

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

PRINTED: 10/07/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2011
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY LOUISVILLE, KY 40229	
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F 000	INITIAL COMMENTS A standard health survey was conducted 09/21/11 through 09/23/11 and a Life Safety Code survey was conducted 09/21/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 226 SS=D	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 interview, record review and the facility's policy, it was determined the facility failed to report an allegation of abuse in accordance with State law through established procedures on one (1) of eighteen (18) sampled residents, Resident #12. The findings include: Review of the facility policy on Abuse and Neglect revealed alleged or suspected violations involving abuse will be reported immediately to officials in accordance with state law, including the state survey and certification agency. Review of the facility's policy, Abuse/Neglect 7 (seven) Key Components, revealed all alleged violations of abuse are to be reported to the state agency and to all other agencies as required.	F 226	Plan of Correction Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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

Beverly M. Edwards

TITLE

Administrative

(X6) DATE

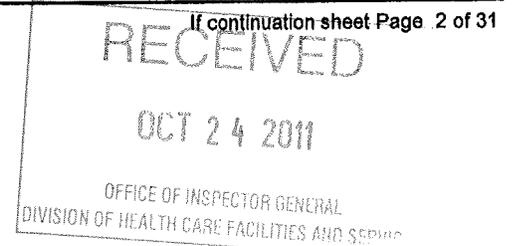
10/20/11

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.

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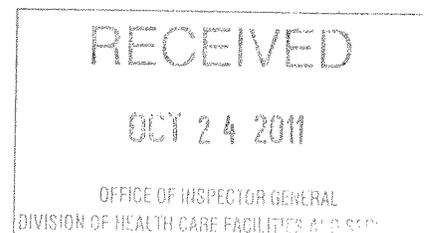
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F 226	Continued From page 1 Record review revealed the facility admitted Resident #12 to the facility on 12/15/09 with diagnoses to include Anemia, Coronary Heart Disease, Hypertension and Gastro Esophageal Reflux Disease. The facility assessed the resident as interviewable and required the use of a walker or wheelchair, and was not steady to walk or move from a seated to a standing position. The resident also required assistive rails on the bed to assist with turning from side to side. Interview, on 09/23/11 at 1:55 PM, with Resident #12 revealed there was an incident of rough treatment by a staff member, a Certified Nursing Assistant (CNA), in the shower and the resident reported it. The facility was unable to locate an occurrence report on the incident reported by Resident #12. Interview, on 09/23/11 at 3:50 PM, with the C/D Registered Nurse (RN) Unit Manager revealed the CNA who was involved in the allegation was suspended and the facility did an investigation. She revealed the abuse was unsubstantiated by the facility. Interview, on 09/23/11 at 3:55 PM, with the Social Services Director revealed she did not have a report on the alleged incident with Resident #12 because she only keeps the reports when the Department of Community Based Services (DCBS) and Office of Inspector General (OIG) are notified. The incident of alleged abuse involving Resident #12 was not reported to DCBS or OIG.	F 226	F226 1. The investigation was reopened by the Social Services Director (SSD) and Director (DON) of Nursing and required reporting was completed on 09/27/11. The identified c.n.a. received education regarding "gentle" care on 09/29/11. A 1:1 observation was made on 09/29/11 by Staffing Coordinator/CNA of the identified c.n.a. performing resident bathing. This included pre and post shower care. An incident report regarding the resident's complaint was completed by the DON on 09/27/11 reflect what was previously reported on 09/15/11. The incident report is dated to indicate that it was developed to report a previous incident.	



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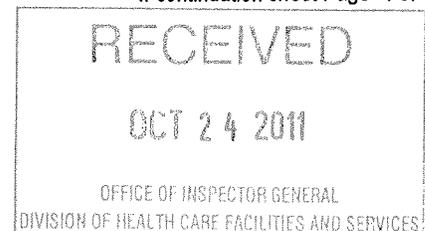
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F 226	Continued From page 2 Interview, on 09/23/11 at 4:00 PM, with the Director of Nursing (DON) revealed she was called at home on 09/15/11 the evening of the incident. The C/D Unit Manager reported she interviewed Resident #12, as did Licensed Practical Nurse (LPN) #4. The CNA involved in the alleged abuse wrote a statement and was sent home. The next day, 09/16/11, the CNA came to the facility and spoke with the DON. The CNA denied being rough. The DON stated at no point did she feel that the "little girl was intentionally rough with the lady". She stated they investigate, and due to the situation, if they feel like abuse occurred, they would report it. She did not feel the Certified Nursing Assistant (CNA) who allegedly abused Resident #12 was intentionally rough with the resident. She revealed she did interview Resident #12 and in response to asking the resident if he/she said anything to the CNA during the shower, where the alleged abuse took place, the resident responded no. She asked Resident #12 why he/she did not say anything to the CNA and the resident said "I just wanted to do what she told me to". Interview, on 09/23/11 at 4:45 PM, with Resident #12 revealed no one in the facility ever asked him/her if he/she felt the incident of the CNA being rough with him/her in the shower was abuse. He/she stated all he clothing was pulled off from the waist up at one time, in a rough manner, and it hurt. Resident #12 also stated she, the CNA, knew exactly what she was doing. Resident #12 further stated he/she told the staff who spoke with him/her about the incident, the CNA, does it to one she'll do it to another.	F 226	2. On 10/25/11, the Social Services Director or Social Worker will educate resident council members on abuse and neglect and how to report any allegations of abuse and neglect. The Administrator, Social Services Director or Admissions Director will send a letter to 100% of all resident family members educating them on abuse and neglect and how to report any allegation of abuse and neglect. This letter will be sent before 11/4/11. The Social Services Director, Staff Development Coordinator (SDC), or Department Director will educate all staff on how to identify abuse and neglect and on what measures to take when abuse is suspected or allegations of abuse are reported. All Staff will be educated by 11/4/11.	



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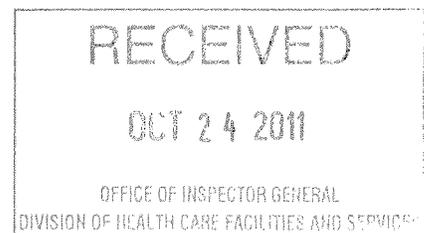
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F 226	Continued From page 3 Interview, on 09/23/11 at 5:20 PM, with the DON revealed she had reviewed the facility policy on abuse and she did not follow the facility policy on reporting an allegation of abuse as it related to Resident #12.	F 226	3. The Social Services Director, Social Worker, Department Director or SDC will educate all staff to report any allegation of abuse to their supervisor and/or any director on duty. They will also be educated on how to report allegations of abuse and neglect to APS and OIG. The Social Services Director, Social Worker, Department Director or SDC will educate all staff on when and how to complete an incident report and where to file it. The Nursing Home Administrator (NHA), DON and SSD will review all allegations of abuse and incident reports Monday - Friday during the Incident Report Meeting. All allegations of abuse will be reported to APS and OIG per facility policy by the Nursing Home Administrator (NHA), DON or SSD. The weekend supervisor or charge nurse will notify the NHA, DON and/or SSD of all allegations of abuse and neglect during the weekends. NHA, DON and/or SSD will instruct the weekend supervisor or charge nurse to report the allegation to APS or OIG.	
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, facility policy and procedure, it was determined the facility failed to provide a clean environment. Multiple dirty floors in need of stripping and waxing, multiple scuff marks, dirt and discoloration built up in corners and around door frames represented fifty (50) percent of the rooms within the facility. In addition, ten (10) window curtains were not properly hung at resident windows. The findings include: Review of the facility's policy, Resident Environment (revised 02/2005), revealed the facility would provide a clean environment for the residents. Review of the facility's procedure, Resident Rooms-Routine Cleaning, revealed it was recommended that a full mopping be done at	F 252		



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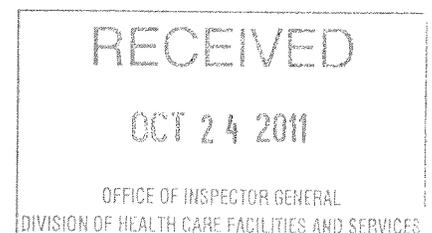
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F 252	<p>Continued From page 4</p> <p>least twice a week, with spot cleaning done throughout the week and needed repairs reported to the supervisor.</p> <p>Observation, on 09/21/11 during the tour of the facility which began at 11:20 AM, revealed a sticky floor in Room D2. Room D4 was in need of mopping and had a black substance on the floor by Bed B, as well as multiple scuff marks around the legs of the beds. The bathroom floorboard around the door frame in Room D11 had dark discoloration and a buildup of dust. Trash, string and dirty Kleenex were present on the floor of Room D14. Room D15 had a floor with multiple scuff marks, black stain/discoloration to the floor. The floor in Room D10 was dingy in color and dirty. Rooms D14 and D15 both had sticky floors and in need of mopping and waxing. Debris was on the floor of Room C13 to include paper and some unidentifiable items. There was also discoloration around the door frames. Room C10 had a sticky floor with numerous scuff marks. In the corners of the room the edging had discolored dark brown/black unidentified buildup. In addition was noted a large carpet bleach stain, a square foot in size, in front of the A/B nursing station white in color. Spots of the discoloration extended down the A hall standing out against the dark color of the carpet.</p> <p>Continued observation, during the tour of the facility, included Room D10 having window curtains that needed to be placed back on the hooks. In rooms C11 and C12 the curtains were falling off the hooks.</p> <p>Observation, on 09/23/11 at 7:30 AM, revealed</p>	F 252	<p>F226 Con't</p> <p>4. The Nursing Home Administrator (NHA), DON or SSD will report all allegations of abuse and neglect and the outcome to the QA committee monthly x 3 for further recommendations.</p> <p>5. All corrective actions will be completed by 11/4/11.</p> <p>F252</p> <p>1. The Env. Services Director and/or Housekeeping Supervisor will deep clean all affected resident floors and straighten all affected resident curtains.</p> <p>2. The Env. Services Director and/or House Keeping Supervisor will audit 100% of all resident rooms to determine if their floors need to be deep cleaned and if their curtains are straight.</p> <p>3. The Env. Services Director and/or House Keeping Supervisor will deep clean all resident floors requiring this attention. The Env. Services Director or House Keeping Supervisor will in-service all Housing keeping staff to sweep and mop all resident's floors daily. They will also be in-serviced to straighten resident curtains during daily routine cleaning.</p>



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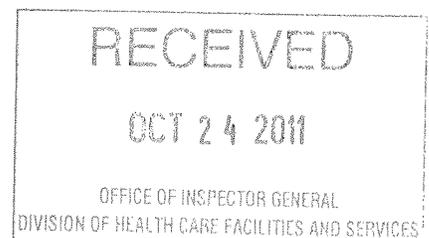
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F 252	<p>Continued From page 5</p> <p>curtains which needed adjusting in order to hang properly in Rooms B7, D11, D10, D16, D8, D7, D5, C1, C8 and C12.</p> <p>Observation, on 09/22/11 at 7:10 AM, in the Occupational/Physical Therapy room revealed the floor had multiple black scuff marks throughout the floor. The floor was dull in color.</p> <p>Interview, on 09/21/11 at 2:45 PM, with Housekeeper #2 revealed the resident rooms were mopped daily. The floors were deep cleaned "when needed". It was further revealed she could not recall the last time the floors in the resident rooms on the D Hall were stripped and waxed.</p> <p>Interview, on 09/22/11 at 6:40 AM, with the Floor Technician revealed housekeeping was supposed to be mopping in the corners and taking care of the areas around the doors in the resident rooms. He tried to get to the floors on Wednesdays for stripping and waxing; however, the facility had been short of help and he alone had tried to maintain the floors. In addition, there was no plan to correct the bleach stain in front of the A/B nursing station. He stated it was a wait and see situation.</p> <p>Interview, on 09/22/11 at 12:00 PM, with Housekeeper #1 revealed the rooms were mopped daily. She stated the supervisor was responsible to make sure the housekeepers were doing what they were supposed to do.</p> <p>Interview, on 09/23/11 at 9:30 AM, with the Housekeeping Supervisor stated there was no excuse for the floors, they had been shortstaffed.</p>	F 252	<p>4. The Env. Services Director and/or House Keeping Supervisor will audit 20% of resident rooms 2 x weekly x 3 months. The results of the audits will be reported to the QA committee monthly x 3 for further recommendations.</p> <p>5. All corrective actions will be completed by 11/4/11.</p>		



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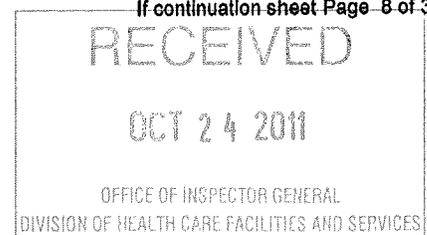
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F 252	Continued From page 6 She stated there was no plan at present to strip and wax the residents' rooms. The floor cleaning schedule was not able to be kept up with due to the lack of staff. The curtains were old and the pulling shut of the curtains by staff made them come off the track. Housekeepers failed to report the curtains were off the track and needed to be repaired. Interview, on 09/23/11 at 3:15 PM, with the Environmental Services Manager revealed the floors on the C/D wing were what they were and definitely needed to be cleaned. It had been three (3) to four (4) months since the floors had been deep cleaned. He indicated a new employee had been hired and was scheduled to start soon. At present there was not enough staff to keep up with the maintenance of the floors. A log was kept for maintenance issues reported by housekeeping; however, no entries for maintenance to address issues about curtains in any resident's room was documented.	F 252	F309 1. On 10/12/11 the Unit Manager or Charge Nurse notified the MD of resident #8's refusal to wear TED hose. The MD discontinued the order for TED hose on 10/12/11. 2. The DON or Unit Manager will audit 100% of all resident records to ensure that every resident with an order for TED hose has been transcribed on the treatment record. The DON or Unit Manager will develop a master list of residents requiring the use of TED hose. They will monitor this list 5 x weekly and inspect the listed resident to ensure that all residents requiring the use of TED hose are using them.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 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. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility	F 309	3. The DON, Unit Manager or SDC will in-service all Licensed Nurses on the importance of checking the Treatment Record early in their shift in order to ensure ordered treatments are in place. They will also be in-serviced on the appropriate documentation regarding refusal of treatment and notification of the MD. In addition, the DON or SDC will in-service all Nursing Staff on how to properly apply TED hose. All in-services will be completed by 11/4/11.	



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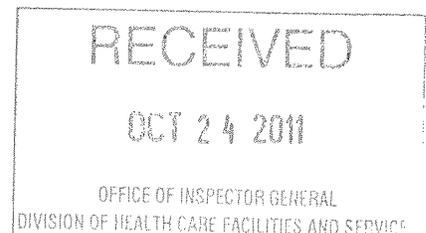
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F 309	<p>Continued From page 7</p> <p>failed to follow physician orders for one (1) of eighteen (18) sampled residents (Resident #8). Resident #8 had an order for Thrombo Embolic Deterrent (TED) hose that was not followed.</p> <p>The findings include:</p> <p>Review of the facility's policy for Physician's Orders revealed the facility's purpose was to provide a procedure that facilitated the timely and accurate processing of physician's orders.</p> <p>Record review revealed the facility admitted Resident #8 on 06/04/11 with diagnoses of Coronary Artery Disease, Peripheral Artery Disease, and Atrial Fibrillation and a physician's order for TED hose to be put on in the AM and taken off at the hour of sleep (hs).</p> <p>Record review of the Treatment Administration Record (TAR) for Resident #8, on 09/23/11, revealed there was no documentation on the TAR for TED hose on 09/23/11.</p> <p>Observation, on 09/23/11 at 9:20 AM, revealed resident sitting in his/her wheelchair in the common area with no TED hose in place. At 11:15 AM, and 2:30 PM the resident continued to have no TED hose in place.</p> <p>Interview with CNA #5, on 09/23/11 at 2:10 PM, revealed he was aware Resident #8 had an order for TED hose; however, he had not put them on him/her because he did not know how to put TED hose on a resident.</p> <p>Interview with Unit A/B Nurse Manager, on 09/23/11 at 2:20 PM, revealed the nurses were</p>	F 309	<p>4. The DON or Unit Manager will audit TED hose application for 100% of residents 5 x weekly for two weeks; then weekly x 3 months. Results of the audits will be reported to the QA committee monthly x 3 for further recommendations.</p> <p>5. The corrective action will be completed by 11/4/11.</p>	



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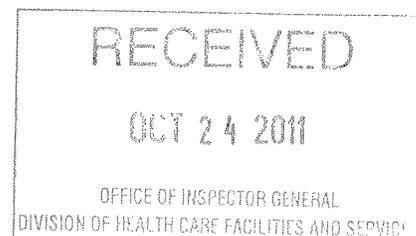
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F 309	Continued From page 8 responsible to ensure the CNAs carried out their tasks. It was likely Resident #8 had refused the TED hose today and the nurse had not yet documented for the AM application of the TED hose. Interview, on 09/23/11 at 2:30 PM, with LPN #6 revealed she was unaware Resident #8 had an order for TED hose. Observation, on 09/23/11 at 2:35 PM, revealed LPN #6 took Resident #8's TED hose out of the drawer in resident's room. Interview with the Director of Nursing (DON), on 09/23/11 at 3:45 PM, revealed that Resident #8 should have TED hose on and documentation in the TAR should have been completed by 2:30 PM on 09/23/11.	F 309	F369 On 10/12/11 the Dietary Director reviewed 100% of all resident tray cards to ensure that assistive devices were listed on tray card for those residents that require them. The Dietary Director, AM Dietary Aide or PM Cook will review and highlight resident tray cards at each meal to direct attention to the residents receiving assistive devices. During tray preparation, the cook will ensure that residents receive assistive devices. During tray delivery, the Unit Manager, Charge Nurse or CNA will ensure that residents receive assistive devices. The DON, Dietary Director or Staff Development Coordinator will train all Nursing/Dietary Staff on the importance of assistive devices and how to identify which assistive device is required for each resident. The Dietary Director began training for the Dietary Department on 10/12/11 and will be complete by 11/4/11. The DON will complete training for all Nursing Staff by 11/4/11. The DON or Dietary Director will audit assistive devices during 1 meal service 3 x weekly x 2 months, then 1 x weekly x 1 month. The results of the audit will be discussed in the QA committee meeting monthly x 3 for further recommendations. All corrective actions will be completed by 11/4/11.	
F 369 SS=E	483.35(g) ASSISTIVE DEVICES - EATING EQUIPMENT/UTENSILS The facility must provide special eating equipment and utensils for residents who need them. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of the resident dietary cards and the facility's policy it was determined the facility failed to provide special eating equipment for residents who had an assessed need for assistive devices. Six (6) of eight (8) unsampled residents did not receive the special eating equipment ordered for them by the physician based on an occupational therapy assessment for Residents C, D, E, F, G and H.	F 369		



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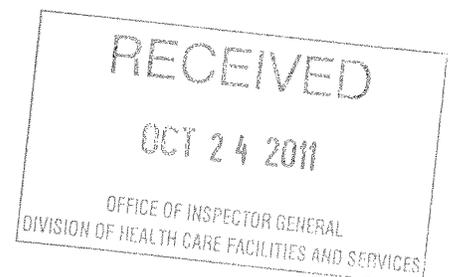
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F 369	<p>Continued From page 9</p> <p>The findings include:</p> <p>Record review of the facility's policy Meal Service/Dining Assistive Devices (revised March 2009), revealed special eating equipment will be provided for the residents that needed them. A sample of assistive devices noted in the policy included a divider plate or partitioned plate. It was further revealed the use of assistive devices would be noted on the dietary card. The Assistive Devices policy stated the dietary department is responsible to evaluate the assistive devices initially and quarterly.</p> <p>Review of the dietary cards, placed on the table at the residents' seating spaces, revealed special needs of the residents related to divided plates, cups with handles and sippy lids listed on those cards.</p> <p>Observation of the noon meal, on 09/22/11 at 12:30 PM, in the dining room revealed the dietary card for Resident G listed a divided plate; however, the resident was served his/her meal on a circular high sided plate. The dietary card for Resident F listed a divided plate; however, the resident was served his/her meal on a circular high sided plate. The dietary card also stated a cup with handles, but the resident received a regular cup. The dietary card for Resident E listed a divided plate; however, the resident was served his/her meal on a circular high sided plate. The dietary card for Resident C listed an EZ sippy lid for hot beverages; however, a regular coffee cup was used for the resident's coffee. The dietary card for Resident D listed a small bowl; however, the resident received his/her meal on a regular</p>	F 369		



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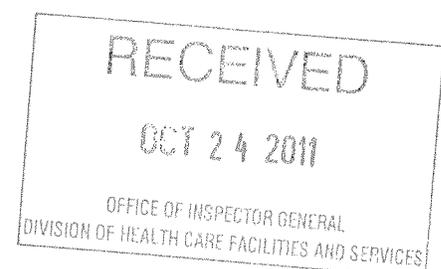
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F 369	<p>Continued From page 10 round plate, not a bowl.</p> <p>Observation of the breakfast meal, on 09/23/11 at 8:00 AM, in the dining room revealed the dietary card for Resident H listed a divided plate; however, the resident was not served his/her meal on a divided plate. The dietary card for Resident D listed a small bowl and the resident was served his/her meal on a plate.</p> <p>Interview, on 09/23/11 at 8:05 AM, with the Dietary Cook revealed the purpose of the divided plate was so food would not fall off the plate as the resident ate. If the resident did not get the divided plate during meal service, food would come off the plate as the resident ate. Orders for divided plates are initiated through an Occupational Therapy assessment.</p> <p>Interview, on 09/23/11 at 8:06 AM, with Certified Nursing Assistant (CNA) #3 revealed the dietary card was checked to verify the resident was getting the correct plate, as in a divided plate.</p> <p>Interview, on 09/23/11 at 8:07 AM, with Red Cross CNA Student #2 revealed the dietary card was checked as the resident received their meal tray to make sure the resident got what they are supposed to get.</p> <p>Interview, on 09/23/11 at 8:08 AM, with C/D Registered Nurse (RN) Unit Manager revealed the divided plates were ordered according to the residents dietary needs to help them keep their independence. Dietary staff were responsible to ensure the resident received the correct plate type and nursing was to monitor to ensure the correct plate was used.</p>	F 369		



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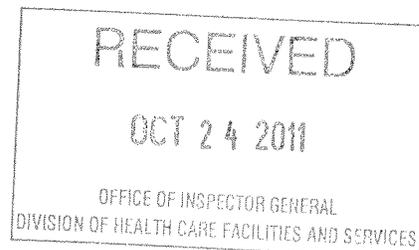
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F 369	Continued From page 11 Interview, on 09/23/11 at 8:15 AM, with the Dietary Manager revealed the purpose of a divided plate was to keep food on the plate and not on the table. An assessment by Occupational Therapy (OT) was how an order for a divided plate was initiated. She stated the person responsible to ensure the resident received the correct plate type was the cook dishing the food and the nursing person that accepts the plate. She was, to some degree, responsible when the residents did not receive the correct plate type. Interview, on 09/23/11 at 9:20 AM, with the Restorative Registered Nurse revealed the divided plates were important to the resident because with decreased dexterity a resident pushes their food off the plate and the divided plate allows the resident to keep food on the utensil. It was further revealed the person serving the food was responsible to ensure the correct plate type was used and the nursing staff should review the ticket before serving the meal to a resident. Interview, on 09/23/11 at 10:30 AM, with the Occupational Therapist revealed Occupational Therapy (OT) would evaluate a resident to determine if an assistive device (to assist with meals) would be appropriate for the resident. If an assistive device was appropriate, an order would be written by OT for the physician to sign and dietary would be informed. A divided plate helps the resident with scooping their food on the utensils, it prevents mixing food together that the resident may want separate and allows the resident to bring the food from the plate to the mouth for consumption and not spill on the table.	F 369			



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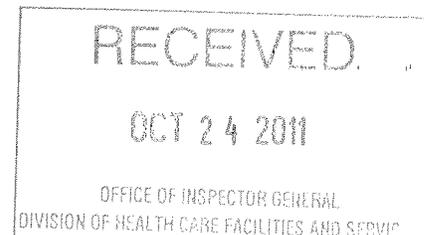
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F 369	Continued From page 12 She stated it creates frustration for the resident to not get food in their mouth, for food to land on the table, and the divided plate prevents that from happening.	F 369			
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policies titled Sanitation Handwashing Technique and Dress Code, it was determined the facility failed to prepare, distribute and serve food under sanitary conditions. Dietary staff used hand sanitizer instead of soap and water to wash hands; two dietary employees were observed during tray line without having their hair properly restrained; tongs were observed being used to distribute food after being placed on the counter; and multiple food items were observed being served with the same utensil. The findings include: Review of the facility's policy titled Sanitation Handwashing Technique, dated 04/2009, revealed staff should wash their hands as needed	F 371	F371 Hair Nets The Dietary Director will ensure that all dietary staff wears hair nets during food preparation and service. The hair nets will completely cover the hair. She started inservicing dietary staff on 10/12/11 on the importance of hair nets and how to properly wear them. In addition, the Dietary Director ordered a new elastic type hair net on 10/13/11 to better fit employees. The Dietary Director will audit employee compliance with properly wearing hair nets daily x 3 months. The results of those audits will be discussed in the QA Committed meeting monthly x 3 for further recommendation. All corrective measures will be completed by 11/4/11.		



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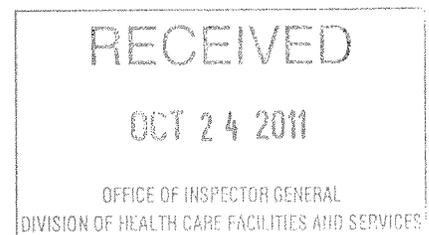
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F 371	Continued From page 13 in order to safeguard the health of those who are dependent on their service. Hands should be washed: when reporting to work and when returning to the kitchen after a break; before, between, and after resident contact; after touching any contaminated object (face, hair, body or clothing, garbage, or dirty utensils, phone, linen or money); before eating or touching food; after sneezing or coughing or blowing nose; after using the toilet; before and after using gloves; between dirty and clean dish handling; after handling raw meat, poultry, fish, or eggs; after use of tobacco products; and after eating/drinking. Review of the facility's policy titled Dress Code, dated 04/2009, revealed dietary staff will maintain clean work attire and shoes. Hairnets (or hair and beard restraints) will be in place while in the food preparation or food storage area. Hair is to be covered completely. Review of the Food and Drug Administration most recent Food Code Guidelines, dated 2009, revealed in section 2-301.11 food employees shall clean their hands and exposed portions of their arms, including surrogate prosthetic devices for hands or arms for at least 20 seconds, using a cleaning compound in a handwashing sink that is equipped as specified under 5-202.12 and subpart 6-301. Section 2-301.14 revealed food employees shall clean their hands and exposed portions of their arms as specified under 2-301.12 immediately before engaging in food preparation including working with exposed food, clean equipment and utensils, and unwrapped single-service and single-use articles and: after touching bare human body parts; after using the	F 371	Serving Utensils The Dietary Director will ensure that all foods served have their own serving utensil. The Dietary Director started in-serving all cooks on 10/12/11 on the importance of not resting the serving utensils on the counter or any other surface. They must be left in the steam table pans. She completed this training on 10/15/11. Newly hired Cook training will be completed by 11/4/11. The Dietary Director will audit meal service daily x 1 month, then 3 x weekly x 2 months to ensure compliance of proper use of serving utensils. The results of those audits will be discussed in the QA Committee meeting monthly x 3 for further recommendation. All corrective measures will be completed by 11/4/11.	



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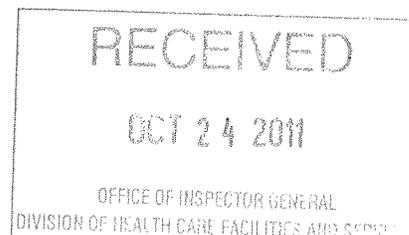
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F 371	<p>Continued From page 14</p> <p>toilet room; after caring for or handling service animals; after coughing, sneezing, using a handkerchief or disposable tissue, using tobacco, eating, or drinking; after handling soiled equipment and utensils; during food preparation, as often as necessary to remove soil and contamination and to prevent cross contamination when changing tasks; when switching between working with raw food and working with ready-to-eat food; before donning gloves; and after engaging in other activities that contaminate the hands. Section 2-301.16 revealed a hand antiseptic used as a topical application, a hand antiseptic solution used as a hand dip, or a hand antiseptic soap shall be applied only to hands that are cleaned as specified under 2-301.12.</p> <p>The facility did not provide a policy on cross-contamination.</p> <p>1. Observation of the meal service in the dining room, on 09/22/11 at 7:25 AM, revealed two (2) sets of tongs sitting on the counter in front of the steam table. The Dietary Cook picked up a set of tongs to prepare a resident's plate, using the same tongs the cook distributed a fried egg, bacon, and a waffle. The tongs were then set back on the counter. The cook then picked up the other set of tongs and proceeded to prepare another plate picking up multiple food items with the same set of tongs.</p> <p>Interview with the Dietary Cook, on 09/23/11 at 8:55 AM, revealed each food item should have its own utensil. The Dietary Cook stated if someone had a food allergy they could have a reaction. The Dietary cook revealed she was aware of one</p>	F 371	<p>Hand Washing</p> <p>The Dietary Director will ensure that all Dietary Staff properly wash their hands. The Dietary Director will in-service all dietary staff on the proper way to wash their hands. All cooks will wash their hands after food temps are taken and recorded and before serving meals. The bathroom in the service hallway will be used. The Dietary Director will audit meal services daily x 1 month, then 3 x weekly x 2 months to ensure compliance of proper hand washing prior to meal service for dietary staff. The results of those audits will be discussed in the QA Committee meeting monthly x 3 for further recommendation. All corrective measures will be completed by 11/4/11.</p>	



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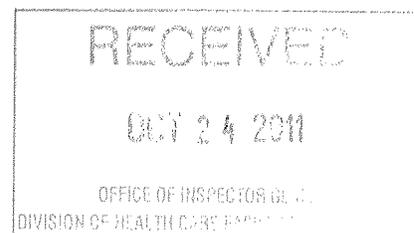
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F 371	<p>Continued From page 15 resident that had a food allergy to eggs.</p> <p>2. Observation of the breakfast meal service in the dining room, on 09/22/11 at 8:05 AM, revealed the Dietary cook's hair net only covered the back of the cook's hair, leaving the front of her hair exposed. At 11:45 AM, during the lunch meal, a dietary aide had the front of her hair exposed and not properly restrained with a hair net. At 1:00 PM, a dietary cook had the front of her hair exposed and not properly restrained with a hair net.</p> <p>Interview with the Dietary Cook, on 09/23/11 at 8:55 AM, revealed not having hair properly restrained could potentially result in hair falling into the food. The Dietary Cook stated "as long as you don't touch your hair though, your fine".</p> <p>Interview with the Dietary Aide, on 09/23/11 at 8:58 AM, revealed she thought it was acceptable to leave the front bangs of her hair exposed as long as she did not touch her hair. However, she admitted there was the potential for hair falling into the food by not having hair properly restrained.</p> <p>3. Observation of the tray line, on 09/22/11 at 12:15 PM, revealed the Dietary Cook placed oven mitts on the steam table counter while setting up the food. The cook then pulled the food temperature log book from a shelf and placed it on the steam table counter while recording the food temperatures. The serving utensils were then laid on the counter, without it being cleaned and sanitized, then used to serve food. Serving utensils were not left in the food during tray line, but repeatedly set on the counter.</p>	F 371	



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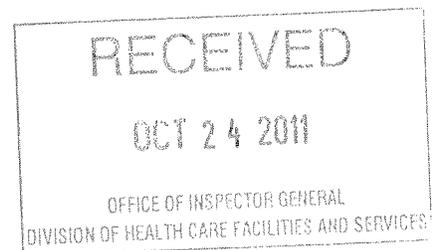
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F 371	<p>Continued From page 16</p> <p>Interview with the Dietary Cook, on 09/23/11 at 8:55 AM, revealed utensils should remain in the food item and not set on the counter which could potentially contaminate the food.</p> <p>4. Observation of the tray line, on 09/23/11 at 12:00 PM, revealed a dietary aide leaving the tray line to use the telephone to announce a cart on the overhead speaker. The aide then used hand sanitizer and returned to the tray line without washing her hands with soap and water.</p> <p>Interview with the Dietary Manager (DM), on 09/23/11 at 9:00 AM, revealed hand sanitizer can be used in the kitchen for three (3) times before the employee must wash their hands with soap and water. The DM revealed staff was still encouraged to use hand hygiene practices, but it depended on the task. The DM further revealed she was not aware hand sanitizer could not be used in the kitchen. The DM revealed the Dietary Cook should have stepped aside during meal service to fix her hair net to prevent contamination. The DM revealed hair should be properly restrained with a hair net. The DM revealed each food item should have its own utensil for good safety, sanitation, or to prevent potential reactions from food allergies. She further revealed utensils should stay in the food item and not be placed on the counter to prevent contamination. The DM revealed a recent in-service was held on 09/14/11 which discussed food safety, production, and sanitation.</p> <p>Review of the in-service records for 09/14/11 revealed the Dietary Cook and the Dietary Aide was in attendance.</p>	F 371		



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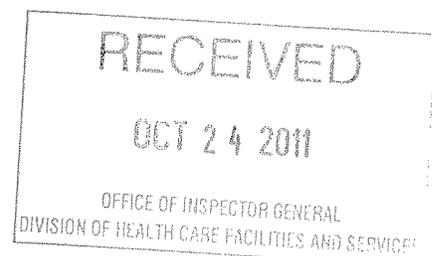
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F 371	Continued From page 17	F 371			
F 431 SS=E	<p>Interview with the Administrator, on 09/23/11 at 1:50 PM, revealed she was not aware hand sanitizer could not be used in the kitchen area. The Administrator revealed using the same utensil to serve multiple food items and placing utensils on the counter could pose a potential risk for infection control, cross contamination, and reactions in those with food allergies.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and</p>	F 431	<p>F431</p> <p>The Env. Services Director, DON or Unit Manager will be responsible for pressure washing all medication and treatment carts by 11/4/11 to ensure that all carts are thoroughly cleaned inside and out. The DON or Unit Manager will check all medication and treatment carts for items that are not dated and/or expired. This will include but is not limited to multi-dose vials and biologicals. All multi-dose vials and biological items will be checked for documented dates when opened. Expired medication will be logged and returned to the pharmacy. If needed, other corrections will be made per accepted guidelines. All corrective actions will be completed by 11/4/11.</p>		



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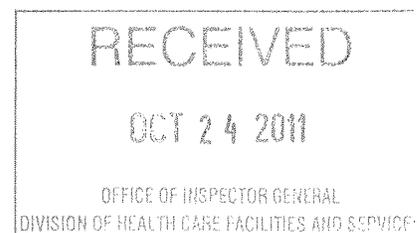
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 09/23/2011
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN			STREET ADDRESS, CITY, STATE, ZIP CODE 3600 GOOD SAMARITAN WAY LOUISVILLE, KY 40229	
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F 431	<p>Continued From page 18</p> <p>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 policy review, it was determined the facility failed to label multi-dose medications and biological products with open dates from two (2) treatments carts out of two (2) treatment carts and failed to discard one (1) expired medication from a file cabinet in one (1) of two (2) Medication Rooms. The facility failed to maintain (3) three out of (4) four medication carts in a clean and sanitary way. The facility failed to label one (1) multi-dose medication with an open date in the refrigerator of one (1) of two (2) medications rooms.</p> <p>The findings include:</p> <p>Review of the facility's Procedure for Acquisition, Receiving and Dispensing of Medications, II.M.8a (revised date January 2007), revealed that checking of expired medications would be done in accordance with state/pharmacy regulations.</p> <p>Review of the facility's Policy & Procedure for Bulk Over-The-Counter Medications, II.M.8j (revised date January 2007), revealed the facility was to date the bulk medication container when it was opened.</p> <p>Observation of the C/D Unit Med Room, on</p>	F 431	<p>The DON, Unit Manager or SDC will in-service all Nurses and CMTs stating that multi-dose containers must be dated when opened and the date must be checked prior to administration in case the medication has expired. The DON, Unit Manager or SDC will in-service all nurses to date all biological items on the treatment cart when opened. The DON, Unit Manager or SDC will in-service all nurses and CMTs on their responsibility of keeping the inside and outside of the medication and treatment carts clean. The DON, Unit Manager, or SDC will in-service all nurses to remove discontinued and expired medication from the applicable medication cart and on the procedure of logging then returning expired medication to the pharmacy. All in-services will be completed by 11/4/11.</p>	



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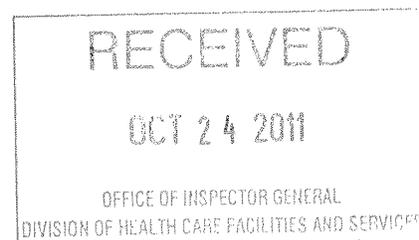
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F 431	<p>Continued From page 19</p> <p>09/22/11 at 10:00 AM, revealed one (1) opened container of Lorazepam Oral Concentrate in the refrigerator not labeled with no open date and one (1) opened container of Silver Nitrate Applicators in a file cabinet drawer not labeled with open date. The container of Silver Nitrate was also labeled with a delivery date of 10/27/08 and had an expiration date of 05/09.</p> <p>Observation, on 09/23/11 at 7:20 AM, of the Certified Medical Technician (CMT) medication cart for Hall C, Cart #1, revealed dust in the inside of the drawers and a brownish grime inside the crease along the molding surrounding the outside bottom of the cart.</p> <p>Observation, on 09/23/11 at 8:00 AM, of the Nurses' medication cart for Hall C and Hall D, Cart #2, revealed the cart had a brownish grime inside the crease along the molding surrounding the outside bottom of the cart.</p> <p>Observation, on 09/23/11 at 8:20 AM, of the CMT medication cart for Hall D, Cart #3, revealed a sticky substance spilled in the bottom of one drawer and several loose rubber bands, labels removed from needles, batteries, and three (3) loose gloves were observed in several drawers. A brownish grime was observed inside the crease along the molding surrounding the bottom of the cart.</p> <p>Observation, on 09/23/11 at 9:30 AM, of the C-Hall Treatment Cart revealed the following medications not labeled with the opening date: one (1) bottle of Ammonium Lotion, seven (7) jars of Magic Butt Cream, five (5) bottles of Nystatin Powder, eight (8) tubes of Pain Relief Gel/Cream,</p>	F 431	<p>The Charge Nurse on third shift will remove the contents in each cart's compartments then sanitize/clean each compartment daily. The DON or Unit Manager will audit each medication cart 3 x weekly for 2 months, then weekly to ensure cleanliness and that items are dated when opened and expired/discontinued medication has been removed/replaced. Results of these audits will be reported to the QA Committee Monthly x 3 for further recommendations.</p> <p>Corrective action will be completed by 11/4/11.</p>	



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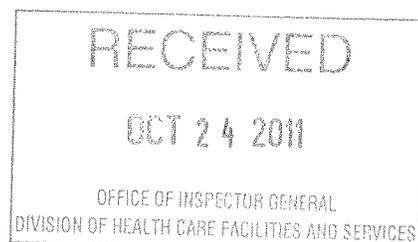
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F 431	<p>Continued From page 20</p> <p>one (1) jar of Muscle Analgesic Balm, three (3) tubes of Antibiotic Ointment, one (1) jar of Mineral Oil Dry Skin Cream, one (1) tube of Hemorrhoid Cream, one (1) tube of Hydrocortisone Cream, one (1) tube of Nystatin Cream, two (2) containers of Granulex Spray, one (1) tube of Dovonex Cream, and one (1) jar of Eucerin Cream.</p> <p>Observation, on 09/23/11 at 10:00 AM, of the D-Hall Treatment Cart revealed the following medications not labeled with the opened date: five (5) jars of Magic Butt Cream, one (1) tube of Vasolex Ointment, three (3) bottles of Nystatin Powder, one (1) tube of Clobetasol Cream, one (1) tube of Risamine Moisture Barrier Ointment, and one (1) container of Granulex Spray.</p> <p>Interview, on 9/22/11 at 10:00 AM, with C/D Unit Nurse Manager (NM) revealed that the staff was trained to label multi-dose containers of medications when they were opened and to remove all expired medications from the Medication Carts, from the Treatment Carts, and from the Medication Rooms. The C/D Unit NM stated the oral solution of Lorazepam should have been dated when opened and that all expired medications should be removed from the Med Room and/or returned to the Pharmacy. The C/D Unit (NM) revealed the former medical director who had left the facility about eighteen months ago left the file cabinet in the Med Room. C/D Unit (NM) stated she should have removed that file cabinet from the Med Room when the medical director left the facility. She was not aware that there was an expired medication in the file cabinet.</p>	F 431	



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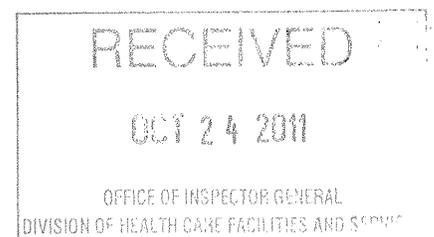
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F 431	<p>Continued From page 21</p> <p>Interview, on 09/23/11 at 7:20 AM, with CMT #1 revealed Med Cart #1 needed to be cleaned and that the third shift staff should have cleaned the cart inside and out.</p> <p>Interview, on 09/23/11 at 8:00 AM, with LPN #3 revealed the nurses should keep the carts clean and organized on the inside and outside and that she tried to clean as she went about administering medications to the residents.</p> <p>Interview, on 09/23/11 at 8:20 AM, with LPN #5 revealed the nurses on the night shift were suppose to clean the carts inside and out and that she tried to clean as she goes through the day.</p> <p>Interview, on 09/23/11 at 10:15 AM, with LPN #5 revealed the nurses were supposed to label medications and treatment products on the treatment cart with date opened. LPN #5 stated she was taught this here as well as in Nursing School. LPN #5 revealed she was not aware that there were so many products in the treatment carts that were not labeled with dates opened. LPN #5 stated that she did not know if the Nurse Managers checked the treatment carts.</p> <p>Interview, on 09/23/11 at 2:55 PM, with C/D Unit NM #1 revealed multi-dose medications or products should be dated when opened and that the staff had been trained to date meds and products when opening. C/D Unit NM stated the night nurses should clean and organize the carts.</p> <p>Interview, on 09/23/11 at 3:00 PM, with C/D Unit NM #2 stated the weekend Nurse Manager was supposed to check the Treatment Carts and the nurses on duty are supposed to date an item</p>	F 431		



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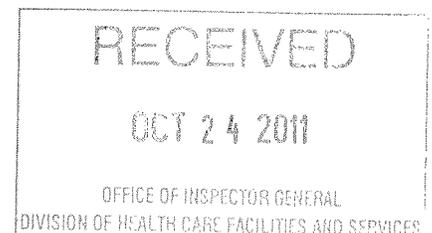
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F 431	<p>Continued From page 22 when opened. C/D Unit NM #2 stated obviously this was not done.</p> <p>Interview, on 09/23/11 at 3:35 PM, with the DON revealed the facility did not have a policy on cleaning or checking the Medication Carts and Treatment Carts. The DON stated she had created a grid for checking the carts but it was on her home computer. The weekend supervisor was supposed to see that the resident's products are in the correct bags on the Treatment Carts. The facility did not have a policy for dating multi-dose products when opened. She had never heard of labeling date opened on products on a treatment cart and that it was just not done there. The DON said she would not date Nystatin Powder with an open date even though it does require a prescription. All medications and ointments require a prescription in this facility. She stated the oral solution of Lorazepam in the Med Room should have been labeled with the date opened. The facility should be able to have a personal cabinet in the Med Room and be able to have an expired medication for a resident in the cabinet because the resident was no longer at the facility. It was ridiculous for the facility not to be able to have a personal cabinet and she would try to find a policy on personal cabinets in the Med Room for Medical Directors. The DON stated all carts were to be checked and cleaned on the weekends and as they are used. The DON stated she needed to check the carts.</p> <p>2. Observation, 09/23/11 at 8:00 AM, revealed white dust, hair, and four (4) loose pills in bottom of two different draws in the Medication Cart for A/B Hall. In a drawer containing multiple resident</p>	F 431		



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F 431	<p>Continued From page 23</p> <p>medications for rooms A7A, A7B, A8A and A8B there were two pills (one blue and one brown) lying in the bottom of the drawer among white dust. In a second drawer containing room A5B, A6A, and A6B medications, was one brown pill lying in the bottom of the drawer in a white dusty substance. In a third drawer containing room A1A, A1B, A2A, and A2B's medications, there was one white pill and one beige pill lying in the bottom of the drawer in white dust. The bottom of medication cart for hall A was found with sticky, dried, yellowish-white substance and white-gray dust around the base of cart and shelves holding the drawers.</p> <p>Interview, 09/23/11 at 8:00 AM, with Licensed Practical Nurse (LPN) # 6 revealed the medication cart for hall A was dusty, and needed to be vacuumed and spot cleaned. LPN #6 explained the carts were cleaned as needed and was not sure of any cleaning schedules but thought the third shift cleaned the medication carts every day. LPN #6 explained loose pills found in the medication cart for hall A should have been removed then discarded into the sharps container as soon as they were discovered.</p> <p>Interview, 09/23/11 at 8:40 AM, with A/B unit manager revealed the medication cart for hall A had sticky, dried, yellowish-white substance, and white-gray dust around the base of cart. In addition medication cart for hall A was dirty and needed to be cleaned.</p> <p>Interview, 09/23/11 at 3:35 PM, with Directory of Nursing (DON), revealed the facility had a problem with resident medication falling out of the blister packs. The facility had no written policy on</p>	F 431	



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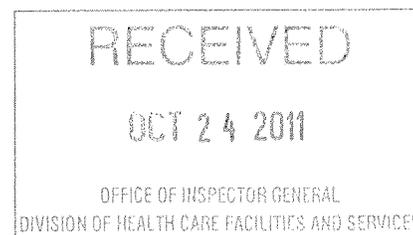
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F 431	Continued From page 24 cleaning medication carts. The DON stated the expectation was for certified medication technicians (CMTs) and nurses using the carts to clean them at the end of each shift and the CMT should be deep cleaning medication carts on the weekends.	F 431			
F 497 SS=D	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to ensure all Certified Nursing Assistants completed the minimum of twelve (12) inservice training hours as required. One (1) of eleven (11) sampled CNAs failed to complete the required training (CNA #6). The findings include: Record review of inservice training records on	F 497	F497 CNA #6 completed her training. The HR Director, HR Assistant or DON will audit 100% of c.n.a.s to ensure the 12 hour mandated education has been completed prior to their certification date. Any C.N.A. out of compliance will be taken off of the work schedule until compliance is established. The Staff Development Coordinator will receive a list of all C.N.A. certification dates from the Human Resource Department. The HR Director or HR Assistant will update the master list after each new employee orientation. The SDC will track each c.n.a.s training throughout the year. The SDC will communicate with each c.n.a the need to provide evidence of the mandated 12 hour training a month prior to their certification date, listing the dead-line date. This information will be given to the staffing coordinator as well. Any c.n.a that has not provided evidence of the required education will be removed from the schedule. The SDC will keep the staffing coordinator updated on a weekly basis regarding compliance of the c.n.a. status.		



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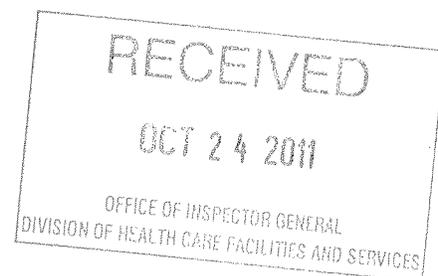
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F 497	Continued From page 25 (11) eleven sampled CNA employee files revealed CNA #6 completed only 3.75 inservice training hours instead of the required 12. Interview with the Staff Development Coordinator (SDC), on 09/23/11 at 3:30 PM, revealed documentation of training records are kept in two areas, paper and computer, and then those hours are added together to get the total number of education hours. The SDC stated she was aware CNA's are required to have twelve hours of continuing education per year. She reported she does not know how CNA #6 failed to complete the required hours. She stated the tracking system was cumbersome due to the hours being recorded in two places.	F 497	The HR Director or DON will meet with the SDC and Staffing Coordinator weekly x 3 months, to audit 20% of facility records to ensure the facility is in compliance regarding regulatory c.n.a. training/certification. The results of the audits will be shared with the QA committee monthly x 3 months for further recommendations. The corrective action will be completed by 11/4/11.	
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE 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: Based on interview, record review, and review of the facility's policy titled Advance Directive, it was	F 514		



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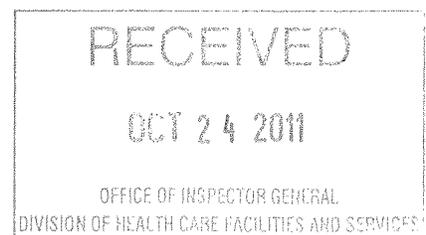
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F 514	<p>Continued From page 26</p> <p>determined the facility failed to ensure one (1) of the eighteen (18) sampled resident's (#9) medical record was complete and accurate in relation to the resident's and family's wishes for advance directives.</p> <p>The findings include:</p> <p>Review of the facility's policy on advance directives, dated 10/2009, revealed at the time of admission or re-admission, the social worker asks the resident/family: whether he or she has discussed his or her health status with the physician; whether he or she has discussed with the physician his or her wishes regarding a medical emergency which may warrant consideration of the need for hospitalization or life-sustaining measures; whether he or she has prepared an Advance Directive such as a living will or durable power-of-attorney for medical decisions; whether a guardianship/conservatorship or general durable power of attorney exists. Stickers or other markers will not be used as an indication of life-sustaining orders or heroic measures. There is no substitute for the actual orders. Having information in multiple places increases the likelihood of error.</p> <p>Review of Resident #9's clinical record revealed the facility admitted the resident on 04/14/10 with the following diagnoses: Diabetes; Alzheimer's; Hypertension; Hyperlipidemia; Dementia; Depression; and Anxiety. The Resident had a history of both bladder and prostate cancer and had a Urostomy. The Admission orders, dated 04/28/10, revealed an advance directive order for a Full Code. The resident was readmitted by the</p>	F 514	<p>F514</p> <ol style="list-style-type: none"> On 9/23/11, the DON, Unit Manager or charge nurse reviewed the chart for resident #9. Corrections were made to ensure a MD order was written stating the resident was a DNR. The DON, Unit Manager or charge nurse performed chart audits on all residents to ensure the advance directives had all required/correct information regarding the DNR forms and MD orders. This was completed 10/15/11. The Administrator, SDC will in-service the Admissions Coordinator and Social Services Department on the importance of obtaining and ensuring that a code status is in place on each resident. They will also be instructed to give all forms regarding code status and/or information to the DON, Charge Nurse, SSD, and HIM Director. If the resident's/POA desire is to be a DNR the Director of Nursing, Unit Manger or charge nurse will be responsible to ensure a MD order is written to coincide with the DNR form. 	



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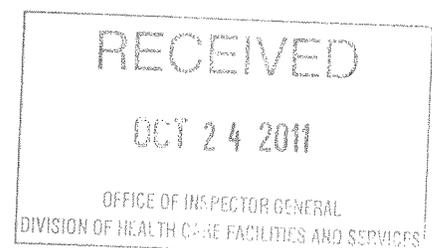
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F 514	<p>Continued From page 27 facility on 06/27/11 with the same diagnoses as above. The admitting orders, dated 06/27/11, revealed an advance directive order for a Full Code. However, a Kentucky Emergency Medical Services Do Not Resuscitate (DNR) Order was found signed and notarized on the front of the chart, dated 04/14/10. A DNR sticker was noted to the inside binder of the clinical record, with no physician order noted.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 09/23/11 at 11:00 AM, revealed she was not aware of the resident's code status and would notify the nurse if something were to happen.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 09/23/11 at 11:13 AM, revealed she verifies a resident's code status by checking for a DNR form and the sticker on the front of the chart. The LPN revealed she was familiar with Resident #9 and stated the resident was a DNR. The LPN stated Social Services was responsible for addressing the resident's code status and she was not aware of the conflicting information on the resident's clinical record.</p> <p>Interview with Registered Nurse C/D Unit Manager, on 09/23/11 11:00 AM, revealed the CNAs are not made aware of the resident's code status, they have been instructed to notify the nurse. The nurses check for a signed DNR form and the sticker on the front of the chart.</p> <p>Advance Directive information is obtained by either Social Services or the Admissions Coordinator at the time of admission. The Unit Manager revealed she always pulls the EMS DNR form and follows that directive if an</p>	F 514	<p>4. The HIM Director or HIM Assistant will perform new and re-admission audits on all 100% of residents that are newly admitted or re-admitted to verify that all paperwork is present on any resident that is a DNR or Full Code. Medical Records will continue to audit 100% of records seen by the care plan committee on a weekly basis. The care plan committee will present any noted concerns to the families/POA present at their current care plan meeting (equivalent to once every three months). Any family that is not present at the care plan meeting will be contacted by the HIM Director or HIM Assistant for an updated status. The results of the audits will be discussed in QA meetings monthly x 3 for further recommendations.</p> <p>5. All Corrective actions will be completed by 11/4/11.</p>		



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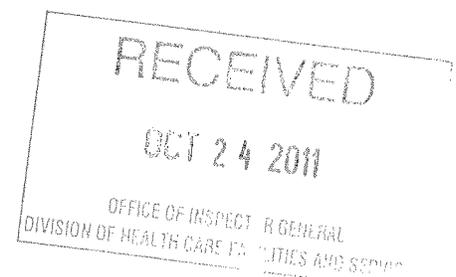
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185268	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/23/2011
NAME OF PROVIDER OR SUPPLIER THE GOOD SAMARITAN SOCIETY-JEFFERSONTOWN		STREET ADDRESS, CITY, STATE, ZIP CODE 3500 GOOD SAMARITAN WAY LOUISVILLE, KY 40229		
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F 514	<p>Continued From page 28</p> <p>emergency was to occur. The Unit manager stated the error should have been caught during the monthly checks of the physician orders, which is completed by the unit managers. She further revealed the Director of Nursing (DON) and Medical Records performs an audit of each admission.</p> <p>Concurrent interview with the Licensed Practical Nurse C/D Unit Manager, on 09/23/11 at 11:00 AM, revealed medical records verifies the admission orders and enters them into the computer. These orders print out on the Physician Order Sheet (POS) for the physician to sign. The unit manager stated the admission coordinator should have notified medical records of the resident's wishes for a DNR to ensure the order printed out correctly. The Unit Manager revealed a potential for the resident to have been resuscitated against the wishes of the resident and the family.</p> <p>Interview with medical records Health Information Management (HIM), on 09/23/11 at 11:25 AM, revealed HIM receives DNR information through the admission coordinator or social services and enters it into the computer. The HIM revealed audits are done on every admission to ensure accuracy of the medical record on the day of admission, day 3, 5, 14, and 21. The HIM revealed audits are not part of medical record and once completed are given to the DON to address with the unit managers.</p> <p>Review of the admission audit tool revealed day 3 review addressed the advance directive order.</p> <p>Interview with the Admissions Coordinator, on</p>	F 514		



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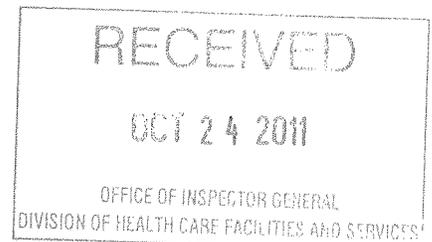
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F 514	<p>Continued From page 29</p> <p>09/23/11 at 11:40 AM, revealed she did discuss the advance directives with the family and had the EMS DNR form signed on the original admission date. She revealed three copies are made; a copy goes to the business office, social services, and medical records. However, she could not recall if she had made the copies to notify the other departments of the resident's and family's wishes.</p> <p>Interview with medical records HIM, on 09/23/11 at 11:45 AM, revealed she had not received a copy of the DNR.</p> <p>Interview with Social Services, on 09/23/11 at 11:50 AM, revealed she did have a file on each resident with advance directives. She stated she did not have a DNR form for Resident #9 and was not aware they had an advance directive. She stated the Social Service Department does not complete audits for advance directives.</p> <p>Further interview with Social Services, on 09/23/11 at 5:25 PM, revealed she did not discuss advance directives with Resident #9 or the family on readmission to the facility. She revealed advanced directives are discussed during the care plan meeting, if it is an annual review. After review of her care plan meeting notes, she revealed advanced directives were not discussed during the July care plan meeting.</p> <p>Interview with the DON, on 09/23/11 at 1:40 PM, revealed the admissions coordinator did not communicate the advance directives with the other departments. She revealed the chart audits are only a tool that was used to monitor records. She further revealed that if there was an</p>	F 514			



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F 514	Continued From page 30 emergency, the nursing staff would have checked the sticker on the chart or the DNR form. The DON stated ultimate responsibility for the accuracy of the clinical records.	F 514			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1980</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Seven (7) 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: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/21/11. The Good Samaritan was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety-eight (98) beds and the census was eighty-nine (89) 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>Plan of Correction</p> <p>Preparation and Execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. For the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrations	(X6) DATE 10/21/11
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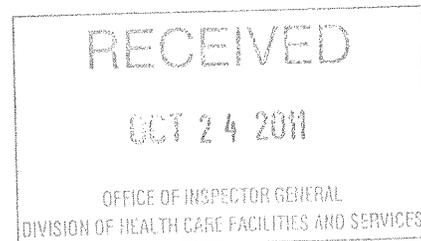
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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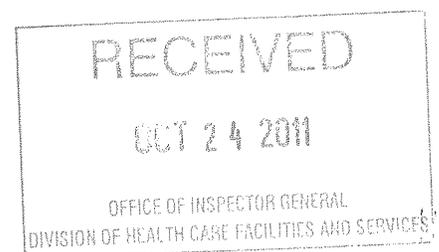
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K 000	Continued From page 1	K 000		
K 027 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure cross-corridor doors located in a smoke barrier would resist the passage of smoke. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in the event of an emergency. The deficiency had the potential to affect two (2) of seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety-eight (98) beds and the census was eighty-nine (89) on the day of the survey</p> <p>The findings include:</p> <p>Observation, on 09/21/11 at 2:25 PM, with the Environmental Services Person and the Maintenance Assistant revealed the</p>	K 027	<p>K-027</p> <ol style="list-style-type: none"> 1. The Env. Services Director or Maintenance Technician repaired the D wing fire door 09/27/11. 2. The Env. Services Director or Maintenance Technician checked all fire doors on 09/27/11 to ensure that they close properly. 3. The Env. Services Director will in-service Maintenance staff on the importance fire doors and closing properly. The Env. Services Director or Maintenance Technician will inspect all fire doors every week and log on a maintenance sheet. 4. The Env. Services Director or Maintenance Technician will audit the closing of all fire doors weekly x 3 months and report results to the QA Committee monthly x 3 for further recommendations. 5. All corrective action will be completed by 11/4/11. 	



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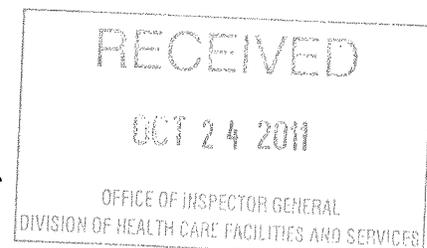
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K 027	Continued From page 2 cross-corridors fire doors located in the "D" Wing, would not completely close when tested. Interview, on 09/21/11 at 2:25 PM, with the Environmental Services Person and the Maintenance Assistant revealed they were unaware that the doors would not completely close and indicated they needed to be adjusted to close properly. Reference: NFPA 101 (2000 edition) 8.3.4.1* Doors in smoke barriers shall close the opening leaving only the minimum clearance necessary for proper operation and shall be without undercuts, louvers, or grilles. NFPA 101 LIFE SAFETY CODE STANDARD No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustibile decorations were used in the facility, according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for ninety-eight (98) beds and the census was eighty-nine (89) on the day of the survey. The findings include: Observation, on 09/21/11 between 1:30 PM and	K 027	K-073 1. The Env. Services Director or Maintenance Technician will obtain a fire retardant spray to use on decorations outside affected resident doors. If unsuccessful, decorations that are in compliance will be obtained. 2. On 10/18/11 the Activity Director audited the outside doors of 100% of resident rooms to determine if items being used outside resident doors could be treated with a fire retardant spray. If items could not be treated with a fire retardant spray, the item was removed and the resident and/or POA was notified. The Env. Services Director or Maintenance Technician secured a fire retardant spray on 10/20/11 after several unsuccessful attempts. The Env. Services Director or Maintenance Technician began treating and tagging resident decorations outside resident doors on 10/20/11. All decorations outside resident doors will be treated by 10/25/11.	
K 073 SS=F		K 073		



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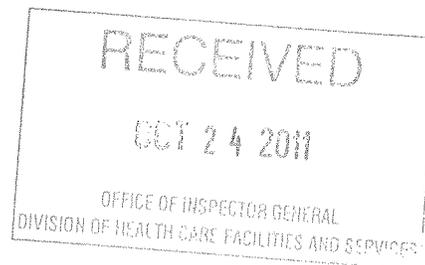
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K 073	Continued From page 3 3:45 PM, with the Environmental Services Person and the Maintenance Assistant revealed hanging decorations mounted on the residents' room doors in various locations throughout the facility. Interview, on 09/21/11 at 1:30 PM, with the Environmental Services Person and the Maintenance Assistant revealed they were unaware hanging decorations were required to be treated with a fire retardant spray; and to have a written policy for documentation that wreaths and other decorations are being treated. Reference: NFPA 101 (2000 Edition) 19.7.5.4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073	3. On 10/19/11 the Administrator sent a letter to residents/resident family members via mail stating the importance of decorating the outside of resident doors with fire rated items or items that have been or can be treated with a fire retardant spray. All new residents/resident family members will receive a letter upon admission stating the importance of decorating the outside of resident doors with fire rated items or items that have been or can be treated with a fire retardant spray. The Administrator, Env. Services Director or Activity Director will in-service all staff on the importance of decorating the outside of resident doors with fire rated items or items that have been or can be treated with a fire retardant spray. This training will be completed by 11/4/11. 4. The Env. Services Director or Maintenance Technician will monitor compliance of resident door decorations being treated with fire retardant spray bi-weekly x 3 months. The results of the audit will be shared with the QA committee monthly x 3 for further recommendations. 5. All corrective measures will be completed by 11/4/11.		
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety-eight (98) beds and the census was eighty-nine (89) on the day of the survey.	K 147			



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K 147	Continued From page 4 The findings include: Observations, on 09/21/11 between 1:30 PM and 3:45 PM, with the Environmental Services Person and the Maintenance Assistant revealed: 1. Electrical panels located in the "A" wing, resident's corridor, were unlocked. 2. Medical equipment was plugged into a power strip in Resident Room A5. 3. Small refrigerators were plugged into power strips in each of the Resident Rooms: A3, A6, B1, B3, B8, D9, D13, D15, C1, C5, C8, and C13. 4. Electronic recording equipment was plugged into "back to back" power strip in Resident Room D11. 5. A small refrigerator was plugged into a power strip in the Assistant Director of Nursing's office. Interviews, on 09/21/11 between 1:30 PM and 3:45 PM, with the Environmental Services Person and the Maintenance Assistant revealed they were unaware of the electrical panels in the resident corridor being unlocked; and the misuse of power strips within the resident's rooms. Reference: NFPA 70 (1999 edition) 110-26. Spaces About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance	K 147	K - 147 1. The Env. Services Director or Maintenance Technician locked the electrical panel on the A corridor on 09/27/11. He also unplugged the medical equipment that was plugged into a power strip and plugged it into an electrical outlet. Additional electrical outlets were ordered on 10/26/11 and will be added to the affected areas to ensure that resident and office refrigerators are plugged directly into electrical outlets. 2. The Env. Services Director or Maintenance Technician will audit all resident rooms and office areas to ensure that refrigerators are plugged directly into electrical outlets.	



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K 147	Continued From page 5 of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons. Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number 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	3. The Administrator, SDC or Env Services Director will in-service all Staff on the importance of refraining from plugging refrigerators or medical equipment into power strips. 4. The Env. Services Director or Maintenance Technician will monitor all resident rooms and offices for compliance weekly x 3 months and report the results of the audits to the QA Committee monthly x3 for further recommendations. 5. All Corrective Measures will be completed by 11/4/11.		

