensuring residents were protected from abuse and that allegations of abuse were investigated and reported. She stated complaints were received from different sources which included residents, families, and employees of the facility. She indicated the staff ensured she received the complaints as soon as they were reported. She stated she read the complaint and entered the information into a log, determined the appropriate Department Manager (DM) and forwarded the complaint to that DM, the DM was responsible to investigate the complaint and return the complaint form to the SSD. She revealed the nursing supervisors received the complaints after hours and on the weekends and forwarded them to her. DM were allowed five (5) days to investigate and return the results to her for review. She stated she was responsible to monitor and supervise the process; however, she did not review the complaints for possible abuse before assigning them to a DM. She stated she knew the residents and felt they would tell her specifically if they were abused. She indicated she was aware the DM were not thoroughly investigating complaints and were returning them with little information; however, she stated she did not believe anyone working at the facility would abuse the residents.

F 226

The Social Services Director / designee will conduct a monthly audit of all grievances or complaints noted on the monthly grievance log to ensure allegations of abuse were not reported incorrectly and report findings to the monthly quality assurance meeting. The Social Services Director / designee will further audit any allegation of abuse monthly to ensure proper reporting, protection and investigation and report findings to the monthly quality assurance meeting. The Social Services Director / designee will conduct weekly interviews with residents or responsible parties per the quarterly / annual MDS calendar to ensure that the facility did not have any allegations of abuse / neglect / misappropriation that were not thoroughly investigated and reported and will report findings to the monthly quality assurance meeting.



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F 226 Continued From page 14

1. Review of the record for Resident #6 revealed the facility admitted the resident on 01/19/11 with diagnoses of Right Mastectomy, Hypertension, Chronic Obstructive Pulmonary Disease and Chronic Kidney Disease. The facility completed a significant change MDS on 06/27/11 which revealed the resident had a Brief Interview of Mental Status (BIM) (a score of 13-15 indicated the resident was interviewable) score of "7" and was not interviewable.

Review of the facility Grievance/Complaint Form, dated 06/19/11, revealed the family of Resident #6 reported a cell phone and charger missing from the room of Resident #6. The report indicated the family had searched the room and did not find the phone. Additionally, the resident reported a mirror missing which is noted on the same report. The form revealed Social Services searched the room and did not locate the phone or the mirror. The review stated the SSD notified Resident #6 that the items could not be found. Documented under Investigative Procedures on the form revealed the family had searched the room without success. The administrator signed off on the form on 07/01/11 with the corrective action being the family would purchase the resident a new phone which was placed at a value of forty (40) dollars. There was no documentation that the facility took further action or that the missing items were reported.

Interview on 10/11/11 at 9:40 AM with Resident #6 during the Quality of Life Resident Assessment revealed he/she had reported a shirt/blouse and a mirror missing to the facility SSD. The resident revealed he/she did not know

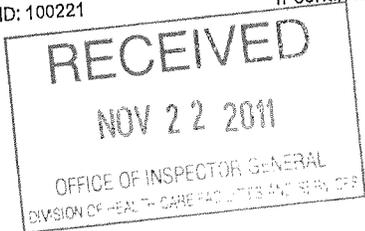
F 226

All audit results will be reviewed by the Quality Assurance team x 3 months and at the team's discretion thereafter.

11/20/11

**F226 Addendum:**

- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11. The Administrator will be the abuse coordinator which involves allegations of abuse being reported immediately to the administrator and the administrator being responsible for the overall investigation, protection of the resident and agency reporting process. Social Services will be auditing the reporting, protection and investigation process of the Administrator. The Medical Director will review all allegations of abuse and reports of abuse during the Quality Assurance meetings. The abuse policies were reviewed by the Quality Assurance Team on 10/25/11 and re-education provided on the above training dates.
- Administrator re-educated to the abuse policy and abuse coordinator responsibilities by the Corporate Social Services Director on 11/18/11.



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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 226

Continued From page 15  
the outcome of the complaint which included information regarding the missing cell phone and charger.

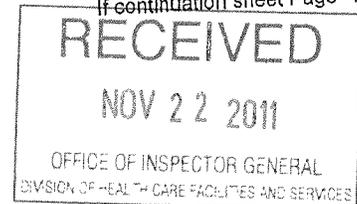
2. Review of the record for Resident #18 revealed the facility admitted the resident on 08/08/11 with diagnoses of Gout, Bipolar Disorder and Weakness. The facility completed an admission Minimum Data Set (MDS) assessment of the resident on 08/19/11 which revealed the resident had a BIM score of "15" and was interviewable.

Review of the facility's complaint report, dated 08/18/11, for Resident #18 revealed the resident and a family member both reported the behavior of a Certified Nurse Aide (CNA) toward Resident #18. The complaint alleged a facility CNA had a demeaning voice and attitude, and failure to respect the resident's privacy on 08/18/11. The resident experienced an incontinent episode during the night and heard the CNA talking about the incident, loudly, in the hallway. The resident stated trust was lost in the employee and the resident preferred not to have this employee provide care again. Interview with the family member of Resident #18, on 10/14/11 at 11:30 AM, revealed he reported the abuse allegation to staff related to the resident calling him and being upset. He stated he received no feed-back from the facility regarding the allegation. Further documentation revealed the resident and the employee had "worked it out". There was no documentation to show the facility policy to protect residents pending investigations was implemented. There was no documentation to show the facility's policy of investigating allegations was implemented or that the complaint was reported to the state agency.

F 226

- Social Services Director will conduct weekly audits of all grievances or complaints as well as any allegation of abuse. However, weekly interviews with residents/responsible parties will be assigned out to different department managers to conduct correlating to the MDS schedule as part of a Corporate QA program called Abaqis. The Social Services Director will coordinate interviews to ensure completion and will review the results.
- QA team will first review the effectiveness and compliance of the POC on December 6, 2011 and will review weekly x 1 month, bi-weekly x 1 month after and at the QA team's discretion thereafter.

11-28-11



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

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S1. STATEMENT OF DEFICIENCIES  
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F 226 Continued From page 16

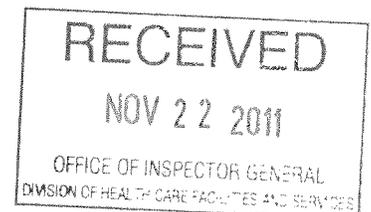
F 226

Attempts to interview Resident #18 were unsuccessful due to the resident's refusal. The resident expressed concern the CNA might lose her job.

Interview with Assistant Director of Nursing (ADON) #2, on 10/13/11 at 10:10 AM, revealed she received the report and provided a copy of the alleged verbal abuse allegation to the SSD on Resident #19. She stated she talked with the resident and obtained a statement from the employee. She indicated she was not familiar with the components of the facility abuse policy and believed the facility completed the incorrect form and possibly caused the breakdown in implementing the abuse policies.

3. Review of the record revealed the facility admitted Resident #19 on 02/01/08 with diagnoses of Congestive Heart Failure (CHF), Anxiety Disorder and Depression. The facility assessed the resident with no cognitive impairment on the Roster Matrix dated 10/11/11.

Record review of the facility Complaint/Grievance Report, dated 09/08/11, revealed Resident #19 complained that a facility Certified Nursing Assistant (CNA) was rough with his/her shower and hurt his/her left leg. The report indicated an investigation was assigned to the Assistant Director of Nursing (ADON) #2 on 09/08/11. A statement was obtained from the CNA involved who denied the allegation. It was revealed the CNA was educated to "be gentle with residents" due to skin integrity. The resolution was documented as having educated the CNA and Resident #19 signing the form with a statement by the resident that he/she "doesn't want to get



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F 226 Continued From page 17  
anyone in trouble" and ADON #2 assured the resident it would be a learning experience for the CNA. There was no facility documentation of the resident being protected pending an investigation. There was no facility documentation investigating the complaint and the incident was not reported to the state agency per facility policy.

F 226

Interview, on 10/14/11 at 9:15 AM, with ADON #2 revealed she had not been educated by the facility on the process of an abuse investigation after a report of alleged abuse was received.

Interview, on 10/13/11 at 5:00 PM, with the Social Services Director revealed the facility had an in-service on abuse and abuse reporting; however, she had no agenda for the training. She stated she only reviewed the Abuse Policy with the staff during the in-service. There was no documentation of staff understanding or staff ability to implement the policy.

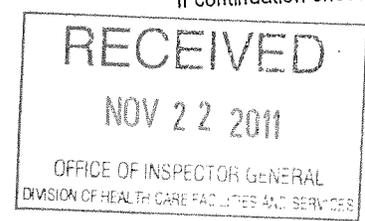
F 250  
SS=E 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE

F 250

The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review, review of facility policy, review of complaints and complaint investigations, it was determined the facility failed to provide medically-related social services to four (4) residents (Resident #6, #8,

F250  
Resident #8 does not have broken dentures and may have been mistaken for Resident #2. Resident #18's family was notified of the outcome of the re-opened investigation and was satisfied with the resolution. Resident #6, 18, 19's allegations of verbal/physical abuse were re-opened, reported to the appropriate agencies and thoroughly investigated. Resident #2 was referred for dental care and an appointment made to see the dentist to assess the need for dentures since



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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

10/14/2011

NAME OF PROVIDER OR SUPPLIER

FOUR COURTS AT CHEROKEE PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

2100 MILLVALE RD.  
LOUISVILLE, KY 40205

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL  
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PROVIDER'S PLAN OF CORRECTION  
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(X5)  
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DATE

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#18, #19). Residents #6, #18, #19 reported  
verbal or physical abuse and the facility failed to  
ensure allegations of abuse were managed in  
accordance with the facility policy. The facility  
failed to provide social services to assist Resident  
#8 in obtaining repair of his/her broken dentures.  
In addition, the facility failed to notify Resident  
#18's family of the outcome of a complaint of  
verbal abuse by a certified nurse aide (CNA).

The findings include:

Review of the facility policy Social Services, dated  
June 2007, revealed the facility provided  
medically-related social services to assure  
residents attained the highest level well-being.  
Social Services were provided to attain the  
residents' physical needs for adaptive equipment  
for eating, etc, and ensured complaints and  
grievances were promptly resolved and  
answered.

Interview with the Administrator, on 10/12/11 at  
3:50 PM, revealed social  
services were responsible for medically-related  
social services and the grievance/complaint  
management.

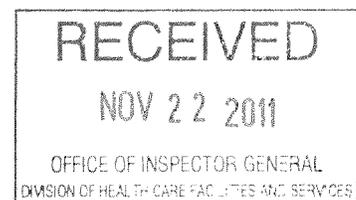
Interview with the Social Services Director (SSD),  
on 10/13/11 at 8:50 AM, revealed Resident #2  
received an assessment for medically-related  
social services on admission. She stated she  
was not aware the resident had broken dentures  
or if the resident had teeth. She stated concerns

F 250

facility has not been able to verify  
that she has broken dentures.

100% of residents or responsible  
parties if cognitively impaired  
were interviewed to ensure that  
the facility did not have any  
allegations of  
abuse/neglect/misappropriation  
that were not thoroughly  
investigated and reported. An  
audit of all grievances filed over  
the last six months was  
conducted by the  
Administrator/designee. The  
Administrator/designee verified  
the notification to  
resident/family of any  
grievances filed since 4/14/11.  
An audit of all residents will be  
conducted by the DON/designee  
to assess for any dental needs  
and follow up appointments to  
the dentist made as indicated.

A change in Social Services  
Director has been made and the  
new Director training provided  
by the Corporate Director of  
Social Services on Social Services



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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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Continued From page 19  
with teeth or dentures would be a nursing or dietician concern and not a social services concern. She stated she did not review the assessment after it was completed by all the disciplines and could not recall if the broken dentures were addressed by the assessment summaries or at the care plan conference for the resident. She stated she was not aware Resident #18's family filed a grievance regarding verbal abuse so the family was not notified of the outcome of the investigation; however, the family of Resident #18's complaint was logged on the grievance/complaint log.

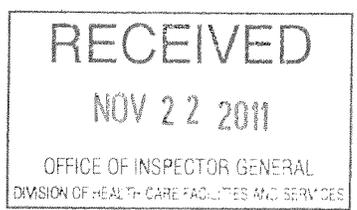
Continued interview with the SSD revealed she accepted responsibility for allegations of verbal and physical abuse regarding Residents' #6, #18, #19 not timely investigated thoroughly, not reported and leaving residents unprotected from further potential abuse during the course of investigations. She stated she did not insist department managers thoroughly investigate and document the results of investigations.

Interview on 10/13/11 at 5:00 PM with the Social Services Director revealed she conducted the facilities in-services on abuse and abuse reporting. The in-services had no written outline or stated objectives. She stated she only reviewed the Abuse Policy with the staff during the in-service. There was no evidence of staff understanding or staff ability to implement the policy.

Interview with the Administrator, on 10/14/11 at

F 250

policy and procedures.  
Corporate Social Services  
Director also educated the new Social Services Director on the abuse policy with emphasis on reporting, protection, investigation, and prevention. All staff were re-educated by 11/28/11 by the Administrator/designee on how to make a dental referral and when appropriate. The Social Services Director will continue to provide abuse training upon hire and at least annually utilizing the company provided abuse training materials and a pre and post test to ensure staff understanding and ability to implement the policy. Upon admission, the Social Services Director will review the nursing assessment that is completed at the time of admission and speak with resident and/or representative about dental needs. Utilizing both the assessment and interview, the Social Services Director/designee will make a decision if to proceed



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Continued From page 20  
1:30 PM, revealed the grievance/complaint process was removed from the SSD's responsibility.  
Resident #2 was admitted to the facility on 08/15/11 with diagnoses of Multiple Sclerosis, Decubitus (severe wound) Stage IV of the Coccyx, Traumatic Brain Injury, Anemia, Diabetes Mellitus, and Gastroesophageal Reflux Disease.

Observation, on 10/11/11 at 11:50 AM, of Resident #2 in his/her room revealed the resident's oral/dental status to be edentulous, (without natural teeth), while eating lunch which included a high calorie and protein supplement shake. Resident #2's physical appearance was very thin and bony. The resident was followed by a Registered Dietitian (RD) for low weight, poor nutrition, anemia and a decubitus.

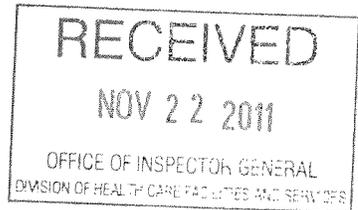
Record review of clinical chart, revealed during nursing admission notes the resident had broken teeth. The RD assessment notes for 08/14/11, revealed documentation of broken teeth was crossed out and the resident was documented as being edentulous. The admission Minimum Data Set (MDS) assessment, dated 08/27/11, revealed the section for Oral/Dental indicated no issues or concerns. The Social Services Director (SSD) provided no documentation of assessment or evaluation related to the resident's edentulous state. There was no indication of a dental referral made within the clinical record.

Interview, on 10/11/11 at 11:50 AM, with Resident #2 revealed the resident's dentures had been broken prior to admission to the facility. The resident confirmed meeting both the SSD and the RD while a resident in facility. The resident

F 250

with dental consult. The Social Services Director/designee will also speak to the resident and/or representative with each quarterly/annual MDS about the need for dental services and proceed as indicated.

The Social Services Director /designee will conduct a monthly audit of all grievances or complaints noted on the monthly grievance log to ensure allegations of abuse were not reported incorrectly and report findings to the monthly quality assurance meeting. The Social Services Director/designee will further audit any allegation of abuse monthly to ensure proper reporting, protection and investigation and report findings to the monthly quality assurance meeting. The Social Services



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stated no one asked about missing teeth or  
dentures.

Interview, on 10/12/11 at 9:00 AM, with the  
Assistant Director of Nursing (ADON) #1 revealed  
that physicians, nursing, RD and SSD could have  
made referrals for residents related to needed  
dental services.

Interview, on 10/13/11 at 9:30 AM, with the SSD  
revealed she had not reviewed the MDS for  
service needs for the resident and while present  
for the care plan conference, did not recall the  
resident's edentulous state or the need for  
services ever coming up. She stated nursing was  
responsible for residents' dental needs. She  
stated she could pass along information  
regarding residents' needs to nursing; however,  
she had not informed nursing of any needs for the  
resident.

F 253 483.15(h)(2) HOUSEKEEPING &  
SS=E MAINTENANCE SERVICES

The facility must provide housekeeping and  
maintenance services necessary to maintain a  
sanitary, orderly, and comfortable interior.

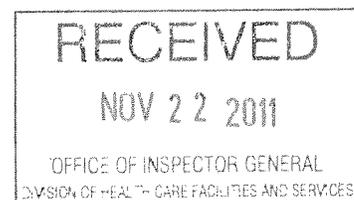
This REQUIREMENT is not met as evidenced  
by:  
Based on observation and interview, it was  
determined the facility failed to maintain an  
environment that was safe and homelike. There  
were eight (8) of thirty eight (38) wheelchairs in  
need of repair. The privacy curtain in Room 111  
was stained. The upholstery on two (2) wing

F 250

Director/designee will conduct  
weekly interviews with residents  
or responsible parties per the  
quarterly/annual MDS calendar  
to ensure that the facility did not  
have any allegations of  
abuse/neglect/misappropriation  
that were not thoroughly  
investigated and reported and  
will report findings to the  
monthly quality assurance  
meeting. Monthly the  
Administrator will audit 10% of  
the resident records and  
interview those  
residents/responsible parties for  
dental needs and dental consults  
as indicated. Results of this audit  
will be brought to the quality  
assurance team monthly x 2  
months and as indicated  
thereafter.

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11/28/11



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Continued From page 22  
back chairs was cracked and splitting. One wing back upholstered chair was stained. There was a loose handrail on a resident hallway. One handrail had a large splinter on the backside of the rail. There were three (3) sink drains identified to be slow to drain. The A Wing shower room had a missing threshold into the shower, an area of baseboard was missing, there was an unpainted patched area on the wall behind the door, there was a collection of dust behind the door and folded mats around the tub area. The clean linen cart cover on A Wing was cracked, split and frayed. There were buckled parquet floor tiles in the therapy area along the wall in front of windows and chimney area.

The findings include:

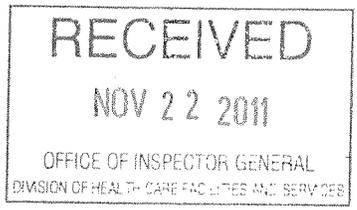
Facility policy review of Cleaning Schedules revealed cleaning schedules should be developed and implemented to ensure that the facility would be maintained in a clean and comfortable manner.

Review of maintenance log on A Wing and Linker revealed the log was being used; however, none of the identified areas of concern had been reported on the maintenance logs.

Observations during the environmental tour of the facility, on 10/11/11 at 6:55 AM, and subsequent observations during the standard survey 10/11/11-10/13/11 revealed the following items were in need of repair:

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f253  
The armrests were replaced on the 8 wheelchairs identified belonging to residents in rooms 117-1, 117-2, 116-2, 115, 109, 120, 113 and 105-2 on 10/13/11 by the Maintenance Director/designee. The privacy curtain in Room 111 was replaced on 10/13/11 by the Maintenance Director/designee with a clean curtain. The two wing back chairs located in sitting area on A wing, hall 130-140 were removed from the facility on 10/13/11 by the Maintenance Director/designee. The wing back chair located in room 143 was removed from the facility by the Maintenance Director/designee on 10/13/11. The hand rail between room 139 and the sitting area was removed and refastened to wall to ensure it was secure by the Maintenance Director/designee on 10/13/11. The hand rail between Rooms 143 and 144 was sanded and glued to ensure no splinters on 10/13/11 by the Maintenance



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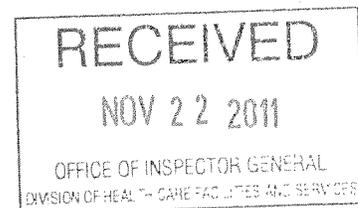
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F 253 Continued From page 23

1. There were eight wheelchairs identified with arm rest that were cracked and peeling with rough edges. The wheelchairs identified belonged to residents in rooms 117-1, 117-2, 116-2, 115, 109, 120, 113, and 105-2.
2. The privacy curtain in Room 111 had two large reddish brown stains on the curtain.
3. Two wing back chairs located in sitting area on A Wing, hall 130-140, were covered with impervious fabric. The arm rests were cracked and peeling with rough edges.
4. The upholstered wing back chair located in Room 143 had dark soiled areas on the arm rests, seat and inner wings of the chair.
5. The hand rail located between Room 139 and the sitting area was loose.
6. The hand rail located between Rooms 143 and 144 had a large splintered area on the back of the hand rail.
7. There sinks in Rooms 102, 109 and the Men's bathroom on Linker were slow to drain.
8. The A Wing shower room had a missing

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Director/designee. Rooms 102, 109 and Men's bathroom sinks were plunged 10/17/11 by the Maintenance Director/designee and are in good working order. The A wing shower threshold was replaced, baseboard repaired, patched area painted, black mats removed from the shower room and dust cleaned by the Maintenance Director/designee on 10/17/11. The cover to the clean linen cart on A wing was replaced by the Central Supply Clerk/designee on 11/5/11. All buckled parquet floor tiles in therapy were repaired by the Maintenance Director/designee on 11/4/11. The ice machine on Linker was cleaned on the sides, on top of the machine, on the top edge under the ice machine door and on top inside by the Maintenance Director/designee on 10/13/11. The ice machine on A wing was



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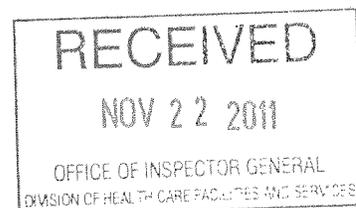
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- F 253 : Continued From page 24
- threshold between the shower and the room, part of the baseboard was missing to the left of the shower, there was a large patched area behind the door to the commode area that was unpainted, there were large black mats that had been folded over near the tub and there was a large accumulation of dust behind the door into the shower room.
9. The cover to the clean linen cart on A Wing was cracked, split and frayed.
10. There were many buckled parquet floor tiles along the windows and by the chimney located in the therapy room.
11. The ice machine located in the serving kitchen on Linker had drips and hard particles on the side of the machine. The gray shelf on top of the machine had dried dark colored particles on it. The top edge in front of the filter and the front seams of the machine had a white crusty buildup on them. The top edge under the ice machine door had both white and dark colored particles on it. On the top inside the ice machine the were black filmy areas.
12. The ice machine on A Wing had a dark sticky substance on the inside of the lid. There was a build up of gray particles and dark slimy substance around the upper edge of metal at the top of the ice machine.

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cleaned inside the lid and around the upper edge of metal at the top of the machine by the Maintenance Director/designee on 10/13/11.

All wheelchairs were assessed by the Maintenance Director/designee to ensure they were in good repair. Repairs were made as indicated. All privacy curtains were audited by the Maintenance Director/designee to ensure cleanliness and were replaced if necessary. All chairs in the facility were assessed by the Maintenance Director/designee to ensure they were in good repair. Repairs/replacements were made as indicated. All hand rails were checked by the Maintenance Director/designee to ensure none loose or splintered. Repairs were made as indicated. All sinks within the facility were audited by the Maintenance Director/designee to ensure they were draining properly and cleared if necessary. All shower rooms were audited



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Continued From page 25  
 Interview with CNA #11, on 10/13/11 at 8:55 AM,  
 revealed all concerns for maintenance were to be  
 placed on the maintenance logs. The  
 maintenance man would then check the log and  
 make necessary repairs, usually within a day or  
 two. CNA#11 stated the cracked arms on  
 wheelchairs could cause skin tears. She stated it  
 would be detrimental for the residents and that  
 there were some residents who wore arm  
 protectors because their skin was so fragile.

Interview with CNA #9, on 10/13/11 at 9:10 AM,  
 revealed staff were supposed to fill out a request  
 in the maintenance log anytime a maintenance  
 need was identified. She stated the request to  
 replace the arms on wheelchairs would be  
 recorded there. CNA #9 reported it is important  
 to report cracked wheelchair arms due the elderly  
 residents skin is fragile and more vulnerable to  
 skin tears.

Interview with Plant Operations and  
 Environmental Director (POED), on 10/13/11 at  
 2:10 PM, revealed he checks the maintenance  
 logs at least daily to respond to identified needs.  
 He stated it is the responsibility of the  
 maintenance department to maintain the  
 wheelchairs and once a year each wheelchair  
 received a routine maintenance check on them.  
 He stated it was important to replace cracked arm  
 rests on residents wheelchairs to prevent skin  
 tears and for infection control. The POED stated  
 the ice machines are cleaned quarterly. He  
 stated they may need to be cleaned more often  
 and the black filmy substance could be an  
 infection control issue and could make residents

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to ensure they were in good  
 repair clean and tidy, with and  
 emphasis on thresholds,  
 baseboards and paint by the  
 Maintenance Director/ designee.  
 All linen carts were audited by  
 the Central Supply  
 Clerk/ designee and replaced if  
 cracked, split or frayed. All  
 parquet floor tile areas were  
 audited by the Maintenance  
 director/ designee and repaired if  
 buckled. All ice machines in the  
 facility were immediately cleaned  
 by the Maintenance  
 director/ designee.

All staff were re-educated by the  
 Administrator/ designee by  
 11/28/11 in regards to using the  
 maintenance log books and on  
 identifying any  
 housekeeping/ maintenance  
 issues that would prevent a  
 sanitary, orderly and comfortable  
 interior. The maintenance staff  
 and housekeeping staff were re-  
 educated by the  
 Administrator/ designee  
 regarding cleaning schedules and  
 preventative maintenance

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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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(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
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F 253 Continued From page 26  
sick. He stated it is important to complete necessary repairs and maintenance needs to maintain the facility in good repair. The POED stated the identified areas of concern would be addressed.

F 282 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  
SS=D

The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.

This REQUIREMENT is not met as evidenced by:  
Based on observation, record review, interview and facility policy, it was determined the facility failed to ensure one (1) of nineteen (19) sampled residents (Resident #10) received care and services for an indwelling catheter as care planned. Resident #10 was found to have an occluded indwelling catheter.

The findings include:

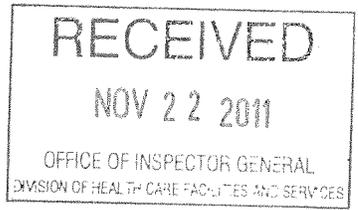
Review of the facility's policy for Care Planning, revealed the facility utilized the MDS 3.0 Manual.

Review of the facility's policy for Foley Catheter Care, dated 12/2010, revealed catheter tubing should be arranged so it does not occlude the catheter.

F 253  
  
F 282

schedules to include any changes made since the date of survey. The preventative maintenance of wheelchairs was changed from annually to quarterly. The preventative maintenance of handrails was changed from quarterly to monthly. Sinks, linen cart covers and parquet flooring are now on a preventative maintenance check monthly. The cleaning schedule for ice machines was changed from quarterly to monthly with weekly checks in between.

All wheelchairs will be audited monthly by Central Supply/designee for any repair issues and reported to maintenance. Maintenance Director/designee will also do a quarterly inspection of all wheelchairs to ensure no cracked or peeling equipment. Privacy curtains will be audited weekly by the Housekeeping Director/designee to ensure cleanliness. All chairs in the facility will be audited weekly by the Housekeeping



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
**STATEMENTS FOR MEDICARE & MEDICAID SERVICES**

PRINTED: 11/03/2011  
 FORM APPROVED  
 OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/14/2011
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 282

Continued From page 27

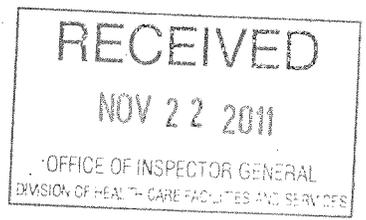
Record review of Resident #10 revealed the resident had an indwelling catheter for infection control purposes and resident comfort. Resident #10 was admitted on 08/23/11 with extensive wounds to both legs as a result of MRSA (methicillin resistant staph aureus) infection and necrotizing fasciitis (bacteria which destroys tissues). Review of the care plan revealed the catheter tubing was to be positioned to allow the flow of urine.

Observation, on 10/13/11 at 2:10 PM, of care provided to Resident #10 by Licensed Practical Nurse #3 (LPN) and Assistant Director of Nursing #1 (ADON), revealed an indwelling catheter was secured to the resident's right inner thigh, and the catheter tubing was twisted which prevented the flow of urine, as no urine was observed in the tubing beyond the point of the occlusion. ADON #1 said the catheter tubing was twisted and kinked, and not draining. ADON #1 untangled the tubing and stated the urine flow was restored.

Interview, on 10/13/11 at 2:30 PM, with LPN #3 revealed Resident #10 was sitting in a wheelchair earlier for physical therapy and the indwelling catheter tubing could have become twisted when staff assisted the resident back to bed. LPN #3 said staff were supposed to check the position of the catheter tubing when the resident was repositioned, to maintain urine flow.

F 282

Director/designee to ensure cleanliness and in good repair. All hand rails will be audited monthly by the Maintenance Director/designee to ensure securely fastened and no splintered areas. All sinks will be tested monthly by the Maintenance Director/designee to ensure they are draining properly and unclogged as indicated. All shower will be checked daily 5 x per week by the Housekeeping Director/designee to ensure cleanliness and in good repair. All linen cart covers will be audited monthly by the Housekeeping Director/designee to ensure they are not cracked, split or frayed. Facility parquet flooring will be audited monthly by the Maintenance Director/designee to identify any buckled areas in need for repair. Ice machines will be cleaned by the Maintenance Director/designee monthly and checked weekly for any cleanliness issues in between.



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

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
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10/14/2011

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F 282

Continued From page 28  
Interview, on 10/13/11 at 2:45 PM, with ADON #1 revealed the catheter tubing should remain patent to allow urine flow and prevent urinary tract infections (UTI).

F 282

The results of these audits will be brought to the Quality Assurance Team x 2months and at the team's discretion thereafter.

11/28/11

Interview, on 10/14/11 at 11:20 AM, with the Director of Nursing (DON) revealed an occluded indwelling catheter tubing could result in a bladder spasm or UTI and the tubing should be checked frequently to avoid obstruction of urine flow. The DON stated indwelling catheters should be secured to the outer thigh to provide resident comfort.

F282

Resident #10 no longer resides in facility.

F 309  
SS=D

483.25 PROVIDE CARE/SERVICES FOR  
HIGHEST WELL BEING

F 309

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

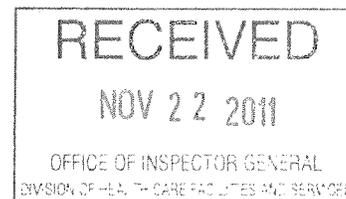
An audit was completed on 11/4/11 of all residents with indwelling catheters by the DON/designee to ensure residents received care for indwelling catheter as care planned. Daily rounds to be conducted by DON/designee to ensure residents with indwelling catheters to ensure residents are receiving care as indicated by care plan. Clinical staff were re-educated by DON/designee regarding care of residents with indwelling catheters by 11/28/11.

This REQUIREMENT is not met as evidenced by:  
Based on observation, record review, facility policy, interview and facility in-service records, it was determined the facility failed to ensure physician orders were followed for one (1) of nineteen (19) sampled residents (Resident #16). Resident #16 had orders for Lasix (a diuretic is used to reduce the swelling and fluid retention caused by various medical problems), and Potassium (supplements was used because

The DON /designee will conduct a 10% audit of care plans weekly to monitor care of residents with indwelling

catheters.

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STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
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(X5)  
COMPLETION  
DATE

F 309

Continued From page 29  
diuretics remove potassium from the body. Potassium supplements are taken to replace potassium losses and prevent potassium deficiency), ordered for a five (5) day period. The orders expired on 10/09/11. The facility continued to administer the medication after the five (5) day period had expired.

The findings include:

The facility policy, Administering Medications, dated 12/2010, revealed medications are administered only as ordered by the physician.

Review of the clinical record for Resident #16 revealed the resident was admitted to facility on 03/13/11 from the hospital with diagnoses of Congested Heart Failure (CHF), Atrial Fibrillation, and Weakness.

Observation of Resident #16, on 10/12/11 at 9:05 AM, revealed the resident was administered Lasix 20 milligrams (mg) by mouth by License Practical Nurse (LPN) #3 during medication pass. The medication Potassium 20 milliequivalent (meq) was held by LPN #3.

Interview, on 10/12/11 at 09:05 AM, with LPN #3 revealed a conflict with the potassium order and she called the Assistant Director of Nursing (ADON) #1 to report a conflict in the order as written on the Medication Administration Record (MAR). Potassium 20 meq was not given at that time. She stated she felt the dosage was incorrect and wanted to review the resident's clinical record.

Record review of clinical chart, on 10/12/11 at

F 309

Findings of audits will be forwarded to the monthly Quality Assurance team for review x 2 months and at the team's discretion thereafter.

F 309

Resident #16 is currently receiving medications per physician's order.

An audit of all active residents conducted before 11/28/11 by the DON/designee to ensure residents are receiving medications per physician's order.

Licensed nursing staff re-educated by 11/28/11 by DON/designee regarding transcription of physician's orders.

The DON /designee will conduct a 10% audit of physicians orders weekly to ensure residents are receiving medications per physician's order.

11/28/11

START

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NOV 22 2011

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

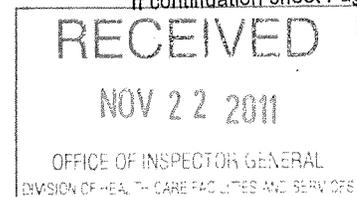
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F 309	<p>Continued From page 30</p> <p>11:00 AM, confirmed an order written on 10/03/11 at 7:30 PM, was received from the physician for Lasix 20 mg by mouth every day for five (5) days and Potassium (KCL) 20 meq by mouth every day for five (5) days. The MAR confirmed a start date for both the Lasix and Potassium for 10/04/11; however, the MAR did not indicate a stop date for either medication. The resident continued to receive both medications for three (3) days after the five (5) day order had expired.</p> <p>Interview, on 10/12/11 at 4:20 PM, with LPN #1 revealed he did not follow the facility policy for transcribing orders for medication from the physician or Advance Registered Nurse Practitioner (ARNP) and explained when taking off medication orders he should have blocked the MAR with the stop date as ordered by the physician. He stated he had received training on medication administration.</p> <p>Interview, on 10/12/11 at 4:00 PM, with ADON #1 confirmed that LPN #1 had taken the order off that was written by the ARPN. The ADON #1 confirmed the nurse taking orders off should fax the order to the pharmacy, and put the order on the MAR. She verified as ADON it was her responsibility to oversee all physician orders were taken off correctly.</p>	F 309	<p>The results of these audits will be brought to the Quality Assurance Team x 2months and at the team's discretion thereafter.</p> <p><b>F309 Addendum:</b></p> <ul style="list-style-type: none"> <li>Resident #16: Clarification order was obtained by the medical director.</li> <li>An audit completed on 11/9 to 11/11/11 and 11/14 to 11/16/11 on all active residents by the Pharmacy nurse to ensure residents are receiving medications per physician's orders.</li> <li>Designee to DON for re-education is the ADON. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.</li> </ul>	11/28/11
F 315 SS=E	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that</p>	F 315	<p>F 315</p> <p>Resident's # 10 and #11 no longer reside in facility. Resident #2 and #5 are currently receiving</p>	11-28-11



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 315 Continued From page 31  
catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, clinical record review, and review of the facility policy for Foley Catheter Care, it was found the facility failed to provide the appropriate treatment and services to achieve urinary function and prevent resident injury to four (4) of nineteen (19) sampled residents. 1. Resident #10 had an indwelling catheter secured to the inner thigh, and the catheter tubing was occluded which prevented the flow of urine. 2. Resident #5 had indwelling catheter care provided by staff without precautions to prevent cross-contamination. 3. Residents #5, #2, and #11, with indwelling catheters, did not have secured catheter tubing to prevent excessive tension on the catheter which could lead to urethral tears or dislodging of the catheter.

The findings include:

1. Record review of the facility record for Resident #10 revealed the resident had an indwelling catheter for infection control purposes and resident comfort. Resident #10 was admitted on 08/23/11 with extensive wounds to both legs as a result of MRSA (methicillin resistant staph aureus) infection and necrotizing fasciitis (bacteria which destroys tissues). The resident record revealed that Resident #10 was sent to a

F 315

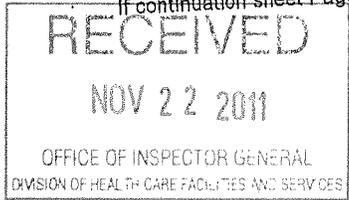
indwelling catheter care per facility policy and according to care plan.

Audit completed by DON/designee 11/4/11 of residents with indwelling catheters to ensure residents are receiving care as indicated by care plan.

Daily rounds to be conducted by DON/ designee to residents with indwelling catheters to ensure residents are receiving care as indicated by care plan.

Clinical staff to be re-educated by DON/ designee by 11/28/11 regarding care of residents with indwelling catheters.

The DON / designee will conduct a 10% audit of physicians orders weekly to ensure residents are receiving medications per physician's order.





DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 315

Continued From page 33  
 not sure if the facility policy for management of indwelling catheters included directions to secure catheters, and was not sure how staff were trained to secure indwelling catheters. ADON #1 stated the catheter tubing should remain patent to allow urine flow and prevent urinary tract infections (UTI).

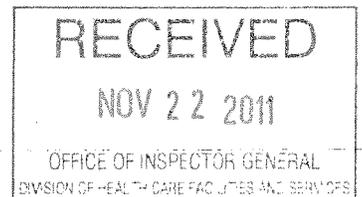
Interview, on 10/14/11 at 11:20 AM, with the Director of Nursing (DON) revealed an occluded indwelling catheter tubing could result in a bladder spasm or UTI and said the tubing should be check frequently to avoid obstruction of urine flow. The DON stated indwelling catheters should be secured to the outer thigh to provide resident comfort.

2. Record review of the facility record for Resident #5 revealed the resident was admitted on 10/06/10 with diagnoses of Cerebral Vascular Accident, paralysis, respiratory failure with tracheostomy, dysphagia (ineffective swallow), and UTI. Resident #5 had an indwelling urinary catheter.

Observation, on 10/12/11 at 11:15 AM, of catheter care for Resident #5 provided by Certified Nursing Assistant #1 (CNA) revealed the tissue surrounding the insertion site of the indwelling catheter with a washcloth in a circular motion without cleaning each area with one clean stroke. CNA #1 did not refold the washcloth after each cleaning stroke to prevent cross-contamination. CNA #1 returned used washcloths inside the clean basin with clean washcloths in soap and water which were used during catheter care.

Interview, on 10/12/11 at 11:30 AM, with LPN #4

F 315



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F 315 . Continued From page 34

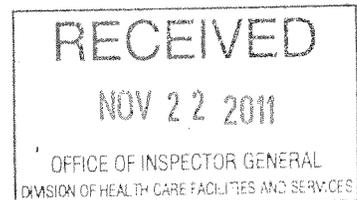
revealed staff were trained to perform catheter care with steps to diminish the risk of infection. LPN #4 said cleaning should begin at the catheter insertion site, and cleaning should be done with one stroke to each area and the washcloth should be folded after each clean stroke to expose a clean part of the washcloth. LPN #4 said it would not be acceptable to perform catheter care by cleaning in a circular motion because of the risk of cross-contamination.

Interview, on 10/12/11 at 11:45 AM, with CNA #1 revealed during her CNA training she was taught to fold the washcloth around her hand, and then fold the washcloth as she cleaned during catheter care. CNA #1 did not realize she did not fold the washcloth to expose the clean area, and did not recall returning the dirty washcloths to the clean basin. CNA #1 said the cleaning should be performed to prevent the risk of infection to the resident.

Interview, on 10/14/11 at 11:20 AM, with the DON revealed that CNA's are responsible for catheter care, and are not trained at this facility because it is understood that the CNA learned the proper technique during the CNA training program which lead to certification. The DON said it was not acceptable to clean in a circular motion by using the same part of the washcloth, without folding the cloth because of the risk of cross-contamination and UTI.

3. Observation, on 10/12/11 at 11:15 AM, during catheter care for Resident #5 revealed the indwelling catheter was not secured to prevent resident injury from tension on the catheter tubing.

F 315



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Interview, on 10/12/11 at 11:30 AM, with LPN #4 revealed residents with an indwelling catheter should have the catheter tubing secured to avoid risk of resident injury if the tubing became tangled or was accidentally pulled. LPN #4 was not aware that Resident #5 did not have secured catheter tubing.

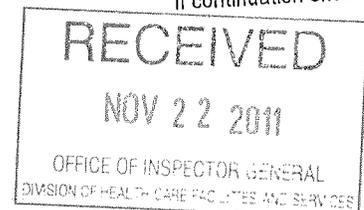
Interview, on 10/12/11 at 11:45 AM, with CNA #1 revealed she did not know why Resident #5 did not have a secured urinary catheter and said the facility has thigh straps available for that purpose.

Interview, on 10/14/11 at 11:20 AM, with the DON revealed that indwelling catheter tubing should be secured to prevent the catheter becoming dislodged or a urethral tear. The DON said the facility has a device which is effective to secure catheter tubing and should be used for each resident with an indwelling catheter to ensure resident safety.

Resident #11 was admitted to the facility on 10/10/11 with diagnoses of Cerebral Vascular Accident (CVA), Diabetes, Coronary Artery Disease and Left Sided Paralysis. Resident #11 had an indwelling urinary catheter.

Observation of the resident, on 10/14/11 at 9:05 AM, revealed the indwelling catheter tubing was not secured to the leg of Resident #11 following catheter care per facility policy.

F 315



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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F 315 Continued From page 36  
Resident #2 was admitted to the facility on 08/15/11 with diagnoses of Multiple Sclerosis, Decubitus Stage IV of the Coccyx, Traumatic Brain Injury, Bilateral Urethral Stent. Resident #2 had an indwelling catheter.

Observation of the resident, on 10/12/11 at 12:05 PM, revealed the indwelling catheter tubing was under the leg of Resident #2. It was further observed the tubing was not secured to the resident's leg per the facility policy.

F 371 483.35(i) FOOD PROCURE,  
SS=F 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 by:  
Based on observation, interview and record review it was determined the facility failed to serve foods under sanitary conditions. The ice machine in the Kosher kitchen had a black filmy substance on the inside wall.

The findings include:

F 315

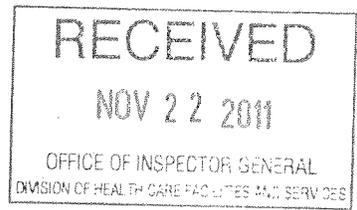
F371

F 371

The ice machines in the kitchen were immediately cleaned on 10/13/11 by the Maintenance Director/designee.

All other ice machines in the facility were cleaned on 10/13/11 by the Maintenance Director/designee.

The preventative maintenance of ice machines was changed from quarterly to monthly. In addition, the Maintenance Director/designee will check all ice machines weekly to ensure cleanliness in between. All staff were re-educated by the



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STATEMENT OF DEFICIENCIES  
 AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
 IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
 COMPLETED

10/14/2011

NAME OF PROVIDER OR SUPPLIER

FOUR COURTS AT CHEROKEE PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

2100 MILLVALE RD.  
 LOUISVILLE, KY 40205

(X4) ID  
 PREFIX  
 TAG

SUMMARY STATEMENT OF DEFICIENCIES  
 (EACH DEFICIENCY MUST BE PRECEDED BY FULL  
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PROVIDER'S PLAN OF CORRECTION  
 (EACH CORRECTIVE ACTION SHOULD BE  
 CROSS-REFERENCED TO THE APPROPRIATE  
 DEFICIENCY)

(X5)  
 COMPLETION  
 DATE

F 371

Continued From page 37

Review of Dietary Maintenance Inspection Log revealed the ice machines were scheduled to be cleaned quarterly. The last cleaning date is recorded as 09/19/11.

Observation of the ice machine in the Kosher kitchen, on 10/13/11, revealed black slimy spots on the inside right wall near the ice.

Interview with Dietary Manager, on 10/13/11 at 1:45 PM, revealed the kitchen staff cleaned the ice machines quarterly and as needed. He stated the ice machine needed to be cleaned now. The black substance could be mold and could result in resident illness.

F 431  
 SS=D 483.60(b), (d), (e) DRUG RECORDS,  
 LABEL/STORE DRUGS & BIOLOGICALS

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.

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.

In accordance with State and Federal laws, the

F 371

Administrator/designee by 11/28/11 on sanitary conditions of the ice machine and on new cleaning schedules.

The Maintenance Director/designee will audit all ice machines weekly to ensure sanitary conditions/cleanliness and will clean all ice machines monthly. The results of this audit will be brought to the Quality Assurance Team monthly x 2 months and at the team's discretion thereafter.

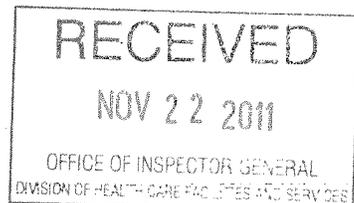
11/28/11

F 431

F371 Addendum:

- Designee to the Maintenance Director is the Maintenance Assistant.
- Designee to the Maintenance Director is the Maintenance Assistant.
- Designee to Administrator for training is Administrator in Training. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- Designee to the Maintenance Director is the Maintenance Assistant.

11-28-11



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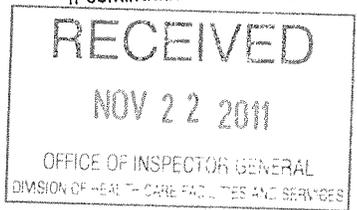
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 431	<p>Continued From page 38</p> <p>facility must store 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> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policies it was determined the facility failed to store medications in accordance with their policy as evidenced by three (3) prescription bottles and two (2) over the counter medications were found stored in a drawer in the Linker Hall medication room with dressing supplies and syringes. A Tubersol (Tuberculin Purified Protein) vial was found opened and not dated. Additionally, the emergency cart on the "A" Hall had expired hand sanitizer which was not in accordance with the facility's policy and an expired suction catheter.</p> <p>The findings include:</p> <p>Record review of the facility policy Medication Administration-Medication Storage (Effective 12/2010) revealed all medications were to be stored in the medication room "in either entire</p>	F 431	<p>F 431</p> <p>Over the counter medications are currently being stored per facility policy. Three prescription bottles, Tubersol vial, suction catheter and hand sanitizer were immediately disposed of per facility policy on 10/13/11.</p> <p>An audit of both medication rooms, emergency carts and medication refrigerators was completed by DON/designee on 10/14/11 to ensure drugs and biologicals being stored according to facility policy.</p> <p>The DON/designee will conduct random audits at least once per week of the medication rooms, emergency carts and medication refrigerators to ensure drugs and biologicals are being stored according to facility policy.</p>	
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F 431 Continued From page 39  
cart or medication bins". The policy also revealed multi-dose vials were to have a puncture date and the nurse's initials to note when it was originally used.

Record review of the facility policy Emergency Carts (Effective 12/2010) revealed it is the policy of the facility to ensure emergency equipment is readily available.

Observation, on 10/12/11 at 9:00 AM, in the Linker Hall medication room revealed three (3) prescription bottles with medication inside and two (2) over the counter medication bottles with medication inside in a storage drawer which held dressing supplies and syringes.

Observation, on 10/11/11 at 4:05 PM, in the refrigerator located in the Conference Room revealed an open and undated Tubersol vial. The vial was also observed present on 10/12/11 at 1:15 PM and 10/13/11 at 5:10 PM.

Observation, on 10/12/11 at 5:00 PM, of the crash cart on the "A" Hall revealed an expired bottle of hand sanitizer. The expiration date was February 2006. In addition, a suction catheter kit with an expiration date of July 2010 was present on the crash cart.

Interview, on 10/12/11 at 9:08 AM, with Licensed Practical Nurse (LPN) #6 revealed medications no longer in use were stored in a bin in the medication room for return to the pharmacy. She revealed there would be no reason to have medication stored with syringes. It was revealed the Assistant Director of Nursing (ADON) was responsible to ensure the medication room was in

F 431

Licensed nursing staff re-educated by DON/designee by 11/28/11 regarding proper storage of drugs and biological.

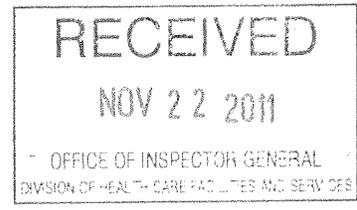
Findings of weekly audits will be forwarded to Quality Assurance team monthly for review x 2 months and at the team's discretion thereafter.

**F431 Addendum:**

- Designee to the DON is the ADON.
- Designee for auditing and training to the DON is the ADON. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- DON/ADON will conduct weekly audits of both medication rooms, emergency carts and medication refrigerators.

11/28/11

11-28-11



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(X2) MULTIPLE CONSTRUCTION

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(X5)  
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DATE

F 431

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order.

F 431

Interview, on 10/12/11 at 9:35 AM, with LPN #4 revealed medications no longer in use were stored in a cubby for pharmacy to pick up. She stated there was no reason for medications to be stored any other place.

Interview, on 10/12/11 at 10:00 AM, with the Assistant Director of Nursing (ADON) #2 revealed medications a resident was no longer receiving were to be placed in a bin for pharmacy.

Interview, on 10/12/11 at 4:00 PM, with the Director of Nursing (DON) revealed medication a resident was no longer receiving should be sent back to pharmacy. She revealed medications should not be stored in drawers in the medication room. The ADON was responsible for the medication room and had a check list to ensure the room was in order she revealed.

Interview, on 10/13/11 at 5:00 PM, with Licensed Practical Nurse (LPN) #2 revealed the night shift nurses were responsible to check the crash cart each night. She revealed, when looking at the clip board attached to the cart for check off when complete, there was no 2011 checklist available, only 2010, and there was no documentation to represent the cart being monitored. She stated the potential harm in not monitoring the equipment could be lethal to a resident.

Interview, on 10/13/11 at 5:00 PM, with the Assistant Director of Nursing (ADON) #1 revealed third shift was responsible to check the crash cart. She further revealed she was responsible to monitor the staff duties for completeness and

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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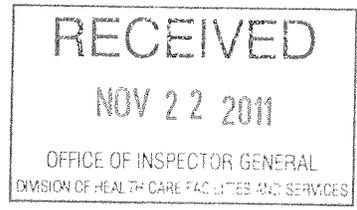
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F 431	Continued From page 41 documentation related to the crash cart. In addition, she stated it was not acceptable practice not to check the crash cart every night. The equipment was to be available for the residents in the event of a cardiac arrest she revealed.	F 431		
F 441 SS=E	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. (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.	F 441	F 441  Therapy equipment is currently being sanitized according to facility policy. Therapy staff are presently following facility policy regarding handwashing. Nursing staff are currently following facility policy regarding care of a resident in isolation. Housekeeping carts are currently being stowed according to facility policy during meals. Laundry personnel are currently returning laundry to unit according to facility policy. Linen is being handled by personnel according to facility policy. Perineal care and indwelling catheter care are being administered according to facility policy. The ice machines and wall outside of kitchen were cleaned.	

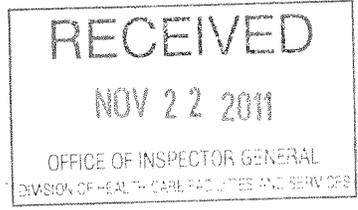


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F 441	<p>Continued From page 42</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policies, it was determined the facility failed to establish and maintain an infection control program to provide a safe, sanitary and comfortable environment and to prevent the development and transmission of diseases and infection. Therapy staff were observed going from resident to resident without washing their hands. Therapy equipment was not sanitized between resident use. Nursing staff were observed to enter and exit an isolation room without protective equipment and without hand washing. Nursing staff were observed to take supplies and equipment off the isolation cart, use them in the room, then return the supplies to the treatment cart. Microbial soap was not used before and after dressing changes in an isolation room. A housekeeping cart was observed open on a unit while nursing staff passed resident meal trays. A clean resident clothing and blanket cart was observed being pulled from room to room without being covered. Indwelling catheter care and perineal care was observed to cause cross-contamination. The hallway outside the kitchens was heavily soiled. Ice machines on the units and in a kitchen contained black filmy substances on the interior walls. The facility was cited at a scope/severity of a "D" for deficient</p>	F 441	<p>A cleaning schedule is being followed regarding cleansing of therapy equipment. Random audits are being conducted of therapy staff by Rehab Services Manager/designee to ensure proper handwashing according to facility policy. An audit of residents in isolation is being conducted by DON/designee to ensure facility policy is being followed regarding cleansing of equipment and caring for a resident in isolation. A 10% audit of meal times are being conducted by Plant Operations Manager/designee to ensure housekeeping staff are storing carts according to facility policy. A 10% audit to be conducted by Plant Operations Manager/designee of laundry personnel returning clean</p>	
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F 441

Continued From page 43  
practice in infection control on the last standard survey dated 08/10/10.

The findings include:

Review of the facility's Rehabilitation Department Infection Control Policy, dated 10/30/07, revealed all surfaces coming into contact with residents, such as treatment tables, reusable therapy equipment and supplies, exercise mats, were to be wiped down daily with cleaning solution. Universal Precautions will be followed according to facility policy. Hands will be washed before and after care of each resident.

Review of the facility policy for Standard Precautions (Universal Precautions now called Standard Precautions), dated August 2007, revealed reusable equipment is not used for the care of another resident until it has been appropriately cleaned and reprocessed.

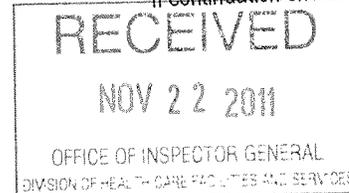
Review of the facility policy for Foley Catheter Care (indwelling catheter), dated 12/2010, revealed no policy was present for preventing the drainage bag from contact with the floor.

Observations of the Therapy Room on the A Wing, on 10/11/11 at 11:45 AM, revealed a therapist going from resident to resident without washing hands or sanitizing hands between residents. Walkers and hand bikes used by

F 441

laundry to the unit as well as staff handling linen appropriately to ensure infection control practices are being maintained. Audit to be completed by DON/designee of residents with indwelling catheters or receiving perineal care to ensure care is being administered according to facility policy. The preventative maintenance of ice machines was changed from quarterly cleaning to monthly cleaning and weekly checks in between to ensure sanitary conditions.

All staff will be re-educated regarding facility policy and procedure for caring for a resident in isolation by DON/designee by 11/28/11. Therapy staff will be re-educated regarding facility handwashing protocol as well as cleansing of resident equipment by Rehab Services Director/ designee by 11/28/11. Nursing staff and Laundry staff re-educated



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F 441

Continued From page 44  
residents were not sanitized between resident use. A resident with an indwelling catheter was returned to his/her room with the down drain bag dragging on the floor.

Interview with the Therapist, on 10/11/11 at 11:50 AM, revealed equipment should be cleaned after each resident use and staff should sanitize/wash hands between residents. In addition, she stated indwelling catheter drainage bags should not be in contact with the floor.

Review of the facility's policy for Standard Precautions: Linen, dated August 2007, did not address soiled linens stored on the floor.

Observation of Room 150, on 10/11/11 at 12:30 PM, revealed a certified nurse aide, changing Resident #4's bed linen, placed the linen on the floor after it was removed from the bed.

Interview with CNA #9, on 10/11/11 at 12:30 PM, revealed soiled linen should not be stored on the floor to avoid bacteria transfer.

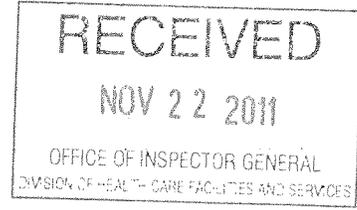
Interview with the Director of Nursing (DON), on 10/13/11 at 3:30 PM, revealed the facility had not had an Infection Control Nurse in a long time. She stated she shared the duties with the Assistant Director of Nursing (ADON). She stated they made daily rounds; however, she had not noticed the infection control issues in Therapy, the hallway floor outside the kitchens or

F 441

regarding handling of linen by DON/designee by 11/28/11. Housekeeping staff re-educated regarding storage of carts during meal times by Plant Operations Manager/designee by 11/28/11. Clinical staff re-educated by DON/designee regarding care of residents with indwelling catheters and those receiving perineal care by 11/28/11. All staff were re-educated by the Administrator/designee by 11/28/11 on sanitary conditions of the ice machine and on new cleaning schedules.

Findings of audits will be forwarded to Quality Assurance team monthly for review x 2months and at the team's discretion thereafter.

11/28/11



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F 441

Continued From page 45  
 the interiors of the ice machines on the units. She stated supplies off the treatment cart should not have been taken into an isolation room then returned to the same cart.

Record review, of the facility policy for Multidrug Resistant Organisms (MDRO), revealed staff will use standard precautions as the primary approach to preventing the transmission of MDRO's, and that caregivers should wash their hands with soap and water after contact with the infected person. The policy stated when a resident was placed in Contact Precautions, the appropriate isolation policy should be consulted. The facility did not provide an Infection Control Policy specific to Contact Isolation procedures.

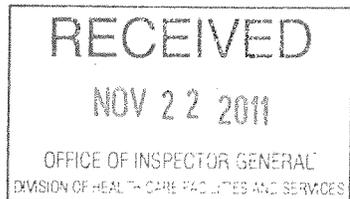
Record review, of the resident record for Resident #10, revealed an admission date of 08/23/11 with extensive wounds to both legs as a result of a Methicillin Resistant Staph Aureus (MRSA) infection and necrotizing fasciitis (bacteria which destroys tissues). Resident #10 was maintained in contact isolation precautions.

Observation, on 10/13/11 at 7:30 AM, of LPN #3 who provided an intravenous medication for Resident #10, revealed LPN #3 entered the room without use of any Personal Protective Equipment (PPE) such as gloves or gown. LPN #3 initiated the intravenous infusion, then exited the room. An isolation cart was located outside the isolation room, near the door and contained one (1) yellow disposable gown and no gloves. A sign on top of the isolation cart stated, "Contact precautions: Gown and gloves required for all persons entering room."

F 441

**F441 Addendum:**

- Therapy equipment is now stowed in cabinets and are checked out by the therapist with each resident use. Upon returning to the cabinet, the equipment is sanitized in between resident use. Nursing staff are entering and exiting resident isolation rooms with proper protective equipment and washing hands upon entering/exiting. Signage on resident doors identify isolation rooms and behind the signage explains the proper protective equipment needed to enter. Isolation supplies and equipment are kept in the treatment cart in a separate, closed compartment and microbial soap is being used before and after dressing changes in an isolation room. Housekeeping carts are taken off the unit and stowed during mealtimes. Housekeeping assignments were changed and duties off the unit given during meals. Resident clothing and linen carts are covered while being pulled or moved room to room. With re-education, proper catheter and perineal care are being done as to eliminate cross contamination. Ice machine and walls outside kitchen cleaned on 10/13/11.



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STATEMENT OF DEFICIENCIES  
 AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
 IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
 COMPLETED

10/14/2011

NAME OF PROVIDER OR SUPPLIER

FOUR COURTS AT CHEROKEE PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

2100 MILLVALE RD.

LOUISVILLE, KY 40205

(X4) ID  
 PREFIX  
 TAG

SUMMARY STATEMENT OF DEFICIENCIES  
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PROVIDER'S PLAN OF CORRECTION  
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 DEFICIENCY)

(X5)  
 COMPLETION  
 DATE

F 441

Continued From page 46

Interview, on 10/13/11 at 7:45 AM, with LPN #3 revealed gloves and gown were worn in the contact isolation room only when the dressing change for Resident #10 was done, and it was not necessary to wear gown and gloves any other time care was provided to Resident #10.

Interview, on 10/13/11 at 7:55 AM, with LPN #5 revealed that she was trained to wear gown, gloves, and mask each time a contact isolation room was entered.

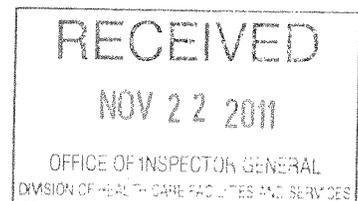
Observation, on 10/13/11 at 12:10 PM, of CNA #3 revealed the lunch tray was delivered by CNA #3 to Resident #10 in contact isolation. CNA #3 carried the tray into the isolation room without use of gown or gloves and assisted the resident to position for the meal and set up the tray, then exited the room without handwashing. CNA #3 returned to the tray cart in the hall and used hand sanitizer, and resumed delivery of food trays.

Interview, on 10/13/11 at 12:15 PM, with CNA #3 revealed she was trained to use hand sanitizer between residents, and said it was not necessary to wash hands with soap and water after exiting a contact isolation room. CNA #3 was not trained to wear a gown or gloves in contact isolation. Record review of the facility Plant Operations and Procedure Manual under the section Procedures for Infection Control revealed there was to be no working or cleaning around food while it was being served. In addition, it stated to schedule and hold regular in-service meetings.

Observation, on 10/11/11 at 12:30 PM, on the Linker Unit revealed an open food cart with food trays inside and a cleaning cart placed directly

F 441

- The month of October individual Infection Surveillance forms were completed by the Director of Nursing 11/1/11 to identify other potential areas of infection control. Ongoing, the Staff Development Coordinator will perform monthly tracking and trending of Infection control incidence by filling out the surveillance form daily with any signs/symptoms of infection identified. If any infection trend identified the DON or SDC will conduct an in-service with the staff. Personal care items and respiratory equipment is bagged and labeled. Monday - Friday the DON or SDC will perform daily environmental rounds throughout the facility utilizing the company infection control rounds form.
- Rehab Manager designee for auditing is the Administrator or the Administrator in Training. Twice per week the Rehab Manager/Admin/AIT will audit three resident treatments to ensure proper therapist handwashing in between patients and proper sanitation of equipment if used. DON designee for auditing is the ADON. DON/ADON audited all residents in isolation on 10/25/11 to ensure



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 441	<p>Continued From page 47</p> <p>next to the food cart during the meal tray delivery. Observed was the housekeeper placing mop duster heads on top of the cleaning cart next to the meal cart.</p> <p>Interview, on 10/11/11 at 12:35 PM, with Certified Nursing Assistant (CNA) #5 revealed the cleaning carts and food trays were not to be on the hall at the same time. She stated it could cause "contamination". She revealed she had not been in-serviced at the facility for the practice of cleaning carts and food trays not being on the hall together but she knew it from her years of experience as a CNA.</p> <p>Interview, on 10/11/11 at 12:37 PM, with CNA #6 revealed it was not sanitary to have the cleaning carts out on the hall with the meal carts. She further revealed the facility has provided no training related to food carts and infection control. She stated she knew it as a CNA.</p> <p>Interview, on 10/12/11 at 4:00 PM, with the Director of Nursing (DON) revealed food carts and cleaning carts are "absolutely not" to be on the floor at the same time. She revealed infection would be the concern.</p> <p>Interview, on 10/12/11 at 4:40 PM, with Housekeeper #3 revealed cleaning carts are "not really supposed to" be on the hall when the food carts were present but she just started work here two (2) weeks ago and nobody had told her. She further revealed she had no training on infection control when she started work.</p> <p>Interview, on 10/12/11 at 4:40PM, with the Environmental and Plant Operations Manager</p>	F 441	<p>proper signage to identify isolation/protective equipment and that facility policies are being followed regarding caring for a resident in isolation. Plant Manager designee is the Housekeeping supervisor to audit one hallway Monday - Friday during a mealtime to ensure proper storage of housekeeping carts and the proper returning of clean linen. Designee for DON is ADON to audit residents with indwelling catheters who also receive perineal care. This audit will be conducted 1 x week on those residents via observation of care.</p> <ul style="list-style-type: none"> <li>• Designee for training to the DON is the ADON. Designee for training to the Rehab Manager and Plant Operations Manager is the Administrator. Designee to the Administrator is the Administrator in Training. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.</li> <li>• Review of the Infection Control policy and procedure (to include the facility policy specific to contact isolation procedures) was completed by the QA team including the Medical Director on 10/25/11 to include the surveillance form, tracking, trending and re-education if necessary as well as infection control</li> </ul>	
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F 441

Continued From page 48

revealed the staff was educated on infection control during orientation and in-services. He revealed as soon as the meal carts hit the floor the cleaning carts are off the floor. "Cross contamination" was stated to be a consequence which might occur with both cleaning carts and food carts being on the floor at the same time.

Review of the facility Plant Operations and Procedure Manual under the section Procedures for Infection Control revealed there was to be laundry and linen procedures which must be designed to prevent cross infection.

Observation, on 10/14/11 at 8:40 AM, revealed a linen cart with clean resident's clothes was being delivered uncovered to residents in their rooms. The side flap of the cart was completely open. In addition, blankets were on top of the cart.

Interview, on 10/14/11 at 8:40 AM, with the Plant Operations and Environmental Director revealed he knew clothes were to be covered when delivered to the floor to prevent contamination. A previous interview noted above revealed housekeeping staff were in-services during orientation and at other in-services presented about cross-contamination.

Interview, on 10/14/11 at 8:45 AM, with Housekeeper #1 revealed no awareness the clothes needed to be covered when delivered to the floor. There was no attempt to cover the clothes when she was asked. The employee did not understand the question asked of her by the surveyor as evidenced by she did not appear to understand or speak English to the surveyor.

F 441

**rounds. The surveillance form, tracking and trending will be brought to the monthly Quality Assurance meeting for the Medical Director to review and make recommendations.**

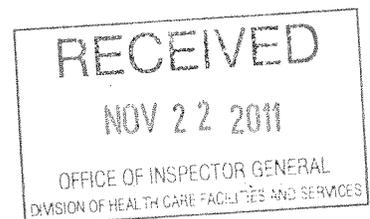
- The Director of Nursing and Staff Development Coordinator will be responsible for the Infection Control program within the facility. They DON received training on the Infection Control Policy and Procedure (to include the specific facility policy for contact isolation procedures) by the Clinical Consultant on 11/2/11 and the new SDC received the same training by the DON on 11/21/11. The SDC will fill out the surveillance form as well as the tracking/trending per policy and will collaborate with the DON on any corrective measures/re-education necessary.**

11.23.11

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F 441	Continued From page 49 Interview, on 10/14/11 at 9:45 AM, with Housekeeper #2 revealed she did know clothing was to be covered when delivered to the residents.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON  The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility records it was determined the facility failed to maintain a clean environment for staff. The Linker Wing basement floor, outside of the laundry and kitchens, was dirty and unwaxed.  The findings include:  Facility policy review of Cleaning Schedules revealed cleaning schedules should be developed and implemented to ensure that the facility would be maintained in a clean and comfortable manner.  Review of the facility Linker Wing -Basement Floor - Buffed Log revealed the last time the floor was buffed was 05/30/11:  The facility was unable to produce a cleaning/mopping log for Linker Wing - Basement Floor.  Observation of Linker Wing basement floor	F 465	F465 The Linker Wing basement floor, outside laundry and the kitchen, was stripped, scrubbed and waxed on 10/17/11.  All other tile flooring was assessed and stripped, waxed and buffed if needed by the Maintenance Director/designee.  The Maintenance/Floor care staff were re-educated to the floor care strip/wax/buff schedule by the Administrator/designee. The Linker Wing basement floor is on a monthly strip/wax schedule and a daily mop schedule.  The Administrator/designee will audit the tile floor care once per week to assure they are kept clean and waxed. The results of these audits will be brought to the monthly Quality Assurance Team x 2 months and at the team's discretion thereafter.	11/25/11



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F 465

Continued From page 50  
outside of laundry and kitchens, on 10/11/13 and  
10/13/11, revealed floor was discolored with dark  
streaks, dark areas and a dull finish.

F 465

Interview with Plant Operations and  
Environmental Director, on 10/13/11 at 2:10 PM,  
revealed the floor in question was due to be  
stripped, waxed and buffed. He stated that  
hallway was difficult to keep clean due to the  
amount of foot and cart traffic through that  
hallway.

F490

Resident #6's  
grievance/investigation was re-  
opened, reported to the  
appropriate agencies and  
thoroughly investigated as much  
as possible. There was no alleged  
perpetrator identified and the  
phone and charger was  
reimbursed per the resident  
representative's preference.  
Resident #18's allegation of  
verbal abuse was re-opened,  
reported to the appropriate  
agencies and the alleged  
perpetrator identified was  
suspended immediately pending  
investigation and later  
terminated. Resident #19's  
allegation of "rough" care was re-  
opened, reported to the  
appropriate agencies and the  
alleged perpetrator identified  
was suspended immediately  
pending investigation and later  
terminated.

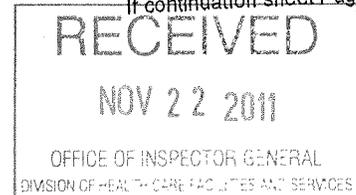
F 490  
SS=F

483.75 EFFECTIVE  
ADMINISTRATION/RESIDENT WELL-BEING

F 490

A facility must be administered in a manner that  
enables it to use its resources effectively and  
efficiently to attain or maintain the highest  
practicable physical, mental, and psychosocial  
well-being of each resident.

This REQUIREMENT is not met as evidenced  
by:  
Based on interview, record review, complaint and  
investigation reports and facility policies on  
Grievances and Abuse, it was determined the  
facility failed to be administered in a manner that  
enabled resources to be used effectively and  
efficiently to attain or maintain the highest  
practicable physical, mental and psychosocial  
well-being for three (3) of nineteen (19) sampled  
residents (Residents #6, #18 and #19). The  
facility failed to monitor and direct resident care in  
a manner that ensured action and implementation  
of abuse policies to protect residents from further  
abuse, and to investigate and report to state  
agencies allegations of misappropriation, verbal



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F 490 Continued From page 51  
abuse and physical abuse by facility employees.  
This failure resulted in substandard Quality of  
Care for residents in the facility.

The findings include:

Refer to F225.

Refer to F226.

Review of the facility policy for Abuse, dated April  
2009, revealed it was the facility's intent to  
immediately report and thoroughly investigate  
allegations of mistreatment, neglect, abuse,  
misappropriation and injuries of unknown injury.  
The Administrator and the Director of Nursing  
were to be notified of any allegations immediately.  
The designated person would report to the  
appropriate state agencies immediately. A  
thorough investigation will be initiated  
immediately for all allegations of abuse involving  
staff, residents, family and/or visitors. The  
resident will receive measures to ensure his/her  
immediate safety during the investigation.  
Accident and incident reports will be completed  
by the charge nurse and monitored routinely by  
administrative staff for any indicators leading to  
suspected abuse, neglect, or misappropriation of  
property.

Review of the facility grievance/complaint log  
revealed residents had alleged verbal and  
physical abuse and misappropriation of property.

F 490

100% of residents or responsible  
parties if cognitively impaired  
were interviewed to ensure that  
the facility did not have any  
allegations of  
abuse/neglect/misappropriation  
that were not thoroughly  
investigated and reported.

Corporate Social Services  
Director re-educated

Administrator on the abuse  
policy with emphasis on  
reporting, protection,  
investigation, and prevention as  
well as abuse coordinator  
responsibilities by 11/28/11. All  
staff were re-educated by  
11/28/11 on the abuse policy and  
procedure by the  
Administrator/designee with  
emphasis on reporting,  
protection, investigation and  
prevention as well as the change  
in abuse coordinator.

The abuse coordinator in the  
facility was changed from the  
Social Services Director to the  
Administrator during the survey.

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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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Continued From page 52  
These reports were requested and reviewed.

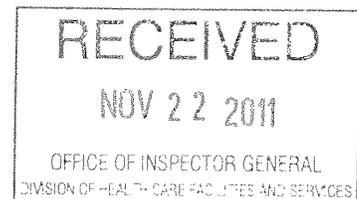
1. Resident #6 was admitted to the facility on 01/19/11 with diagnoses to include Hypertension and Chronic Obstructive Pulmonary Disease.

Record review of the Resident/Visitor/Grievance/Complaint Form filled out on 06/19/11 revealed the daughter of Resident #6 reported a cell phone and charger missing from the room of Resident #6. The missing phone and charger were not reported to the state agency. The form revealed Social Services and the daughter searched the room and did not locate the phone. There was no evidence of any further investigation and the incident was not reported to state agencies as required.

2. Review of the facility's complaint report for Resident #18 revealed the resident and a family member both reported allegations of verbal abuse. The resident and a family member reported a CNA used a demeaning voice and failed to respect the resident's privacy on 08/18/11. The resident stated trust was lost in the employee and the resident preferred not to have this employee provide care again. Further documentation revealed the resident and the employee had "worked it out". There was no evidence provided by the facility to demonstrate the resident was protected from further abuse, or that the allegation was reported to the state

F 490

The Social Services Director / designee will conduct a monthly audit of all grievances or complaints noted on the monthly grievance log to ensure allegations of abuse were not reported incorrectly and report findings to the monthly quality assurance meeting. The Social Services Director/designee will further audit any allegation of abuse monthly to ensure proper reporting, protection and investigation and report findings to the monthly quality assurance meeting. The Social Services Director/designee will conduct weekly interviews with residents or responsible parties per the quarterly/annual MDS calendar to ensure that the facility did not have any allegations of abuse/neglect/misappropriation



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F 490

Continued From page 53  
agency nor evidence of an investigation to determine if abuse occurred.

Review of the record for Resident #18 revealed the resident was admitted with diagnoses of Gout, Bipolar Disorder and Weakness. The facility assessed the resident on 08/19/11 and the resident required assistance with all Activities of Daily Living (ADL).

Attempts to interview Resident #18 were unsuccessful due to the resident's refusal. The resident expressed concern the CNA might lose her job.

Interview with the family member of Resident #18, on 10/14/11 at 11:30 AM, revealed he reported the abuse allegation to staff related to the resident calling him and being upset.

Interview with Assistant Director of Nursing (ADON) #2, on 10/13/11 at 10:10 AM, revealed she received the report and provided a copy of the alleged verbal abuse allegation to the SSD on Resident #19. She stated she talked with the resident and the employee denied the allegation. She indicated she was not familiar with the components of the facility abuse policy and believed the facility completed the incorrect form and possibly caused the breakdown in

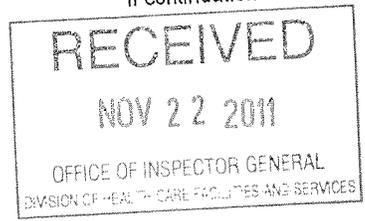
F 490

that were not thoroughly investigated and reported and will report findings to the monthly quality assurance meeting. All audits and findings will be brought to the monthly Quality Assurance team for review each month ongoing unless the team deems no longer necessary.

11/22/11

**F490 Addendum:**

- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11. The Administrator will be the abuse coordinator which involves allegations of abuse being reported immediately to the administrator and the administrator being responsible for the overall investigation, protection of the resident and agency reporting process. Social Services will be auditing the reporting, protection and investigation process of the Administrator. The Medical Director will review all allegations of abuse and reports of abuse during the Quality Assurance meetings.
- Social Services Director will conduct weekly audits of all grievances or complaints as well as any allegation of abuse. However,



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Implementing the abuse policies.

F 490

3. Resident #19 was admitted to the facility on 02/01/08 with diagnoses to include Congestive Heart Failure (CHF) and Anxiety Disorder.

Record review of the Complaint/Grievance Report filled out on 09/08/11 revealed Resident #19 stated a Certified Nursing Assistant (CNA) was rough with his/her shower and hurt his/her left leg. The incident of alleged abuse was not reported to the state agency. The facility did not suspend the CNA implicated pending an investigation to protect the resident from further abuse. The facility was unable to provide evidence on a thorough investigation.

Interview, on 10/14/11 at 9:15 AM, with ADON #2 revealed she had not been educated on the process of conducting an abuse investigation.

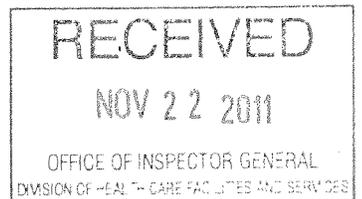
Interview with the Social Services Director, on 10/13/11 at 8:50 AM, revealed she did not take the allegation of physical abuse seriously as she knew the resident well. She stated she did not believe abuse had occurred at the facility as she knew the residents would tell her if abused. She stated she would talk with residents and if the resident indicated an occurrence was "not that bad", she felt no abuse had taken place. She stated she took full responsibility for not

weekly interviews with residents/responsible parties will be assigned out to different department managers to conduct correlating to the MDS schedule as part of a Corporate QA program called Abaqis. The Social Services Director will coordinate interviews to ensure completion and will review the results.

- The Corporate Clinical Consultant or the Corporate Director of Social Services will review all grievances and allegations of abuse twice per month to ensure all grievances/allegations of abuse are investigated and resolved per facility policies and procedures by facility administration.
- QA team, to include the Medical Director, will first review the effectiveness and compliance on December 6, 2011 and will review weekly x 1 month, bi-weekly x 1 month after and at the QA team's discretion thereafter.

11/20/11

If continuation sheet Page 55 of 64



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

PRINTED: 11/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES  
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA  
IDENTIFICATION NUMBER:

185237

(X2) MULTIPLE CONSTRUCTION

A. BUILDING \_\_\_\_\_

B. WING \_\_\_\_\_

(X3) DATE SURVEY  
COMPLETED

10/14/2011

NAME OF PROVIDER OR SUPPLIER

FOUR COURTS AT CHEROKEE PARK

STREET ADDRESS, CITY, STATE, ZIP CODE

2100 MILLVALE RD.  
LOUISVILLE, KY 40205

(X4) ID  
PREFIX  
TAG

SUMMARY STATEMENT OF DEFICIENCIES  
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DEFICIENCY)

(X5)  
COMPLETION  
DATE

F 490 Continued From page 55  
monitoring abuse investigations and should have  
insisted on more documentation. She stated the  
process was flawed related to the turn-over in  
administration.

F 490

Interview with the Administrator, on 10/14/11 at  
12:20 PM, revealed she was new to the facility  
and was not aware allegations of abuse were  
submitted to nursing and social services without  
staff following the facility's abuse policies. She  
stated the facility utilized a grievance report form  
and the resident signed off on the report when  
satisfied with the actions taken by the facility  
regarding their complaints. She stated the facility  
had audits for process review; however, abuse  
was not audited.

F 497

Every nurse aide is currently  
receiving in-servicing to maintain  
the minimum 12 hours required  
per year.

F 497 483.75(e)(8) NURSE AIDE PERFORM  
SS=E REVIEW-12 HR/YR INSERVICE

F 497

An audit of current certified  
nursing assistants was completed  
by the DON/designee to note in-  
services that are needed. Any  
nurse aide in need of further  
education hours was brought in  
to attain them.

The facility must complete a performance review  
of every nurse aide at least once every 12  
months, and must provide regular in-service  
education based on the outcome of these  
reviews. The in-service training must be  
sufficient to ensure the continuing competence of  
nurse aides, but must be no less than 12 hours  
per year; address areas of weakness as  
determined in nurse aides' performance reviews  
and may address the special needs of residents  
as determined by the facility staff; and for nurse  
aides providing services to individuals with  
cognitive impairments, also address the care of  
the cognitively impaired.

Certified Nursing Assistant staff  
provided with username and  
password for online free  
inservices provided through  
MedCOM. Facility to provide  
ongoing in-servicing within the  
facility itself, as well, to assist

This REQUIREMENT is not met as evidenced  
by:

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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

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DATE

F 497

Continued From page 56

Based on interview and review of the facility's documentation of certified nurse aide (CNA) inservice training hours, it was determined the facility failed to ensure CNAs received no less than twelve (12) hours per year for four (4) of five (5) sampled CNAs. The facility failed to ensure CNAs working without mandatory training were removed from providing direct resident care.

The findings include:

Review of the facility's policy for In-service Training, dated 01/01/08, revealed CNAs were required to obtain twelve (12) hours of training per year and were mandatory as a condition of employment. The policy failed to address how CNAs not obtaining at least 12 hours of inservice training per year would be handled.

Review of the facility's in-service attendance log for CNAs revealed four (4) of five (5) sampled CNAs, employed for greater than one (1) year, failed to obtain twelve (12) inservice training hours. CNA #1 had obtained 5.25 hours. CNA #2 had obtained 2.75 hours. CNA #3 had obtained 6.0 hours. CNA #5 had obtained 5.0 hours.

Interview with the Human Resources Director, on 10/14/11 at 11:00 AM, revealed the facility discovered in August 2011 that CNAs did not have the required inservice training hours. She stated she took it upon herself to organize some

F 497

with obtaining required in-service hours.

Ongoing audits monthly will be performed on in-service hours of certified nursing assistants to ensure minimum of 12 hours is being met by Human Resources/designee. The HR/designee will not only audit the prior month but the upcoming month as well.

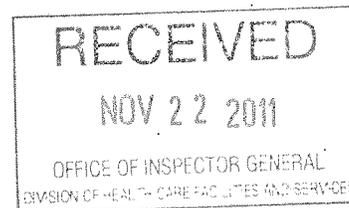
Findings of audit will be forwarded to Quality Assurance team monthly for review x 3 months and at the team's discretion thereafter.

F497 Addendum:

- The Human Resources Director provided C.N.A. training 10/19 - 10/21/11 via our Corporate provided online education series called Medcom.
- Designee to the DON for auditing is the Human Resources Director/Staff Development Coordinator. The audit of certified nursing assistants for in-services needed was completed 10/21/11.
- The Director of Nursing is responsible for C.N.A. hours of education. The Director of Nursing was trained by the Corporate Clinical Consultant on the process for ensuring C.N.A.s

11/20/11

If continuation sheet Page 57 of 64



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

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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/14/2011
NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205	
(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 497	Continued From page 57 training in August 2011 for the CNAs as she saw the hours were too low. She stated there was no staff development person so this area had not received attention.  Interview with the Director of Nursing (DON), on 10/14/11 at 11:10 AM, revealed she discovered CNAs were short on inservice training hours in August 2011. She stated there was no staff development person to ensure training was provided. She stated CNAs were suspended when they failed to obtain their required twelve (12) hours, however, only one (1) CNA had been suspended and that person was suspended on 10/13/11. She stated the rest of the CNAs were still working all shifts and on both units without having the required training hours.	F 497	received no less than 12 hours per year of inservice training hours. C.N.A. in-service sheets are filed by month that their 12 hours are due. The Director of Nursing will audit the upcoming month at the beginning of each month and provide in-servicing as needed to include Medcom username/password for online education to ensure all C.N.A.s meet their 12 training hours timely. • Designee to the Human Resources Director for auditing is the Administrator. Each month the HRD/Administrator will audit 100% of C.N.A. in-service records to ensure the minimum 12 hours training each year is met.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE  The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.  This REQUIREMENT is not met as evidenced by:	F 514	Resident #16 is currently receiving medications per physician's order.  An audit of all active residents to be conducted by the DON/designee by 11/28/11 to ensure residents are receiving medications per physician's order.  Licensed nursing staff re- educated DON/designee by 11/28/11 regarding transcription of physician's orders.  The DON / designee	

11-28-11

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

STATEMENT OF DEFICIENCIES  
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F 514

Continued From page 58  
Based on observation, record review, facility policy, and interview, it was determined the facility failed to ensure one (1) of nineteen (19) sampled residents (Resident #16) physician's orders were transcribed accurately to the Medication Administration Record (MAR) for Resident #16. Medication orders were written by the Advance Practice Registered Nurse (APRN) for a five (5) day period and were continued to be given after the five (5) day period related to the facility's failure to indicate the length of time the medications were to be given.

The findings include:

The facility policy, Administering Medications, dated 12/2010, revealed written physician orders should be signed, dated, initialed in the appropriate space, and reviewed for accuracy after transcription to the MAR.

Record review for Resident #16 was admitted to the facility on 03/13/11 from the hospital with diagnoses of Congested Heart Failure (CHF), Atrial Fibrillation, and Weakness. Resident #16 had orders for Lasix (a diuretic is used to reduce the swelling and fluid retention caused by various medical problems), and Potassium (supplements was used because diuretics remove potassium from the body. Potassium supplements are taken to replace potassium losses and prevent potassium deficiency), ordered for a five (5) day period starting on 10/04/11. The orders expired on 10/09/11, however, this information was not indicated on the MAR.

Review of the record revealed the physician's order written for Resident #16 on 10/03/11 at 7:30

F 514

will conduct a 10% audit of physicians orders weekly to ensure residents are receiving medications per physician's order.

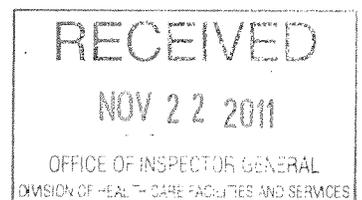
Findings of audits will be forwarded to Quality Assurance team monthly for review x 2 months and at the team's discretion thereafter.

**F514 Addendum:**

- Resident #16: Clarification order was obtained by the medical director.
- An audit completed on 11/9 to 11/11/11 and 11/14 to 11/16/11 on all active residents by the Pharmacy nurse to ensure residents are receiving medications per physician's orders.
- Designee to DON for re-education is the ADON. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- A complete audit completed on 11/9 to 11/11/11 and 11/14 to 11/16/11 on all active residents by the Pharmacy nurse to ensure MD orders are written on MAR with stop dates and residents are receiving medications per physicians order.
- The weekly physician order audit looks as well at the accuracy of the MAR.

11/20/11

11-20-11



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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F 514

Continued From page 59  
PM was for Lasix 20 milligrams (mg) by mouth  
everyday for five (5) days and for Potassium 20  
milliequivalent (meq) by mouth for five (5) days.  
The five (5) day period was not written on the  
MAR.

Interview, 10/12/11 at 4:40 PM, by telephone with  
License Practical Nurse (LPN) #1 revealed when  
taking this order off, he had made a mistake and  
was moving too fast. He further revealed he  
should have indicated the stop date at the five (5)  
day mark. LPN #1 verified it is the facility policy  
and expectation to take orders from physicians  
and transcribe them accurately to the MAR.

Interview, 10/12/11 at 4:00 PM, with Assistant  
Director of Nursing (ADON) #1 revealed all  
nursing staff had received training regarding  
policy and produces related to medication  
administration, including taking orders from  
physicians, faxing orders to pharmacy, and  
transcribing orders to MAR's accurately. ADON  
#1 stated she reviewed documents the order in  
the chart was not the same as what was written  
on the MAR and was not transcribed accurately.  
ADON #1 acknowledged it was her responsibility  
to ensure orders were reviewed and transcribed  
accurately for Wing A.

F 520

SS=F

483.75(o)(1) QAA  
COMMITTEE-MEMBERS/MEET  
QUARTERLY/PLANS

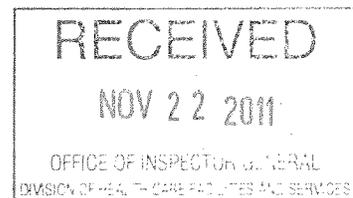
A facility must maintain a quality assessment and  
assurance committee consisting of the director of  
nursing services; a physician designated by the  
facility; and at least 3 other members of the  
facility's staff.

F 514

F520

Resident #6's  
grievance/investigation was re-  
opened, reported to the  
appropriate agencies and  
thoroughly investigated as much  
as possible. There was no alleged  
perpetrator identified and the  
phone and charger was  
reimbursed per the resident  
representative's preference.  
Resident #18's allegation of  
verbal abuse was re-opened,  
reported to the appropriate  
agencies and the alleged  
perpetrator identified was  
suspended immediately pending  
investigation and later  
terminated. Resident #19's  
allegation of "rough" care was re-  
opened, reported to the  
appropriate agencies and the  
alleged perpetrator identified  
was suspended immediately  
pending investigation and later  
terminated.

F 520

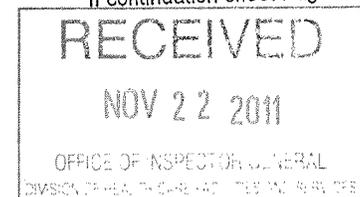


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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205	

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F 520	<p>Continued From page 60</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and grievance/complaint review, it was determined the facility failed to evaluate the process for preventing abuse to ensure the facility's system were functioning and any issues with the system were identified and corrected. The facility failed to identify abuse after residents complained of physical and verbal abuse and misappropriation of property. The facility failed to recognize that employees were not able to identify abuse. The facility failed to recognize management's inability to identify when an alleged perpetrator of abuse needed to be suspended from resident care. The facility failed to recognize that management staff lacked the skills to investigate allegations of abuse. The facility failed to recognize the management staff were not reporting allegations</p>	F 520	<p>100% of residents or responsible parties if cognitively impaired were interviewed to ensure that the facility did not have any allegations of abuse/neglect/misappropriation that were not thoroughly investigated and reported.</p> <p>Corporate Social Services Director re-educated Administrator by 11/28/11 on the abuse policy with emphasis on reporting, protection, investigation, and prevention as well as abuse coordinator responsibilities. All staff were re-educated on the abuse policy and procedure by the Administrator/designee by 11/28/11 with emphasis on reporting, protection, investigation and prevention as well as the change in abuse coordinator.</p> <p>The abuse coordinator in the facility was changed from the Social Services Director to the Administrator during the survey. All abuse education included a</p>	



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F 520

Continued From page 61  
 of abuse to the appropriate state agencies.  
 These failures resulted in substandard Quality of  
 Care for residents in the facility.

The findings include:

Refer to F225.

Refer to F226.

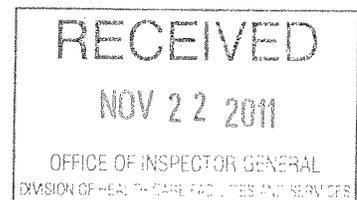
Record review of the facility policy on Prevention  
 of Abuse, Neglect, and Misappropriation of  
 Resident's Property found in the Nursing Services  
 Policy and Procedure Manual (Revised April  
 2009) stated within the policy "It is the intent of  
 this facility to immediately report and thoroughly  
 investigate allegations of mistreatment, neglect,  
 abuse, misappropriation of resident's property or  
 any injury of unknown origin". The policy  
 revealed under the heading Investigation, a  
 thorough investigation would be initiated  
 immediately for all alleged incidents of abuse  
 involving staff members, residents, family, and/or  
 visitors who have potential knowledge of the  
 incident or its circumstances. In addition, under  
 the same heading the policy states the  
 Administrator/designee will make all reasonable  
 efforts to investigate and address alleged reports,  
 concerns, and grievances presented to them.

Residents #6 reported a missing cell phone and  
 charger to staff on 6/19/11. There was no  
 evidence provided by the facility to demonstrate a

F 520

pre and post test to ensure  
 employees were able to identify  
 abuse and implement the abuse  
 policy. The management staff  
 were given a more inclusive  
 inservice, pre and post test by  
 the Administrator/designee to  
 include identification of abuse,  
 identification when an alleged  
 perpetrator of abuse needed to be  
 suspended from resident care,  
 investigating allegations of abuse  
 and reporting allegations of abuse  
 to the appropriate  
 agencies.

The administrator will conduct  
 10 weekly audits for employees  
 in every department and  
 management staff to ensure staff  
 know how to identify/report  
 abuse. Management audits will  
 ensure they know how to identify  
 abuse, identification when an  
 alleged perpetrator of abuse  
 needed to be suspended from  
 resident care, investigating  
 allegations of abuse and  
 reporting allegations of abuse to  
 the appropriate state agencies.



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

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F 520

Continued From page 62  
thorough investigation was completed or that a  
report was made to the appropriate state  
agencies.

Resident #18 reported verbal abuse from an  
employee to staff on 08/18/11. There was no  
evidence provided by the facility to demonstrate  
the alleged perpetrator was suspended from  
direct care duties to ensure resident protection  
during the course of an investigation. There was  
no evidence provided by the facility to show a  
thorough investigation was completed to  
determine if abuse occurred.

Resident #19 reported physical abuse by an  
employee to staff on 09/08/11. There was no  
evidence provided by the facility to show the  
alleged perpetrator was suspended from direct  
resident care pending the outcome of an  
investigation. There was no evidence provided  
by the facility to demonstrate a thorough  
investigation was completed to determine if  
abuse occurred.

Interview with the Social Service Director (SSD),  
on 10/13/11 at 8:50 AM, revealed she did not  
ensure that resident complaints were reviewed for  
possible abuse or investigated thoroughly. She  
stated she was responsible for all complaints and  
grievances. She stated she should have insisted  
investigations were completed and documented.

Interview with the Administrator, on 10/14/11 at  
12:30 PM, revealed the facility had a Quality

F 520

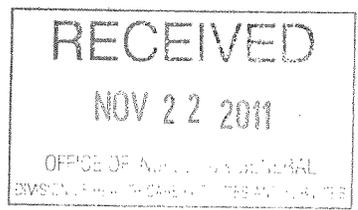
The results of these audits will be  
brought to the monthly Quality  
Assurance Team for review x 2  
months and at the team's  
discretion thereafter.

11/28/11

**F520 Addendum:**

- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11. The Medical Director will review all allegations of abuse and reports of abuse during the Quality Assurance meetings. The abuse policies were reviewed by the Quality Assurance Team on 10/25/11 and re-education provided on the above training dates. The Administrator will be the abuse coordinator which involves allegations of abuse being immediately reported to the administrator and the administrator being responsible for the overall investigation, protection of the resident and agency reporting process. Social Services will be auditing the reporting, protection and investigation process of the Administrator.
- QA team will first review the effectiveness and compliance of the POC on December 6, 2011 and will review weekly x 1 month, bi-weekly x 1 month after and at the QA team's discretion thereafter.

11-28-11

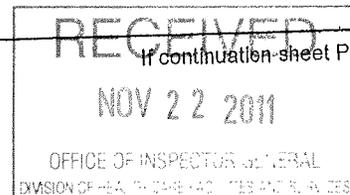


DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 11/03/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/14/2011
NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK		STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205	

(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 520	Continued From page 63 Assurance Meeting monthly. She stated processes were reviewed; however, the process for abuse was not reviewed and was not identified as problematic. She stated the grievance report used for complaints did not have an area for her to sign; however, she received a verbal report during the morning meetings. She stated the SSD failed to monitor abuse. She stated she would now take over the responsibility to ensure residents were free from abuse.	F 520		



Four Courts at Cherokee Park

2100 Millvale Rd. Louisville, KY 40205

Amendment to Plan of Correction for annual survey ending 10/14/11

Page 65 for Federal (F) Deficiencies

**F250 Addendum:**

- Designee to Administrator is Administrator in Training or Social Services Director to audit all grievances filed over the last six months for notification of resolution. The designee to the DON for assessing dental needs is the Assistant Director of Nursing.
- The designee to Social Services to make decisions if to proceed with dental consult is the Assistant Director of Nursing. Social Services or the ADON will document refusal or desire for dental care in the social services notes.
- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- Designee to Social Services for audits is the Director of Nursing. QA team will first review the effectiveness and compliance on December 6, 2011 and will review weekly x 1 month, bi-weekly x 1 month after and at the QA team's discretion thereafter.

Completion Date: 11/28/11

**F253 Addendum:**

- Designee to the Maintenance Director is the Maintenance Assistant.
- Designee to the Central Supply Clerk is the Housekeeping Supervisor.
- Designee to Administrator for training is Administrator in Training or Social Services Director. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- Designee for Maintenance Director audits is Maintenance Assistant. Designee for Central Supply audits is Housekeeping Supervisor. Designee for Housekeeping Supervisor is Maintenance Director.

Completion Date: 11/28/11

**F282 Addendum:**

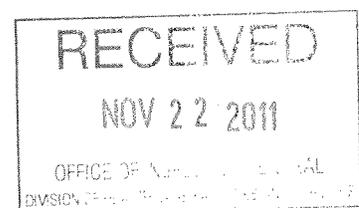
- Designee to DON is the ADON. Daily rounds of foley catheters will be documented Monday - Friday.
- Designee to DON for re-education is the ADON. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- Designee to DON for auditing is the ADON.

Completion Date: 11/28/11

**F465 Addendum:**

- Designee to the Maintenance Director is the floor tech.
- Designee to the Administrator for training is the Administrator in Training. Training dates 11/18, 11/19, 11/21, 11/22 and 11/26/11.
- Designee to the Administrator for auditing is the Administrator in Training.

Completion Date: 11/28/11



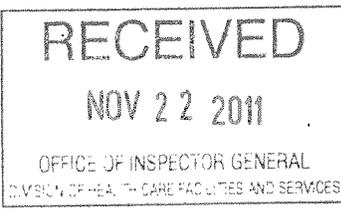
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STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0202  B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2011
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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(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 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III protected.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 10/11/11. Four Courts at Cherokee Park was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for eighty-four (84) beds and the census was sixty-three (63) 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 Fire)</p>	K 000	<p>Responses to the cited deficiencies do not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with Federal and State Law.</p>	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kelly Thompson TITLE: Administrator (X6) DATE: 11/7/11

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.

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

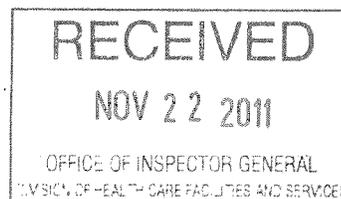
PRINTED: 10/28/2011  
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STATEMENT OF DEFICIENCIES A. PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0202 B. WING _____	(X3) DATE SURVEY COMPLETED  10/11/2011
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD: LOUISVILLE, KY 40205
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(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
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K 000  K 147 SS=E	<p>Continued From page 1</p> <p>Deficiencies were cited with the highest deficiency identified at E level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, approximately thirty (30) residents, staff, and visitors. The facility is licensed for eighty-four (84) beds and the census was sixty-three (63) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 10/11/11 between 9:00 AM and 11:30 AM, with the Regional Director of Plant Operations and the facility's Director of Plant Operations revealed:</p> <ol style="list-style-type: none"> <li>1. A small refrigerator was plugged into a power strip in resident room 113.</li> <li>2. A small refrigerator was plugged into a power strip in resident room 119</li> <li>3. A coffee maker, microwave oven and refrigerator were plugged into a power strip in the Assistant Administrator Lounge.</li> </ol>	K 000  K 147	<p>K147</p> <p>The power strips were removed in rooms 113, 119 and the Assistant Administrator Lounge by the Maintenance Director/designee on 10/11/11. All items stored in front of the electrical switchgear in Mechanical Room #2 were arranged over 3 feet of the switchgear by the Maintenance Director/designee on 10/11/11.</p> <p>All other facility rooms and common areas were checked by the Maintenance Director/designee on 10/11/11 and no other power strips were found inappropriately used. All other mechanical rooms were checked by the Maintenance Director/designee of 10/14/11 for proper clearance to the switchgear and no other storage problems found.</p> <p>All staff were re-educated by the Administrator/designee regarding the proper use of power strips and the proper</p>	
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NAME OF PROVIDER OR SUPPLIER  FOUR COURTS AT CHEROKEE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205	
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K 147	Continued From page 3 of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

