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

PRINTED: 12/14/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2010
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
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F 000	INITIAL COMMENTS	F 000		
F 174 SS=E	<p>483.10(k) RIGHT TO TELEPHONE ACCESS WITH PRIVACY</p> <p>The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, and interviews it was determined the facility failed to provide private phone services for six (6) of nine (9) residents.</p> <p>The findings include:</p> <p>Interview with the Quality of Life Group participants on 12/01/10 at 9:00am, revealed six (6) of the nine (9) residents present stated, you have to make phone calls from the nursing station if you do not have your own private phone. The group confirmed there were portable phones at the nurses' stations, but they did not work</p> <p>Interview with Registered Nurse (RN) #1 on 11/30/10 at 11:46am revealed the portable phone on the 200 hallway at the nurses' station did not work. Demonstration with the surveyor when the phone was turned on revealed there was no dial tone. At the time of the interview with RN #1, the phone was on the desk top, out of the charging cradle.</p>	F 174	<ol style="list-style-type: none"> 1. The portable telephone on 200 Unit was replaced. A Resident Council Meeting was held on 12/2/10 to inform residents of the availability of the new portable telephone. 2. The Social Services Director and the Unit Managers completed visits with alert and oriented residents throughout the facility to inform them of the availability of the portable telephones that are available for private use. 3. An in-service education program was completed on 12/2/10 by the Director of Nursing regarding the new portable telephone on 200 Hall and the availability of portable telephones throughout the facility for private usage by residents. The Charge Nurse on each unit will be responsible for ensuring that the portable telephones are maintained in 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
<i>Charles G. Meyer</i>	<i>Adm. Director</i>	<i>12-20-10</i>

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.

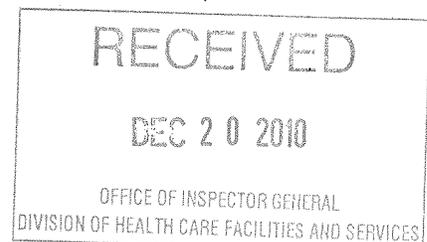
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F 174 F 256 SS=D	Continued From page 1 483.15(h)(5) ADEQUATE & COMFORTABLE LIGHTING LEVELS The facility must provide adequate and comfortable lighting levels in all areas. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide adequate over the bed reading lighting for one (1) of nineteen (19) sampled residents (Resident #18). The findings include: Interview with the Quality of Life Group participants on 12/01/10 at 9:00am revealed one (1) of the nine (9) group members did not have an overhead light that worked. The light was assessed on 12/01/10 at 10:30am, 1:00pm, and 3:34pm as not working. Further observations were made on 12/02/10 at 8:45am, 11:00am and 2:15pm and revealed the light did not work when the cord was pulled. Interview with maintenance staff on 12/01/10 at 4:00pm revealed they were not aware the light was not working and had no work order to correct the problem. However, further documentation provided by the facility post survey was a work order dated 11/27/10. Interview with Resident #18 on 12/02/10 at 10:00am revealed the resident had requested the light to be repaired for at least two (2) weeks prior to the survey.	F 174 F 256 F256	their charging cradle when not in use. The Social Services Director will complete an interview with 5 alert and oriented residents weekly to ensure they have been provided with portable telephone usage upon their request. The Maintenance Director will complete an audit of portable telephones throughout the facility weekly to ensure appropriate function. 4. Findings of the above stated audits for appropriate portable telephone availability and function will be discussed in the monthly Quality Assurance meeting for 3 months for recommendations and further follow-up as indicated. 1. The over-bed light for residents #18 was repaired on 12/2/10 by the Maintenance Supervisor. 2. An audit was completed throughout the facility by the Maintenance Staff on 12/2/10 to ensure that there were no other over-bed lights that were not

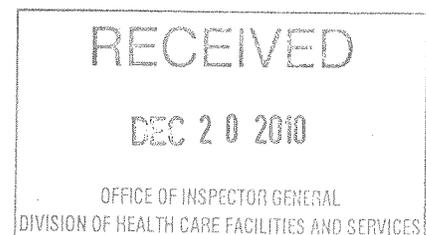
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F256 (Continued)

- functioning properly. No other concerns were identified.
3. An in-service was completed for facility staff on 12/3/10 by the Maintenance Supervisor and the Director of Nursing regarding immediate reporting through completion of a work order when over-bed lights are not functional in a resident's room. Work orders will be reviewed in the morning meeting 5 days per week with weekend work orders reviewed in the meeting each Monday. Follow-up to work orders will be reported in the subsequent morning meeting to ensure appropriate completion. The Maintenance Staff will complete an audit of over-bed lights throughout the facility weekly to ensure appropriate function.
 4. Findings of the above stated audit will be reviewed in the Quality Assurance Meeting monthly for 3 months for recommendations and further follow-up as indicated.



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F 279 SS=E	<p>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</p> <p>A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.</p> <p>The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to review and revise care plans for six (6) of nineteen (19) sampled residents (Residents #1, #2, #4, #6, #10, and #11). The facility failed to ensure care plans were developed when Residents' #4 and #11 were identified as falls risks. The facility failed to ensure Resident #2 had a revised care plan to reflect the current need for foot treatments. Resident #10's care plan did not reflect the resident's elopement risk. Per Resident #6's plan of care, the facility failed to</p>	F 279 1.	<p>The care plans for resident's #4 and #11 were reviewed by the Interdisciplinary Team on, and were revised to identify their risk for falls and ensure that all interventions were included on their care plans as indicated. The care plan for resident #10 was reviewed by the Interdisciplinary Team on 12/3/10 and a care plan for the risk for elopement was developed. The care plan for Resident #2 was reviewed by the Interdisciplinary Team on 12/3/10 and was revised to include the most recent interventions as per the Physician's order regarding her care. Interventions that are no longer in place were discontinued from the care plan as indicated. The care plan for resident #1 was reviewed by the Interdisciplinary Team on 12/1/10 and was revised to identify the current code status wishes of the resident. A care plan regarding Resident #1's isolation precautions was developed immediately upon identification by LPN #4. This was reviewed by the Interdisciplinary Team on</p>	

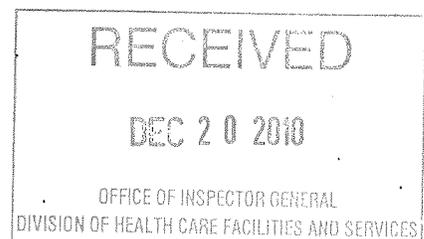
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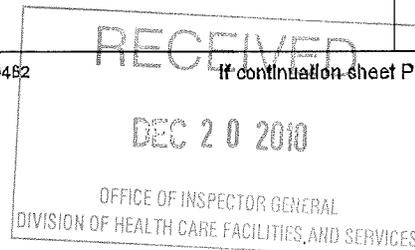
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F 279	Continued From page 3 ensure the call light remained in reach for the resident to use. The facility failed to include Resident #1's health code status on the plan of care. The findings include: 1. Record review of Fall Risk Evaluation dated 11/09/10 revealed Resident #4 scored twelve (12). The scale indicates a score greater than ten (10) places the resident at risk for falls. Record review of Incident/Occurrence Investigation dated 08/23/10 revealed Resident #4 leaned forward while sitting in a wheelchair and slipped out onto the floor. Review of Incident/Occurrence Investigation dated 11/23/10 revealed Resident #4 was leaning forward in a wheelchair to reach an item in the bottom drawer of a chest near the bed and the wheelchair tipped forward and the resident fell onto the floor. Interview on 12/01/10 at 9:15am with Unit Manager revealed that Falls Care Plan was not initiated and placed on the chart for Resident #4. The Unit Manager agreed that based on two falls from the wheelchair and the Falls Risk Evaluation, the Falls Care Plan should have been implemented. Interview on 12/02/10 at 9:20am with the Minimum Data Set (MDS) Coordinator revealed that the Falls Care Plan was not initiated for Resident #4 as indicated by MDS triggers dated 11/16/11 (incorrect date of 2011) and should have been implemented. She stated she would initiate the Falls Care Plan immediately. 2. Record review of an Interim Plan of Care dated 11/23/10 for Resident #10 revealed the resident	F 279	12/3/10 to ensure appropriate completion. 2. Care plans will be reviewed for all residents by the Interdisciplinary Team by 12/20/10 to ensure appropriate identification and interventions for fall risk and elopement risk, changes in physician's orders that would require a change in their plan of care, and to ensure that interventions that are no longer applicable are discontinued from the care plan, and that care plans appropriately reflect each resident's code status wishes. Development and revision of care plans will be completed as indicated. 3. In-service education was completed on 12/23/10 by the Director of Nursing for the Interdisciplinary Team and Licensed Nursing Staff regarding appropriate development and updating of care plans for all residents. Care plans will be reviewed and revised daily in the Clinical Meeting by the Interdisciplinary Team for residents who have changes in their orders that would require a	



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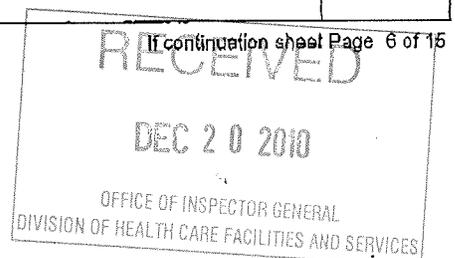
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F 279	<p>Continued From page 4</p> <p>was not found to be at risk for elopement, and no interventions were implemented.</p> <p>Observation on 12/01/10 at 12:40pm and 12/02/10 at 9:00am, found Elopement Risk documentation including a photo of Resident #10 posted at East and West nursing stations.</p> <p>Interview on 12/01/10 at 9:05am with the Unit Manager revealed that Resident #10 was admitted on 11/23/10 and was not found to be an elopement risk upon admission. She said Resident #10 was observed by nursing staff seeking exits and asking, "How do I get out of here?" several days after admission. The Unit Manager said the Elopement Risk Protocol was initiated as a result of the exit seeking behavior of Resident #10. When asked if the Interim Care Plan should have been updated based on the most current assessment of Resident #10 and the implementation of the Elopement Risk Protocol, she replied that this should have been done.</p> <p>Interview on 12/02/10 at 9:40am with the MDS Coordinator revealed that the Interim Care Plan should have been updated when the Elopement Risk Protocol was initiated.</p> <p>3. Record review of the Fall Risk Evaluation dated 11/29/10 for Resident #11 revealed a score of twenty (20). The scale indicated a score of greater than ten (10) places the resident at risk for a fall. Record review of care plans for Resident #11 revealed a hand-written Falls Care Plan on plain white paper with an implementation date of 07/13/10 and two (2) interventions for wheelchair alarm and reassess for bowel and bladder program, both dated 07/13/10.</p>	F 279	<p>change in their plan of care. The Unit Manager will be responsible for ensuring appropriate changes have been made to the care plans for the residents on their assigned units. The Director of Nursing and MDS Coordinator will complete an audit of 10% of care plans weekly to ensure appropriate development and updating to reflect the resident's current needs.</p> <p>4. Findings of the above stated audits regarding appropriate development and updating of care plans will be reviewed in the Quality Assurance Meeting monthly for 6 months for recommendations and further follow-up as indicated. 12-23-10</p>	



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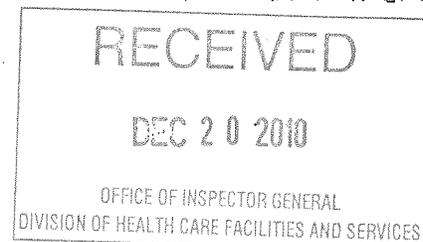
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F 279	<p>Continued From page 5</p> <p>Observation on 12/01/10 at 4:00pm and 12/02/10 at 8:30am of Resident #11 lying in bed, revealed a mat on the floor by the bed and a pressure sensitive alarm in use.</p> <p>Interview on 12/02/10 at 9:45am with the Unit Manager revealed that the Falls Risk care plan for Resident #11 was incomplete because it did not include interventions. The Unit Manager stated the facility has a standardized care plan for Falls Risk which is available and she did not know why it was not utilized.</p> <p>Interview on 12/02/10 at 9:55am with the MDS Coordinator revealed the Falls Risk care plan for Resident #11 was incomplete because the plan "did not include approaches." She stated that she would update the care plan immediately.</p> <p>4. Resident #2 was admitted to the facility on 07/30/09 and readmitted on 08/11/09 with the diagnoses of, Malignant Neoplasm of the Hard Palate, Bone and SKIn Neoplasm, Protein Calorie Malnutrition and a Gastrostomy.</p> <p>Record review of the physician orders dated 10/28/10 revealed an order for ace wrap toes to knees during the day and off at hour of sleep. The ace wraps were changed to TED hose on 10/30/10 and then discontinued.</p> <p>Observation of Resident #2 on 11/30/10 at 11:10am, 2:23pm, and 3:15pm revealed he/she was sitting on the side of the bed with bare feet and legs.</p> <p>Record review of the care plan revealed an intervention dated 09/23/10 for ace wrap toes to</p>	F 279			



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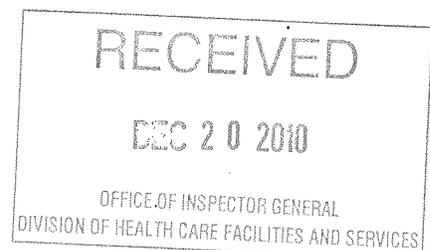
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F 279	<p>Continued From page 6</p> <p>knees, as per a medical doctor order, for lower extremity edema. The current care plan did not reflect the updated changes for the TED hose use or when the TED hose were discontinued.</p> <p>Interview with the West Hall MDS Coordinator on 12/02/10 at 1:15pm revealed she was responsible for updating the care plans. In addition, she stated she missed those orders and just did not catch the new orders, or place the interventions on the care plan. She stated she failed to update the plan of care.</p> <p>5. Observation of Resident #6 on 12/01/10 at 10:50am revealed the call light was on the floor against the wall between the resident's bed and dresser and out of reach of the resident. The resident was sitting in a Broda chair beside the bed and in front of the dresser.</p> <p>Record review of the Care Plan for Resident #6 on 12/01/10 at 11:00am revealed the call light was to be kept within reach.</p> <p>Interview on 12/01/10 at 10:50am with RN #1, and on 12/02/10 at 11:30am with CNA#2 revealed the call light should have been within reach of Resident #6.</p> <p>6. Record review of the Code Status Care Plan for Resident #1, dated 09/28/10, revealed Resident #1 had chosen a Full Code Status. Further review of the resident's file revealed a physician's order for Do Not Resuscitate (DNR) status dated 11/05/10. Advance Directives/Informed Consent in the resident's file also indicated a DNR status for resident #1 dated 11/05/10. The resident's care plan was not revised to reflect this change.</p>	F 279		



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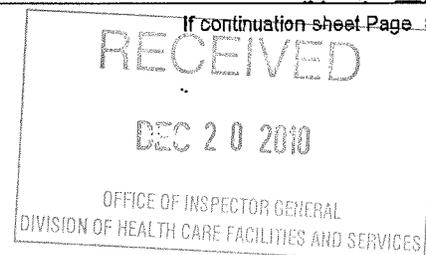
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F 279	Continued From page 7 Interview with LPN #4 revealed she had worked at the facility for 16 (sixteen) years. She stated she was responsible for care plans of the residents' on the East Wing 100 Hall, which included Resident #1. In reviewing the care plan for Resident #1, she acknowledged that the resident's care plan should have been updated when the DNR status change was made. She stated she normally updated those types of changes, but just failed to do it this time. Record review of the Care Plan for Resident #1 did not include a Plan of Care for isolation precautions even though the resident was on isolation precautions for Vancomycin-Resistant Enterococci (VRE) of urine according to the resident's file. Observation revealed a bedside table outside the room of Resident #1 with disposable gloves, red bags, and disposable masks covered with a sheet. A sign posted on the resident's door directed visitors to see the nurse before entering the resident's room. Interview with LPN #4 revealed that she failed to create a Plan of Care for isolation precautions for Resident #1. She acknowledged that she should have implemented a Care Plan for isolation precautions for VRE of urine for Resident #1 but it just got missed. She stated she would take care of it immediately.	F 279			
F 366 SS=E	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name.	F 366	1. No specific residents were identified in this citation. 2. Posting of nursing staffing was completed immediately upon identification of the concern.		



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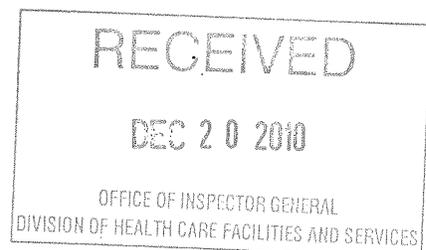
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F 356	<p>Continued From page 8</p> <ul style="list-style-type: none"> o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: <ul style="list-style-type: none"> - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. <p>The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows:</p> <ul style="list-style-type: none"> o Clear and readable format. o In a prominent place readily accessible to residents and visitors. <p>The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.</p> <p>The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to post the nurse staffing data sheet on a daily basis at the beginning of each shift. The East and West Nurse's Station staffing data sheet posted was dated 11/17/10 as observed on 11/30/10.</p> <p>The findings include:</p>	F 356	<p>3. The Staffing Coordinator received in-service education on 11/30/10 provided by the Director of Nursing regarding the requirement of daily posting of nursing staffing. The Staffing Coordinator will be responsible for posting of daily nursing staffing each morning 5 days per week. The Nursing Supervisor will be responsible for posting of nursing staffing each weekend morning. The Staff Development Coordinator will complete a daily(5 days per week) audit to ensure that nursing staffing is posted for that date as required. The Nursing Supervisor will complete the audit on weekends.</p> <p>4. Findings of the above stated audit will be reviewed in the Quality Assurance Meeting monthly for 3 months for recommendations and further follow-up as indicated.</p>	12/23/10



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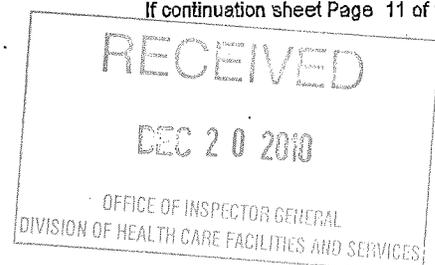
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2010
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214	
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F 356	Continued From page 9 Observation of the East and West Nurse's Station on 11/30/10 at 9:00am revealed the nurse staffing data sheet was dated 11/17/10 and the census was eighty-two (82). Observation on 11/30/10 at 9:05am at the East Nurse's Station revealed the staffing sheet dated 11/17/10 was looked at, then slide back into the clear packet, and left posted on the nursing unit by the Staffing Coordinator. Interview with the Staffing Coordinator on 11/30/10 at 9:15am revealed she had been in this staffing position for a couple of weeks, and that she was still learning her new position. She reported she had forgotten to post the daily staffing sheets on the units as she was new to this position. Interview with the Director of Nursing on 12/02/10 at 2:20pm revealed the staffing coordinator was responsible for posting the staffing data sheet on East and West nurse's station. She did confirm the staffing person had only been in her position for a few weeks. She reported the staffing data information was to be posted on a daily basis at the beginning of the shift.	F 356		
F 371 SS=D	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	F 371	1. No specific residents were identified in this citation. 2. The identified Dietary Employee received immediate re-education provided by the Dietary Supervisor on 12/2/10 regarding the requirement of completely covering the hair with a bonnet or hair net when entering the kitchen.	



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F 371	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure all dietary staff wore hair nets when entering and working in the food preparation area. The findings include: Review of the facility's personal hygiene information sheet revealed there were no guidelines for the covering of hair by food services staff that have short hair or beards. Observations on 11/30/10 at 8:15am revealed a dietary worker entering the kitchen area with a baseball cap on. Hanging below the baseball cap were strands of hair braided. The staff member exited the kitchen for about 30-45 seconds, re-entered the kitchen still wearing the baseball cap, and then replaced the cap with a hair bonnet. Interview with the dietary manager on 11/30/10 at 11:05am revealed, all dietary staff are educated on hand washing, hair nets, beard covers, cross contamination and food handling procedures during orientation. Reviews are part of monthly in-services.	F 371	3. Re-education was completed for facility staff by the Dietary Manager on 12/2/10 4. regarding the requirement of complete covering of the hair with a hair net or bonnet upon entering the kitchen. The Dietary Manager or the Cook will complete an audit daily of staff to ensure that staff have their hair completely covered upon entering the kitchen. 5. Findings of the above stated audit to ensure staff members have their hair completely covered upon entering the kitchen will be reviewed in the Quality Assurance Meeting monthly for 3 months for recommendations and further follow-up as indicated.	12-23-10
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	1. In-service education was provided immediately for Nursing Staff members by the Director of Nursing on 12/1/10 regarding ensuring that resident's food is not touched with bare	



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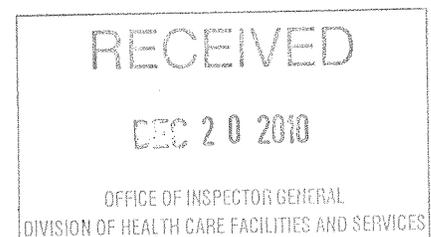
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F 441	<p>Continued From page 11</p> <p>(a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to maintain a sanitary environment to prevent the transmission of disease and infection for four (4)</p>	F 441	<p>hands during meal service. Cleansing of the wound and changing of the dressing was re-completed for resident #5 by the 12/1/10 upon identification of the concern. Re-education regarding provision of wound care was completed by the Staff Development Coordinator for LPN #5 on 12/1/10. Catheter care was completed for Resident #13 by the Unit Manager on 12/2/10. Nursing Assistant #3 received immediate re-education regarding catheter care provided by the Staff Development Coordinator on 12/23/10.</p> <p>2. In-service was completed by the Director of Nursing upon identification of the concern for Nursing Staff regarding not touching resident's food with their bare hands. Re-education regarding provision of wound care was completed by the Staff Development Coordinator for LPN #5 on. Residents who require dressing changes had their dressings changed utilizing aseptic technique. Residents with catheters received catheter care</p>

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If continuation sheet Page 12 of 15
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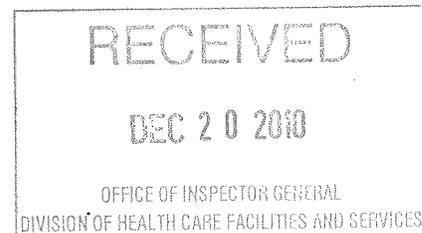
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F 441	<p>Continued From page 12</p> <p>unsampled and two (2) sampled residents (#5 and #13). Observation revealed a Certified Nursing Assistant (CNA) and a Licensed Practical Nurse (LPN) handle four (4) unsampled residents' food with bare hands during meal service, which created the potential for cross-contamination. In addition, the facility failed to utilize correct wound care technique for Resident #5 and correct indwelling catheter care technique for Resident #13.</p> <p>The findings include:</p> <p>Review of the facility policy on Skin Integrity for wounds dated November 2006 (revised) states to wash hands, utilize gloves, change gloves after removing soiled dressing, cleanse wound with normal saline or other wound cleanser, gently dry around the wound, and apply appropriate dressing per physician's order. Facility policies for indwelling catheter care and food service in the dining room and residents' rooms were requested but not provided.</p> <p>Observation of lunch meal service on the 100 Hall on 11/30/10 at 1:00pm revealed CNA #4 removed bread from a wax wrapper with her bare hands for two (2) unsampled residents.</p> <p>Observation of the lunch meal service in the main dining room on 12/01/10 at 12:25pm revealed CNA #4 removed bread from a wax wrapper with her bare hands for one (1) unsampled resident. LPN #3 was observed to pick up an unsampled resident's bread with her bare hands and butter it for the resident.</p> <p>Interview with CNA #4 on 12/01/10 at 12:55pm revealed she had worked in the facility for a little</p>	F 441	<p>provided by Wound Care Nurse 12/23/10 utilizing clean technique</p> <p>3. In-service education was provided by the Staff Development Coordinator and the Director of Nursing for nursing staff regarding not touching resident's food with bare hands, provision of wound care utilizing aseptic technique, and provision of catheter care utilizing clean technique. Unit Managers will complete an audit of dining services 3 times weekly for 4 weeks to ensure resident's food is not touched with bare hands. The Staff Development Coordinator will complete an audit of provision of wound care and catheter care 3 times weekly for 4 weeks, then once weekly for 4 weeks to ensure appropriate technique is utilized to decrease the potential spread of infection.</p> <p>4. Findings of the above stated audits will be reviewed in the Quality Assurance Meeting monthly for 3 months for recommendations and further follow-up as indicated.</p>	12-23-10



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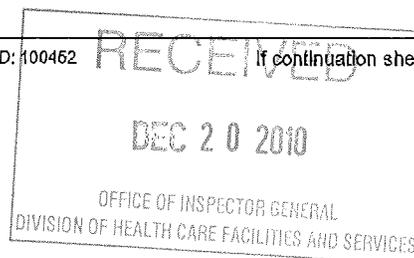
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F 441	<p>Continued From page 13</p> <p>over three years. She stated she thought it was okay to touch bread with bare hands as long as her hands were sanitized. She stated she did not remember any training regarding this. She acknowledged this practice could cause cross-contamination and lead to the spread of illness or disease.</p> <p>Interview with LPN #3 on 12/01/10 at 1:00pm revealed she thought as long as her hands were clean it was fine to touch resident's bread. She also acknowledged this could lead to cross-contamination and spread of infection throughout the facility. On 12/02/10, LPN #3 reported that an in-service was provided within the past year that educated staff on not handling resident's food with bare hands; however, she missed the in-service and failed to review the information presented.</p> <p>Observation of wound care for Resident #5, on 12/01/10 at 11:45am by LPN #5, revealed that after the nurse cleaned the Stage II pressure wound on the coccyx with normal saline, she allowed the resident to roll back onto the brief. She then rolled the resident back onto their left side and applied a hydrocolloid dressing without cleansing the wound again.</p> <p>Interview with LPN #5 on 12/01/10 at 12:00pm revealed she was unaware of any error in the wound care technique performed on Resident #5. Upon becoming aware that the resident was allowed to roll back onto their brief after the wound had been cleaned, and the dressing applied without cleansing the area, she acknowledged this was incorrect. She stated that she should have gotten another nurse to hold the resident on his/her side while she cleansed the</p>	F 441			



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

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F 441	<p>Continued From page 14</p> <p>wound and applied the new dressing. She stated that rolling the resident back onto the brief could contaminate the wound causing infection or poor wound healing.</p> <p>Observation of indwelling catheter care for Resident #13 on 12/02/10 at 10:50am revealed that the resident was on isolation precautions for Vancomycin-Resistant Enterococci (VRE) of urine. CNA #3 donned gown and gloves, raised the resident's bed, and got supplies ready. The CNA then removed the resident's brief. Without washing her hands or changing her gloves the CNA cleaned catheter tubing with a clean warm washcloth from urethra down, approximately six inches, while holding the catheter at the base. The CNA placed the contaminated washcloth in a garbage bag. Without removing gloves, the CNA pulled a sheet over the resident, lowered the resident's bed, and emptied the resident's catheter bag. The CNA then cleaned the tip of the catheter bag with an alcohol swab, poured the urine in the toilet and flushed. The CNA then removed her gloves, gown and washed her hands.</p> <p>Interview with CNA #3 on 12/02/10 at 11:05am regarding catheter care for Resident #13 revealed the CNA knew she should have removed the soiled gloves, washed her hands, and applied clean gloves after she cleaned the resident's catheter. She stated she was nervous because she was being watched and just forgot. She acknowledged that cross-contamination could occur and spread bacteria causing spread of infection to other residents.</p>	F 441		



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K 000	INITIAL COMMENTS	K 000		
K 012 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure a complete sprinkler system was maintained according to NFPA standards. The deficiency had the potential to affect one (1) smoke compartment and staff.</p> <p>The findings include:</p> <p>Observation on 12/02/10 at 10:03am revealed a storage room near the laundry room was not protected by an automatic sprinkler head. The observation was confirmed with the Plant Operations Director.</p> <p>Interview on 12/02/10 at 10:03am, with the Plant Operation Director, revealed the storage room had been constructed approximately one (1) year ago, and he had not identified the room as not having an automatic sprinkler head for protection.</p>	K 012	<p>K012</p> <p>On 12-2-10, During the Annual Life Safety Survey, the Facility immediately called Century Fire Protection Company to replace the Automatic Sprinkler Head in the Closet which was located near the laundry room. The identified closet was monitored daily by the housekeeping/laundry personnel to ensure there were no fire hazards. The sprinkler head was replace and work was completed on the 12-10-10.</p> <p>To insure the safety of the residents and staff, complete Facility rounds were made by the Plant Operations Director and the Life Safety Code Inspector. No other Sprinkler Heads were found to be missing. Education of the staff was completed regarding the</p>	12-10-10

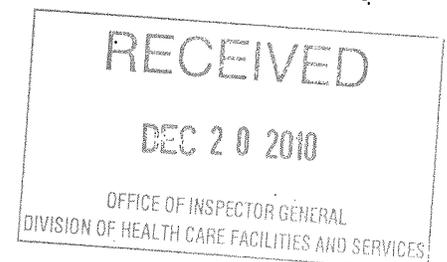
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Charles G Meyer TITLE: Administrator (X6) DATE: 12-20-10

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.

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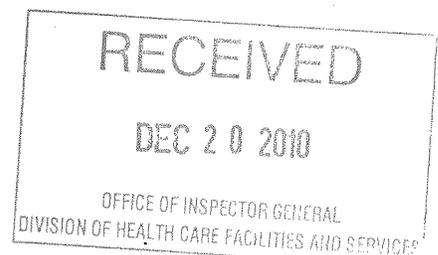
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K 012	Continued From page 1 Reference: NFPA 101 (2000 edition) 19.3.5.1 Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Exception: In Type I and Type II construction, where approved by the authority having jurisdiction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specified areas where the authority having jurisdiction has prohibited sprinklers, without causing a building to be classified as nonsprinklered.	K 012	K012 (Continued) requirement of functional sprinkler heads in a storage room on that day (12-2-2010) by the Plant Operation Director. Monitoring of the Sprinklers will be completed weekly by the Plant Operation Staff and findings reported to QA Monthly for (3) months.	12-10-10
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities.	K 018	K018 On 12-2-10 during the Annual Life Safety Survey, a metal strip was added to the fire door by the Plant Operation Department staff to seal the door with less than a 1/4 inch gap when closed. Education of the Plant Operation staff was completed that day (12-2-2010) by the Plant Operation Director. All fire doors will be audited weekly to insure safety of staff and residents. Findings will be reported at the QA meeting monthly for (3) three months.	12/10-10



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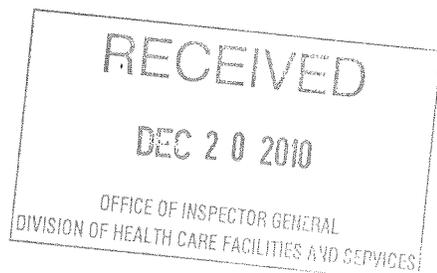
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K 018	Continued From page 2 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure corridor doors were maintained to provide a suitable means of keeping doors closed, according to NFPA standards. Corridor doors must be maintained to provide a suitable means of keeping shut to limit fire and smoke spread into the Corridor. The deficiency affected one (1) smoke compartment, thirty four (34) residents, and staff. The findings include: Observation on 12/02/10 at 10:44am revealed resident room 203 would not latch when shut. The observation was confirmed with the Plant Operations Director. Interview on 12/02/10 at 10:44am, with the Plant Operations Director, revealed he had not identified the door as having a problem latching before the Life Safety Code Survey. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved	K 018	K018 (Continued) Latch on the resident's door room 203 was immediately repaired by the Plant Operations staff on 12-02-10. Education of the Plant Operation staff completed that day (12-2-2010) by the Plant Operation Director. Resident doors will be audited weekly by the Plant Operations staff to insure safety of all residents. Findings will be reported at the QA meeting monthly for (3) three months.	12-10-10	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/02/2010	
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214		
(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	<p>Continued From page 4</p> <p>Record review of the sprinkler maintenance on 12/02/10 at 12:44pm revealed no documentation of the sprinkler control valves being inspected monthly. The observation was confirmed with the Plant Operations Director.</p> <p>Interview on 12/02/10 at 12:44pm, with the Plant Operations Director, revealed he did check the sprinkler control valves monthly, but could not produce any documentation.</p> <p>Reference: NFPA 25 (1998 edition)</p> <p>9-3.3 Inspection.</p> <p>9-3.3.1 All valves shall be inspected weekly.</p> <p>Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised.</p> <p>9-3.3.2* The valve inspection shall verify that the valves are in the following condition:</p>	K 062		



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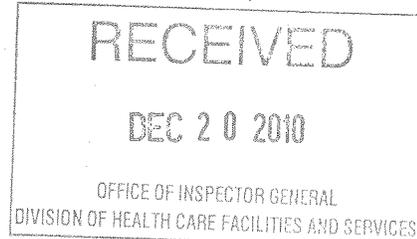
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K 062	Continued From page 5 (a) In the normal open or closed position (b) *Properly sealed, locked, or supervised (c) Accessible (d) Provided with appropriate wrenches (e) Free from external leaks (f) Provided with appropriate identification	K 062		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were free of all obstructions, according to NFPA standards. Exits must be clear of obstruction to allow for safe exiting in an emergency. The deficiency affected one (1) smoke compartment, thirty (30) residents, and staff. The findings include: Observation on 12/02/10 at 10:53am revealed a door from the Housekeeping office projected into the corridor two (2) feet when in the fully open position. The observation was confirmed with the Plant Operations Manager. Observation on 12/02/10 at 10:53am, revealed a door from the storage room for housekeeping items, projected into the corridor two (2) feet when in the fully open position. The observation	K 072	K072 During the Life Safety Inspection Door Closures were installed on 12-2-10 on the Central Supply and Janitor's Closets by the Plant Operations staff. Education of the staff completed that day (12-2-2010) by the Plant Operation Director. To insure safety of residents and staff, the doors will be monitored weekly by the Plant Operation staff, and findings will be reported at QA Meeting monthly for (3) months.	12-10-10

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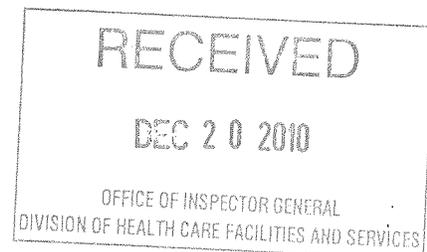
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K 072	<p>Continued From page 6 was confirmed with the Plant Operations Manager.</p> <p>Observation on 12/02/10 at 11:01am, revealed a door from the Central Supply office projected into the corridor two (2) feet when in the fully open position. The observation was confirmed with the Plant Operations Manager.</p> <p>Interview on 12/02/10 at 10:53am, with the Plant Operations Manager, revealed he had not identified the doors as projecting into the corridor before the Life Safety Code survey.</p> <p>Reference: NFPA 101 (2000 edition) 7.2.1.4.4* During its swing, any door in a means of egress shall leave not less than one-half of the required width of an aisle, corridor, passageway, or landing unobstructed and shall not project more than 7 in. (17.8 cm) into the required width of an aisle, corridor, passageway, or landing, when fully open. Doors shall not open directly onto a stair without a landing. The landing shall have a width not less than the width of the door. (See 7.2.1.3.)</p> <p>Exception: In existing buildings, a door providing access to a stair shall not be required to maintain any minimum unobstructed width during its swing, provided that it meets the requirement that limits projection to not more than 7 in. (17.8 cm) into the required</p>	K 072		



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K 072 K 147 SS=E	Continued From page 7 width of a stair or landing when the door is fully open. 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 use extension cords according to NFPA standards. Extension cords must be used according to NFPA standards to limit the possibility of fire. The deficiency affected one (1) smoke compartment and staff. The findings include: Observation on 12/02/10 at 8:56am revealed an extension cord plugged into a power strip being used to supply power to a microwave oven and a small refrigerator. The observation was confirmed with the Plant Operations Director. Interview on 12/02/10 at 9:56am, with the Plant Operations Director, revealed he had not noticed the extension cord and power strip being used to supply power to the microwave oven and refrigerator. Observation on 12/02/10 at 12:20pm revealed an extension cord in use to supply power to a battery charger. The observation was confirmed with the Plant Operations Director. Interview on 12/02/10 at 12:20pm, with the Plant	K 072 K 147	K147 During the Life Safety Inspection of the Annual Survey, all extension cords were removed from the facility by the Plant Operations staff on 12-2-10. Education of the staff was completed that day (12-2-2010) by the Plant Operation Director. To insure safety of residents and staff, use of extension cords will be monitored weekly by the Plant Operation staff, and findings will be reported at QA Meeting monthly for (3) months.	12/2-10



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K 147	Continued From page 8 Operations Director, revealed the extension cord had been in use a few days. Reference: NFPA 70 (1999 edition) 400-8. Uses Not Permitted Unless specifically permitted in Section 400-7, flexible cords and cables shall not be used for the following: 1. As a substitute for the fixed wiring of a structure 2. Where run through holes in walls, structural ceilings suspended ceilings, dropped ceilings, or floors 3. Where run through doorways, windows, or similar openings 4. Where attached to building surfaces Exception: Flexible cord and cable shall be permitted to be attached to building surfaces in accordance with the provisions of Section 364-8. 5. Where concealed behind building walls, structural ceilings, suspended ceilings, dropped ceilings, or floors 6. Where installed in raceways, except as otherwise permitted in this Code	K 147		

