

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

PRINTED: 05/25/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/12/2011
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NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
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F 000	INITIAL COMMENTS A standard health survey was initiated on 05/10/11 and concluded on 05/12/11. The Life Safety Code survey was initiated and concluded on 05/10/11. The facility was found to not meet minimum requirements and deficiencies were cited with the highest scope and severity at an "F". This was a Nursing Home Initiative survey with entrance at 6:30am on 05/10/11.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 161 SS=E	483.10(c)(7) SURETY BOND - SECURITY OF PERSONAL FUNDS The facility must purchase a surety bond, or otherwise provide assurance satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. This REQUIREMENT is not met as evidenced by: Based on record review, interview, and review of the facility policy it was determined the facility failed to ensure that a surety bond had been purchased to assure all resident personal funds deposited with the facility were secured. The resident account fund held by the facility for the residents totaled \$10,741.45. The facility's security bond which had been purchased to secure resident funds was \$10,000, \$741.45 less than amount the facility held in trust for the thirty-five (35) residents. The findings include: Review of facility policy : Potection of resident funds, section (c) #7, the facility must purchase a surety bond, or otherwise provide, assurance	F 161	F161 1. The Surety Bond was increased to \$15,000 on 5/12/2011 to assure the security of all resident personal funds deposited with the facility. 2. No residents with resident account funds were affected. The Surety Bond was increased to \$15,000 on 5/12/2011. 3. The Business Office Manager was reeducated on 5/13/2011 by the Administrator to ensure the Surety Bond covers the highest monthly balance for the resident account fund.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Y Deane Harrett</i>	TITLE <i>X Administrator</i>	(X6) DATE <i>X 6/3/11</i>
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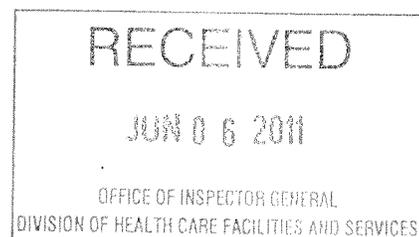
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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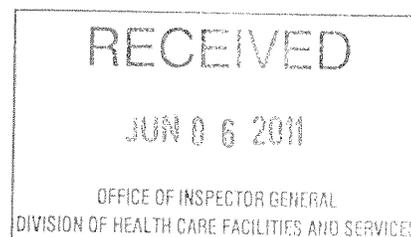
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F 161	Continued From page 1 satisfactory to the Secretary, to assure the security of all personal funds of residents deposited with the facility. Interview with the Business Office Manager on 05/12/11 at 10:30am revealed she had only worked at this office about two (2) weeks and had not looked at the Surety Bond amount. The Business Office Manager stated there were thirty-five (35) residents who have resident trust accounts. Interview with the Administrator on 05/12/11 at 10:40am revealed they have a new business office manager. The Administrator stated she did not know they were out of compliance with the Surety Bond but would get this taken care of immediately.	F 161	4. The Business Office Manager will conduct an audit weekly of the resident account fund for 4 weeks and then monthly times for 2 months to ensure proper Surety Bond amount. The Business Office Manager will submit findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services Director, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations. 5. Date of compliance 6/13/2011		
F 205 SS=D	483.12(b)(1)&(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies the duration of the bed-hold policy under the State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility, and the nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (b)(3) of this section, permitting a resident to return. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and a family member or legal representative written notice	F 205	1. Resident #15 was discharged on 03/05/2011 from the facility. 2. A review of resident's who have been discharged in the past 7 days was conducted by the Administrator and Social Services Director on 5/16/2011 to determine if the bed-hold notice policy and readmission was offered No other residents were affected.		



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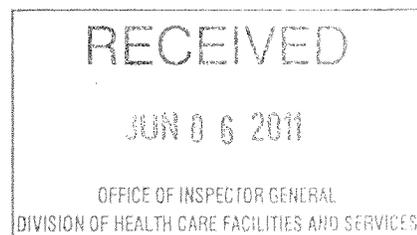
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F 205	<p>Continued From page 2</p> <p>which specifies the duration of the bed-hold policy described in paragraph (b)(1) of this section.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed resident record review, interview and facility policy review, it was determined the facility failed to provide Notice of the Bed-hold Policy and Readmission to one (1) of fifteen (15) sampled residents, Resident #15, when they were transferred to an acute care facility.</p> <p>The findings include:</p> <p>The facility Bed-Hold Notice of Policy states "You may request that we hold a bed while you are absent from the center for therapeutic leave or temporary stays in an acute hospital. You must request any desired bed-hold within 24 hours of receiving the notice of discharge or transfer."</p> <p>Review of the closed medical record for Resident #15 revealed the resident was admitted to the facility on 07/30/10 with diagnosis including Chronic Airway Obstruction, Dysphasia, Congestive Heart Failure, and Depression. Resident #15 was transferred to an acute care facility on 02/26/11 with chest pain and decreased oxygen saturation. The resident had a Power of Attorney (POA) listed on the medical record.</p> <p>Review of the clinical record revealed no evidence the facility provided Resident #15 and the POA with Bed Hold Notice of Policy.</p> <p>Interview, on 05/12/11 at 2:15pm, with the</p>	F 205	<p>3. The Administrator was educated on the bed hold notice policy and readmission on 5/13/2011 by the Regional Director of Clinical Operations, Social Services Director, Business Office Manager and Medical Records staff were re-educated 5/16/2011 by the Administrator regarding bed hold notice policy and readmission. The licensed nursing staff will be re- educated on bed hold notice policy and readmission by the Administrator, Social Services Director, or the Business Office Manager on or before 6/12/2011.</p> <p>4. The Social Services Director will review resident discharges weekly for 4 weeks then monthly times 2 months to ensure bed hold notice of policy and readmission is being offered and charted in the interdisciplinary note. The Social Services Director will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Service Director, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 6/13/2011</p>	



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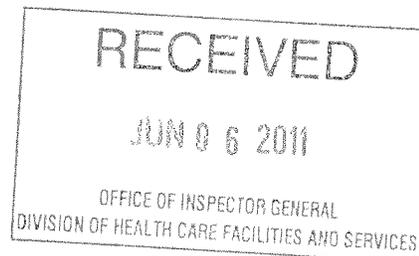
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F 205	<p>Continued From page 3</p> <p>Medical Records Director revealed the facility social worker was responsible to obtain the Bed-hold Notice Policy and Authorization. (Social Services was unavailable for interview.)</p> <p>Interview, on 05/12/11 at 2:20pm, with the Administrator revealed she was unfamiliar with the process for the bed-hold when a resident was sent out urgently to the hospital. She stated if there was a Power of Attorney (POA), that person would be notified, and usually the facility obtained a verbal yes or no from the POA if there was to be a bed-hold.</p> <p>Interview, on 05/12/11 at 3:40pm, with the Administrator revealed she had not been educated on and did not know the bed-hold process and she was not "the one to sign off on it".</p> <p>F 272 483.20(b)(1) COMPREHENSIVE SS=D ASSESSMENTS</p> <p>The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity.</p> <p>A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns;</p>	F 205	
		F 272	<p>F272</p> <ol style="list-style-type: none"> 1. Resident #3 had a therapy screen completed on 5/12/2011 by the physical therapist. 2. The Therapy Program Manager and MDS Coordinator completed a review on or before 6/04/2011 of current residents. Identified residents were evaluated and treated as indicated by appropriate therapist as of 6/12/2011.



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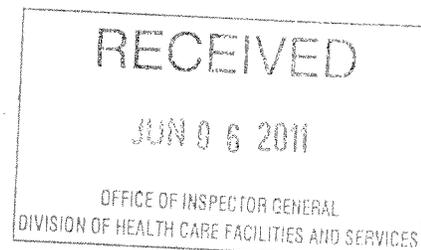
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F 272	<p>Continued From page 4</p> <p>Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the facility's policy Resident Assessment Instrument (RAI) version 3.0 Manual, and medical record review, it was determined the facility failed to complete a periodic comprehensive assessment of physical capacity for one (1) resident (#3) of the fifteen (15) sampled residents. Resident #3 was not assessed for Special Therapies including: Physical; Occupational; Speech; or Restorative Therapies, from September 28th, 2010 until May 12th, 2011.</p> <p>The findings include:</p>	F 272	<p>3. Therapy disciplines including Occupational, Physical and Speech were re-educated by the Director of Nursing and Administrator on 6/01/2011 for timely quarterly and readmission therapy screens.</p> <p>4. The interdisciplinary team (Administrator, Director of Nursing, and Assistant Director of Nursing, Unit Manager, Therapy and MDS Coordinator) will review 5 residents weekly times 4 weeks and monthly times 2 months to ensure that quarterly therapy screens are being conducted. The Therapy Program Manager will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 6/13/2011</p>



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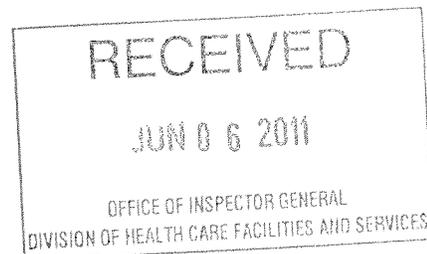
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F 272	Continued From page 5 Interview with the facility Corporate Nurse on 05/12/11 at 3:00pm revealed the facility utilized the RAI as a policy/guide on Resident Assessments. Review of the CMS.RAI version 3.0 Manual section 2.I revealed the regulation requires nursing homes to conduct initial and periodic assessments for all residents. Review of the Assessment Timing detailed, if the resident did not experience a change in condition or was not discharged, the assessment scheduling would proceed through three (3) Quarterly and one (1) Comprehensive Assessments. Section O400 Therapies revealed functional decline can lead to depression, withdrawal, and complications of immobility, such as incontinence and pressure ulcers, which contribute to a diminished quality of life. Continued review of the RAI revealed steps for Assessment by Therapies should include a review of the resident's medical record and consultation with each of the qualified care providers to collect information. Steps for Assessment of Restorative should include, evidence of a periodic evaluation by the licensed nurse. In addition, Restorative nursing does not require a physician's order. Observation of Resident #3, on 05/10/11 at 9:45am, revealed the resident laying on a low air loss mattress. A Foley Catheter to bed side drainage. Resident #3 was alert and pleasant. Contractures were noted to the resident's legs. The right and left leg was fully flexed at the knee. Resident #3 was tilted to the left side. There was no contracture to the right arm. The left arm was	F 272	
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F 272	<p>Continued From page 6</p> <p>flexed at the elbow and wrist, however, the resident could perform range of motion with the left arm, on command. The resident was unable to do active range of motion of the lower extremities.</p> <p>Observation of Resident #3, on 05/10/11 at 12:45pm, revealed the resident sitting in a Geri chair, in the resident's room, watching TV.</p> <p>Review of the medical record revealed the facility admitted Resident #3 on 06/01/10 with diagnosis including Multiple Sclerosis since the age of 18, Dysphagia, Pressure Ulcer, Diabetes Type 2, and Chronic Kidney Disease.</p> <p>Review of the Physical Therapy Evaluation conducted on 06/04/10 revealed Resident #3 was assessed to have "severe bilateral lower extremity knee and hip contractures. Will require orthotic management for resident skin and musculoskeletal integrity".</p> <p>Continued review of the medical record revealed Resident #3 was evaluated by Therapy upon admission and received Speech, Occupational, and Physical Therapy. Resident #3 was referred to the Restorative Program on 07/14/10 for Passive Range of Motion and Splint/Brace application. Resident #3 continued with Restorative for Range of Motion and Splint placement until September 28, 2010. Restorative Therapy was discontinued due to the resident's refusal in September 2010.</p> <p>Review of the Quarterly Assessment completed on 02/21/11 for Resident #3 revealed no documentation that the resident was assessed for</p>	F 272		



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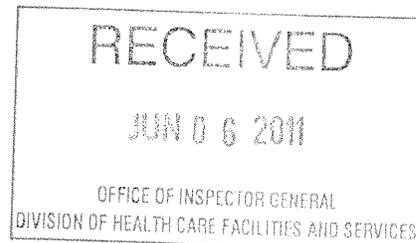
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F 272	<p>Continued From page 7</p> <p>Therapies or Restorative Nursing. In addition, the facility assessed the resident as not resisting care.</p> <p>Interview with the Therapy Department Manager(TDM), on 05/12/11 at 8:00am, revealed all new admissions and re-admissions are evaluated for Therapies. He stated once the resident is discharged from therapy, they will refer residents to restorative that are appropriate. The TDM stated Restorative Nursing does not need a referral from therapy for the residents to receive Restorative and you don't need a Physician's order for Restorative. In addition, he stated residents should be re-evaluated for Therapy or Restorative at least quarterly, even for those residents that are non compliant.</p> <p>Interview with the Physical Therapist (PT), on 05/12/11 at 8:45am, revealed she was familiar with Resident #3 and stated the reason the resident was not on Restorative or Therapy was because the resident refused the splints. The PT stated Resident #3 should be referred back to therapy periodically for re-evaluation of splints and Range of Motion. She stated Resident #3 had not been re-evaluated for Therapy of Restorative since September 2010.</p> <p>Interview with the Unit Manager, on 05/12/11 at 9:50am, revealed residents should be re-evaluated at least quarterly for Therapies and Restorative, even if the reason they are not on therapy or restorative is refusal. She stated this should take place during Quarterly Assessments with Care Plan meetings.</p> <p>Interview with the Director of Nursing (DON), on</p>	F 272		

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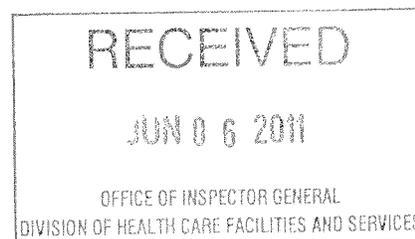
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F 272	Continued From page 8 05/12/11 at 2:35pm, revealed she is responsible for the Restorative program, and Care Planning for Restorative. The DON stated the Inter-Disciplinary Team meeting determined if Restorative was discontinued, and then the resident should be re-assessed with the Minimum Data Set(MDS) Assessment completed quarterly. The DON indicated Resident #3 was not re-assessed in February with the Quarterly Assessment. The DON stated the potential complications for Resident #3 not receiving Range of Motion are potential worsening of the contractures, and the resident could develop wounds from the contractures. F 279 483.20(d), 483.20(k)(1) DEVELOP SS=D 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. 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).	F 272 F 279 F279	1. The care plan and nursing assistant care card for resident #3 was updated to reflect resident's current needs on 5/13/2011 by Director of Nursing. 2 A review of current residents care plans and nursing assistant care cards was completed 6/3/2011 by the Director of Nursing and updates were made to reflect resident current needs including goals and interventions



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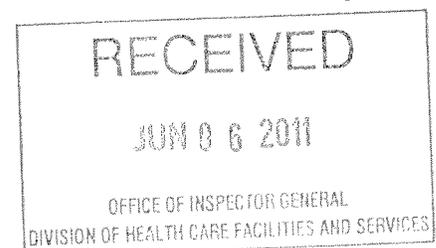
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F 279	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy on Interdisciplinary Care Plans, it was determined the facility failed to develop a Comprehensive Care Plan for one (1) resident (#3) of the fifteen (15) sampled residents. The facility failed to develop a Restorative Care Plan when Resident #3 was receiving Restorative Therapy. In addition, the facility failed to include any goals or interventions on the Comprehensive Care Plan to prevent a decline in Range of Motion for Resident #3. The findings include: Review of the facility's policy on Interdisciplinary Care Plan, effective date 01/08, revealed the Interdisciplinary Team (IDT) will develop an individualized plan of care for each resident utilizing information gathered during each assessment. Step 2 stated the IDT will develop care plans within 24 hours of admission addressing the residents' most acute problem. Observation of Resident #3, on 05/10/11 at 9:45am, revealed the resident laying on a low air loss mattress. A Foley Catheter to bed side drainage. Resident #3 was alert and pleasant. Contractures were noted to the legs. The right and left leg was fully flexed at the knee. Resident #3 was tilted to the left side. There was no contracture to the right arm. The left arm was flexed at the elbow and wrist, however, the resident could perform range of motion with the	F 279	3. The nursing staff will be re-educated on or before 6/12/2011 by the Director of Nursing or Assistant Director of Nursing on development, review and revision of the care plan and nursing assistant care card. 4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review 5 resident care plans and nursing assistant care cards weekly for 4 weeks then monthly times 2 months. The Director of Nursing will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations. 5. Date of compliance 6/13/2011



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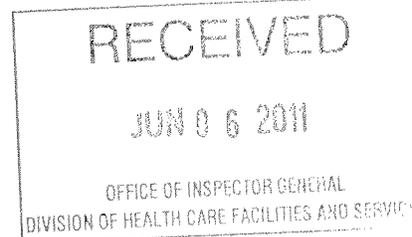
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F 279	<p>Continued From page 10</p> <p>left arm on command. The resident was unable to do active range of motion of the lower extremities.</p> <p>Review of the medical record for Resident #3 revealed an admission date of 06/01/10 with diagnoses of Multiple Sclerosis, Pressure Ulcer, Diabetes Type 2, and Chronic Kidney Disease. Resident #3 was assessed for Physical, Occupational and Speech Therapy on 06/04/10. Resident #3 was transferred to Restorative Therapy on 07/14/10. Restorative Therapy was discontinued on 09/28/10 because Resident #3 refused splint placement.</p> <p>Review of all Comprehensive Care Plans for Resident #3 revealed no evidence that a care plan had been developed for Restorative Care including Range of Motion and Splint placement. In addition, there was no goals or interventions on any of the current or previous Care Plans including Self Care Deficit, Impaired Skin Integrity, Impaired Range of Motion, and Risk for Falls to prevent the decline or worsening of contractures for Resident #3.</p> <p>Review of the Nursing Assistant Care Card for Resident #3 revealed no evidence of any type of Range of Motion to be provided. Listed under special needs it was written "Resident has splints-but refuses".</p> <p>Interview with the Unit Manager, on 05/12/11 at 9:50am, revealed the IDT reviewed weekly and monthly progress notes then discussed the residents' needs during care plan meetings. She stated, the facility changed goals and added</p>	F 279	



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F 279	Continued From page 11 interventions as needed for each resident. Interview with the Director of Nursing, on 05/11/11 at 7:30am, revealed she was responsible for the Restorative Program. She stated she was responsible for care planning Restorative and when residents are on Restorative Therapy there is a separate care plan specific to Restorative. The DON stated she failed to develop a care plan for Resident #3 to address Range of Motion/Restorative Services.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility policy Care Plan-Interdisciplinary it was determined the facility failed to follow the comprehensive plan of care for two (2) residents (#2 and #7) of the fifteen (15) sampled residents. The facility failed to remove a splint to complete skin checks on Resident #2 and failed to ensure a tab alarms was in place for Resident #7. The findings include: Review of the facility's policy Care Plan-Interdisciplinary, dated 010/2008, revealed "The IDT (interdisciplinary team) educates the resident/responsible party to the care plan and	F 282	F282 1. Resident #2's skin was assessed by the Assistant Director of Nursing on 5/13/2011 and no skin impairment identified. The tab alarm for resident #7 was discontinued on 5/17/2011 after being assessed by the Interdisciplinary team (Director of Nursing, Assistant Director of Nursing, Unit Manager, Therapy and MDS Coordinator). 2. A review of current resident's care plans and nursing assistant care cards was completed on 5/24/2011 by the Director of Nursing and updates were made to reflect the current status of the resident including alarms and skin checks when splints are in use.	



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F 282	<p>Continued From page 12 implements the care plan".</p> <p>1. Review of clinical record revealed the facility admitted Resident #7 on 07/01/05 with diagnoses of Alzheimer's, Dementia, Stroke and Schizophrenia. The facility assessed the Resident on the Minimum Data Set (MDS) as being moderately impaired in cognition; requiring extensive assist for transfers, bed mobility, and toileting; and sustained a non-injurious fall in the previous three (3) months. Review of the May/2011 physician orders revealed a tab alarm was to be in place on the wheelchair and the bed related to falls. This order was originally obtained on 12/28/10 and remained a current active order. Review of the comprehensive plan of care on Risk for Falls, initiated on 06/05/08 and revised on 04/04/11 revealed an intervention for a tab alarm to be placed to the wheelchair and the bed.</p> <p>Observation, on 05/10/11 at 9:55am, revealed Resident #7 sitting in the wheelchair in his/her room. At 12:45pm the resident was sitting in the wheelchair in the television room. At 1:50pm the resident was sitting in the wheelchair in the Dining Room participating in a birthday party.</p> <p>Observation, on 05/11/11 at 8:10am, revealed Resident #7 sitting in the wheelchair in the Dining Room eating breakfast. At 9:30am the resident was sitting in the wheelchair by the television room resting with his/her eyes closed. At 10:30am the resident was sitting in the wheelchair in the South Hall hallway.</p> <p>Observation, on 05/12/11 at 8:35am, revealed Resident #7 sitting in the wheelchair in the television room. At 1:05pm the resident was sitting in the wheelchair in the Dining Room listening to music. There was no tab alarm</p>	F 282	<p>3. Nursing and therapy staff have been re-educated on following resident care plans and nursing assistant care cards by the Assistant Director of Nursing on or before 6/10/2011. Education included alarms and responsibility for splinting and skin checks.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review 5 residents to ensure that care plans and nursing assistant care card interventions are being followed per week times 4 weeks then monthly times 2 months. Review to include skin checks and alarms. Findings will be submitted to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, and Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations.</p> <p>5. Date of compliance 6/13/2011</p>	

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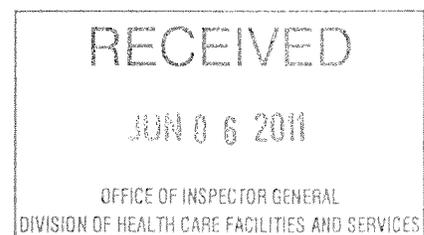
JUN 06 2011

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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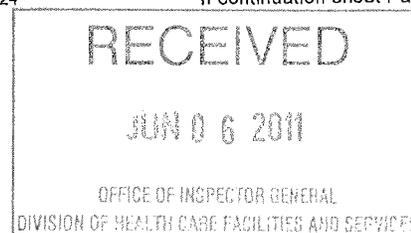
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F 282	<p>Continued From page 13</p> <p>connected to the wheelchair and the resident during any of these observations.</p> <p>Interview, on 05/12/11 at 1:15pm, with Licensed Practical Nurse (LPN) #1 revealed the LPN did not know that Resident #7 was to have a tab alarm in place. The nurse stated that if it was ordered it should be in place, but was unable to confirm placement.</p> <p>Interview, on 05/12/11 at 1:40pm, with Certified Nursing Assistant (CNA) #1 revealed Resident #7 had a tab alarm ordered. CNA #1 could not confirm the tab alarm was in place. CNA #1 revealed the facility utilized a CNA care plan to inform staff which devices are ordered and are to be utilized.</p> <p>Review of the CNA care plan revealed the tab alarm was not listed on Resident #7's CNA care plan.</p> <p>Interview, on 05/12/11 at 1:41pm, with the Unit Manager revealed the manager was a member of the Interdisciplinary team (IDT) which meets weekly to discuss the residents status and changes. She further stated that all nurses are responsible for checking the care plan. The Unit Manager was unable to confirm if Resident #7 was to have a tab alarm in place. The Unit Manager stated there was currently no system in place to alert staff as to which residents are to have an alarm system and stated staff must refer to the chart for confirmation. The Unit Manager stated this system is not effective. The Unit Manager also stated that Resident #7's care plan was not being followed by not having the alarm device in place.</p>	F 282		



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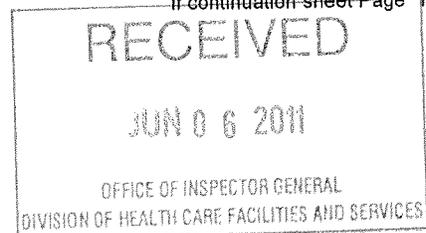
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F 282	Continued From page 14 Interview, on 05/12/11 at 2:05pm, with LPN #1 revealed the nurses should be reviewing the residents care plan and checking the CNA care plan to ensure devices are listed and that they are being initiated. Interview, on 05/12/11 at 2:30pm, with the Director of Nursing (DON) revealed the Unit Manager or DON are responsible for updating care plans and ensuring the CNA care plans are accurate. The DON stated the facility was not following Resident #7's care plan to prevent falls, and confirmed ultimate responsibility in the facility's failure to follow the care plan. Refer to F323 2. Review of the medical record for Resident #2 revealed the resident was admitted to the facility on 03/09/10 with diagnoses of Quadriplegia, Renal Insufficiency, Contracture of the left hand, Abnormal Posture and Depression. Resident #2 had on his/her care plan that he/she required a splint related to paralysis and contracture. The facility failed to follow the care plan and remove the splint every two hours and as needed to complete a skin check. Review of the Care Plan for Resident #2 revealed a Focus as "Resident requires Splint to paralysis and contracture", with an initiation date 10/01/10. The intervention "Remove brace every 2 hrs and as needed to complete skin check" was noted. Review of the Minimum Data Set (MDS), dated 03/04/11, revealed the facility assessed Resident #2 as impaired on both sides of the upper and	F 282	



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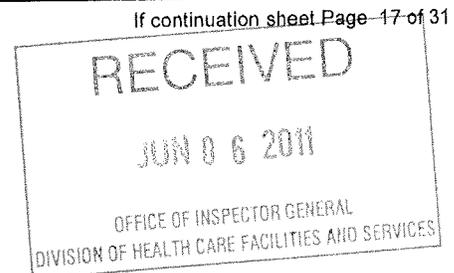
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F 282	Continued From page 15 lower extremity. The MDS further revealed, the resident required the staff to assist with the splint or brace. Review of the Physician Orders for Resident #2, dated 04/20/11, revealed the order "character checks to right hand every shift r/t (related to) cast. Check capillary refill, temperature of hand, and any edema present". The Treatment Administration Record (TAR) for Resident #2 revealed no treatment or documentation for the intervention of removing the splint and completing a skin check. Interview, on 05/11/11 at 8:55am, with Certified Nursing Assistant (CNA) #2 revealed if a resident had a splint to be removed every two hours physical therapy would do it. Interview, on 05/11/11 at 9:10am, with the Physical Therapist revealed if a splint was to be removed every two hours, nursing would be responsible. Interview, on 05/11/11 at 11:30am, with Licensed Practical Nurse (LPN) #1 revealed "The nurses do" check the splint of Resident #2 and chart on the TAR. She further revealed "normally I don't chart" when the splint is checked. She stated she checked them "frequently". Interview, on 05/11/11 at 11:33am, with the Unit Manager revealed "Therapy is the one applying it (the splint) so they would be the one to go back and check".	F 282	
F 318	483.25(e)(2) INCREASE/PREVENT DECREASE SS=D IN RANGE OF MOTION	F 318	



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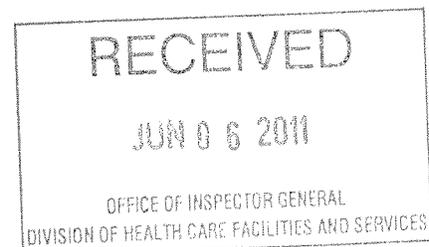
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F 318	Continued From page 16 Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy Restorative Nursing Program, it was determined the facility failed to provide appropriate treatment to prevent further decrease in range of motion for one (1) resident (#3) of the fifteen (15) sampled residents. Resident #3, who had a limited range of motion, was not assessed, or care planned, and did not receive services to prevent a decline in range of motion. The findings include: Review of the facility policy for Restorative Nursing Program effective 06/10 revealed the program was for the interdisciplinary approach to manage each residents' functional status. The program relied on evidence-base treatment and standards of practice to maintain a resident's functional abilities, promote resident ability and wellness, preventing decline or loss and enable residents to achieve/maintain their highest practicable level of functioning. Review of the medical record for Resident #3	F 318	F318 1. The restorative program for range of motion for resident #3 was discontinued 9/28/2010. Resident #3 was re-screened by Physical Therapy on 5/12/2011. 2. Director of Nursing, Assistant Director of Nursing or Unit Manager will assess current residents for appropriate treatment to prevent further decrease in range of motion. Identified residents will be referred to restorative nursing or therapy as indicated on or before 6/12/2011. 3. The nursing staff will be re-educated by the Director of Nursing or Assistant Director of Nursing on or before 6/12/11 on providing appropriate treatment to prevent further decrease in range of motion and the restorative program. The education will include identifying when a resident is placed on restorative.



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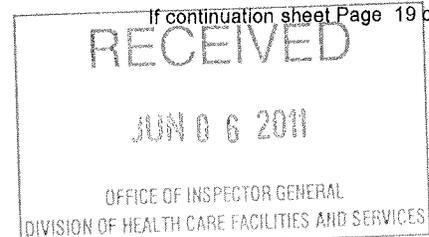
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F 318	<p>Continued From page 17</p> <p>revealed an admission date of 06/01/10 with a diagnosis of Multiple Sclerosis since the age of eighteen (18). Continued review of the Medical record revealed Resident #3 had been in a long Term Care facility since 2004.</p> <p>Review of the Minimum Data Set(MDS) admission assessment dated 06/12/10 revealed Resident #3 required extensive assistance of two (2) person for bed mobility and transfers. The facility assessed Resident #3 with impairment on one side of the upper extremities and impairment of both sides on lower extremities. This assessment remained the same on the Quarterly Assessment completed on 09/12/10 and 02/16/11.</p> <p>Review of the Physical Therapy assessment for Resident #3 completed on 06/04/10 revealed resident with severe bilateral lower extremity knee and hip contractures. Resident will require orthotic management for skin and musculoskeletal integrity.</p> <p>Review of Physical Therapy (PT) progress notes for Resident #3 revealed weekly notes up through 07/14/10 including goals for staff education on proper application of splints to lower extremities. On 07/28/10 PT was discontinued as resident had met goals by tolerating wearing of splints six (6) hours daily and various staff education on splint placement. PT took pictures of splint placement to aide nursing staff with proper splint placement.</p> <p>Review of the Restorative Referral to Nursing for Resident #3 revealed the resident was referred to Restorative on 07/14/10, for Passive Range of</p>	F 318	<p>4. The Director of Nursing, Assistant Director of Nursing and/or Unit Manager will review 5 residents weekly times 4 weeks and monthly times 2 months to ensure appropriate treatments are in place to prevent further decrease in range of motion. The Director of Nursing will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations</p> <p>5. Date of compliance 6/13/2011</p>	



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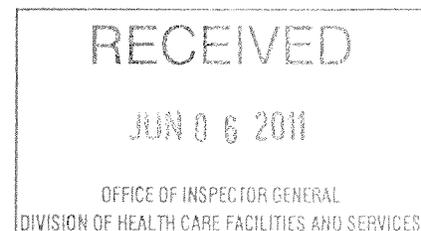
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F 318	<p>Continued From page 18</p> <p>Motion to upper extremities and lower extremities, and splint placement to bilateral lower extremities</p> <p>Review of the Restorative Nursing Flow Sheet for July 2010 through September 2010 for Resident #3 revealed documentation of residents inconsistent refusal of splints and Passive Range of Motion. Restorative Therapy was discontinued on 09/28/10. There was no evidence that Resident #3 was referred back to Therapy for a re-evaluation.</p> <p>Review of the Physical Therapy Assessment for Resident #3 completed on 05/12/11 revealed, the resident's passive range of motion was slightly more limited than last assessed with passive range of motion. Resident #3 was tested with no repetitious range of motion prior to measurements.</p> <p>Interview with the Director of Nursing (DON), on 05/11/11 at 7:30am, revealed she was responsible for writing treatments for restorative. She stated all Certified Nursing Assistants (CNA) are trained on Restorative when they are hired. In addition, Therapy would inservice for special needs.</p> <p>Interview with CNA #3, on 05/11/11 at 7:45am, who was providing care for Resident #3, stated he was not sure who was getting Restorative or Range of Motion in his group. He stated it would be in the Activities of Daily Living (ADL) book. CNA #3 stated they also get an assignment sheet in the morning on the group they are assigned to.</p> <p>Review of the CNA assignment sheet revealed Resident #3 was on Regular liquid and required</p>	F 318		



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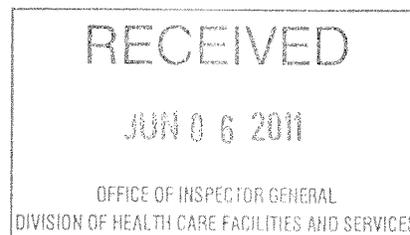
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F 318	Continued From page 19 assistance with eating. Hoyer life, Reposition, and Foley Catheter is all that was listed for the resident. There was no indication that Resident #3 had contractures or needed range of motion. Review of the CNA Care Card for Resident #3 revealed no indication the resident had contractures or that range of motion was required. Listed under special needs, it was hand written "Resident has splints-but refuses". Interview with the sister of Resident #3, on 05/11/11 at 10:15am, revealed she was very involved in the care of Resident #3. She stated she did come to some Care Plan meetings but sometimes she can't make it. The sister of Resident #3 stated as far as she knew, the resident had not refused any care needs. Interview with Physical Therapy Manager (PTM), on 05/11/11 at 10:00am, revealed the Therapy department should be informed if a resident was refusing Restorative. He stated he did not know about Resident #3 because he was not a permanent employee back in September, 2010. He stated he had only been the Manager for a couple of months and they are still trying to work out the quarterly assessment with the Interdisciplinary Team(IDT). Interview with CNA #2, on 05/12/11 at 7:45am, revealed she had worked at the facility since February 2011. She stated she was trained on Restorative during orientation, and had received inservices from Therapy. CNA #2 stated she didn't know which residents on her team received range of motion or Therapy. CNA #2 stated she usually checked the CNA book after breakfast to	F 318	
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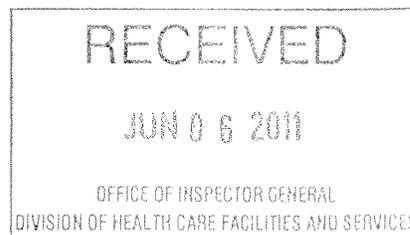
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F 318	Continued From page 20 see who needed Restorative. Interview with the Unit Manager, on 05/12/11 at 9:50am, revealed she was aware Resident #3 was not receiving Therapy or Restorative because of refusals. She stated residents should be re-evaluated quarterly with Care Plan updates for Therapy or Restorative even if they have refused in the past. Interview with the DON, on 05/12/11 at 2:35pm, revealed she was over the Restorative Program. She stated Restorative was an off shute of Therapy. She stated the IDT had meetings to determine if Restorative was to be discontinued. She stated Resident#3 was discontinued because the resident was refusing. The DON stated the resident should have been re-evaluated with the quarterly Assessment. The DON stated the potential complications for Resident #3 not getting range of motion are potential worsening of contractures, and the resident could develop wounds from contracture.	F 318	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review,	F 323	F323 1. The tab alarm for resident #7 was discontinued on 5/17/2011 after being assessed by the Interdisciplinary team (Director of Nursing, Assistant Director of Nursing, Unit Manager, Therapy and MDS Coordinator). 2. The Director of Nursing completed a safety device review on current residents on 5/24/2011. No residents were identified to be affected.



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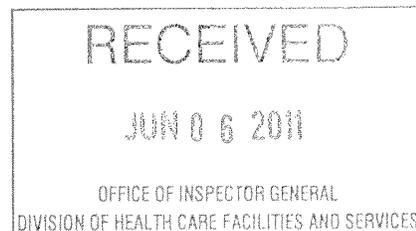
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F 323	Continued From page 21 and review of the facility policy on Accidents/Incidents it was determined the facility failed to implement interventions for safety devices consistent with a resident's needs, goals, and plan of care in order to reduce the risk of an accident for one (1) resident (#7) of the fifteen (15) sampled residents. The facility did not ensure Resident #7 wore a tab alarm as ordered to alert staff of attempts to self transfer and the resident sustained a fall on 03/05/11. In addition, observations of Resident #7 revealed a personal tab alarm was not in place. The findings include: Review of the facility's policy on Accidents/Incidents, dated 01/2008, revealed the facility identifies each resident at risk for accidents and/or falls, and adequately plans care and implements procedures to prevent accidents. Review of Resident #7's clinical record revealed an admission date of 07/01/05 with diagnoses of Alzheimer's, Dementia, Stroke and Schizophrenia. The facility assessed the Resident on the Quarterly Minimum Data Set (MDS) dated 03/24/11 as being moderately impaired in cognition; requiring extensive assist for transfers, bed mobility, and toileting; and sustained a non-injurious fall in the previous three (3) months. Review of the May/2011 physician orders revealed a tab alarm was to be in place on the wheelchair and the bed related to falls. This order was originally obtained on 12/28/10 and remains a current active order. Review of the Risk for Falls care plan revealed an intervention for a tab alarm to be placed on the wheelchair and the bed. Review of the interdisciplinary progress	F 323	3. The nursing staff will be re-educated on or before 6/12/2011 by the Assistant Director of Nursing on safety device placement and validating placement of devices. An updated safety device list will be located at each nurses' station. The Director of Nursing or Unit Manager will update the safety device list as indicated. 4. A review for safety devices of 10 residents weekly times 4 weeks will be conducted by the Unit Manager then monthly times 2 months. The Director of Nursing will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations 5. Date of compliance 6/13/2011	



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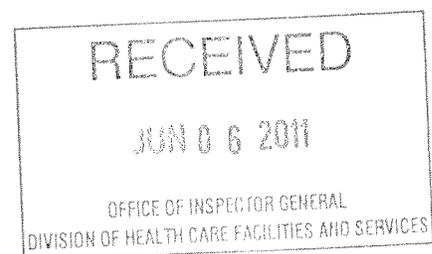
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F 323	Continued From page 22 notes revealed an entry on 03/06/11 describing Resident #7's fall on 03/05/11 as an attempt to transfer self out of bed. Review of the investigation summary revealed the ordered tab alarm was not being used for the Resident at the time of the fall. Observation, on 05/10/11 at 9:55am, revealed Resident #7 sitting in the wheelchair in his/her room. No tab alarm was in place on the wheelchair. Observation, on 05/10/11 at 12:45pm, revealed Resident #7 sitting in the wheelchair in the television room. No tab alarm was in place to the wheelchair. Observation, on 05/10/11 at 1:50pm, revealed Resident #7 sitting in the wheelchair in the Dining Room participating in a birthday party. No tab alarm was in place to the wheelchair. Observation, on 05/11/11 at 8:10am, revealed Resident #7 sitting in the wheelchair in the Dining Room eating breakfast. No tab alarm was in place to the wheelchair. Observation, on 05/11/11 at 9:30am, revealed Resident #7 sitting in the wheelchair by the television room resting with his/her eyes closed. No tab alarm was in place to the wheelchair. Observation, on 05/11/11 at 10:30am, revealed Resident #7 sitting in the wheelchair in the South Hall hallway. No tab alarm was in place to the wheelchair. Observation, on 05/12/11 at 8:35am, revealed Resident #7 sitting in the wheelchair in the television room. No tab alarm was in place to the wheelchair. Observation, on 05/12/11 at 1:05pm, revealed Resident #7 sitting in the wheelchair in the Dining Room listening to music. No tab alarm was in place to the wheelchair. Interview, on 05/12/11 at 1:15pm, with Licensed Practical Nurse (LPN) #1 revealed the LPN did	F 323	



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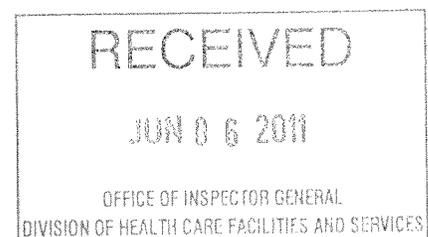
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F 323	<p>Continued From page 23</p> <p>not know that Resident #7 was to have a tab alarm in place. The nurse stated that if it was ordered it should be in place, but was unable to confirm placement.</p> <p>Interview, on 05/12/11 at 1:30pm, with Registered Nurse (RN) #1 revealed the resident is to have a bed and wheelchair tab alarm. The RN stated that alarms are written on the treatment administration record (TAR) and are to be signed off each shift to ensure they are in place.</p> <p>Review of the TAR revealed the tab alarm had been signed by the nurse on the 05/10/11 and 05/11/11.</p> <p>Continued interview with RN #1, on 05/12/11 at 1:35pm, revealed the initials noted on the TAR signify that the tab alarm was in place during that shift. The TAR had not been signed for 05/12/11. The RN stated she had not checked the tab alarm placement for the shift, therefore had not signed the TAR. The RN revealed she was not aware the tab alarm was not in place.</p> <p>Interview, on 05/12/11 at 1:40pm, with Certified Nursing Assistant (CNA) #1 revealed Resident #7 has a tab alarm ordered. CNA #1 could not confirm tab alarm was in place.</p> <p>Review of the CNA care plan revealed the tab alarm is not listed on Resident #7's CNA care plan.</p> <p>Interview, on 05/12/11 at 1:41pm, with the Unit Manager revealed the manager is a member of the Interdisciplinary team (IDT) which meets weekly to discuss the residents status and</p>	F 323	



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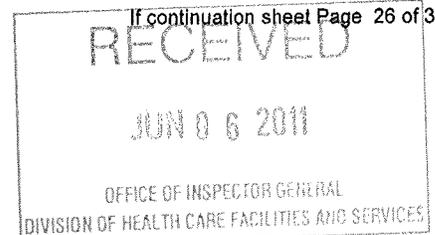
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F 323	Continued From page 24 changes. The Unit Manager stated alarm devices are placed on the TAR. The nurses are responsible to ensure alarms are in place and sign the TAR, which signify's alarm placement as ordered. The Unit Manager was unable to confirm if Resident #7 was to have a tab alarm in place. The Unit Manager stated there was currently no system in place to alert staff as to which residents are to have an alarm system and stated staff must refer to the chart for confirmation. The Unit Manager confirmed this system was not effective. The Unit Manager further revealed the alarm system should have been in place the day of the fall and the alarm would have alerted the staff of the Residents attempt to get up and might have prevented the fall. The Unit Manager confirmed responsibility for ensuring the staff were placing the alarm device to the wheelchair. Interview, on 05/12/11 at 2:05pm, with LPN #1 revealed the nurses should be reviewing the resident's care plan and checking the CNA care plan to ensure devices are listed and that they are being initiated. The LPN stated Resident #7 could be at risk for another fall without the alarm in place. Interview, on 05/12/11 at 2:30pm, with the Director of Nursing (DON) revealed the Unit Manager or DON are responsible for updating care plans and ensuring the CNA care plans are accurate. The DON further revealed the department heads consisting of the Assisstant Director of Nursing, the Administrator, and the DON are assigned weekly to check residents to ensure alarm devices are in place. The DON stated they follow a master list which contains all residents with alarms and the type of alarm in	F 323			



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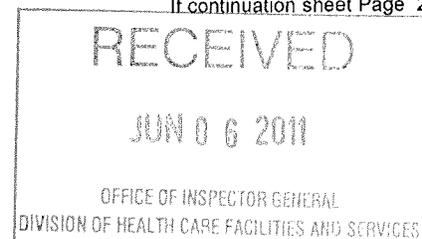
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F 323	Continued From page 25 use. Review of the master list for alarm devices revealed Resident #7 is on the list as having a tab alarm. Continued interview with the DON, on 05/12/11 at 2:40pm, revealed the facility failed to ensure the alarm was in place. The DON confirmed ultimate responsibility for not ensuring Resident #7's tab alarm is being used. The DON also revealed the system for ensuring alarm devices are being placed needs improvement. Refer to F282 F 441 483.65 INFECTION CONTROL, PREVENT SS=E 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	F 323 F 441	F441 1. Resident #7's nebulizer mouth piece was changed and placed in a bag by the Medsource oxygen representative on 5/11/2011. Resident #5 and # 6's oxygen tubing was changed and placed in bag by the Medsource oxygen representative on 5/11/2011. 2. A review of current resident's oxygen and nebulizer equipment was completed by Director of Nursing and Oxygen supplier on 5/17/2011. Oxygen tubing and nebulizer mouth pieces were changed by the Unit Manager as of 5/17/2011 and stored in plastic bags when not in use.



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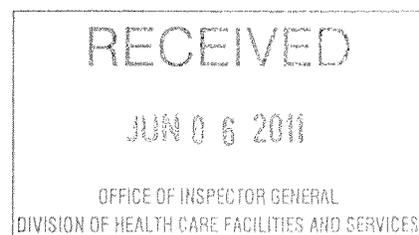
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F 441	<p>Continued From page 26</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the 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 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, record review and review of the facility's policy Oxygen Equipment: Supply Change, it was determined the facility failed to store, label and change Disposable Respiratory Equipment to prevent the transmission of disease and infection for two (2) sampled resident (Resident #6 and #7) and three (3) unsampled of the fifteen (15) residents.</p> <p>The findings include:</p> <p>Review of facility policy Oxygen Equipment: Supply Change revealed, when not in use, disposable supplies (including Nebulizer set up, nasal cannula, suction supplies, and oxygen supply tubing) should be kept in plastic set-up bag. Number 5, 6, and 7 of this policy stated tubing, cannulas, and mask are replaced every</p>	F 441	<p>3. The Director of Nursing re-educated the MedSource oxygen representative on 5/17/11 on changing oxygen supplies per protocol. Nursing staff will be re-educated on infection control by the Assistant Director of Nursing as it relates to storage of oxygen and nebulizer equipment when not in use on or before 6/12/2011.</p> <p>4. The Director of Nursing, Assistant Director of Nursing or Unit Manager will review oxygen and nebulizer equipment weekly times 4 weeks and monthly times 2 months to ensure equipment is stored within infection control guidelines. The Director of Nursing will submit the findings to the Performance Improvement Committee (Administrator, Medical Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator, Social Services, Dietary Manager, Therapy, Activities, Health Information Manager and Maintenance Director) monthly times 3 months for review and further recommendations</p> <p>5. Date of compliance 6/13/2011</p>



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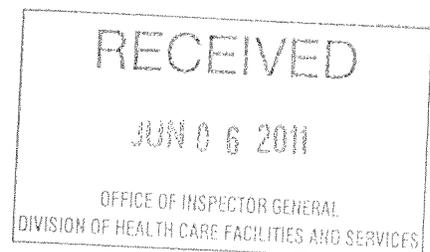
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F 441	<p>Continued From page 27 seven (7) days and as needed.</p> <p>Observation on initial tour, on 05/10/11 at 7:00am, revealed the resident in room #1 had oxygen tubing that was on the floor. The resident also had Nebulizer equipment not stored in a bag. The resident in room 16 bed 2 had nebulizer equipment not stored in a bag. Resident #6 had oxygen tubing and nasal cannula not store in a bag, and laying on the floor.</p> <p>Observation, on 05/10/11 at 9:55am, revealed Resident #7 had a nebulizer sitting in a chair next to the bed with the mouth piece not stored in a bag. Continued observation on 05/12/11 at 1:05pm revealed Resident #7 had a nebulizer still sitting in the chair next to the bed with mouthpiece not in bag.</p> <p>Observation of Resident #6, on 05/10/11 at 10:00am, revealed a well groomed appearing resident sitting in a wheelchair in the main dining room. Observation in the room of Resident #6 revealed an oxygen concentrator beside the bed. The oxygen tubing was draped over the concentrator with the nasal cannula laying on the floor behind the concentrator. The end of the oxygen tubing that was connected to the concentrator and was dated 04/01 with the initials DM.</p> <p>Observation, on 05/10/11 at 1:25pm, revealed the oxygen tubing in the room of Resident #6 revealed the tubing to now be a bag. However, the tubing was still dated 04/01 with the initials DM.</p> <p>Observation, on 05/11/11 at 07:10am, revealed</p>	F 441	



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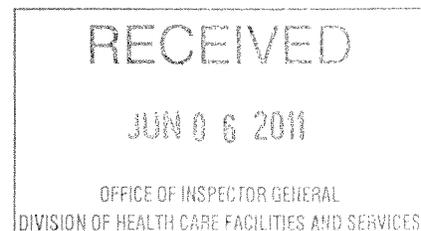
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F 441	<p>Continued From page 28</p> <p>Resident #6 sleeping quietly in bed. Oxygen was in place per nasal cannula at two (2) liters per minute. Further observation of the oxygen tubing revealed the same date of 04/01 and initials DM.</p> <p>Observation, on 05/11/11 at 10:00am, revealed Resident #6 still sleeping with Oxygen per nasal cannula at 2 liters per minute. The tubing is still dated 04/01 with the initials DM</p> <p>Observation, on 05/12/11 at 7:30am, revealed Resident #6 in bed sleeping. Oxygen per nasal cannula at 2 liters. The tubing was then dated 05/11/11 with the initials DM.</p> <p>Review of the medical record for Resident #6 revealed the resident was originally admitted to the facility on 07/01/05. The resident was readmitted to the facility on 03/04/11 after a hospital stay for aspiration pneumonia. Other diagnosis for Resident #6 include, Multifactorial Dementia, Depression, and Spinal Stenosis. Review of the admission orders revealed the resident had an order for oxygen at 2 liter per minute as needed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 05/12/11 at 1:10pm, revealed there was a contract person who comes in and manages the facility Respiratory Care equipment, and she was not aware how often oxygen tubing was changed but believed it was one (1) time a week. She stated that if she found oxygen tubing on the floor, or it was "nasty" she would change it and date the tubing. LPN #1 stated that if disposable respiratory equipment is not changed when they are scheduled or after found on the floor it could cause a respiratory infection.</p>	F 441	
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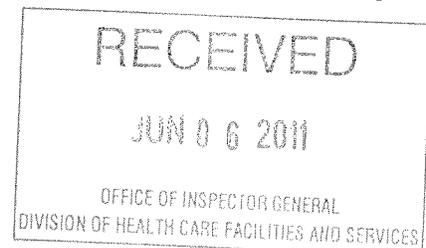
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NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE
F 441	Continued From page 29 Interview with Certified Nursing Assistant (CNA) #2, on 05/12/11 at 1:20pm, revealed if the oxygen tubing was on the floor, she would take it out and throw it away and report this to the nurse. CNA #2 stated it needs to be changed because it was on the floor and contaminated. Interview with Medisource contact employee for the facility, on 05/12/11 at 1:25pm, revealed she was responsible for coming to the facility and changing all disposable respiratory equipment. She stated she also reviewed new orders for respiratory needs. She stated she came in every week but not every seven (7) days. The contract employee stated she had a list of residents that had any type of respiratory equipment. She stated she went in every room when she came to the facility. She stated Resident #6 was on the list for respiratory care needs. When ask about Resident #6 oxygen tubing that had a date of 04/01 with the initials DM, the contract employee stated, if the resident does not use the equipment, she will not change it. When ask how she knew if it was used, she stated she could tell by how it was wrapped up and in the bag. The contract employee stated it would not be a good practice to put a nasal cannula on the resident if the cannula was on the floor. She stated it could possibly cause an infection. Interview with the Director of Nursing (DON), on 05/12/11 at 1:30pm, revealed the facility used a contract company called Medisource that managed their oxygen equipment and supplies. She stated that the Administrator oversaw the contract company, but staff should be monitoring and disposing of contaminated equipment. She	F 441	



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

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NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
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F 441	Continued From page 30 went on to say that Resident #6 used oxygen every night when in bed.	F 441		



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NAME OF PROVIDER OR SUPPLIER KLONDIKE CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
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K 000	INITIAL COMMENTS A Life Safety Code Survey was initiated and concluded on 05/10/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "F".	K 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Care & Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
K 056 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, according to NFPA standards. The deficiency has the potential to affect all fifty-seven (57) residents, staff and visitors. The facility is licensed for sixty-two (62) beds and the census on the day of the survey was fifty-seven (57). The findings include:	K 056	K 056 1. The exterior roof overhang, at the exit door between resident rooms 30 and 31 will be equipped with a sprinkler head by an outside contractor on or before 6/12/11. Landmark Sprinkler, Inc. was contracted on 5/26/11 to install a sprinkler head 2. The Maintenance Director inspected the facility on 5/10/11 to ensure complete sprinkler system and no other issues were identified.	

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

TITLE

(X6) DATE

X *Diane Garrett*

X Administrator

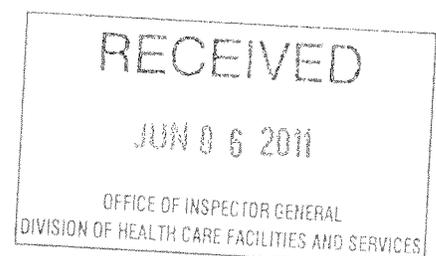
X 4/3/11

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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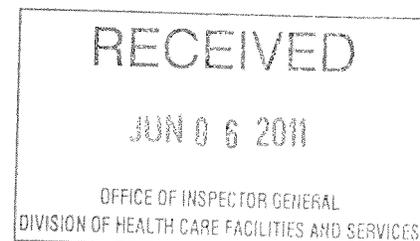
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/10/2011
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K 056	Continued From page 1 Observation on 05/10/2011 at 10:00 AM, with the Maintenance Director, revealed an exterior roof overhang, at the exit door between resident rooms 30 and 31. The overhang construction is of combustible materials, perforated vinyl panels on wood framing, without sprinkler coverage. Interview on 05/10/2011 at 10:00 AM, with the Maintenance Director indicated that he was not aware that the overhangs needed to be sprinkled. Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.	K 056	3. The Maintenance Director was re-educated to by the Administrator on 6/1/2011 regarding the building having a complete sprinkler system. 4. The Maintenance Director or Administrator will complete an audit of the center monthly times 3 months to ensure a complete sprinkler system is in place. A summary of these findings will be submitted to the PI Committee monthly times 3 months for review and further recommendations. 5. Date of Compliance 6/13/2011.	
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 means of egress were maintained free and clear of obstructions according to NFPA standards. The deficiency has the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has the capacity for sixty-two (62) beds; the census on the day of the survey	K 072	K 072 1. The lifts were relocated outside of the corridor on 5/12/11. 2. The Maintenance Director inspected the facility on 5/10/11 and no other issues were identified. 3. The Maintenance Director re-educated the nursing staff, administrative staff and housekeeping staff on storage of lifts when not in use and ensuring means of egress are maintained free and clear of obstructions on 5/12/2011.	



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K 072	Continued From page 2 was fifty-seven (57). The findings include: Observation during the Life Safety Code Survey on 05/04/2011 between 8:30 AM and 2:00 PM, with the Maintenance Director, revealed a Hoyer lift located outside of resident room 28, and a standing lift located outside of resident room 30. The items observed in the corridors to be stationary for a period of more than thirty (30) minutes. Interview on 05/10/2011 at 10:30 AM, with the Maintenance Director, confirmed the lifts located in the corridors and indicated the facility lacked in storage space. The lifts were relocated outside of the corridor. Reference: NFPA 101 (2000 edition) 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.	K 072	4. The Maintenance Director or Housekeeping supervisor will check the halls for proper storage of lifts and ensure means of egress are maintained free and clear of obstructions weekly times 4 weeks and then monthly times 2 months. A summary of findings will be submitted by the Maintenance Director to the Performance Improvement Committee monthly times 3 months for review and further recommendation. 5. Date of Compliance 6/13/2011	
K 147 SS=D	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:	K 147	K 147 1. Maintenance Director repaired malfunctioning lock on electrical panel in resident corridor 5/10/2011.	



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K 147	<p>Continued From page 3</p> <p>Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. The deficiency affected all smoke compartments, including residents, staff, and visitors. The facility is licensed for sixty-two (62) beds with a census of fifty-seven (57) on the day of the survey.</p> <p>The findings include:</p> <p>Observations on 05/10/2011 at 9:25 AM, with the Maintenance Director, revealed an electrical panel located in the resident corridor was unlocked.</p> <p>Interview on 05/10/2011 at 9:25 AM, with the Maintenance Director, revealed a malfunction of the lock prevented it from locking. The malfunction of the lock was corrected before the 2:00 PM exiting conference..</p> <p>Reference: NFPA 99 (1999 edition)</p>	K 147	<p>2. The Maintenance Director reviewed the locks of all electrical panels on 5/10/2011. No other concerns identified.</p> <p>3. The Maintenance Director was re-educated on maintaining electrical wiring and electrical panel being locked by the Administrator on 6/1/2011.</p> <p>4. The Maintenance Director will review electrical panels for defective or nonfunctional locks during weekly rounds. The Maintenance Director will submit a summary of findings to the Performance Improvement Committee monthly times 3 months for further review and recommendations</p> <p>5. Date of Compliance 6/13/2011.</p>	