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

PRINTED: 11/09/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION OFFICE OF THE DIRECTOR GENERAL DIVISION OF HEALTH CARE FACILITIES AND SERVICES A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  10/28/2010
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted 10/26/10 through 10/28/10 and a Life Safety Code survey was 10/28/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.  An abbreviated survey investigating KY00015085, KY00014649 and KY00015137 KY00015443 was initiated on 10/26/10 and concluded on 10/28/10. KY00015085, KY00014649, KY00015137 and KY00015443 were unsubstantiated.	F 000	1. The eleven discontinued 100ml bags of intravenous normal saline were immediately returned to the pharmacy on 10/27/10.  2. All facility medication rooms were audited on 10/27/10 for any discontinued/expired medications/biologicals and no others were found that needed to be returned to the pharmacy.  3. Facility nurses were educated by the Staff Development Coordinator regarding the facility policy on Medication Administration-Return to Pharmacy on 11/22/10, 11/23/10 and 11/24/10. The unit managers will audit the medication rooms and medication carts weekly for discontinued and/or expired medications/biologicals as well as to ensure that all discontinued/expired medications/biologicals are on the Medication Return form.  4. The results of these audits will be brought to the weekly QA Committee x 4 weeks, monthly x 2 months and at the QA Committee's discretion after 100% compliance x 2 months.	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 431		11/25/10

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  <i>X Konev</i>	TITLE  <i>X Administrator</i>	(X6) DATE  <i>X 11/17/10</i>
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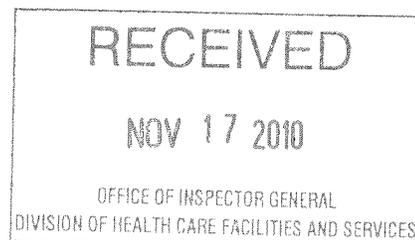
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the Institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 252B SIX MILE LANE LOUISVILLE, KY 40220	

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F 431	<p>Continued From page 1</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to remove eleven (11) 100ml bags of intravenous normal saline for antibiotic use after it expired past room temperature use.</p> <p>The findings include:</p> <p>Review of the facility policy on Medication Administration-Return to Pharmacy dated February 2005 revealed; when the resident's physician discontinues medication, the medication is removed and is written on the Medication Return form.</p> <p>Observation of the 100 unit locked medication room, on 10/27/10 at 2:40pm revealed eleven (11) bags of 100ml IV NS for antibiotic use. The dose order date was 09/29/10 to be kept at room temperature. The room temperature expiration date was 10/13/10.</p> <p>Interview with LPN #1 on 10/27/10 at 2:45pm revealed the resident went to the hospital and the IV fluid was never returned to pharmacy.</p>	F 431		



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F 431	Continued From page 2	F 431		
F 514 SS#B	<p>Interview with RN #1 on 10/27/10 at 2:50pm revealed the resident went to the hospital and the IV fluid should have been taken out of the closet and returned to the pharmacy.</p> <p>483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on Interview and record review it was determined the facility failed to maintain clinical records in accordance with acceptable professional standards and practices for one (1) of twenty-nine (29) sampled residents. Resident #5 did not have three (3) months of signed physician orders in the clinical record.</p> <p>The findings include:  A review of the facility policy regarding physician orders dated May 2003 revealed that three months of physician orders should remain in the resident's chart at all times. The policy also</p>	F 514	<ol style="list-style-type: none"> <li>The Director of Nursing educated the Nurse Practitioner on 10/28/10 on the policy of signing physician orders. Resident #5's physician orders were reviewed by the Medical Director on 10/28/10.</li> <li>A 100% audit of all resident charts was done on 10/28/10 by Medical Records to ensure three months of physician orders were on every resident chart and that all orders were signed by the doctor within 14 days. The facility Medical Director reviewed 100% resident audit on 10/28/10 for any corrective action necessary.</li> <li>100% of facility attending medical Staff and medical records staff have been educated by the Director of Nursing on 11/17/10 on the policy regarding signing of physician orders protocols. Facility nurses were educated by the Staff Development Coordinator on 11/22/10, 11/23/10 and 11/24/10 on the policy regarding signing of physician orders. Medical records will audit 100% physician orders weekly to ensure</li> </ol>	

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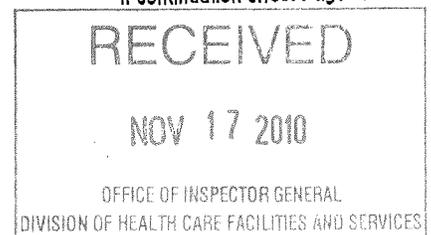
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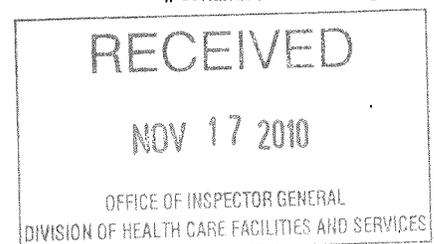
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185360	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  10/28/2010	
NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2629 SIX MILE LANE LOUISVILLE, KY 40220		
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F 514	<p>Continued From page 3</p> <p>states that all physician orders must be signed and dated within (14) fourteen days by the attending/prescribing physician unless mandated sooner by state regulations.</p> <p>Review of the clinical record for Resident #5 revealed the resident was admitted on 08/25/10. Further review of the record on 10/26/10 revealed there were no physician orders for the entire month of September and, the October computer printed orders that were located in the clinical record, were unsigned by the physician.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 10/26/10 at 11:15am, who looked at the unsigned October orders as well, stated that the physician has until the last day of the month of October to sign the computer printed orders for October. She stated the September orders should be in the file and she would check with medical records to try to locate them. The ADON reported on 10/27/10 at 10:50am that the September physician orders could not be found. She once again stated that the orders should be in the file.</p> <p>Review of the clinical record for Resident #5 on 10/28/10 at 1:30pm revealed the October orders had been signed by someone other than the ordering physician and were dated 10/20/10, the date the resident's physician seen the resident and documented the visit on a progress note.</p> <p>Interview with the ADON on 10/28/10 at 2:00pm regarding the October physician orders that were unsigned on 10/26/10, and then signed on 10/28/10, with the date of 10/20/10, revealed the signature was that of the nurse practitioner who works with the resident's physician. The ADON</p>	F 514	<p>that three months of physician orders are on the chart and that all orders are signed by the physician within 14 days.</p> <p>4. The results of these audits will be brought to the weekly QA Committee x 4 weeks, monthly x 2 months and at the QA Committee's discretion after 100% compliance x 2 months.</p>	11/25/10



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F 514	Continued From page 4 acknowledged that the signature on the orders was dated 10/20/10, when there had been no signature or date when previously reviewed on 10/26/10. No explanation was given regarding the back-dated orders.	F 514		



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K 000	INITIAL COMMENTS	K 000		
K 073 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that no combustible decorations were used in the facility, according to NFPA standards.</p> <p>The findings include:</p> <p>Observation on 10/28/10 at 10:15am with the Maintenance Director, revealed eighteen (18) resident rooms with hanging decorations on the doors that were not flame retardant. The resident rooms were numbered 102, 107, 108, 109, 111, 114, 115, 116, 303, 305, 306, 309, 311, 313, 324, 327, 328, and 329.</p> <p>Interview with the Maintenance Director on 10/28/10 at 10:15am, indicated they would spray the decorations with a flame retardant and keep record of this information on file.</p> <p>NFPA Standard NFPA 101.2000 Edition 19.7.5.4</p>	K 073	<ol style="list-style-type: none"> <li>1. The 18 resident rooms with hanging decorations were all sprayed with a flame retardant by the Maintenance Director on 10/28/10.</li> <li>2. 100% combustible decorations used in the facility were sprayed by the Maintenance director on 10/28/10 with a flame retardant then logged for quarterly treatment.</li> <li>3. All facility staff were educated by the Staff Development Coordinator on 11/18/10 regarding the treatment of any combustible decorations. Upon Admission, the Admissions Director will explain this standard to residents/responsible parties and notify Maintenance of any combustible decorations in need of treatment. Maintenance will keep a log book by month of items needing flame retardant treatment and will re-treat on a quarterly</li> </ol>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 11/17/10

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K 073  K 147 SS=D	<p>Continued From page 1</p> <p>Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panel boxes were clear of all obstructions in a 36 inch radius of the panel box.</p> <p>The findings include:</p> <p>Observation on 10/28/10 at 10:15am with the Maintenance Director revealed the electrical panel in the medication room on the 200 Hallway was blocked by a table and cart. In addition, the electrical panel box in the 100 Hallway nurse's station was also blocked by a cart. Continued observation revealed the electrical panel box in the laundry room on the 300 Hallway was blocked by a housekeeping cart.</p> <p>In an interview at 10:15am the Maintenance Director indicated the blocked electrical panel boxes would be cleared of all obstructions.</p> <p>Reference: NFPA 70, National Electrical Code. 9.1.2</p>	K 073  K 147	<p>basis. The Administrator will audit the log book monthly.</p> <p>4. The results of these audits will be brought to the monthly QA Committee x 3 months and at the QA Committee's discretion thereafter after 100% compliance x 2 months.</p> <p>1. The blocked electrical panel boxes were immediately cleared of all obstructions by the Maintenance Director on 10/28/10.</p> <p>2. All other electrical panel boxes were checked by the Maintenance Director on 10/28/10 and no others were found to be blocked.</p> <p>3. All facility staff were educated by the Staff Development Coordinator</p>	11/19/10

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			<p>on 11/18/10 that electrical panel boxes are to be clear of all obstructions in a 36 inch radius of the panel box. Three days per week as part of the daily preventative maintenance program, the Maintenance staff will log all electrical panel boxes in the facility to ensure they are clear of obstruction in a 36 inch radius of the panel box.</p> <p>4. The results of these audits will be brought to the weekly QA Committee x 4 weeks, monthly x 2 months and at the QA Committee's discretion thereafter after 100% compliance x 2 months.</p>	11/19/10
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