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

OFFICE OF INSPECTOR GENERAL  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 10/02/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185462	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/19/2013
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NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS	STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272
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F 000	INITIAL COMMENTS  A recertification survey was initiated on 09/17/13 and concluded on 09/19/13. The Life Safety Code survey was initiated and concluded on 09/19/13. The highest scope and severity was cited at an "F". The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE  A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.  The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure a copy of the SSA inspections were available for resident and public review.  The findings include:  Observation and review of the facility's state survey binder, on 09/19/13 at 10:50 AM, revealed the standard survey results from 2012 were the only records present and available for public review. The binder did not include the results of the four (4) abbreviated surveys conducted on	F 167	The facility will ensure a copy of the SSA inspections are available for examination and will post in a place readily accessible to residents and will post a notice of their availability. The facility will ensure the standard survey results and any abbreviated standard survey results are available for resident and public review 10/8/13. The ED posted a notice indicating survey results are available according to regulatory requirement and included in binder all the required standard and abbreviated surveys on 10/8/13. The facility will update binder with any surveys conducted and make them available for resident and public inspection.	

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

*X [Signature]*

*X [Signature]*

*X 10/24/13*

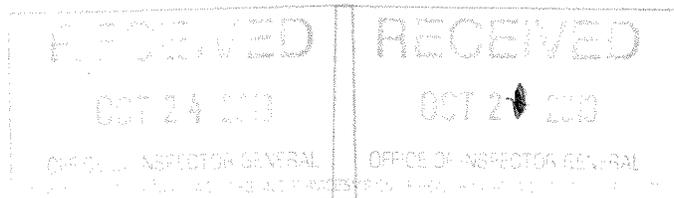
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable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

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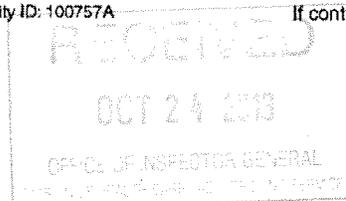
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F 167	Continued From page 1 01/10/13, 06/19/13, 06/26/13, and 08/12/13.  Interview with the Executive Director, on 09/19/13 at 3:35 PM, revealed she was not aware all information was to be available for public view. The Executive Director revealed the purpose of the binder was to ensure the public could make an informed decision regarding health care providers. The Executive Director revealed she was responsible to ensure the binder was current with all appropriate information.	F 167	The facility will review binder containing survey and abbreviated survey results quarterly in the Q.A. committee and take correction action if deficient practice is identified. The Executive Director will be responsible for ensuring compliance and updating binder with survey results.		
F 221 SS=D	<b>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</b>  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Guidelines for Restraint/Enabler Use, it was determined the facility failed to ensure one (1) of the sixteen (16) sampled residents (Resident #7) was free from physical restraints. The facility failed to appropriately assess Resident #7 for a lap tray, utilize an alternate intervention, and develop a restraint reduction plan.  The findings include:  Review of the facility's policy Guidelines for Restraint/Enabler Use, not dated, revealed each resident shall have an individualized nursing assessment upon admission, monthly and PRN	F 221	The facility will ensure residents are free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. The facility will appropriately assess residents for restraints, utilize an alternate intervention, and develop a restraint reduction plan according to facility policy. DHS/ADHS reassessed resident #7 on 9/25/13 for use of a lap tray related to the resident's medical symptoms. Based on reassessment Resident #7 had restraint reduced to half tray on 10/4/13 based on medical symptoms identified. DHS/ADHS will reassess all	10/9/13	



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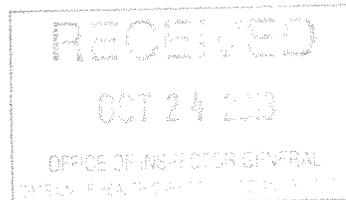
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F 221	Continued From page 2 that shall address the need for safety device, medical reason for use of the device and identification of rather the device restricts movement, or limits the resident from doing something they could previously do. The interdisciplinary team (IDT) shall evaluate all factors leading to the consideration of a device, determine that resident needs are being met and the need to restrain is not the result of an unmet need, investigate alternatives to restraints and determine that all alternative measures have been exhausted and found to be unsuccessful, with the risk and benefits of restraint/enabler use, develop measures to minimize the risks and resident decline, and make decisions that the device is the most appropriate for the situation.  Observations of Resident #7, on 9/17/13 at 1:46 PM, 2:15 PM, 3:30 PM, 4:30 PM, and 9/18/13 at 8:30 am and 10:08 AM, revealed the resident sitting in their wheelchair with a lap tray in place. Velcro straps were noted holding the tray in place, and although the resident played with Velcro closure and pushed at the tray, the resident was not able to remove the lap tray.  Review of Resident #7's clinical record revealed the facility admitted the resident, on 12/07/12, with diagnoses of Depression, Parkinson's Disease, and Hallucinations. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/03/13, as having a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident was cognitively impaired, and able to walk with a one person physical assist. On 07/29/13, the physician wrote an order for a lap tray, which prevented the resident from rising, to be placed while the resident was sitting up in the wheelchair.	F 221	residents utilizing devices to ensure assessed appropriately and medical reason for use identified before application by 10/28/13. The nursing staff will be in-serviced on facility policy on Restraints/Enabler use with emphasis on appropriate assessment for medical symptoms by ED/DHS/ADHS by 10/28/13. DHS/ADHS will review residents identified with restraints and/or enables monthly in Clinically At Risk review and take corrective action as needed. The Q.A. Committee will review results of audits and make recommendations for auditing, corrections or staff education. This audit will be on-going. The facility will monitor compliance through semi-annual Peer Review and Clinical Assessment Tool.	10/29/13



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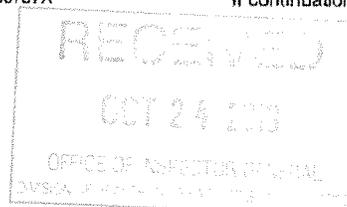
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F 221	<p>Continued From page 3</p> <p>Review of the Physical Restraint Information and Consent, dated 07/29/13, revealed a wheelchair tray was placed for positioning related to a left Humerus fracture with a benefit of falls reduction, a feeling of security, and maintaining body positioning. Review of the Restraint/Enabler Circumstance, Assessment and Intervention form revealed the lap tray was being used for positioning and did not identify the medical condition for restraint use. The IDT review, dated 07/30/13, revealed the resident had a left humerus fracture and the tray supported the upper extremity related to the resident being noncompliant with a sling. Potential contributing behavioral factors and alternatives to restraint use were not addressed. Review of the Nursing notes revealed no mention of the resident's refusal to wear a sling or other non restricting devices used to ensure positioning of the arm. Review of the Monthly Nursing Assessment and Data Collection, dated 08/06/13, revealed the resident did not require a physical restraint, despite the use of the lap tray, and a reduction plan was not developed.</p> <p>Interview with the resident's family member, on 09/18/13 at 4:42 PM, revealed the family requested the lap tray after the resident fell and broke his/her arm. The family member revealed the resident had several falls prior to the incident, and was worried the resident would fall again.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 09/18/13 at 12:51 PM, revealed the resident had a lap tray to prevent falls. The CNA revealed the resident had a splint on his/her arm for support and was not aware of the tray ever being used for positioning of the arm.</p>	F 221		



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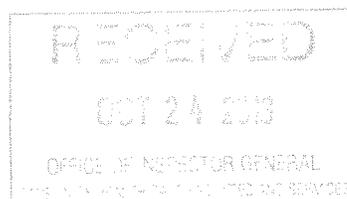
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F 221	Continued From page 4  Interview with Licensed Practical Nurse (LPN) #3, on 09/19/13 at 1:45 PM, revealed the lap tray was requested by the family and was used to prevent falls. After reviewing the restraint consent form and assessment form, the LPN revealed she was not aware the tray was for positioning and was confused as to how that was possible.  Interview with the Assistant Director of Nursing (ADON), on 09/19/13 at 2:10 PM, revealed she did complete the consent and restraint circumstance form. The ADON revealed Resident #7's family requested the use of the lap tray. The ADON revealed she was aware restraints could not be used for convenience and documented the tray was per family request for safety. The ADON was not able to explain how the tray was used for positioning of the upper arm. The ADON identified the inability to get out of the chair, increased pressure, increased agitation, increased behavior, and increased depression as potential risks associated with restraints use.	F 221			
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  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.	F 279	The facility will 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.		



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F 279	<p>Continued From page 5</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, record review, and review of the facility's policy Clinical Documentation Systems, it was determined the facility failed to develop a comprehensive plan of care for a restraints and a hand splint for one (1) of the sixteen (16) sampled residents (Resident #7).</p> <p>The findings include:</p> <p>Review of the facility's policy Clinical Documentation Systems, not dated, revealed the interdisciplinary team (IDT) would plan care and treatment to ensure appropriateness of services to meet the residents needs, and address the severity of conditions, impairment, disability or disease.</p> <p>Review of Resident #7's clinical record revealed the facility admitted the resident, on 12/07/12, with diagnoses of Depression, Parkinson's Disease, and Hallucinations. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/03/13, as having a Brief Interview for Mental Status (BIMS) score of six (6), indicating the resident was cognitively</p>	F 279	<p>Therapy assessed resident #7 on 9/24/13 and determined resident did not require left resting hand splint due to no limitation in range motion with meeting functional activities of daily living. DHS/ADHS/MDS updated resident #7's care plan on 9/25/13 with current restraint device being used according to resident assessment and physician order. DHS/ADHS/MDS will audit care plans for residents who have been identified as having a restraint, enabler or other adaptive equipment, such as, splints, to ensure a comprehensive care plan is in place and reflects current services by 11/1/13. Home Office Clinical Support will educate DHS/ADHS/MDS/Unit Manager and Social Services on the need to implement and update a comprehensive care plan that reflects the services to meet the residents needs with specific emphases on restraints/enables/splints by 11/1/13.</p>	

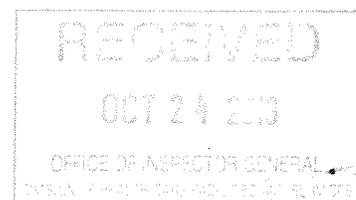


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F 279	<p>Continued From page 6</p> <p>impaired. The resident was seen by Occupational therapy for management of a contracture to the left wrist caused by a progressive neurological condition. The resident was discontinued from therapy on 01/25/13 with a recommendation and physician's order for a left resting hand splint to reduce contractures. On 07/29/13, the physician wrote an order for a lap tray, which prevented the resident from rising, to be placed while the resident was sitting up in the wheelchair. Review of the resident's comprehensive plan of care revealed neither the restraint nor the hand splint had been addressed.</p> <p>Observation of Resident #7, on 09/17/13 at 1:46 PM, 2:15 PM, 3:30 PM, 4:30 PM and on 09/18/13 at 8:30 AM and 10:08 AM, revealed the resident sitting up in a wheelchair with a lap tray in place and no splint in place to the resident's left hand.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 09/18/13 at 12:51 PM, revealed the resident used a lap tray to prevent the resident from falling. Further interview, on 09/19/13 at 1:40 PM, revealed the resident used to wear a splint, but had not seen the splint since the resident stopped working with therapy in July 2013.</p> <p>Observation of CNA #6 searching Resident #7's room, on 09/19/13 at 1:40 PM, revealed no hand splint was located in the room to be used to prevent contractures.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 09/19/13 at 1:45 PM, revealed she did remember the resident used to have a hand splint which she thought was used to increase hand strength. The LPN revealed the lap tray was</p>	F 279	<p>DHS/ADHS/MDS will review residents with restraints/enabler/splints weekly if orders are received and will audit resident care plans to ensure the care plan reflects services being provided for six weeks and take action if deficit practice is identified. The DHS/ADHS will submit findings to the Q.A. Committee monthly. The Q.A. Committee will review results of audits and make recommendations for auditing, corrections or staff education. The facility will monitor for on-going compliance through semi-annual Peer Review and Clinical Assessment Tool.</p>

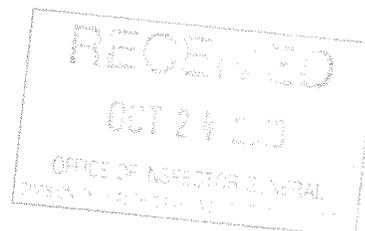
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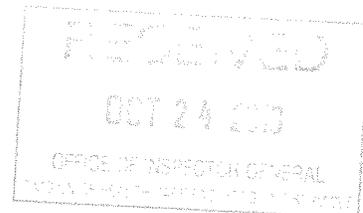
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F 279	Continued From page 7 requested by the family and was used to prevent falls.  Interview with the Assistant Director of Nursing (ADON), on 09/19/13 at 2:10 PM, revealed she was responsible for monitoring restraints and their associated forms. The ADON revealed she did not care plan the lap tray as a restraint, but it should have been, due to the many complications related to the use of restraints. The ADON revealed she was not aware the resident had a hand splint ordered.	F 279			
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION  Based on the comprehensive assessment of a 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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and the facility's policy Contracture Prevention and Management Program, it was determined the facility failed to ensure one (1) of the sixteen (16) sampled residents (Resident #7) received the appropriate treatment to prevent further decrease in range of motion.	F 318	The facility will ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or prevent further decrease in range of motion.  Therapy reassessed resident #7 on 9/24/13 and based on evaluation discontinued use of hand splint due to resident able to complete daily functional task.  Therapy will screen other residents in facility identified with loss of range of motion and make		



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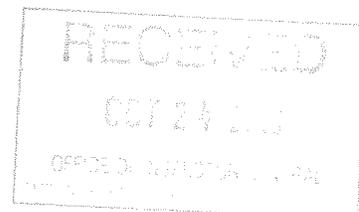
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F 318	<p>Continued From page 8</p> <p>The findings include:</p> <p>Review of the facility's policy Contracture Prevention and Management Program, dated October 2007, revealed a purpose to prevent or reduce contractures and deformity, and/or preserve range of motion (ROM ) by determining the goal of the ROM activities and evaluation of the need for splint device use and assistance. Specific interventions and goals would be documented on the Restorative/Functional Maintenance Program Plan and the care giving team would be informed of strategies and assist during care giving activities.</p> <p>Review Resident #7's medical record revealed the facility admitted the resident, on 12/07/12, with a diagnosis of Parkinson's Disease. The facility assessed the resident using the Minimum Data Set (MDS), dated 08/03/13, as having functional limitation in ROM of both the upper and the lower extremities. The resident was active with occupational therapy to manage his/her left wrist contracture and increase the resident's independence with the activities of daily living (ADL's). The resident was fitted for a resting hand splint, on 02/06/13, and the resident was educated on the splinting schedule then discontinued from occupational therapy with a plan to continue with nursing restorative therapy.</p> <p>Observation of Resident #7, on 09/17/13 at 1:46 PM, 2:15 PM, 3:30 PM, 4:30 PM and on 09/18/13 at 8:30 AM and 10:08 AM, revealed the resident sitting up in a wheelchair with a lap tray in place and no splint in place to the resident's left hand.</p> <p>Review of the Resident's Comprehensive Plan of</p>	F 318	<p>recommendation for need for evaluation and treatment and/or proper use of current preventative devices by 10/28/13.</p> <p>DHS/ADHS/Therapy Program Director will educate nursing staff on range of motion, contracture prevention and use and application of devices as ordered by 10/28/13. DHS/ADHS will review residents identified with decreased range motion or contracture prevention devices monthly in Clinically At Risk review and take corrective action as needed. The Q.A. Committee will review results of audits and make recommendations for auditing, corrections or staff education. The facility will monitor compliance through semi-annual Peer Review and Clinical Assessment Tool.</p>	10/29/13



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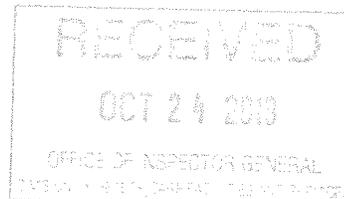
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185462</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/19/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>PARK TERRACE HEALTH CAMPUS</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>9700 STONESTREET ROAD LOUISVILLE, KY 40272</b>		
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F 318	<p>Continued From page 9</p> <p>Care revealed no mention of the left hand splint. Review of the Nursing Assistant Assignment sheet revealed no mention of the left hand splint.</p> <p>Interview with Certified Nursing Assistant (CNA) #6, on 09/19/13 at 1:40 PM, revealed the resident did have a hand splint to prevent contractures, but she had not seen the splint since July 2013, which was 2 months ago. The CNA revealed she thought the splint had stopped being used after the resident sustained a fractured arm and was using a hard splint to the upper arm. However, the CNA revealed use of the upper arm splint would not have prevented the application of the hand splint and should still be used.</p> <p>Observation of CNA #6, on 09/19/13 at 1:40 PM, revealed the CNA searching Resident #7's room, but was unable to even find the resident's splint.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 09/19/13 at 1:45 PM, revealed the resident did have a hand splint and should still have the splint. However, the LPN revealed she had not recently seen the splint and did not notice that the resident was not wearing the hand splint. The LPN revealed use of the splint was on the treatment administration record, but she did not investigate as to why the splint was not in use.</p> <p>Interview with the Director of Rehabilitation, on 09/19/13 at 2:10 PM, revealed Resident #7 was active with Occupational Therapy for management of a left wrist contracture. The Director of Rehabilitation revealed the resident was fitted for a hand splint in January of 2013 and was placed on a splinting schedule. The resident was discharged from therapy with the recommendations of continuing with the splint,</p>	F 318		



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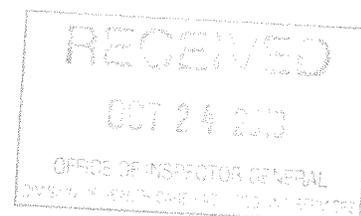
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F 318	Continued From page 10 and the splinting schedule with restorative therapy. The Director of Rehabilitation revealed a potential for worsening contracture and complications by not utilizing the ordered hand splint.  Review of the Restorative Care Program form, dated 01/21/13, revealed a goal to maintain bilateral upper and lower extremity strength by completing active range of motion. No mention of the splint or recommended splinting schedule was noted. Review of the Restorative Program Plan revealed use of the splint was not marked to be done with the restorative program.  Interview with the Director of Nursing (DON), on 09/19/13 at 4:35 PM, revealed the nurse in charge of the restorative program was not available for interview and she did not know how restorative communicated with the rehabilitation department or how plans were developed. The DON revealed the hand splint should have been on both the nursing and the CNA plan of care to ensure monitoring and use of the splint. The DON revealed a potential for worsening contracture by not using the ordered hand splint. The DON revealed she did complete random chart audits, but did not know why it was missed.	F 318		
F 364 SS=E	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	The facility will ensure each resident receives food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	



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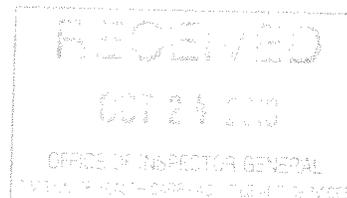
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F 364	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to serve palatable food. Observation of the lunch meal and test tray on 09/18/13 revealed cream turkey noodle and succotash were served at lukewarm temperatures. The findings include: Review of the facility's policy regarding Food Temperature-Serving Line, revised 07/2013, revealed the temperature of all foods on the serving line would be measured and recorded at every meal. Hot foods at the steam table would be maintained at greater than 135 degrees Fahrenheit (F) so that the items would arrive at palatable temperatures when the resident was served.</p> <p>Interview with unsampled Resident A, on 09/17/13 at 12:30 PM, revealed the food was too cold, and just did not taste good. The resident stated no one likes to eat cold food and it had been reported before, but had yet to see a difference.</p> <p>Observation, on 09/18/13 at 12:03 PM, revealed Dietary Aide (DA) #1 obtained food temperatures on the three (3) North steam table. The creamed turkey noodle temperature was 123 degrees (F) and the succotash temperature was 102 degrees (F). The DA then began to serve lunch from the steam table.</p> <p>Observation of a test tray, on 09/18/13 at 12:32 PM, from the three (3) South steam table revealed the creamed turkey noodle temperature was 108 degrees (F) and the succotash temperature was 109 degrees (F). The creamed</p>	F 364	<p>The facility will ensure hot foods on the steam table are maintained above 135 degrees Fahrenheit(F). The Dietary Manager educated dietary staff on 10/8/13 on food temperature requirements for food being served from the steam table and instructed staff not serve food if temperature was not above 135. Dietary staff instructed on 10/8/13 to remove food not at appropriate temperature and reheat to 170 degrees (F). The Dietary Manager will review steam table food temperature logs daily to ensure food is served at a temperature above 135 degrees (F). The DFS will audit food temperatures on the steam table once per week for breakfast, lunch and dinner meals for four weeks then monthly and take corrective action if deficit practice is identified. The facility will monitor compliance by reviewing monthly resident Council Meeting minutes, Peer Review results, and Resident Customer Service Surveys. The</p>	



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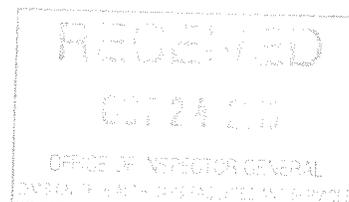
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F 364	<p>Continued From page 12</p> <p>turkey noodle and the succotash were tasted by three surveyors who agreed the creamed turkey noodle was bland and lukewarm. The succotash also tasted lukewarm.</p> <p>Interview with the DA #1, on 09/19/13 at 1:35 PM, revealed the food temperature should be at least 140 degrees (F). DA #1 stated if the food temperature was below 140 degrees, she would just turn up the steam table to get the food temperature to go up. DA #1 stated no one told her what to do if the food temperatures were too cold.</p> <p>Interview with DA #2, on 09/19/13 at 1:44 PM, revealed he was trained to turn up the steam table if the temperatures were too cold. DA #2 stated on average the food temperatures ranged in the 130's (F). DA #2 stated no one had come up to the floor to monitor him when conducting the tray line. DA #2 stated he would like to see the food temperatures be above 150 to 160 degrees (F). DA #2 stated he felt part of the reason why food was too cold was because they had to go in and out of the cart before transporting onto the units.</p> <p>Interview with the Dietary Manager, on 09/19/13 at 2:48 PM, revealed he tried to monitor the tray line at least once a week. The Dietary Manager stated when the food comes off the tray line in the main kitchen they like the temperatures to be around 170 degrees (F) so that when they transport, the food can be around 147 or 152 degrees (F) on the steam tables. The Dietary Manager stated he felt the food was too cold because of the time that was spent in the main kitchen getting the supplies together to go</p>	F 364	facility will take corrective action if deficient practices are identified.	10/29/13



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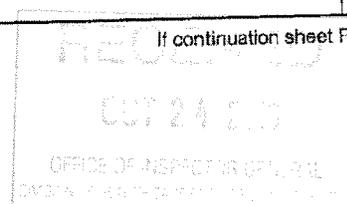
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F 364 F 371 SS=F	Continued From page 13 upstairs and place on steam table. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and policy review, it was determined the facility failed to serve food in a sanitary manner. Staff served biscuits with gloved hands and handled resident meal tickets with the same gloved hand. A dietary aid changed gloves without hand washing and proceeded with food service at the steam table. Staff cleaned the thermometer with a gloved finger between each container of food. Staff cross contaminated food during the tray line in the main kitchen.  The findings include:  Review of the facility's policy regarding Food Production Guidelines-Sanitation and Safety, revised 2009, revealed safe and sanitary handling of food would be employed during food production. Hands would be washed thoroughly before touching food or equipment. Suitable utensils, such as forks, knives, tongs or scoops	F 364 F 371	The facility will (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. The Registered Dietitian educated dietary staff on 10/9/13 on serving food in a sanitary manner, hand washing, and cross contamination. RD educated dietary staff on 10/9/13 on sanitary procedures for taking food temperatures. RD will observe two food service meals a week from the steam table for four weeks and report findings to the Q.A. Committee and Executive Director. The facility will take corrective action if deficit practice is identified. The facility will monitor compliance through monthly RD sanitation reviews, Dining Services Support visits and Peer Review Audits and take	



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F 371	<p>Continued From page 14</p> <p>shall be provided to minimize handling of food.</p> <p>Observations during the tray line, on 09/18/13 at 11:00 AM, revealed Dietary Aid (DA) #3 with gloved hands wipe pureed meat off of a resident's plate, then touched tomatoes and lettuce to garnish a hamburger. DA #3 then garnished another resident's hamburger with tomatoes, lettuce and onion, then touched her shoulder with the same gloved hands. Dietary Aid #3 never removed her gloves or washed her hands.</p> <p>Interview with Chef Cook #2, on 09/19/13 at 1:30 PM, revealed while Dietary Aid #3 was on the tray line, Chef Cook #2 observed her to touch items and cross contaminate the resident's trays. Chef Cook #2 also observed Dietary Aid #3 wipe the plate with her gloved hands. Chef Cook #2 stated he talked with Dietary Aid #3 about using tongs when on the tray line and to not cross contaminate. Chef Cook #2 stated they do not want to cross contaminate to prevent the spread of infection.</p> <p>Interview with the Assistant Director, on 09/19/13 at 1:52 PM, revealed he had talked to the staff about cross contamination. The Assistant Director stated they had huddles three (3) times a day on Monday, Wednesday and Friday to teach how to handle food. The Assistant Director stated Dietary Aid #3 should have removed her gloves and washed her hands. The Assistant Director stated he was trying to prevent the residents from getting sick or infections.</p> <p>Observation, on 09/18/13 at 12:18 PM, of Dietary Aide (DA) #1 revealed the DA changed her gloves without washing her hands, after taking food temperatures on the 3 North steam table, and</p>	F 371	take corrective action if deficit practice is identified.	10/11/13



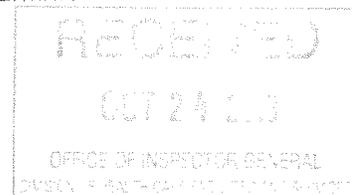
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F 371	Continued From page 15 began to serve the lunch meal. Continued observation revealed the DA plated biscuits with her gloved hand and touched resident meal tickets with the same gloved hand.  Observation of the Dietary Manager during the Main Dining tray line, on 09/18/13 at 12:15 PM, revealed temperatures were taken of the noodle dish, succotash, hamburger, chicken and baked potatoes. The Dietary Manager wiped the thermometer with his gloved fingers when he pulled the thermometer out of each dish and before each temperature taken. He did not use any wipes to clean the thermometer before or after each dish temperature was taken.  Interview with the Dietary Manager, on 09/18/13 at 12:28 PM, revealed he was just trying to speed up the process. He stated, he used a paper towel between and then reported, he should have wiped the thermometer off with the approved wipes.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441	The facility will 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. DHS/ADHS in-serviced nursing staff which included LPN identified as #4 on policy and procedure for infection control	

medication administration with

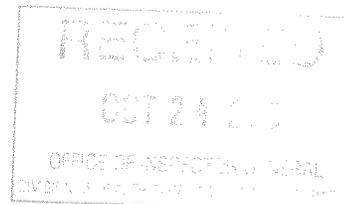


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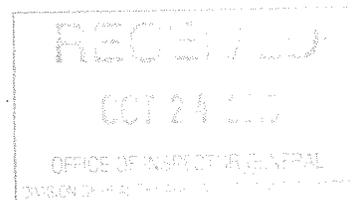
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F 441	<p>Continued From page 16</p> <p>should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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</p> <p>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 facility policy review, it was determined the facility failed to follow their Infection Control Program for one (1) of nineteen (19) unsampled resident and sixteen (16) sampled residents. LPN #4 failed to wash her hands when going from a dirty task to a clean task during medication pass for Unsampled Resident S.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Guidelines</p>	F 441	<p>emphasis on hand hygiene and washing hands when changing gloves by 10/22/13.</p> <p>ADHS will observed employee #4 LPN medication pass to ensure return demonstration of education provided by 10/28/13.</p> <p>DHS/ADHS/Unit Manager will educate facility staff administering medications on policy and procedures related to infections control, and hand hygiene by 10/28/13.</p> <p>DHS/ADHS/Consultant Pharmacist will observe two medication passes per week on different shifts, units, and Nurse/CMT for four weeks and take corrective action if deficient practice is identified.</p> <p>The Q.A. Committee will review results of audits and make recommendations for auditing, corrections or staff education.</p> <p>The facility will monitor for on-going compliance through semi-annual Peer Review and Clinical Assessment Tool audits and take corrective as needed.</p>	11/2/13



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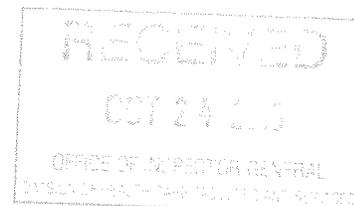
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F 441	Continued From page 17 for Handwashing, dated 10/2004, revealed handwashing was the single most important factor in the prevention of infection transmissions. All health care workers shall wash their hands frequently and appropriately. Health care workers should wash their hand after removal of gloves.  Observations during the medication administration with Licensed Practical Nurse (LPN) #4, on 09/18/13 at 9:20 AM, revealed Unsampld Resident S had a ginger root capsule roll out of their mouth and land on the floor. LPN #4 picked up the medication from the floor, carried the capsule to the medication cart and threw it in trash. She obtained a new medication from the medication cart and returned with applesauce. She administered the medication to the resident without washing her hands; she obtained gloves from bathroom; administered eye drops; changed gloves without hand hygiene; donned gloves and administered a nasal spray to the resident.  Interview with LPN #3, on 09/18/13 at 9: 25 AM, revealed she should have washed her hands after she picked up the capsule from the floor. She stated, handwashing should have been completed between glove changes also. In addition, hand washing should have been completed between eye drops and nasal spray administration.  Interview with Director of Nurses, on 09/19/13 at 5:55 PM, revealed the staff was trained to practice hand hygiene between glove changes and certainly, after picking items up off the floor.	F 441		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET	F 520		



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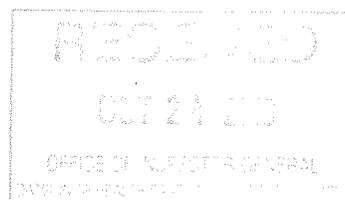
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F 520	<p>Continued From page 18 QUARTERLY/PLANS</p> <p>A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.</p> <p>The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's Quality Assessment and Assurance (QAA) policy and attendance record, it was determined the facility failed to maintain the Quality Assessment and Assurance Program for two (2) of the last three (3) quarterly committee meetings. The facility presented an unsigned attendance record and the second attendance record had three (3) members in attendance.</p>	F 520	<p>The facility will maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility and at least 3 other members of the facility's staff. ED will complete quarterly Q.A. Committee meetings that include ED, DHS, and Medical Director, and three additional facility employees. The ED will have Q.A. Committee Meetings signed and dated quarterly and maintained in facility with next meeting held 10/11/13. Home Office Clinical Support will educate ED/DHS on Q.A. Policy by 10/28/13. The facility will monitor compliance through Peer Review semi-annual audits and corrective action will be taken as needed.</p>	10/29/13



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER  PARK TERRACE HEALTH CAMPUS			STREET ADDRESS, CITY, STATE, ZIP CODE 9700 STONESTREET ROAD LOUISVILLE, KY 40272		
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F 520	<p>Continued From page 19 The findings include:</p> <p>Review of the facility's policy for Guidelines for the QAA Process, undated, revealed the purpose was to provide continuous evaluation of systems to distinguish between isolated, pattern or systemic concerns, ensure systems functioned appropriately, to prevent problems from arising to the extent possible, recognize incremental changes that may be early signs of a potential or future problems and correct. Each campus shall maintain a QAA Committee consisting of the Director of Health Services, the Medical Director or designee and at least three (3) other members of the interdisciplinary team.</p> <p>Review of the facility's QAA Committee attendance record, dated 12/27/12, revealed an unsigned attendance record.</p> <p>Review of the facility's QAA Committee attendance record, dated 06/28/13, consisted of the Medical Director, the Director of Health Services and the Executive Director.</p> <p>Interview with the Executive Director, on 09/19/13 at 4:50 PM, revealed they meet daily and on a monthly basis; however, the Medical Director meets at least quarterly with the committee. She reported the committee consisted of the Assistant Director of Health Services, the Minimum Data Set (MDS) Nurse, Medical Records Director and the Business Office Manager, in addition to the required Medical Doctor and the Director of Clinical Health. She reported she was unable to locate the sign in sheet with the signatures of who attended the 12/2012 meeting and only had three (3) members of the committee during the 06/2013 meeting.</p>	F 520			



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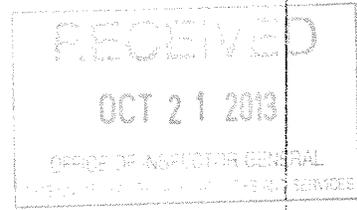
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP, occupying the second and third floors.</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II protected.</p> <p>SMOKE COMPARTMENTS: Seven (7) smoke compartments; four (4) on the second floor and three (3) on the third floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic wet sprinkler system.</p> <p>GENERATOR: Two (2) Type II, 300 KW generators, installed in 1976. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 09/19/13. Park Terrace Health Campus was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*x Document Due to X 10/24/13*

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.

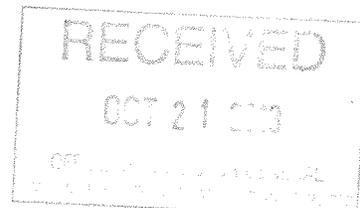
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K 000	Continued From page 1 Regulations, 483.70 (a) et seq. (Life Safety from Fire).  Deficiencies were cited with the highest deficiency identified at F level.	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Hazardous areas are protected in accordance with 8.4. The areas are enclosed with a one hour fire-rated barrier, with a 3/4 hour fire-rated door, without windows (in accordance with 8.4). Doors are self-closing or automatic closing in accordance with 7.2.1.8. 18.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of (4) smoke compartments on the second floor, approximately twenty (20) residents, staff and visitors. The facility has eighty-eight (88) certified beds and the census was seventy-nine (79) on the day of the survey.  The findings include:  Observation, on 09/19/13 at 9:52 AM, with the Director of Plant Operations revealed the door to the Med Prep/Storage Room, located on the second floor, did not have a self-closing device installed on the door.  Interview, on 09/18/13 at 9:52 AM, with the Director of Plant Operations revealed he was not	K 029	The facility will ensure hazardous areas are protected in accordance with 8.4. The facility will ensure doors are self-closing or automatic closing in accordance with 7.2.1.8. Director of Plant Operations installed an automatic door closure to the Med Prep/Storage Room located on the second floor on 10/3/13.  The Director of Plant Operations audited all facility doors and installed a door closure on second door identified as containing hazardous items in accordance with 8.4. on 10/3/13. ED educated DPO on ensuring any hazardous areas has an automatic door closures installed and if any door is replaced in the facility to an area that contains hazardous material that an automatic door closure is installed. or replaced.	



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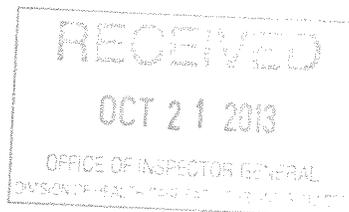
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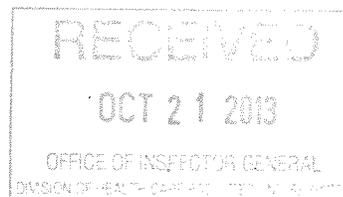
K 029	<p>Continued From page 2 aware of the door to the Med Prep/Storage Room not being equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or</p>	K 029	<p>DHS/ADHS/Unit Manager will educate nursing staff on requirements for automatic door closures to areas in the the facility containing hazardous material and instruct to complete work order for DPO if door closure is not present or not working by 10/28/13. DPO will audit doors in campus quarterly and submit findings to Q.A. Committee for review and corrective action as needed. Compliance will be monitored through semi-annual Peer Review inspections.</p>	10/29/13
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K 029	Continued From page 3 field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke detectors were installed in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the seven (7) smoke compartments, all residents, staff and visitors. The facility has one-hundred and eighty-eight (88) certified beds and the census was seventy-nine (79) on the day of the survey.  The findings include:  Observations, on 09/19/13 between at 9:21 AM and 11:30 AM, with the Director of Plant Operations revealed the individual battery-powered smoke detectors installed in the Resident's Rooms on the second and third floors had been located on a side wall, approximately three (3) feet down from the finished ceiling.  Interviews, on 09/19/13 between 9:21 AM and 11:30 AM, with the Director of Plant Operations,	K 054	The facility will ensure smoke detectors are installed in accordance with National Fire Protection Association (NFPA) standards. The Director of Plant Operations removed the smokes detectors in all resident rooms in the facility and reinstalled smoke detectors in accordance with NFPA requirements 4" to 12" from the ceiling on 10/3/13. The DPO audited all residents rooms in the campus to ensure all smoke detectors were installed at the proper space from the ceiling on 10/3/13. ED in-serviced DPO on NFPA 101 Life Safety Code Standard related to installation of smoke detectors to ensure any new smoke detectors that may be installed in the facility meet Life Safety Code Standards on 10/22/13.	



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K 054	Continued From page 4 revealed he was unaware of the battery-powered smoke detectors being installed outside of the acceptable range of four (4) to twelve (12) inches down from the finished ceiling.  Reference: NFPA 72 (1999 Edition)  5.7.3.2* Spot-Type Smoke Detectors. 5.7.3.2.1* Spot-type smoke detectors shall be located on the ceiling not less than 100 mm (4 in.) from a sidewall to the near edge or, if on a sidewall, between 100 mm and 300 mm (4 in. and 12 in.) down from the ceiling to the top of the detector.	K 054	DPO will audit resident rooms quarterly and submit findings to Q.A. Committee for review and corrective action as needed. Compliance will be monitored through semi-annual Peer Review inspections.	10/29/13

