

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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
--	--	--	--

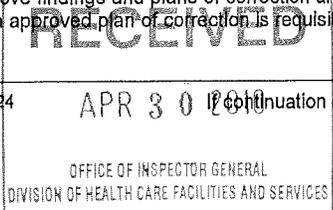
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS  A standard health survey was conducted on 04/06/10 through 04/08/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	<p><i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Klondike Care and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies. Klondike Care and Rehabilitation Center maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i></p> <ol style="list-style-type: none"> <li>No residents were identified. The employee was screened via The Kentucky Abuse Registry on 04/01/10. Additionally, on 04/08/10 the employee was screened for abuse in Indiana and Georgia.</li> <li>Current employee files will be audited by the Administrator and Business Office Manager to ensure that Abuse Registry, Criminal Records and reference checks as well as license verification/abuse registry identification via The Kentucky Board of Nursing website is complete.</li> </ol>	
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS  The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.  The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).  The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.  The results of all investigations must be reported to the administrator or his designated	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: y Deane L Harrett TITLE: Administrator (X6) DATE: 4/30/2010

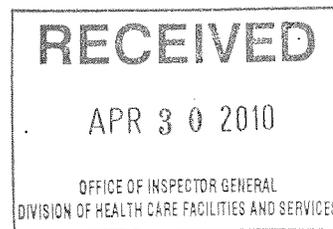
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

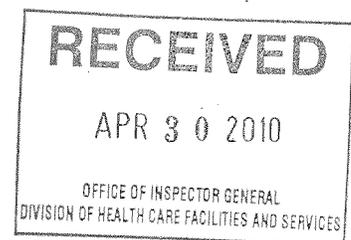
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	<p>Continued From page 1</p> <p>representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure they did not employ individuals who had been found guilty of abusing, neglecting, or mistreating residents by a court of law. The facility failed to screen one (1) of five (5) employees (#1) for abuse prior to hiring.</p> <p>The findings include:</p> <p>Review of the facility policy for abuse dated 01/08 revealed the facility would screen potential employees prior to the first day of work.</p> <p>Review of the personnel record for Employee #1 revealed the employee was hired and began work on 04/02/10. The Kentucky nurse aide abuse registry check was completed for the employee on 04/05/10. The employee had also worked in Indiana and Georgia but the facility did not contact these states for nurse aide abuse registry information.</p> <p>Interview with the Regional Consultant on 04/08/10 at 4:00pm, revealed Employee #1 was not screened for abuse prior to employment by the facility and when finally screened, the states of Indiana and Georgia were not contacted in order to screen the employee for those states.</p>	F 225	<p>3. Department managers responsible for hiring new employees will be re-educated by 05/07/10, on the facility hiring process, by the facility Administrator to review the importance of Abuse Registry checks, Criminal Records checks, employment reference verification and license/abuse registry verification via The Kentucky Board of Nursing website. Background screening via Kroll will now include validation and verification of out of state licensure and abuse registry identification.</p> <p>4. New employee files will be reviewed and signed off by the Administrator weekly to ensure all pre-employment components are complete prior to the employee's first day of orientation. The Administrator will report findings of the employee record review at monthly PI meeting for the next three months, whom will then determine the need for further monitoring.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

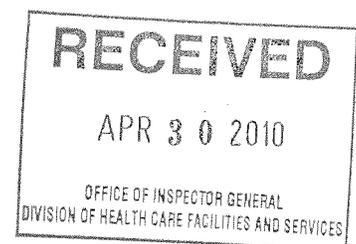
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 225	Continued From page 2 She confirmed that the facility policy does state applicants for employment will be screened prior to hire.	F 225	5. Date of Compliance 05/07/10.	
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 and record review, it was determined the facility failed to implement written policies and procedures that prohibited mistreatment, neglect, and abuse of residents, and misappropriation of resident funds. The facility failed to screen one (1) of five (5) employees (#1) for abuse prior to hire.  The findings include:  Review of the facility policy for Prohibition of Abuse, Neglect, Mistreatment, and Misappropriation of Resident Property, dated 01/08, revealed the facility Department Manager or designee screens potential employees in accordance with state and federal laws prior to their first day of employment for a history of abuse, neglect, or mistreatment of residents.  Review of the personnel file for Employee #1 revealed the employee was screened in Kentucky for abuse on 04/05/10 by the facility; however, the employee started work on 04/02/10. In addition, the facility did not screen the employee for abuse in Indiana or Georgia even though the facility was	F 226	1. No residents were identified. The employee was screened via The Kentucky Abuse Registry on 04/01/10. Additionally, on 04/08/10 the employee was screened for abuse in Indiana and Georgia.  2. Current and new employee files will be audited by the Administrator and Business Office Manager to ensure that Abuse Registry checks, Criminal Records checks, employment reference checks in KY and in states where the employee previously resided and/or was employed, as well as screening via The Kentucky Board of Nursing website for license validation and abuse registry check is in place before scheduling the employee for orientation.  3. Upon completion of the employment application, The Business Office Manager will make inquiry to abuse registries for all states that a potential employee has resided or was employed via Kroll.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

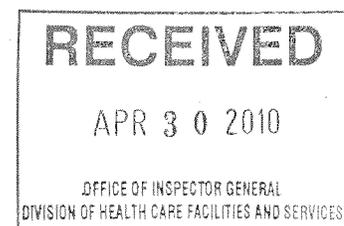
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 226	Continued From page 3 aware the employee had worked in those states in the past.	F 226	4. New employee files will be reviewed and signed off by the Administrator to ensure required background screenings and licensure verification are complete before scheduling the employees' orientation.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & 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 interview, observation, and record review, it was determined the facility failed to provide housekeeping and maintenance necessary to maintain a sanitary interior. The facility failed to ensure the North and South Shower Rooms were clean for resident use.  The findings include:  Observation of the North Shower Room on 04/08/10 at 10:20am revealed the following: a yellow stain and built up debris all around the perimeter of the tile floor, a buildup of brown and yellow particles between the tub and the chair lift, the caulking around the hand sink had cracked, missing pieces, and the sink was separating from the wall, the door to the hallway was scuffed and black, the AC unit had peeling paint and a lid was missing that covered a deep reach-in area with pipes, there were no trash liners in the trash cans, the mat in the lift chair was stained, the toilet call light had a dark brown stained cord, the floors had black stained areas, the shower chair seat	F 253	5. Date of Compliance 05/07/10.  1. The facility will provide the following to maintain a sanitary interior:  North Hall Shower Room  a. The shower room will be steam cleaned to remove build up of brown and yellow particles between the tub and chair lift, stains and built up debris around the perimeters of the tile floors by 05/03/10 by an outside contractor (Stanley Steamer). Sink caulking will be replaced, and sink refastened to the wall, shower room entrance door will be cleaned and painted, AC unit will be painted and lid replaced, tile, grout, and grab bars replaced and the mat in lift chair cleaned by 05/07/10.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

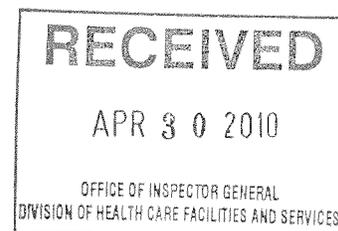
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 4 had dark stains and the grab bars in the toilet area had areas that were rusty colored.  Observation of the South Shower Room on 04/08/10 at 10:30am revealed the following: a long thin piece of metal was bent in half and placed in the toilet area, the metal had nails/screws in place and was a section of metal used to hold draw curtains in the shower area, the grab bars had large areas of rust colored metal, the floor tile were discolored orange and brown especially around the perimeter of the floor as well as a dirt build up, the AC unit was scuffed and there were grayish stains across the front of the unit, the exit door had rust colored areas, the caulking around the hand sink was cracked and peeling away, there were several small holes in the tile floor, the outside of the storage cabinet was soiled with brown and white drips and there was grout missing in the shower and tiles were broken.  Interview on 04/08/10 at 3:22pm with the Director of Maintenance revealed he did have a monthly check list in the facility for various duties, such as generator, fire safety, and water temperatures, but the monthly checks do not list the shower rooms or resident rooms to evaluate for repairs. He reported the hand sink (North Hall Shower Room) was loose, causing the cracked caulking, and stated this is an area of concern for infection control. He reported he had been off from work due to illness for a few months, but, had returned a couple of months ago. During the tour of the North Shower room he indicated the toilet call light was dirty and he would change the pull cords. He reported he would have to cut a block of wood to fit into the lid area of the AC unit in the bathroom in the North Shower Room. He	F 253	b. Trash liners were placed in each trash can. Toilet call-light cord was replaced on 04/09/10 by maintenance director and housekeeping staff.  South Hall Shower Room  a. The metal strip in the shower area was discarded on 4/09/10. Grab bars, shower tiles and grout will be replaced by 05/07/10. Shower room entrance door will be cleaned and painted, AC unit will be painted, caulking around the sink replaced and shower storage cabinet cleaned and repaired by 05/07/2010.  2. All residents residing in the center have the potential to be affected. No resident was adversely affected  3. Facility staff will be re-educated by SDC and Administrator by 05-07-2010 on the process of maintenance work order request for notification of needed repairs. The Administrator will re-educate housekeeping staff by 05/07/10 on proper procedures related to cleaning responsibilities and equipment cleaning. Resident equipment and shower rooms will be cleaned, sanitized and maintained daily.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

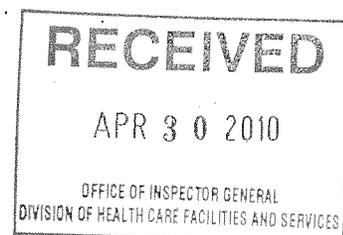
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 5 reported the privacy curtain in the South Shower Room had been taken down while he was off during a ceiling repair. He was aware it needed to be replaced, but was not aware until now the location of the missing piece of metal to attach the curtain to the ceiling. He stated he was aware it was missing, but had not looked for the metal piece to hang a privacy curtain since his return to work a couple of months ago. He was able to easily wipe off the discolored orange and brown stains in the shower stalls and around the corners of the shower room. He reported he would have to do some painting, caulking and clean up in both shower rooms on the North and South Halls.	F 253	4. The Maintenance Director has created a daily cleaning schedule and checklist for housekeeping staff. Each Department Manager will conduct weekly rounds to their assigned resident areas and report findings to the Administrator. The Administrator will report findings in monthly PI for three months, whom will then determine the need for further monitoring.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  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, interview and record review, it was determined the facility failed to ensure the staff correctly implemented the plan of care for two (2) of the fifteen (15) sampled residents (#3 and #7). Resident #3 failed to have a splint in place during the survey. Resident #7 was not lifted with a mechanical lift as directed on the care plan.  The findings include:  Review of facility records revealed Resident #3 was to receive restorative nursing program for range of motion (ROM) and splint/brace	F 282	5. Date of Compliance 05/7/10.  1. The comprehensive Plan of Care of resident # 3 and #7 will be reviewed by IDT team and updated with current restorative and/or lift needs where necessary by 05/07/2010.  2. All residents have the potential to be affected. Care plans, including Restorative Programs, of all residents will be reviewed by the IDT team, and updated by 05/07/10.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

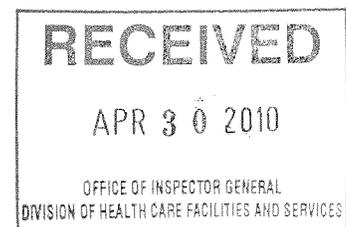
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 6</p> <p>application four (4) to six (6) hours per day to prevent further contraction to the right hand and forearm. Documentation of the Restorative Flow Sheet revealed that Certified Nursing Assistants (CNAs) documented the resident was wearing the splint/brace ten (10) minutes each shift while performing ROM exercises.</p> <p>Observation of Resident #3's right hand on 04/06/10, 04/07/10, and 04/08/10 revealed no splint/brace was applied to Resident #3's right hand for any length of time.</p> <p>Interview with CNA #2 on 04/07/10 at 3:50pm revealed the CNA was not aware that Resident #3 was to wear a splint/brace to the right hand. Resident #3 was to perform ROM exercises for about 10 to 15 minutes in the morning and at bedtime.</p> <p>Interview with CNA #3 on 04/07/10 at 4:05pm revealed the CNA was not aware that Resident #3 was continuing to wear a splint/brace to the right hand, but stated that the resident did wear a splint/brace in the past.</p> <p>Interview with the Unit South Manager on 04/07/10 at 3:40pm revealed he/she was not aware that Resident #3 was not receiving splint/brace to the right hand. The Manager stated that Resident #3 did not like to wear the splint/brace and was observed to take the splint/brace off after it was applied. The Manager was unaware of what the ten (10) and initials were that was documented on the Restorative Flow Sheet. The Manager related that the documentation could mean the CNA's were placing the splint/brace on the right hand and doing range of motion exercises for ten (10)</p>	F 282	<p>3. Nursing staff and department managers will be re-educated by the DNS, concerning the use of the residents Care Plans by 05/07/10. Residents whom require splinting and the use of mechanical lifts will be annotated on the TAR, so that the nursing staff will be required to assess and validate that proper splinting and the use of mechanical lifts are being utilized.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

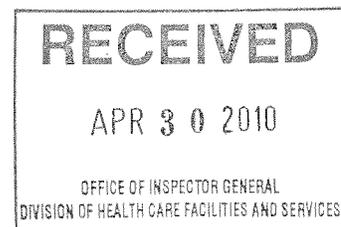
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010	
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 7 minutes at a time.</p> <p>Interview with Resident #3's daughter on 04/07/10 at 12:00pm revealed she was unaware that Resident #3 was to wear a splint/brace to the right hand and has not observed a brace/splint in the resident's room at any time. Resident #3's daughter further stated that the contracture to the right hand appears to be getting worse.</p> <p>Record review on 04/06/10 revealed Resident #7 was admitted to the facility on 03/10/09 with diagnoses of; Atrial Fibrillation, Hypertension, Congestive Heart Failure, Muscle Weakness, Anxiety State, Chronic Airway Obstruction, and Esophageal Reflux. Record review of the Minimal Data Set (MDS) dated 02/23/10 revealed Resident #7 has a height documented as sixty-three (63) inches, and a weight of one hundred ninety-four (194) pounds.</p> <p>Record review of the nurse care plan dated 03/02/10, and the current nursing assistant care card revealed a Hoyer lift with two (2) assist for transfers of Resident #7.</p> <p>Interview on 04/07/10 at 9:15am with Resident #7 revealed he/she was transferred from their bed to a wheelchair by Certified Nurse Aide (CNA) #7. Resident #7 stated he/she was weighed and then the CNA transferred the resident back their bed without assistance of another staff. Resident #7 reported CNA #7 transferred him/her both times without any assistance from other staff.</p> <p>Interview with LPN #1 on 04/07/10 at 9:18am revealed the CNA care plan did include the intervention for Resident #7 to be transferred with a Hoyer lift and the assist of two (2) people.</p>	F 282	<p>4. The Unit Manager or DNS will complete weekly rounds on their assigned units to validate care is being provided, as per the Plan of Care. Findings will be documented and reported to the DNS/Administrator for review and presented to the PI Committee for three months, whom will then determine the need for further monitoring.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

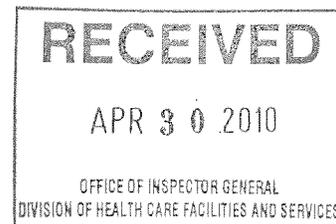
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 8  Interview on 04/07/10 at 9:29am with CNA #7 revealed he got Resident #7 up to weigh him/her. CNA #7 reported he did transfer Resident #7 from the bed to the wheelchair, weighed the resident, and then transferred the resident back to bed from the wheelchair by himself, without assistance of a Hoyer lift, or a second person for the transfer. CNA #7 stated Resident #7 did have a Nursing Assistant Care Card for a Hoyer lift and two (2) people to transfer the resident. He reported he was aware of the Hoyer lift and the assist of two (2) people for this resident, but, did not get help from anyone else because the other staff were busy. He reported he did not ask for assistance, or notify his Unit Manager of the need for assistance for this transfer. He reported he had been trained on how to use a Hoyer lift, and was aware of the requirement to use two (2) people for the transfer. He reported he had used the lift with assistance on another resident earlier in the shift but did not use the lift with this resident.  Interview with the Director of Nurses (DON) and the Cooperate Nurse Consultant on 04/07/10 at 10:40am revealed the facility follows the manufacturer's recommendations and best practice to use a Hoyer lift for transfers with the assist of two (2) people.	F 282	5. Date of Compliance 05/07/10.	
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312	1. Resident #8, #14, and #15 were shaved to remove excess facial hair. The comprehensive care plans of resident # 8, #14 and #15 regarding ADL's were reviewed and revised to reflect current needs of the residents.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

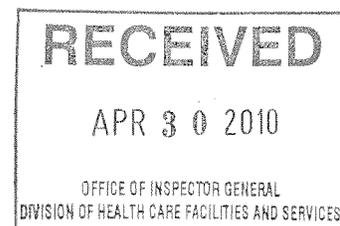
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide facial shaves to dependent residents for three (3) of the fifteen (15) sampled residents (#8, #14, and #15).</p> <p>The findings include:</p> <p>Observations of Resident #14 on 04/07/10 at 12:22pm revealed long facial hair to the chin area approximately a quarter inch long; cheeks and mustache area had no visible hair seen.</p> <p>Observation of Resident #15 on 04/07/10 at 12:24pm revealed white facial hair to cheeks, chin, and mustache in large amounts.</p> <p>Interview with Resident #14 on 04/07/10 at 12:21pm revealed the resident shaved them self with their own clippers and was not intentionally trying to grow a beard. Staff would assist but would only help with hair removal of the cheek area. Resident #14 had not noticed that he/she was not shaving the chin area and wanted no facial hair at all.</p> <p>Interview with Resident #15 at 12:24 pm revealed the resident was not intentionally growing a facial beard and sometimes was shaved on shower days.</p> <p>Interview with the Unit North Manager on 04/08/10 at 1:53pm revealed that he/she had noticed the facial hair on residents.</p> <p>Interview with the Unit South Manager on</p>	F 312	<p>2.. All residents have the potential to be affected. All residents were assessed for the need to be clean shaven. All assessments and comprehensive care plans will be reviewed and updated by 05/07/10, to reflect the resident's current needs.</p> <p>3. All nursing staff will be re-educated by the SDC on the proper technique of removing facial hair by 05/07/10. Return demonstration will be given as needed.</p>		



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

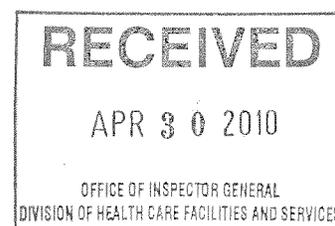
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 10 04/08/10 at 2:00pm revealed that he/she was not aware that Resident #14 had long facial hairs to the chin area. The Unit Manager was aware that Resident #14 was having difficulty seeing their entire face when shaving and that staff would assist if needed.  Observation of Resident #8 on 04/07/10 at 3:30pm revealed the resident had facial hair on the cheeks, chin, and above the lips. Observation of the resident on 04/08/10 at 8:45am, and 2:00pm, revealed the resident continued to have facial hair and had not been shaved.  Interview with Resident #8 on 04/08/10 at 2:00pm, revealed the resident was not attempting to grow a beard.  Interview with Certified Nurse Aide (CNA) #1 on 04/08/10 at 11:00am, revealed Resident #8 would shave them self and staff assisted as needed. She was unable to state the last time the resident was shaved, but thought it was with a shower given on Tuesday. She stated the staff were to shave residents as needed and was not aware of a facility policy.  Interview with Unit Manager #1 on 04/08/10 at 1:50pm, revealed she scheduled residents for showers by room number and the policy was to shave residents on their shower day. She stated she had not noticed Resident #8 needed to be shaved. She stated she did not directly monitor residents for showers and shaves since there were no complaints regarding these tasks.	F 312	4. Department Managers will complete weekly rounds on their assigned units to ensure facial hair is being removed as per the plan of care. Nursing staff will monitor shaving needs on a daily basis and the unit manager will validate during routine rounds. Findings will be documented and given to the DNS/Administrator for review and presented to the PI Committee for three months, whom will then determine the need for further monitoring.  5. Date of Compliance 05/07/10.	
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a	F 318	1. The Comprehensive Care Plan and assessments of #2, #3, and #4 will be reviewed by the IDT and re-screened by therapy to determine current care needs. Resident #13 is no longer in the facility.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

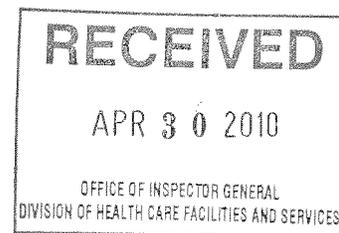
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 11</p> <p>resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to consistently provide the appropriate treatment and services to residents to promote their optimal functional level in Activities of Daily Living (ADL's) for four (4) of the fifteen (15) sampled residents (#2, #3, #4, #13).</p> <p>The findings include:</p> <p>Review of the undated Restorative Nursing Program Policy revealed all residents will be assessed on admission and quarterly, or more often as change of condition warrants it. An individualized program will be developed based on the resident's needs. This program will be reflected on the interdisciplinary care plan and consistently carried out by staff. The therapy department will work closely with the nursing staff in communicating goals and recommending approaches to assure continuity of the plan of care and continued progression of the resident. The Restorative Nurse will complete the flow sheet to evaluate the resident's participation, progress, or lack of progress made each month and determines if the resident continues to be a candidate for continuing in the program.</p> <p>Review of facility records revealed Resident #3</p>	F 318	<p>2. All residents have the potential to be affected. All residents will be screened by Therapy for decline in range of motion and contractures by 05/07/10.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

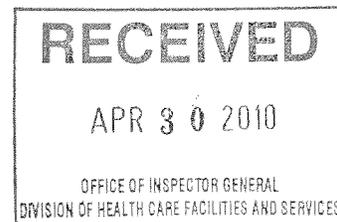
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	<p>Continued From page 12 .</p> <p>had a stroke in the last six months. Review of the resident's care plan revealed the facility was to provide Restorative Program for Range of Motion (ROM) and splint/brace application to right hand daily.</p> <p>Record Review of Resident #3's Restorative Nursing Program Flow sheet revealed the Goal for Resident #3 was to avoid further contractures of the right upper extremity (RUE). The Plan for Resident #3 was to tolerate the application of the right upper extremity "air graduated care" daily for 4-6 hours with the assistance of staff application and removal.</p> <p>Interview of Unit South Manager on 04/08/10 at 2:25pm revealed that he/she did not know what an "air graduated care" was, and assumed that it meant splint/brace application. The Manager stated that they monitored documentation weekly. Restorative came up with the plan of care and the Certified Nursing Assistants (CNAs) provided the restorative care needed for residents who were receiving restorative services.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator on 04/08/10 at 4:15 pm revealed he/she does not create Restorative Programs for residents, but makes recommendations to Physical Therapy.</p> <p>Observations of Resident #3 on 04/06/10 at 10:15am, 10:20am, noon, 12:07pm, 2:45pm, 3:50pm, and 4:37pm revealed the resident's right hand was contracted, closed into a fist, and no splint/brace applied.</p> <p>Observations of Resident #3 on 04/07/10 at 7:30am and 8:45am revealed no splint/brace was</p>	F 318	<p>3. The Interdisciplinary Team will be re-educated by the SDC on the recommendation/assessment process of referrals to the Restorative Program by 05/07/10. Certified Nursing Assistants and Licensed Nurses will be re-educated to the Restorative Program including documentation by the SDC by 05/07/2010.</p>		



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

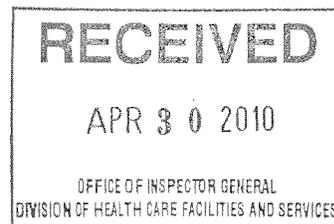
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY. 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 13 applied.</p> <p>Interview of CNA #2 on 04/07/10 at 3:50pm revealed that he/she was not aware that Resident #3 was to wear a splint/brace to the right hand. ROM exercises are completed in the morning with morning care and at night with evening care. ROM exercises take about 10 to 15 minutes to accomplish and then are documented on the Restorative Nursing Program Flow Sheet.</p> <p>Record review of the Restorative Nursing Program Flow Sheet revealed CNA's documented ten (10) to fifteen (15) minute increments of ROM exercises for a total of thirty (30) minutes a day. Record review did not contain documentation of the splint/brace being applied for four (4) to six (6) hours as ordered.</p> <p>Interview with Director of Nursing (DON) on 04/07/10 at 11:00am revealed that Unit Managers of the North and South halls were responsible for monitoring and documenting assessments for Restorative therapies routinely.</p> <p>Review of the Clinical record for Resident #13 revealed the resident was admitted to the facility with diagnoses of Alzheimer's Disease, Contractures and Diabetes. The facility completed an annual Minimum Data Set (MDS) assessment on the resident on 10/08/09 which revealed the resident had multiple contractures and required total care with all activities of daily living. The resident received restorative nursing for passive range of motion and splinting of the elbow. Review of the restorative nursing flow sheet for October 2009 revealed the resident was to have both elbows splinted for six (6) hours nightly; however, the review documented the</p>	F 318	<p>4. DNS will review 5 residents per week for the next three months to ensure the program is in compliance. These findings will be reviewed by the PI committee for three months, whom will then determine the need for further monitoring.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

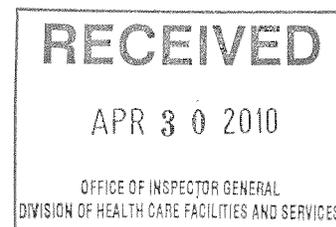
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 318	<p>Continued From page 14</p> <p>resident did not wear the splints at night but wore them for ten (10) minutes on the first and second shifts. A summary regarding resident progress was completed by a nurse on 10/15/09 and 10/22/09 and revealed the resident continued to tolerate the splints. Review of the restorative documentation for Resident #13 for November 2009 revealed the splints were utilized for ten (10) minutes on the first shift and five (5) minutes on the second shift. The night shift continued to document that the splints were not used at night, even though the care plan directed the splints be used nightly for six (6) hours. There was no evidence provided by the facility to show a nurse completed an evaluation of the resident in November 2009. There was no evidence provided by the facility to show restorative services were received during December 2009.</p> <p>A quarterly MDS assessment for Resident #13 was completed on 01/10/10 which revealed the resident no longer received restorative services or any therapies. The resident still required total assistance with all activities of daily living. On 01/14/10, the facility obtained orders for occupational therapy.</p> <p>Interview with the MDS Coordinator on 04/08/10 at 3:25pm, revealed she was responsible for the completion of the MDS and care plan for each resident. She stated she played no role, during the assessment process, in determining a resident's potential to improve or maintain their highest functional level even if the activities of daily living (ADLs) triggered for further assessment. She stated the facility depended on therapy to outline and put into place restorative programs and then the Unit Managers would implement those programs. When asked if any</p>	F 318	5. Date of Compliance 05/07/10.		



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

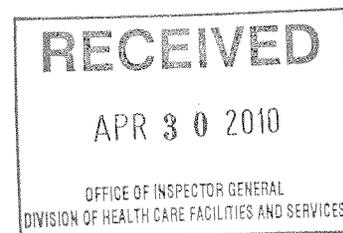
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 15</p> <p>residents received restorative dining services, she stated that program was not utilized. She stated Resident #13 was currently receiving occupational therapy; however, she was not aware of why the restorative program for splints was discontinued.</p> <p>Interview with Unit Manager #1 on 04/08/10 at 2:40pm, revealed she did not review residents' MDS assessments for restorative needs but rather depended on therapy to direct nursing restorative programs. She stated the resident should have had a summary of progress or lack of progress completed November 2009 and was not sure why the restorative program was discontinued. She stated the resident did need to go back to therapy and an order was received 01/14/10.</p> <p>Interview with the Director of Nursing on 04/07/10 at 5:00pm, revealed the facility nursing staff had not received any formal education on the restorative nursing program.</p> <p>Record review on 04/06/10 revealed Resident #2 was initially admitted on 09/16/09, and readmitted on 01/22/10 with diagnoses that included; Hypertension, Depression Disorder, Primary Hyperparathyroidism, Muscle Weakness, Dysphagia Oropharyngeal Phase, Dementia, Altered Mental Status, Digestive-Genital Tract Fistula, Protein-Calorie Malnutrition, and a Urinary Tract Infection.</p> <p>Record review of the physician's orders revealed Resident #2 had Jevity 1.5 at 80 cc/hr via PEG tube for fourteen (14) hours started each night at 6:00pm and removed at 8:00am. The resident had a Puree House Diet ordered. Record Review</p>	F 318		



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

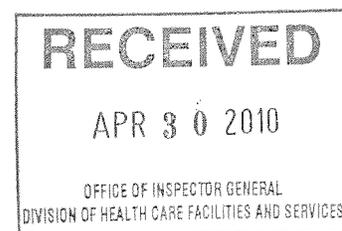
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010	
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	<p>Continued From page 16</p> <p>of the physician's orders on 03/19/10 revealed Speech therapy treatment was extended for language and cognition for an additional eight (8) weeks. Record Review of the physician's orders dated 03/22/10 revealed Skilled Occupational Therapy for an additional eight (8) weeks for therapeutic exercises, therapeutic activities, ADL, and group. Record Review of the physician's orders dated 03/29/10 revealed Physician Therapy for an additional four (4) weeks for therapeutic exercises, therapeutic activities, ADL, and group</p> <p>Observations on 04/06/10 at 12:22pm, 12:45pm, and on 04/07/10 at 12:10pm and at 12:26pm revealed Resident #2 sat in a wheelchair at the dining room table with a plate of pureed food placed in front of the resident. The resident sat at the table without any attempts to feed them self, and no observation of staff cueing the resident to take bites.</p> <p>Record review on 04/06/10 of Resident #4 revealed he/she was readmitted on 01/08/10 with a diagnosis of Hypertension, Anxiety disorder, Depression, Osteoporosis, Cerebral Vascular Accident, dementia, Anemia, G-tube secondary to Pseudo-Pancreatic Cyst. Record review of the Resident Assessment Protocol (RAP) dated 02/01/10 revealed the resident required cues and reminders, and had short term and long term memory impairment. The RAP revealed the resident had Remeron ordered for appetite, and had missing natural teeth. The RAP revealed he/she had a mechanically altered diet, and had a feeding tube.</p> <p>Observation on 04/06/10 at 12:20pm and on 04/07/10 at 12:22pm and at 12:43pm revealed</p>	F 318		



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

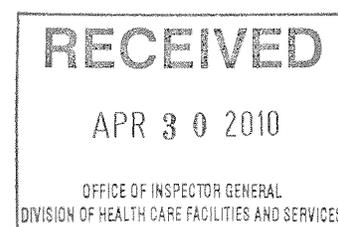
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 318	Continued From page 17 Resident #4 sat in a wheelchair at the dining room table with a plate of mechanically altered food placed in front of the resident. The resident sat at the table without any attempts to feed them self, and no observation of staff cueing the resident to take bites.  Interviews with Unit Managers #1, and #2 on 04/08/10 at 2:48pm revealed that Resident #2 and Resident #4 are brought to the dining room for social opportunities, and the meals were not their primary source of food as the residents' both receive nourishment via tube feedings. She reported Resident #2 and Resident #4 both have had a deterioration in ADL's and had therapy, but the residents were not assessed for a restorative program. Unit Manager #1 and Unit Manager #2 indicated both Residents would benefit from participation in a restorative program.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to provide supervision and assistive devices during a lift and transfer of one (1) of fifteen (15) sampled residents. (Resident #7)	F 323	1. Resident #7 was assessed for proper transfer needs. Based on her size, weight and immobility, she requires the use of a mechanical lift. The plan of care for resident #7 was reviewed and reflects the residents' current needs.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

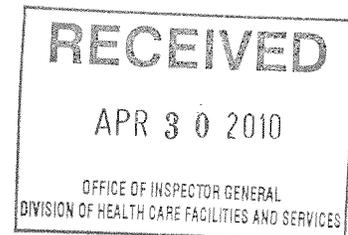
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	<p>Continued From page 18</p> <p>Record review on 04/06/10 revealed Resident #7 was admitted to the facility on 03/10/09 with diagnoses of Atrial Fibrillation, Hypertension, Congestive Heart Failure, Muscle Weakness, Parkinsonism, Anxiety State, Chronic Airway Obstruction, and Esophageal Reflux. The facility completed an annual Minimal Data Set (MDS) on 02/23/10 which revealed Resident #7 had a height documented as sixty-three (63) inches, and a weight of one hundred ninety-four (194) pounds.</p> <p>Record review of the nurse care plan dated on 03/02/10, and the current nursing assistant care card revealed a Hoyer lift with two (2) assist for transfers of Resident #7.</p> <p>Interview on 04/07/10 at 9:29am with Certified Nurse Assistant (CNA) #7 revealed he got the resident up to weigh him/her. The CNA reported he did transfer Resident #7 from the bed to the wheelchair, weighed the resident, and transferred him/her back to bed from the wheelchair by himself, without assistance of a Hoyer lift, or a second person for the transfer. The CNA reported Resident #7 did have a care card for a Hoyer lift and required two (2) people for the transfer of this resident. He reported, he was aware of the Hoyer lift and the assist of two (2) people for this resident, but, did not get help from anyone else because the other staff were busy. He reported he did not ask for assistance, or notify his Unit Manager of the need for assistance for this transfer. He reported he had been trained on how to use a Hoyer lift, and was aware of the requirement to use two (2) people for the transfer with this resident. He reported he had used the lift with assistance on another resident earlier in the shift but did not use the lift on this resident.</p>	F 323	<p>2. All residents will be assessed for transfer needs per the IDT team. Residents with specific transfer needs, according to their plan of care, have the potential to be affected by this practice.</p> <p>3. All nursing staff will be re-educated on the need to follow the residents individualized plan of care, by the DNS/SDC by 05/07/2010. All residents will be assessed upon admission for specific transfer needs. Identified needs will be documented on the plan of care.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

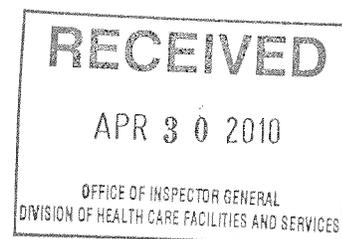
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19  Interview on 04/07/10 at 9:15am with Resident #7 revealed he/she was transferred from their bed to a wheelchair by CNA #7, then weighed, and transferred back to bed. Resident #7 reported the CNA transferred him/her both times without any assistance from other staff.  Interview with the Director of Nurses (DON), and Corporate Nurse Consultant on 04/07/10 at 10:40am revealed the facility follows the manufacturer's recommendations and best practice to use a Hoyer lift for transfers with the assist of two (2) people.	F 323	4. The DNS and Unit Manager will complete daily rounds to validate that transfers are being performed as per the plan of care for each resident.  5. Date of Compliance 05/07/10.	
F 431 SS=E	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 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.	F 431	1. The expired medications, biologicals, identified in the medication room were disposed of per guidelines by the DNS, on 4/08/2010.  2. No residents were identified. The pharmacy was contacted to label the Emergency Drug Kit with a date and inspect for expired medications. An audit of the medication room and medication carts was conducted by the DNS on 04/08/2010, to ensure expired medications and biologicals were either dated or destroyed per guidelines.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

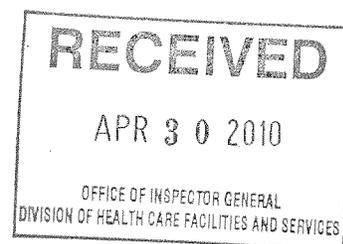
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	<p>Continued From page 20</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 record review it was determined the facility failed to ensure expired medications, and biologicals were removed and not available and accessible for staff use on residents, and an opened Tuberculin PPD vial not labeled.</p> <p>The findings include:</p> <p>Record review of the facility's policy 5.3 on Storage and Expiration Dating of Drugs, Biologicals, Syringes, and Needles, effective date 12/01/07, revised on 01/15/09 revealed the facility should ensure that drugs and biologicals that; (1) have an expired date on the label; (2) have been retained longer than recommended by manufacturer or supplier guidelines; or (3) have been contaminated or deteriorated, are stored separate from other medications until destroyed or returned to the supplier, 13. The facility should destroy or return all discontinued, outdated/expired, or deteriorated drugs or biologicals, 14. The facility personnel should inspect nursing station storage areas for proper storage compliance on a regularly scheduled</p>	F 431	<p>3. Licensed nursing staff will be re-educated on storage, labeling, and destruction of outdated/expired drugs and biologicals by 05/07/10. A monitoring log will be developed and put in place by 05/07/10 to allow licensed nursing staff to sign off, on a weekly basis, indicating that inspection of the nursing station storage areas was completed.</p>	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

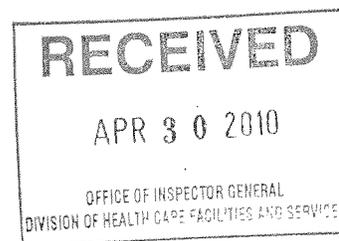
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 21 basis.  Observation on 04/08/10 of the medication room revealed, expired medications remained available for resident use. The expired medications identified in the medication room included ten (10) containers of Milk of Magnesia thirty milliliters (ml) expired in December 2009, one (1) vial of Lidocaine 1% injectable 10 mg/ml, twenty (20) ml multidose vial expired on 04/01/10, six (6) capsules of Phenytoin Sodium 100 mg expired in March, 2010, two (2) Diphenhydramine 50 mg/ml vial expired in February, 2010, three (3) Sulfamethoxazole and Trimethoprim 800 mg/160 mg tablets expired on 02/15/10, ten (10) Heparin lock flush 100 USP Units/ml 30 ml multi-dose vial expired on 05/01/09, one (1) vial of Tuberculin PPD in the refrigerator opened, not dated, or initialed by staff. In addition, there were eleven (11) Para-Pak Saf Fixative for O&P Stool Specimens expired August, 2009, one (1) Gen Probe Specimen Collection expired on 02/28/09, fifteen (15) Star Swab II Culture Swabs expired on 03/04/10, and four (4) Specimen Collection Kit for Virus, Chlamydia, Mycoplasma, and Ureaplasma expired in January 2009, and one (1) expired November, 2008.  Interview on 03/11/10 at 1:45pm with Unit Manager #2 revealed that each nurse is responsible to check the expiration date on the medication prior to opening the package. She indicated expired medications were not to be given to residents. She did not have any explanation as to why expired medications remained in the medication room available for use. She reported that night shift is responsible for checking the medication room. She reported the nurse should date, and initial the	F 431	4. The unit manager will monitor this process weekly and report to the DNS/Administrator, who will report to the PI Committee for three months, whom will then determine the need for further monitoring.  5. Date of Compliance 05/07/10.	



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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/08/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 22 Tuberculin PPD vial at the time it is opened. She reported she would not use PPD from the vial in the refrigerator to give to someone, as it did not have a date or initial as to when it was opened.  Interview on 04/08/10 at 1:55pm with the Director of Nursing (DON) revealed the night shift nurses do the medication room check, and are responsible for the expired medications and biologicals. The DON indicated she did not have a method in place to ensure the medication room was checked by staff and there were not any one person assigned to a specific task for that purpose. The DON revealed the facility notifies the pharmacy when they need to send cancelled or expired drugs back. She confirmed the nurse should date, and initial the Tuberculin PPD vial at the time it is opened.	F 431		



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

PRINTED: 05/03/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/22/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and conducted on 04/22/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an E.	K 000	<i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Klondike Care agrees with the citations noted on the pages of this Statement of Deficiencies. Klondike Care maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i>	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 04/22/10, it was determined the facility failed to ensure sprinkler heads were free of corrosion as required by NFPA 25 1999 Edition.  The findings to include:  A tour of the facility conducted 04/02/10 at 9:30am, revealed seven sprinkler heads in the kitchen and two sprinkler heads in North Hall shower were stained with a green substance.  Interview with the Maintenance Director on 04/22/10 at 9:35am, revealed he was not aware of the green substance on the sprinkler heads.	K 062	1. All residents have the potential to be affected. No residents were identified. Facility will have the defective sprinkler heads replaced by an outside contractor.  2. On 4/29/10, Landmark Sprinkler, Inc. was contracted to inspect and identify sprinkler heads that were not in compliance with NFPA 25 1999 Edition.  3. Sprinkler heads identified with corrosion, foreign materials, paint and physical damage in the kitchen and North shower room will be replaced by 5/20/2010 by Landmark Sprinkler, Inc. Quarterly tests and inspections will be conducted by Landmark Sprinkler, Inc.	

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

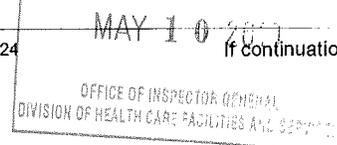
TITLE

(X6) DATE

*x Diane L Harrett*

*Administrator 5/10/10*

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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

PRINTED: 05/03/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  04/22/2010
NAME OF PROVIDER OR SUPPLIER  KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	Continued From page 1  Reference to: NFPA 25 1999 Edition 2-2 Inspection. 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062	<i>This plan of correction is prepared and executed because it is required by the provisions of State and Federal Law and not because Klondike Care agrees with the citations noted on the pages of this Statement of Deficiencies. Klondike Care maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to limit our capability to render adequate care.</i>  4. Maintenance director will monitor sprinkler heads on monthly rounds to ensure compliance. Findings will be reported to the Process Improvement team. These findings will be reviewed by the PI committee for three months and determine the need for further monitoring.  5. Date of compliance: 5/21/2010	

