

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

PRINTED: 12/20/2012  
FORM APPROVED  
OMB NO. 0938-0391

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>12/13/2012</b>
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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 000 INITIAL COMMENTS

F 000

A standard health survey was conducted from 12/11/12 through 12/13/12 and a Life Safety Code survey was conducted on 12/12/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.

F 252 483.15(h)(1)  
SS=D SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT

The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

This REQUIREMENT is not met as evidenced by:  
Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure a safe, clean, and homelike environment as evidenced by four (4) of ninety-three (93) wheelchairs that were not maintained, and one lap buddy, used for sampled Resident #8, that was in disrepair. In addition, four (4) of seventy-seven (77) resident rooms had large gouged areas in the dry wall.

The findings include:

Review of the facility's policy regarding Preventive Maintenance Procedure/Campus Interiors, dated 01/01/2008, revealed walls were to be inspected monthly based on the master PM schedule.

The facility did not provide a policy for wheelchair

F 252 The facility will provide a safe, clean, comfortable and homelike environment. The four resident wheelchairs identified as having damaged arm rest were replaced and one lap buddy was replaced on 1/5/13. The Director of Plant Operations will check wheelchairs arm rest and lap buddies and replace any damaged ones by 1/12/13. The DPO will repair gouged dry wall in resident rooms for the four rooms identified by 1/12/13.

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

TITLE

(X6) DATE

*[Signature]*

*[Signature]* Executive Director 1/10/13

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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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 252 Continued From page 1 care and maintenance.

Observation, on 12/11/12 at 8:30 AM, on initial tour revealed the lap buddy in use for Resident # 8 had foam protruding through broken seams in the covering.

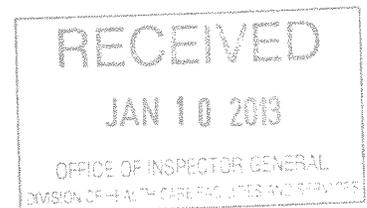
Observation, on 12/11/12 at 8:30 AM, on initial tour revealed (4) wheelchairs that were in use had cracked and frayed arm rests.

Observation, on 12/11/12 at 8:30 AM, on initial tour revealed large areas of gouged dry wall behind and to the side of the resident's beds in rooms 322, 343-1, 345-1, and 346-1.

Interview, on 12/13/12 at 11:00 AM, with the Assistant Director of Nursing (ADON) revealed staff should complete a maintenance request form and place it in the maintenance folder available at each nurses' station when repairs are needed. The plant operations manager also received verbal reports of maintenance concerns daily during morning staff meetings.

Interview, on 12/13/12 at 11:15 AM, with the Director of Plant Operations revealed he did not have a work order for repair of the gouged dry wall in the identified resident rooms, and he did not have a plan in place to repair them, but he had been aware of the damaged walls in two of the rooms (Rooms 321 and 345-1) for about two (2) weeks. The Director of Plant Operations stated it took more coordination and planning to get repairs completed on the long term care units because he worked around the resident's preferred schedule, and he also coordinated with nursing when it was difficult for some residents to

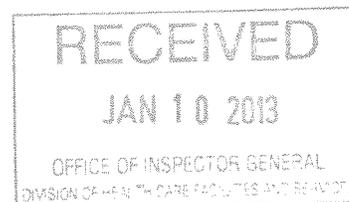
F 252 The DPO will audit resident rooms monthly and repair any gouged areas in dry wall identified and submit Preventative Room Maintenance Audit to the Q.A. Committee Monthly for review by 2/12/13 for six months or until 100% compliance is reached for three consecutive months. The DOP will audit wheelchair arms and lap buddies monthly using audit tool and replace if damage is observed or when a work order is submitted by staff. Nursing staff and department managers trained on completing work orders if they observe damaged wheelchair arms, lap buddies, or dry wall damage on 1/5/13 by DHS and ED.



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F 252	Continued From page 2 be out of their rooms for the amount of time necessary to make the repairs.  Interview, on 12/13/12 at 11:20 AM, with the Executive Director (ED) revealed the Director of Plant Operations and the physical therapy department were responsible for wheelchair maintenance. The ED stated it was very important to keep the wheelchairs in good repair in order to protect the residents from skin tears and abrasions. In addition, the ED stated the gouged walls in the residents' rooms needed to be repaired to ensure a comfortable, home-like environment for the residents.	F 252	The DPO will submit monthly resident room wheelchair, and lap buddy audits to the Q.A. Committee monthly for review and corrective action and monitoring for three months and corrective action will be taken as needed.	1/25/13
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to ensure kitchen equipment used to prepare, store and cook food for the residents was clean and sanitary before using.  The findings include:	F 371	The facility will store, prepare, distribute and serve food under sanitary conditions. The Dietary Manager (DFS) cleaned cook top, shelf under the grill, and floor area between the grill, fryers, and stove. DFS cleaned the door of the convection oven and floor area on 12/14/12. The DFS educated staff on completing weekly cleaning schedule and signing off on 1/3/13. DFS will check cleaning	



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F 371 : Continued From page 3  
Review of the facility's Food Production Guidelines - Sanitation and Safety, dated 2009, revealed the guidelines did not discuss the cleaning of kitchen equipment.

Observations of the kitchen, on 12/11/12 at 8:40 AM, revealed there were spilled dark brown substances on the cook top, shelf under the grill, floor area between the grill, fryers, and stove. A white substance was on the front of the oven panel and the side of the grill. A dark brown substance was present under the door of the convection oven. The substance appeared liquid. There was a shiny clear substance on the floor in the fryer area, between the oven and grill, and on the shelf under the grill. When touched this substance had a greasy feel.

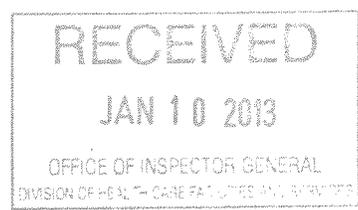
Review of the kitchen's routine cleaning schedule revealed a staff member had not signed-off the cleaning of the convection oven and floor under the oven for more than a week. There was no schedule for the cleaning of the fryer or area under the grill.

Review of a power point presentation presented to all kitchen staff on equipment cleaning procedures revealed the grill, fryer, convection, and floor cleaning are discussed on proper cleaning techniques.

Interview with the Dietary Director, on 12/12/12 at 2:30 PM, revealed he felt all cooking equipment and the kitchen floor should not have any debris, stains or substances. In addition, he stated the white substance on the stove was oven cleaner and the clear substance was grease

F 371 schedule and kitchen sanitation weekly using checklist to ensure cleanliness of area by 1/12/13.  
DFS will complete weekly sanitation audit and submit to Q.A. Committee for review for three consecutive months to ensure standard is consistently obtained and corrective action will be implemented as needed. The facility will also monitor compliance through Peer Reviews and home office routine monthly visits.

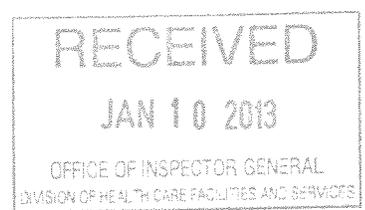
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F 371	Continued From page 4  Observation, on 12/11/12 at 2:40 PM, revealed the second floor kitchen area between the north and south units had a dark brown substance on the refrigerator under the door.  Interview with the Dietary Director, on 12/13/12 at 11:00 AM, revealed it was the kitchen staff's responsibility to clean the refrigerator.	F 371		
F 441 SS=F	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, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (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	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. Nursing staff educated on procedures for passing and serving drinks and the appropriate storage of ice scoops on 1/5/13 by DHS. The facility purchased separate ice receptacles for ice scoops for use on the second and third floor on 12/18/12.  The Director of Health	

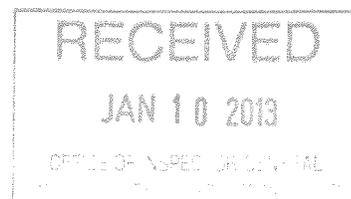


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F 441	<p>Continued From page 5</p> <p>hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to prevent the risk of possible cross contamination of ice for two (2) of two (2) ice buckets by not providing a separate receptacle for the ice scoops on the second floor and third floor ice buckets.</p> <p>The findings include:</p> <p>Observations, on 12/11/12 at 12:15 PM, revealed on the second and third floors at the lunch meal, ice buckets on the drink carts with the ice scoops in the ice buckets. On the second floor during hall tray passage the Certified Nursing Assistant (CNA) removed ice from the ice bucket with the scoop and then placed the scoop back in the ice bucket. On the third floor the CNA removed ice from the ice bucket and then replaced the scoop back into the ice. In addition, the CNA placed ice into a glass for a resident after the resident had drank from the glass. She then placed the ice scoop into the ice bucket.</p> <p>Interview with CNA #1, on 12/13/12 at 8:45 AM, revealed the ice scoop should have been in a</p>	F 441	<p>Services or Assistant Director of Health Services will monitor compliance weekly completing Peer Review Meal Observation Audit Tool and take corrective action is deficit practice is observed by 1/12/13.</p> <p>DHS will submit weekly audit to the Q.A. Committee for review and analysis for three consecutive months to ensure ongoing compliance is established and maintained.</p>	1/25/13



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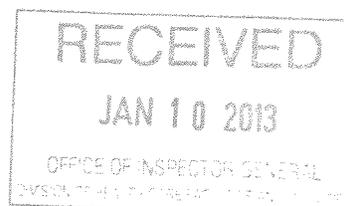
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F 441 Continued From page 6  
separate container or a plastic bag. The scoop should not have been placed back in the ice.

Interview with the Dietary Director, on 12/13/12 at 11:00 AM, revealed the dietary department did not provide a separate container for the ice scoop to be placed in to prevent cross contamination of the scoop.

Interview with CNA #2, on 12/13/12 at 2:10 PM, revealed she stated she placed the ice scoop on top of the ice bucket's plastic cover. She agreed handling the plastic cover with her bare hands and then placing the scoop onto the plastic could cross contaminate the ice scoop.

F 441



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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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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 12/11/12. Park Terrace Health Campus was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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