

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

PRINTED: 11/30/2010
FORM APPROVED
OMB NO. 0938-0391

DEC - 9 2010
Office of Inspector General
Northern Enforcement Branch

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2010
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NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 7604 WESTPORT ROAD LOUISVILLE, KY 40222
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F 000	INITIAL COMMENTS AMENDED SOD 11/29/10 A standard health survey was conducted 11/08/10 through 11/10/10 and a Life Safety Code survey was 11/09/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. 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 279	F279 483.20(d), 483.20(k)(1) Develop Comprehensive Care Plans The resident # 8 had a case reviewed for implementation of a restorative plan. Therapy Services had evaluated resident # 8 previously, a staffing change and miscommunication resulted in failure to follow through. Therapy Services understands to refer consistently for maintenance programs, if of benefit to the resident. Nursing staff has also been educated that they share in the responsibility of referring to restorative nursing services. MDS Coordinators have been instructed to review the questions on the MDS pertaining to restorative nursing and take action as appropriate in referral to the restorative nurse and /or Therapy Services for evaluation and will assist with developing the plan of care.	12/8/2010

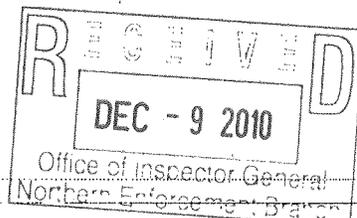
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *x [Signature]* TITLE: CEO DATE: 12/8/10

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

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, It was determined the facility failed to develop a restorative care plan based on the admission Minimum Data Set (MDS) assessment for one (1) of twenty-four (24) sampled residents (Resident #8). The facility identified in the admission MDS that the resident was capable of being more independent in at least some Activities of Daily Living (ADL). The findings include: Review of the facility's Restorative Nursing Policy, dated 08/14/2007, revealed all residents will be screened for restorative needs by all disciplines upon admission to the facility. Record review of Resident #8 revealed the resident was admitted to the facility with diagnoses of Dementia, Anemia and Hypertension. The facility completed an admission MDS assessment on 10/01/10 which revealed the resident required assistance with transfer, dressing, ambulation, and bathing. The staff felt the resident was capable of increased independence; however, there was no evidence the resident received a restorative assessment nor was there evidence the facility developed a restorative care plan based on the admission MDS. Observation of Resident #8 on 11/09/10 at 11:00am revealed the resident sitting up on the side of the bed being assisted into a wheelchair	F 279	A restorative plan has been implemented for resident # 8. (See in the Attachment for F279) A complete audit of current residents leaving therapy who would benefit from a restorative plan was conducted by the Therapy Department. No further residents were identified as in need of restorative nursing services than those already referred and with a plan implemented. Nurses and aides were also educated that they share responsibility for identifying residents needing a restorative plan. No other restorative nursing program candidates were identified during the education process with the nurses and aides. Therapy Services will audit all residents discharged from therapy for need for restorative nursing and report the information to the QA/QI committee on a minimum of a quarterly basis. (See Attachment for F279)	



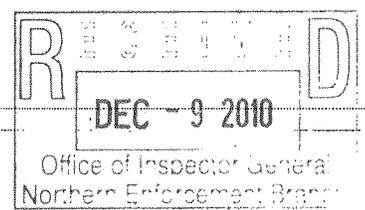
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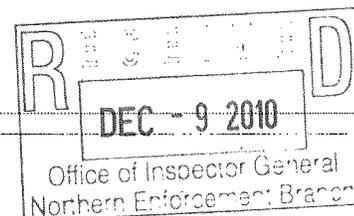
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F 279	<p>Continued From page 2</p> <p>by one staff person. The bed was fitted with short rails which the resident used to move with while in the bed. The resident was able to propel self in the wheelchair using feet. Observations on 11/09/10 at 1:00pm, and 3:00pm revealed the resident was able to propel self around the nursing unit.</p> <p>Interview with Resident #8 on 11/10/10 at 2:00pm revealed the resident could assist with dressing and grooming, and being more independent would be fine with the resident.</p> <p>Interview with Certified Nurse Aide (CNA) #7 on 11/09/10 at 11:00am revealed Resident #8 needed extensive assistance with dressing and transfers. She stated the resident could do more to dress and groom self. She stated the resident was cooperative and tried to help with ADLs.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 11/09/10 at 11:30am revealed Resident #8 was not receiving restorative nursing; however, she did not know why since the resident tried to assist with care. She was unable to locate an admission restorative assessment.</p> <p>Interview with the Nurse Manager on 11/09/10 at 11:45am revealed Resident #8 was not receiving restorative nursing. She was unable to locate an admission restorative assessment.</p>	F 279		
F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p>	F 280	<p>F280 483.20(d)(3), 483.10 (k)(2) Right to Participate planning care-revise CP</p> <p>Resident #12: The nurse aide assignment form and plan of care were updated with the proper settings for the low air loss mattress. The Treatment Administration Record (TAR) was also noted with the information for a daily</p>	



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F 280	<p>Continued From page 3</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to revise three (3) of twenty-four (24) sampled residents (Residents' #12, 13 and 16) comprehensive care plans to reflect the action taken after resident falls in order to prevent future falls. Resident #12's fall was caused by overfilling an air mattress. Resident #13 fell trying to toilet self. Resident #16 slid out of the wheelchair.</p> <p>The findings include:</p> <p>Record review of the facility's policy on occurrence tracking revealed: Avoidance- opinion is solicited on how to prevent future occurrences. Along this line, participation in the Falling Hearts program is reviewed. Two or more falls in 60 days qualifies a resident to be enrolled in the program. If the resident is already in the Falling hearts program the physician should be alerted via fax if the</p>	F 280	<p>check by the nurse. A Desktop Reference (DTR/procedure) was updated with instructions on how to check for proper inflation and is available on the Neighborhoods. Staff was instructed on December 6 & 7, 2010 on the availability of the procedure for their use and how to check the mattress manually for proper inflation. All Residents with low air loss mattresses had their care plans and nurse aide assignment forms checked and/or updated with the appropriate settings required. TARs were updated. Note: These residents had experienced no falls related to mattress use. Education of nurse aides and nurses was conducted December 6 & 7, 2010. A Desktop Reference was put in place for specialty mattresses. A specific instruction for routine verification of proper inflation was placed on the TAR and nurse aide assignments sheets and in the plan of care. All resident beds with a low air loss mattress will be checked daily for the proper setting which is to appear on the TAR. The care plan and nurse aide assignment sheet will be checked monthly by the nurse or nurse manager and a report submitted to the Director of Clinical Services and the QA/ QI Committee.</p> <p>Resident # 13: This resident's care plan was updated to include HS toileting. The resident has poor decision making</p>



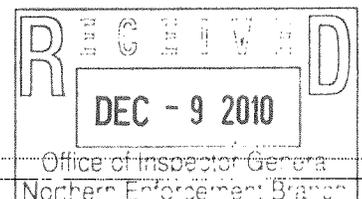
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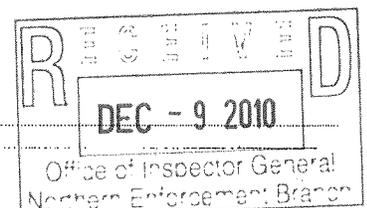
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F 280	<p>Continued From page 4</p> <p>physician participates in the fax program. A form is available for use. The Medical Director's book may be used for placing the copy of the form along with the MAR for the Medical Director's review. The behavior plan should also be reviewed and updated.</p> <p>1. Observation of Resident #12 on 11/09/10 at 11:15am and 3:00pm, and on 11/10/10 at 8:15am, and 10:00am revealed the resident in bed on an air mattress. The bed was in low position. The resident was making no attempts to move self in bed.</p> <p>Review of the clinical record for Resident #12 revealed the resident was admitted to the facility with diagnoses of Diabetes, Dementia, and Failure to Thrive. The facility completed a quarterly Minimum Data Set (MDS) assessment on 10/28/10 which revealed the resident had a severe impairment in the ability to make daily care decisions, and required extensive assistance with transfers, dressing, bathing, and eating. Review of the event occurrence report for 08/03/10 revealed the resident rolled out of bed to the floor. The causative factor on the event occurrence report was overfilling of the air mattress. Review of the resident's care plan revealed there were no specific interventions on filling the air mattress in order to prevent another fall.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 11/09/10 at 2:00pm revealed she had no information on Resident #12's air mattress and adjusting the mattress to prevent falls. She stated she used the assignment sheet as a guide to care and there was no information present.</p>	F 280	<p>related to dementia and at times self propels with a minimal to no amount of communication related to toileting needs. The resident is encouraged to participate in activities and socialize outside the room. The resident is generally unaware of any toileting needs. The resident is encouraged to be in areas that allows for observation by care giving staff. The resident does not process/retain the potential harm to self when walking or transferring alone. Staff is to observe the resident when in the room alone- except when asleep. Staff has been instructed by the nurse manager and the resident's care plan has been revised. Other residents with falls risks were identified/validated, evaluated, and their plan of care reviewed/updated as well as the nurse aide assignment sheets. All nurses and nurse aides were in-serviced and instructed to carefully analyze the causes/contributing factors related to any fall and communicate with one another. Nurses were instructed to revise the care plans with new interactions and to revise the nurse aide assignment sheets accordingly. Falls circumstances and prevention plans are reviewed at the interdisciplinary Falls Committee meeting weekly and Falling Hearts Meeting monthly. A new addition to the falls prevention monitoring has become the review of care plan interventions at weekly Falls Committee meeting to</p>	



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F 280	<p>Continued From page 5</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 11/09/10 at 11:30am revealed she had no information on Resident #12's air mattress to prevent falls from the bed. She stated the information regarding the air mattress should be on the care plan. She stated she was not sure who was responsible to revise the care plan; however, she believed anyone could revise the plan. She stated someone should have reviewed the fall and written an intervention to prevent the fall from recurring. She stated she was not aware of any system to review resident care plans for accuracy.</p> <p>Interview with the MDS Nurse on 11/10/10 at 11:30am revealed the unit nurses were educated on revising care plans on a daily basis. She stated she only reviewed the care plans quarterly. She stated she did not have any system in place to review resident care plans for accuracy.</p> <p>2. Observation of Resident #16 on 11/09/10 at 11:45am, 3:15pm, and on 11/10/10 at 8:45am revealed the resident sitting upright in a high back tilting wheelchair. The resident was noted to be slumped down and leaning to the right in the wheelchair at each observation.</p> <p>Review of the clinical record for Resident #16 revealed the resident was admitted to the facility with diagnoses of Alzheimer's Disease, Dysphasia, and Dementia. The facility completed a quarterly MDS assessment on 09/30/10 which revealed the resident had a severe impairment in the ability to make daily care decisions and required extensive assistance with transfers and total assistance with dressing and bathing. Therapy treated the resident on 06/28/10 for wheelchair positioning with the last visit occurring</p>	F 280	<p>ensure updates have occurred, any new cause or contributing factors are identifies in the problem statement and make any additional changes that the interdisciplinary team might offer. A summary of the actions of the Falls Committee will be circulated to the caregiver team. Falls summaries will be included in the QA/QI reporting a minimum of quarterly.</p> <p>Resident #16: Resident #16's positioning was an issue ECH had been addressing. Therapy had been consulted on 6/21/2010 for positioning. A special chair was ordered and arrived July 19, 2010 when Therapy saw her again. The resident has a preferred position of comfort and returns to this position repeatedly, despite repositioning efforts. Physical Therapy was consulted again on 11/16/2010 for additional assistance. A Restorative Nursing program for positioning was implemented on 11/16/2010. Observations of meal time positioning by the Nursing Leadership and staff are ongoing. A Meal Observation audit tool, that includes proper positioning, has been implemented to verify implementation of the restorative nursing program for resident # 16. The resident's care plan was revised. An audit of all residents with dysphasia with potential positioning issues was conducted by the skilled area nurse managers and</p>	



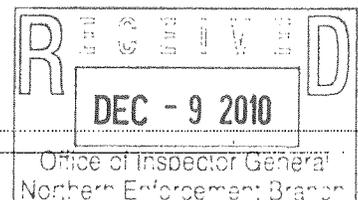
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F 280	<p>Continued From page 6</p> <p>on 07/20/10. A note from the physician dated 10/11/10 revealed the resident was declining and no longer walking. There was no evidence the resident had been recently assessed for positioning in the wheelchair to ensure an upright position during meals related to the diagnosis of dysphasia and the physician's order to sit upright for meals.</p> <p>Interview with LPN #2 on 11/10/10 at 9:45am revealed Resident #16 had experienced a decline related to the progression of Alzheimer's Disease. She stated Resident #16 should be seated upright during meals, not slumped down and leaning. She was not able to locate any care planning revisions to address this positioning concern; however, she stated she would have therapy see the resident and revise the resident's care plan.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 11/10/10 at 9:55am revealed she fed Resident #16 breakfast in a slumped down and leaning position. She stated the resident had been having trouble sitting upright in the chair for two (2) months.</p> <p>3. Record review of resident # 13 revealed the care plan was not revised reflect the Interventions from a previous fall on 05/31/10 and 06/14/10.</p> <p>Record review of the occurrence reports revealed Resident #13 had a fall on 05/31/10 while getting out of bed. The causative factor was the resident was trying to go to the bathroom. The intervention was to take the resident to the toilet before bedtime. The fall on 06/14/10 revealed the resident was transferring from the wheelchair to the toilet and fell. The causative factor was the</p>	F 280	<p>completed on 11/22/2010. One resident was found to have dysphasia and have difficulty with positioning. Therapy Services had already been consulted and cushions added in the chair to aid in proper positioning. Restorative Nursing Services twice a day was added for positioning. The interventions were noted in the plan of care and nurse aide assignment sheets. No deficient practice was identified related to this resident.</p> <p>To prevent reoccurrence of this sort, an end of therapy audit will be conducted by Therapy Service to insure referrals by Therapy Services for restorative nursing are made. If no restorative referrals are made, follow up analyses are to be made by nursing staff through interaction with the resident and nurse aides in their monthly review and note and a referral made as needed. Ongoing monitoring will occur through an audit conducted a minimum of monthly by Therapy Services of residents discharged from therapy services and an audit of mealtime positioning will be conducted to identify any actual positioning concerns that may develop overtime. A report of the audits will be submitted to the Director of Clinical Services monthly with reporting to the QA/QI Committee a minimum of quarterly. (See Attachment F280)</p>	



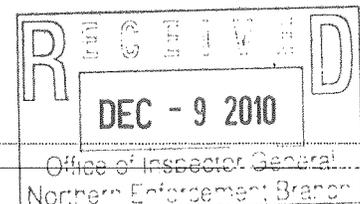
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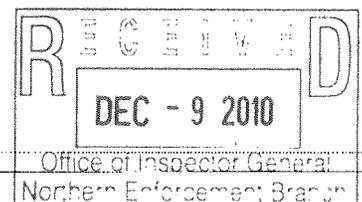
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F 280	<p>Continued From page 7</p> <p>wheelchair was not locked during the transfer. The intervention was not to leave the resident alone in their room by themself. Review of the careplan revealed there were no interventions related to taking the resident to the bathroom before bedtime or supervision of the resident while in the room by themself.</p> <p>Interview on 11/10/10 at 2:00pm with RN #3 revealed that documentation of a fall would be in the nursing notes and interventions would be in the careplan.</p> <p>Interview on 11/10/10 at 1:20pm with the Director of Clinical Services revealed the interventions would be in the careplan and also stated the nurse taking care of the patient was ultimately responsible for updating the careplan.</p> <p>Interview on 11/10/10 at 10:45am with RN #2 revealed that it should have been added to the care plan that the resident not be in the room by themself as much as possible because the resident wanders and the nurses should have added to the careplan at the time of the fall that the resident needs to be tolleted before going to bed.</p>	F 280		
F 309 SS=D	<p>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p>	F 309	<p>F309 483.25 Provide Care/Services for Highest Well Being</p> <p>Resident #16: The resident's positioning was an issue ECH had been addressing. Therapy Services had been consulted on 6.21.2010 and a special wheelchair was obtained. The resident has had a preferred position she returns to repeatedly, despite positioning by care givers. Physical Therapy was consulted for the positioning suggestions on July 19th when Therapy saw her again. The wheelchair was</p>	



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F 309	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services for one (1) resident of twenty-four (24) sampled residents (Resident #16) to maintain the highest practicable physical well-being in accordance with the comprehensive care plan. The facility failed to identify appropriate positioning of Resident #16 during meals to prevent the resident from experiencing a slumped and leaning posture.</p> <p>The findings include:</p> <p>The facility was not able to provide a policy for positioning residents during meals.</p> <p>Observation of Resident #16 on 11/09/10 at 11:45am (during lunch), 3:15pm and on 11/10/10 at 8:45am (during breakfast) revealed the resident sitting upright in a high back titling wheelchair slumped down and leaning to the right with their chin on the chest. Staff were observed feeding the resident in this position.</p> <p>Review of the clinical record for Resident #16 revealed the resident was admitted to the facility with diagnoses of Dysphagia and Alzheimer's Disease. The facility completed a quarterly Minimum Data Set assessment on 09/30/10 which indicated the resident required total assistance with mobility and was not able to verbalize needs. The care plan indicated the resident should be watched for positioning in the chair and reposition as needed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on 11/10/10 at 9:45am revealed Resident #16</p>	F 309	<p>reevaluated and deemed appropriate. A Restorative Nursing program for positioning was implemented. Observations of meal time positioning by the Nursing Leadership and staff are ongoing. A Meal Observation audit tool has been implemented to document the findings. The care plan was revised on 11/16/2010. An audit of all residents with dysphasia /potential positioning issues was conducted. One resident was found to have dysphasia and have difficulty with positioning. Therapy Services had already been consulted and cushions added in the chair to aid in positioning. The interventions were noted in the plan of care and nurse aide assignment sheets. No deficient practice was identified related to this resident. To prevent a reoccurrence, restorative referrals will be considered by nursing and therapy. Observations will be made of residents as contact is made on rounds or through care. Meal time audits of positioning will be conducted as discussed previously with the expectation that repositioning occur on a regular basis if improper alignment is identified. Ongoing monitoring will occur through restorative nursing services and nursing services. An audit of mealtime positioning to identify any actual positioning concerns will be conducted on the schedule provided in the F 309 Attachment and if the resident is found to be consistently well</p>	

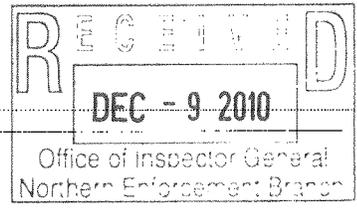


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185310	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/10/2010
NAME OF PROVIDER OR SUPPLIER EPISCOPAL CHURCH HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 7504 WESTPORT ROAD LOUISVILLE, KY 40222	

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F 309	<p>Continued From page 9</p> <p>was not able to reposition self in the wheelchair and was sitting in a slumped leaning position. She stated the resident should not be sitting in the slumped position and that all staff were responsible for repositioning the resident. She stated the resident had to sit up for meals and it was not appropriate for the resident to be fed while slumped in the wheelchair. She stated she had been in the dining room during breakfast on 11/10/10 and did not notice the resident's position in the wheelchair. She stated the wheelchair was no longer meeting the resident's needs. She was not sure if nurse aides had been trained on positioning.</p> <p>Interview with Certified Nurse Aide (CNA) #1 on 11/10/10 at 9:55am revealed she fed Resident #16 breakfast on 11/10/10 while the resident was in a slumped down and leaning position. She stated she would usually pull the resident up in the chair when needed; however, the resident only stayed in the correct position for a short time then slumped down again. She stated the resident's chair was not working. She stated she had received training regarding positioning residents correctly.</p> <p>Interview with the Unit Manager on 11/10/10 at 11:00am revealed the CNA's were trained to position residents correctly. She stated the nurses were responsible for monitoring the dining room.</p>	F 309	<p>positioned will decrease in frequency based on the consistency of correct positioning findings. Reports will be submitted to the Director of Clinical Services monthly with reporting to the QA/QI Committee a minimum of quarterly. (See Attachment F309)</p>	
F 334 SS=E	<p>483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS</p> <p>The facility must develop policies and procedures that ensure that -- (I) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the</p>	F 334	<p>F334 483.25(n) Influenza and Pneumococcal Immunizations</p> <p>The surveyors were informed during the visit that the release form was not available on all residents for pneumococcal vaccines because it had been implemented on new admissions</p>	

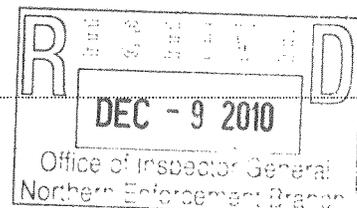


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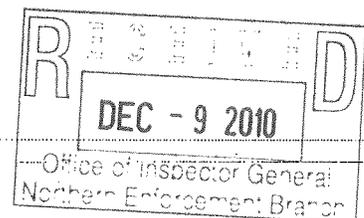
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F 334	<p>Continued From page 10</p> <p>(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and</p> <p>(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.</p> <p>The facility must develop policies and procedures that ensure that --</p> <p>(I) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;</p> <p>(II) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicated, at a minimum, the following:</p> <p>(A) That the resident or resident's legal representative was provided education regarding</p>	F 334	<p>before being finalized for use by all residents and withdrawn from further use for revision, thus reverting to the older system of notifying on admission and discussing and influenza vaccines notice sent during the annual September billing process. (See F 334 Attachment)</p> <p>In-servicing had been provided to the Nursing staff on both influenza and pneumococcal vaccine during staff meetings on 9/8/2010. The Vaccines Desktop Reference (DTR) had also been developed and introduced. (See F334 Attachment) Residents # 5, and 14's refusals were investigated and Nurse's Note found that included the name of the person who refused the date and the nurse's signature. This process was completed 12.6.2010. Resident #3's family was re-approached on 11.15.2010 and the resident received the pneumococcal vaccine. Nurses were educated on the appropriate refusal mechanisms used to document them. The DTR was expanded to include this information. (See F344 Attachment) Residents # 8 & 17 both were administered the pneumococcal vaccine with completion on December 2, 2010, with consents, orders and records documents in accordance with DTR. A total resident medical records audit was conducted and follow-up completed on 11/22/2010 and follow-up with refusal forms completed and properly documented information on past history</p>	



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F 334	<p>Continued From page 11</p> <p>(A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.</p> <p>(v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 6 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to follow its policy and procedure for the documentation of acceptance or refusal of Influenza and Pneumococcal vaccinations. Documentation of the acceptance or refusal of the Influenza or Pneumococcal vaccination by the resident or their legal representative was absent in the medical record for six (#1, 3, 5, 8, 14, and 17) out of twenty-four (24) sampled residents.</p> <p>The findings include:</p> <p>Review of the facility policy and procedure revealed: Influenza and Pneumococcal are to be researched via interview, family contact or contact with the Resident's primary physician. The dates the vaccinations were received was to be</p>	F 334	<p>of injections clarified, and clarification if continued refusal to receive the vaccine was desired. If residents desired the vaccine, it was administered and documents in accordance with the DTR with all records complete on December 6, 2010. System changes implemented include the revision of the resource tool- the DTR for vaccines clarifying the addressing and handling of refusals. Education was provided to current staff and will be provided to all new hires regarding the requirements and included on the orientation checklist. (See F 344 Attachment) A monthly audit report is to be generated by the nurse managers of the neighborhoods addressing the administration and refusal of vaccines to insure the review of vaccine administration stays current. The report will be submitted to the Director of Clinical Services and presented to QA/QI a minimum of quarterly.</p>	



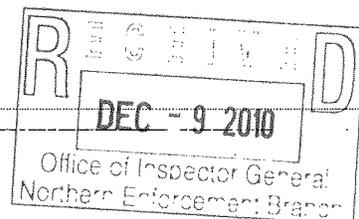
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F 334	<p>Continued From page 12</p> <p>documented in the medical record. Attached to the policy is a flow chart adopted from the CDC 01/2009. In addition the policy also included a copy of the TB screening record and a Resident Influenza and Pneumococcal Release form. The release form allows the Resident or their legal representative to accept or refuse the vaccinations.</p> <p>Review of Residents # 1, 5 and 14 medical records on 11/08/10 at 2:45pm revealed no documentation of the Resident or legal representative's refusal of the vaccinations.</p> <p>Interviews on 11/10/10 at 8:45am with the Corporate Compliance Officer and Director of Nursing revealed that staff were given to read and sign a policy which was to go into effect 10/08/10. The facility then decided to place a hold on the policy which required identification of the person accepting or refusing the vaccinations. The Corporate Compliance Officer stated education and notification of vaccine availability is provided in a monthly statement to residents that includes facility charges. She further stated, that since the information is included in the billing statement, the facility has met their obligation. She could not confirm statements were received or information provided was read. She did confirm Social Services is using the form for new admissions, but did not provide information on how the form would be used on existing residents.</p> <p>Review of the clinical record for Resident #8 revealed no record of having the pneumonia immunization. There was no documentation regarding consent or refusal, or education on the benefits and potential side effects of the immunization signed by the resident or responsible party. There was no information from</p>	F 334		

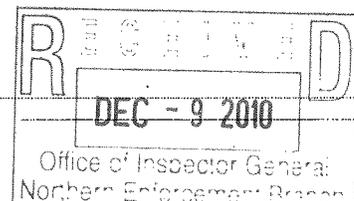


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F 334	<p>Continued From page 13</p> <p>the physician stating the immunization was medically contraindicated.</p> <p>Record review of the file for Resident #3 on 11/08/10 revealed that the resident was admitted on 12/09/09. The resident, or the resident's representative, was offered the pneumonia vaccine and the word "refused" was written in the resident's file. There was no documentation regarding education on the importance of the vaccine provided to the resident or his representative. No reason was documented for the refusal of the vaccine. No signature of the staff person, or date the vaccine was offered, was recorded in the resident's file.</p> <p>Interview with RN #5, the unit manager, on 11/09/10 at 2:00pm revealed that consent to receive vaccination or refusal of vaccination as well as resident education was left up to the nurses on the unit. She stated that it was their responsibility to document anything like that.</p> <p>Interview with LPN #6 on 11/09/10 at 2:05pm, who has worked at the facility for approximately eight (8) years, stated that they do not have a consent form or education sheet on their unit for pneumococcal vaccines or influenza vaccines. She stated that the nurse was supposed to just document in the resident's file if they gave the injection or not, sign, and date.</p> <p>Interview with the staff development coordinator on 11/10/10 at 10:05am revealed that it was not his responsibility for training the staff on education and consent for influenza and pneumococcal vaccination. He stated that the unit manager has the responsibility of making sure that education and consent was done with</p>	F 334		



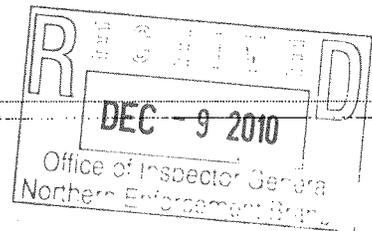
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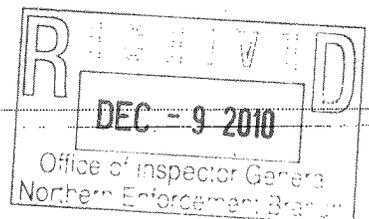
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F 334	Continued From page 14 the resident or their families. He stated that it was a standard expectation that all residents, or their responsible party, receive education and give consent for vaccinations. Interview with LPN #2 on 11/10/10 at 10:40am, who has worked at the facility for approximately six (6) years, revealed that the resident, or their responsible party, is offered the influenza and pneumococcal vaccines upon admission to the facility. If they refuse and say they already received it the nurse documents that in the resident's file and attempts to find out where and when they had it and then record in the resident's file. She stated an allergy to eggs would also be documented if that were the case. She stated that an inservice was done within the last month on documentation/education/consent for influenza and pneumococcal vaccination. She did not attend but did read the information presented in the inservice. She stated that if a resident or their responsible party refuses the influenza or pneumococcal vaccine the refusal should be documented by the nurse with the signature of the nurse and the date.	F 334		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility;	F 441	F441 483.65 Infection Control, Prevent Spread, Linens By the evening of 11/10/2010 all areas that have ice in holders have been utilizing a system where ice scoops are held outside all containers. The ice handling procedure has been updated to include the standard of ice scoops being held outside of any storage bins. All involved staff and volunteers were educated by 12/6/2010. Dining Services Leadership and Nursing staff are	



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F 441	<p>Continued From page 15</p> <p>(2) Decides what procedures, such as Isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to Infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs Isolation to prevent the spread of Infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure proper infection control practices were maintained by storing ice scoops in the ice cooler and observations of employees touching food with their bare hands.</p> <p>The findings include: Record review of the Handwashing Policy states</p>	F 441	<p>observing the implementation of the revised procedure & practice on an assigned rounding schedule (See F441 Attachment) and reporting outcomes to supervisory staff. During these rounds the expectation is that each observer is monitoring for compliance to the infection control standards. See the attached Meal Observation Study and Tool to be used in the Nursing observation monitoring to record data for the quality improvement processes. The form is used by the Director of Dining Services and the Director of Clinical Services. Nursing observation monitoring to record data for the quality improvement processes. The form is used by the Director of Dining A review of the infection history indicated no infection trends are traceable to food handling. Continued periodic monitoring of actual performance and analysis of the infection log will be used to monitor incidences of potential issues and outcomes as described above. Staff Education has been conducted for current employees including an emphasis on instructing mentors and the SDC to cover the techniques in detail in general orientation when discussing infection control. The rounding system above has been implemented with immediate feedback to staff regarding performance to ensure education has been placed into practice. Dining Services Leadership and Nursing staff</p>	



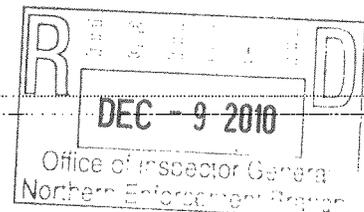
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F 441	<p>Continued From page 16</p> <p>appropriate fifteen second handwashing must be performed under the following conditions: contact with blood, body fluids, secretions, excretions, mucous membranes and broken skin.</p> <p>Observation on 11/09/2010 at 8:30am revealed Certified Nurse Aide (CNA) #6 touched food with bare hands after a resident had spit, while placing a napkin up to the resident's mouth for the resident to cough, then turned to the resident sitting to the right and began feeding a second resident immediately afterwards.</p> <p>Observation on 11/09/10 at 8:50am CNA #6 touched a resident's scrambled eggs with bare hands after the resident spit it out of their mouth and placed the egg in the resident's bowl. The CNA then turned immediately to the right and began feeding another resident.</p> <p>Interview on 11/10/10 at 2:45pm with CNA #6 revealed that they were not aware they had touched the resident's food with bare hands and furthermore stated that touching food with bare hands is a risk for spreading disease to residents.</p> <p>Interview on 11/10/10 at 2:55pm with Director of Clinical Services revealed training for infection control is performed once a year as an in-service with employees.</p> <p>Record review of the policy #F016, revise date 3/09 revealed: 1. Ice must be protected from splash, drip, and hand contamination during storage and service.</p> <p>Observation of the lunch meal on the D Unit on 11/08/10 at 12:00pm revealed (CNA) #2 filled glasses with ice then served residents. She was</p>	F 441	<p>are on an assigned rounding schedule. During these rounds the expectation is that each are monitoring for compliance to the infection control standards. Any deviation from these standards is to be communicated to the appropriate supervisor for follow-up. Nursing will maintain an observation log which will be shared with appropriate supervisory staff and then be complied for QA purposes. Observers were educated to conduct meal observations using a tool to record findings which will be shared with the Nursing Leadership group and the Food Services Director for use in directly working with performers not meeting the standard. One on one instruction was provided to those not meeting standard. All incidents are to be documented in the Dining Services supervisor communication book and reported as QA results a minimum of quarterly.</p>	



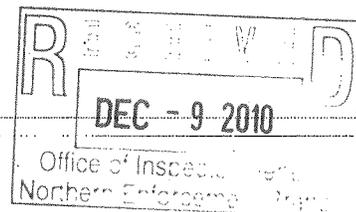
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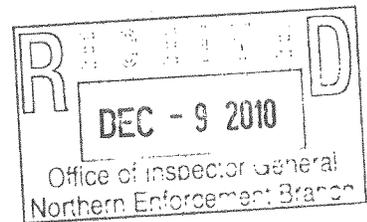
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 441	<p>Continued From page 17</p> <p>observed to place the ice scoop back in the ice bin after each use. In addition, CNAs were observed adding toppings to hamburgers, cutting the hamburgers into pieces and feeding the residents with bare hands.</p> <p>Interviews with CNAs #1 and #2 on 11/09/10 at 2:00pm revealed they had not received training on handling resident food without touching it. They both stated they were trained to store the ice scoop in a clean container between uses; however, they forgot.</p> <p>Observations during breakfast and lunch meals from 11/8/10, 11/9/10 and 11/10/10 revealed the ice scoop handle laying in the ice bin.</p> <p>Observation on 11/10/10 at 1:30pm revealed two ice scoops laying in ice bin in the Canterbury Dining Room. Further observation on 11/12/10 at 2:20pm revealed Director of Dietary removed both ice scoops which were laying in ice.</p> <p>Interview at 2:15pm on 11/10/10 with Dietary Aide #1 revealed that she was never trained to remove ice scoop from ice bins during dietary services.</p> <p>Interview at 2:20pm on 11/10/10 with the Director of Dietary Services revealed that staff had not been train to remove ice scoops from the ice bin after every use because the staff is supposed to sanitize their hands. She further stated that the policy only referred to the ice storage bin of the ice machine. She was unable to state the difference in infection control between an ice scoop being left in an ice machine and ice scoop being left in a ice bin.</p>	F 441		



F309 Attachment



2101 Survey Follow-up Quiz

- The following questions are designed to assess your knowledge of the areas in which the survey team determined we have a problem meeting the requirements for licensure.
- All of us must adhere to the infection control guidelines covered within this quiz- EVERY time!
- You are expected to think about what you are doing and do it correctly EVERY time.

Thank you in advance for the important role you play in our residents' health.

Kathy Shireman, RN

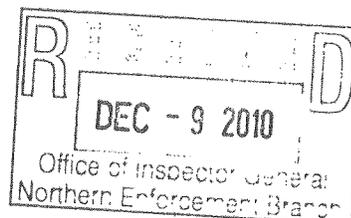


Infection Preventionist

Anne H. Veno, RN, LNHA



CEO/Administrator



2010 Survey Follow-up

Content Outline

I. TB Screening/PPD Employee

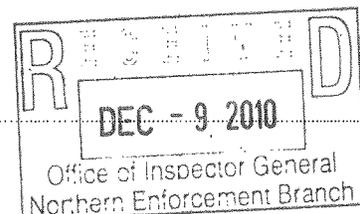
- A. PPD Tests upon hire and annually. Exception: History of TB or Positive PPD Reactor > 10mm. If not a known reactor previously, refer to Health Dept. If is previous positive reactor, do history. If any questions result in suspicion of disease, send to Health Dept. who conducts Chest X-Rays and epidemiological studies.
- B. TB Histories on positive reactors are to be done every six months.
- C. PPD's are required to be done no later than 365 days from the last PPD –annually-with the exceptions above.
- D. Must have PPD done and read before the due date listed on the posting.
- E. If PPD is not done and read before the 365th day, suspension of the employee and counseling will be done. They are to remain off work until it is completed.

II. Resident PPD

- A. Is to be done on admission- a two step and no later than 365 days annually. CAN NOT BE LATE.
- B. Nurses are responsible for checking during the monthly audits to ensure PPD's upcoming are on the neighborhood's calendar and added to the MAR as appropriate. These checks need to be looking a month ahead as the PPD can not be beyond the 365th day when read.

III. Pneumococcal vaccine (pneumo)

- 1. Refusals are to be properly documented on the Immunization Record- including the date, reason, who the refusal came from and the nurse receiving the refusal.
- 2. ECH offers all employees the pneumococcal vaccine upon hire-sign up with your supervisor by 12.30.2010 if you have not received the vaccine and are interested in receiving it or want to learn more about it.
- 3. A new consent form has been started for all new admissions. The Social Services Department will complete it on admission.
- 4. Formal notice of flu vaccine administration will be given with the billing notice the month prior to administration (usually September) on an annual basis. ECH nurses will convert our LTC residents to the new consent as they come due for flu and/or pneumo. The CDC standard information & forms for each vaccine are in the file drawers at each nurse's station and are to be shared with residents and/or decision makers regarding the vaccines and side effects and right to decline. Guidelines for pneumococcal vaccine administration are in the DTR.



5. If the pneumo. vaccine date is unknown, the nurse is to find out where it was given and contact, if possible, to confirm exact dates of administration. If the vaccine was given > 5 years ago, seek an order from the physician, re-educate the resident/responsible party and with permission administer the vaccine or document its refusal.

IV. Infection Control

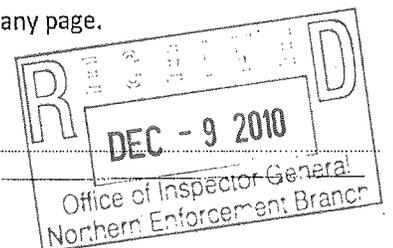
1. Handling food- handwash and reglove between residents.
2. Do NOT lay or leave an ice scoop in the ice container- cross contaminates.
3. Not remembering will not be tolerated-no excuses.
4. Feeding two residents- can not cross over with touching.
5. Meal tickets/ slips are to be used to make sure the dining services worker/nurse aide serves the correct foods, the correct adaptive equipment is used, and likes/dislikes are honored in serving the resident.
6. Do NOT touch food with ungloved hands or with contaminated/dirty gloves while setting up a resident, cutting up food, or buttering rolls.

V. Restorative

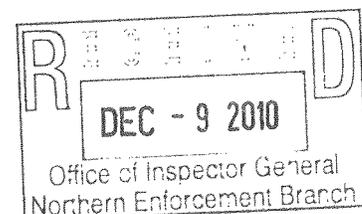
1. Nursing or therapy staff can recommend restorative nursing services to restore OR MAINTAIN a resident's highest level or functional ability. Aides or Nurses may identify the need and request that an evaluation by the therapy or restorative nursing staff be completed.
2. All staff has a responsibility to identify the need to reposition a resident. Positioning can prevent choking in those with swallowing problems. Residents need to sit up straight. Plans for special dysphagia- swallowing issues- are to be communicated by Speech Therapy and put on the care plan and aides assignment sheets.
3. Therapy may be re-consulted for positioning issues, as needed. Note that such has been done in the nursing/therapy notes and care plan.

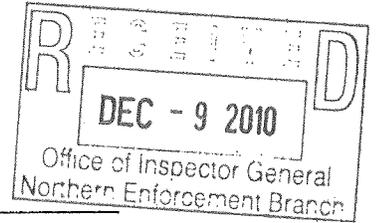
VI. Falls

1. Note on the resident's Care Plan all interventions tried- even if the intervention was not effective, to reflect the process ECH used historically. Date & initial all entries and discontinuations. Update the care plan after each fall. If no change is made, write a note in the Nurses Notes explaining why. Add to cause/ contributing factors in the problem statement and place interventions under the actions/ intervention section of the appropriate problem statement after each fall, NOT just at the bottom of any page.



2. Over-inflation of an air mattress may cause a fall and is unacceptable and this indicates we have a communication or knowledge deficit with possible ineffective monitoring. Consult the DTR "Specialty mattresses" to find the appropriate settings as well as other mattress choices that might best fit a resident's needs. Place mattress orders on the TAR for every shift checks to make sure proper inflation is present and verified by the nurse. Place proper inflation levels on the TAR, care plan, and aide assignment sheet.
3. If a resident falls going to the toilet- Assess why this is happening (e.g. orthostatic hypotension, urgency, memory loss, leaking, are call lights answered timely, are nurses also answering call lights? Does a toileting plan need be developed? Is supervision of employees adequate? Investigate thoroughly and devise a plan/revise the care plan based on the findings.





Nursing Staff -Training from State Surevy-2010

Name: _____

Date: _____ Neighborhood: _____

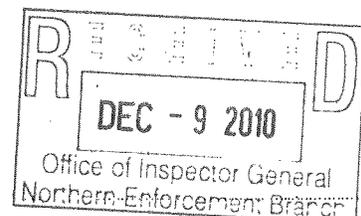
Regulation: Each resident is to receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well being in accordance with the assessment and plan of care. **Circle all appropriate responses.**

1. A resident believes she/he can do more for themselves. You believe they might be able to do so also. What should you do?
 - A. Tell the nurse/ physician and discuss it with them the reasons why you think so.
 - B. Compliment the resident and do for them as much as you can.
 - C. Encourage the resident to attend activities.
 - D. Nursing or therapy can consider requesting restorative services.
 - E. Discuss with the resident what his/her goals are and make a plan to help them achieve them in the plan of care.

2. You have a nonverbal resident with a repeating slumping problem when in a chair. The resident also has dysphagia-trouble swallowing. Which of the following are correct statement(s) in this situation?
 - A. The aide assignment sheet is to have information related to how to position residents with special positioning needs to help prevent choking.
 - B. Therapy is to be consulted for difficult positioning problem solving recommendations.
 - C. The basic principle of positioning is to sit a resident straight up to prevent choking when eating -which is important to well being.
 - D. It is everyone's responsibility to ensure residents are positioned properly and repositioned.
 - E. Care plans are to reflect difficult positioning problems and historically reflect what actions were taken to attempt to resolve the positioning issues.
 - F. Nurses as well as aides are responsible for monitoring the positioning of residents.

3. You have a resident who has fallen on several occasions. When reviewing the falls, you would expect to be able to:
 - A. Review the Occurrence Report to identify cause/ contributing factors and see those identified in the problem statement in a "Potential for injury: falls " statement.
 - B. See a Falling Heart symbol on the nameplate outside the resident's door to alert everyone.

- C. See any recommendations made on the Occurrence Report reflected in the Interventions or action statement of the care plan and on aide assignment sheet.
 - D. Talk with all involved in the fall to determine why it happened to help prevent future falling.
 - E. Ignore it because we have tried everything with no success in preventing a fall.
4. You have a resident on a low air loss mattress. When transferring a resident the mattress was inflated more. You know this is high risk for causing a fall and possible skin breakdown. What do you do?
- A. Feel the mattress to see if it feels to be the right amount of inflation by pushing on it.
 - B. Nothing. The resident wished to be higher to see out the window better. More is better, the extra air will not hurt. Bolsters will protect the resident.
 - C. Look at how the resident is positioned- the resident should sink low into the mattress so that the mattress edges are the same height as the top of chest of the resident.
 - D. Check for positioning-the resident should be two to four inches from bottoming out.
 - E. Nurses document oversight of mattress/proper settings checks on the Treatment Record. Consult the plan of care or aide assignment sheet for the proper setting and adjust accordingly.
5. A resident fell trying to go to the toilet. Investigation reveals the call light was on 30 minutes before being responded to and by then the resident had tried to toilet on his/her own. What strategies might be applied to prevent future falls?
- A. Nothing. Was an unusual event.
 - B. Analyze if the aide had on the pager and it was working in order to know the light was ringing.
 - C. Determine if other falls were related to toileting and determine if urgency, leaking, memory loss or poor decision making contributed to not being able to wait for assistance. Ask resident for input.
 - D. Note on the aide assignment sheet that the resident is unable to wait to toilet-and likely to try to go on his/her own and fall.
 - E. Analyze the resident's voiding pattern and consider using a scheduled toileting plan.



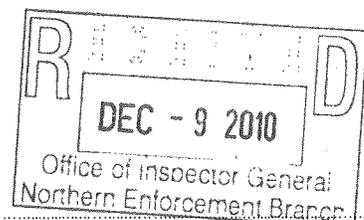
Learning Module: Influenza, Pneumovaccine and PPD

Approximate time needed: 30 minutes

Resources Available, if desired: Vaccine-Flu & Pneumo Release Form, Immunization Form, TB procedure, Vaccinations desk top reference. Post test.

Upon completion of this module, the learner will:

1. Implement their role in employee and resident PPD Testing, monitoring for compliance with state regulations, and include this information in the new employee orientation process consistently.
2. Identify the national guidelines for administration of the pneumococcal vaccine and where to find them in the desktop reference, the role expectations for determining last dose given and refusals, common adverse reactions to the pneumococcal vaccine, and what teaching is required plus documentation requirements- release and medical record recording.
3. Identify the process for identifying if a resident has received a flu vaccine, what instruction information about the vaccine is needed and how to document, what to do about refusals, and documentation of administration.
4. Verbalize understanding that mandatory in-service and meeting requirements are just that- mandatory with the expectation to attend, make arrangement to obtain the training at an alternate time/place within established deadlines or face disciplinary action so systems are implemented by all.



TB Screening/PPD's -All employees

Name: _____

Date: _____ Department: _____ Neighborhood: _____

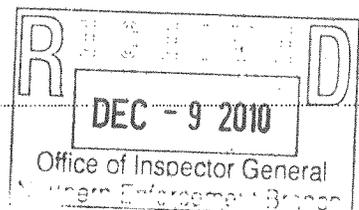
Post test: Employees-PPD, Influenza and Pneumococcal vaccine **Circle all that apply.**

1. Employee PPD tests are to be obtained a minimum of how often?
 - A. Upon hire
 - B. If you have a cough
 - C. Once a year
 - D. Anytime -it does not matter
 - E. Every two years

2. The PPD test is important because.... **Circle all that apply.**
 - A. It detects exposure to the tuberculosis bacteria
 - B. It detects active TB illness
 - C. It can help prevent the spread of TB
 - D. Kentucky has a high amount of TB in the state and knowing is a step toward treatment
 - E. It is required in this facility by state law.

3. If the December posting notice says that January third is the due date for your PPD test, when should you play it safe and go to Clingman to receive it? **Circle all correct responses.**
 - A. On January third
 - B. At least three days before January the third so that it can be read before it is too late
 - C. When my supervisor reminds me
 - D. When I am taken off the schedule because I did not have it read in time to be done by January 3.
 - E. A week after it is given.

4. What will be the consequences of not receiving your PPD timely?
 - A. Nothing
 - B. Counseling
 - C. Reminder again
 - D. Taken off schedule
 - E. Supervisor will talk to me

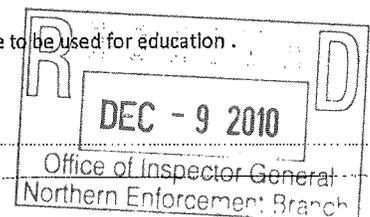


TB Screening/PPD's/Pneumococcal Vaccine -Nurse Quiz

Name: _____ Date: _____

Circle all that applies.

1. Residents are to have PPD tests how often?
 - A. Annually
 - B. When they have a history of TB
 - C. On admission
 - D. Before discharge
 - E. If they have had a positive reaction in the past
2. What is the system for monitoring PPD compliance?
 - A. Check the Blue Immunization/ Screening form when doing monthly chart audits
 - B. Ask the resident
 - C. Keep a listing of the last TB screening date and repeat skin testing on/before the last anniversary of last skin test
 - D. Check old MAR's
 - E. Ask the nurse manager
3. When discovering that TB screening time is approaching, what steps are to be taken?
 - A. Check TB history- If has had TB, give PPD.
 - B. Do a TB sign and symptoms history every 6 months on positive reactors, not a PPD
 - C. Do a TB signs and symptoms history on everyone on admission and annually
 - D. Write the PPD on the desk calendar for a two step
 - E. When doing the monthly review, check if TB screening is due and note it on MAR and calendar.
4. Which of the following are correct statements related to Pneumococcal Vaccines ?
 - A. Pneumococcal vaccine is to always be given on admission and every five years thereafter.
 - B. Information on when pneumococcal vaccine was received is to be determined on admission.
 - C. If information about when the vaccine was received is unknown, find out where and contact them for the info.
 - D. Consult the Immunization Record during the monthly review to determine what vaccines may be due.
 - E. Refusals must be documented and include the date, nurses's signature, person refusing and the reason.
 - F. All employees are being offered the opportunity to receive the pneumococcal vaccine.
 - G. Pneumococcal vaccine information sheets are available in the forms drawer and are to be used for education .



Infection Control-All Staff

Name: _____ Date: _____

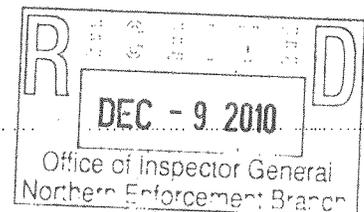
Circle all that apply.

1. The most important means of preventing the spreads of infection is:
 - A. Wipe up spills.
 - B. Use gloves when touching items contaminated with blood or body fluids.
 - C. Handwash when touching a potentially contaminated hand to a different surface.
 - D. Wear clothing or hair protection.
 - E. Cough into your elbow.

2. When handling an ice scoop while serving ice, it is important to:
 - A. Wear gloves.
 - B. Store the ice scoop in the ice cooler.
 - C. Touch the ice scoop to the used glass when filling it to keep from spilling ice.
 - D. Handwash or sanitize -if less than three times using sanitizer.
 - E. Place the scoop in the holder between uses.

3. When serving residents food, which of the following would apply?
 - A. Set up for meal service by placing the dietary slip on the residents' tables to make sure the right type of food is served.
 - B. Use the dietary slip to identify the likes and dislikes of residents.
 - C. Give an appearance of home by picking up food bare handed and cutting up food as needed.
 - D. Keep tidy by wiping noses while serving and feeding residents with no handwashing necessary in between.
 - E. Feed two residents while one is coughing moving one to the other without handwashing.

4. What are good excuses for poor infection control practices?
 - A. When cutting up a hamburger with bare hands say-"I was in a hurry."
 - B. You are between two residents and a resident coughs so you grab a napkin and wipe their mouth returning to give the other resident a bite. "I always did it this way."
 - C. You had a fire drill in the middle of the meal and are trying to get drinks served. You lay the ice scoop down in the ice container. "I have to get this done-we are late."
 - D. You pick up a roll to place it on the plate or butter it with your bare hands. "I forgot."
 - E. All the above answers are not good excuses for poor infection control. One slip up in what we do well can spread infection to many others.



Episcopal Church Home
Meal Observation Quality Study-2010

Purpose: To insure infection control, food handling and customer service standards are met consistently at all meal service times and locations.

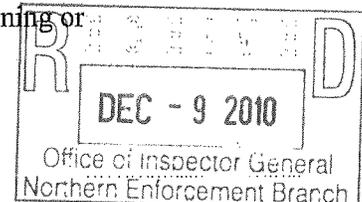
Standards:

Infection Control:

1. Handwashing is to occur for 15 seconds after exposure to blood, body fluids, secretions, excretions, mucous membranes and broken skin. This includes picking up items that have been in a person's mouth, contact with spit, contact with nose discharge/ coughing spray. Going from feeding one resident to another without cleansing hands in these situations is a violation of infection control standards.
2. Touching food with bare hands can spread disease. Gloving is to be practiced with changing gloves between residents or if touching something potentially soiled/contaminated. Use gloves when cutting food and with feeding a resident.
3. Ice scoops are to NOT be laid down in the ice storage container. The scoop is to be placed in the receptacle furnished. Touching the scoop handle and then laying it in the ice can potentially contaminate the ice.
4. Any food items dropped are to be discarded and NOT fed to the resident. Replacement food is to be obtained.

Customer Service:

1. Introduce yourself to the resident and describe the meal about to be served.
2. Always offer or assist the resident with a warm disposable cloth to clean their hands before eating. The resident's hands/faces are also to be cleaned after eating, when necessary and clothing changed if necessary.
3. Residents are to be asked if they want/ offered clothing protectors, but not encouraged or forced to wear them if they do not desire to do so.
4. Residents are to be talked to respectfully and encouraged to engage in conversation during the dining experience (no general talking among staff members that is not resident related is permissible), food is to be introduced as it is being offered, asked residents about their preferences, and if they are not eating, inquire if they would like seasoning or



something different to eat, and the offering of alternatives is to be documented on the Care Flow sheet.

5. Residents are to be called by the name they have listed as preferred. Do NOT use "Honey", Sweetie", "Sugar", etc. as these are interpreted as demeaning by some or being too familiar.
6. Residents needing to toilet (during the meal) are to be accommodated by the nurse aide and/or nurse and preferably, residents are to be toileted before meals.
7. Personal phone use/ texting is NEVER to occur during resident care times, such as meals and is only allowed to occur while on breaks.

Positioning/ Dysphagia Precautions

1. Residents are to be positioned in an upright position for eating- especially if they have swallowing issues.
2. Residents with positioning issues are to be referred to PT/OT for consultation and positioning instructions written in the care plan and on the nurse aide assignment sheets. Observation that these instructions are followed is to be included in the meal observation. A list may be obtained from the nurse's station of who this might effect.

Methodology:

Meal observations are to happen daily on day and evening shifts by a nurse, dietician or dietary manager who has been educated by reading the standards. Observations are to occur in the neighborhoods as well as Canterbury Court. Nurses are to be assigned the duties on a rotational basis.

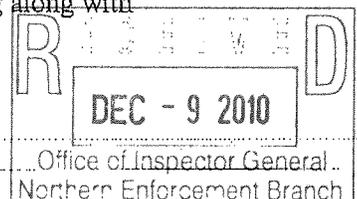
The Meal Observation form is to be completed by the observer assigned. The date and time of the observation can be written on the line provided. The areas to be observed include: food handling, hand washing, ice scoop management, and customer service (positioning of residents).

Immediate intervention is to be given by the observer if standards are breached to ensure infection control practices are upheld and resident's rights are protected. The break from standard is to be recorded on the QA study data collection report.

Reporting:

Forms are to be submitted to the nurse manager of the neighborhood, Director of Dining Services, and Director of Clinical Services.

Results are to be reported by the nurse manager at the monthly QA meeting along with interventions applied and improvement plan recommendations.



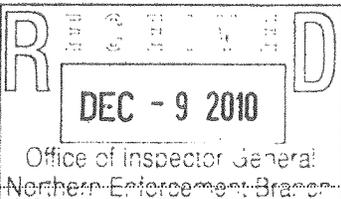
Episcopal Church Home
 QA- Meal Observation

Confidential

Meal Service- Date: _____ Time: _____ Observer: _____

List all employees on duty. Describe per employee the areas listed below that need be managed better to improve practice. Name employees involved and interventions taken. Inappropriate repeat poor practice behavior is not to be tolerated and is to be subject to disciplinary action.

SRNA/Nurses	Food Handling-infect contr/HW	Ice Scoop Management	Customer Service	Position/Dysphagia Prec
OK	Not OK-describe	OK	Not OK-describe	OK



Episcopal Church Home
Meal Observation Study

Date: _____

Day of Week/ Neighborhood	Morton	Clingman	Marmion	MCC	Woodcock
Sunday	B		D		L
Monday		L		B	
Tuesday	D			D	
Wednesday		B			B
Thursday			L	L	
Friday	L				D
Saturday		D	B		

RECEIVED
DEC - 9 2010
Office of Inspector General
Northern Enforcement Branch

Section: SANITATION AND INFECTION CONTROL	POLICY #F016
Subject: ICE HANDLING	Date Issued 5/95 Revised: 12/2010

POLICIES:

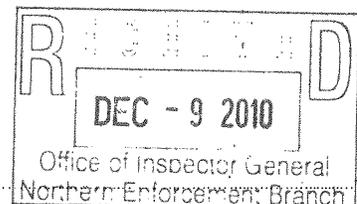
- Ice made by ice machines on the premises must be made with water from a source approved by the State/local health department.
- Only ice is permitted to be kept in the ice storage bin of the ice machine.
- Ice must be protected from splash, drip, and hand contamination during storage and service.
- In the event of a mechanical malfunction, ice will be transported in a clean, covered, food service approved container from another machine in the facility/community or bought from an approved source.

PROCEDURES:

All Facility employees

- Use a scoop to remove ice from the storage bin into the receptacle used for service. (A scoop should be designated for removing ice from the bin, and should not be used for other purposes.)
- Scoops are utilized for dispensing ice from the secondary dispensers. Scoops are not to be held in the ice, but in appropriate holders outside the ice receptacles.
- Inside of ice storage bins are cleaned on a monthly basis.

P&P CROSS REFERENCE: F – Area and Equipment Cleaning Frequency (for ice machine)



	Breakfast Units	Breakfast MDR	Lunch Units	Lunch MDR	Dinner Units	Dinner MDR	FACTing 11:20	FACTing 4:20
5:30 – 1PM	X-3	X	X				X-2	
9:30 – 6PM				X	X		X	
11:30 -8PM				X		X		X
RD	X							

Dining Services Meal Observation Schedule:

- X-2: Early supervisor to cover when no Third supervisor available
- X-3: Early supervisor to cover when no RD available

Rounds prior to service to each unit to be certain they have what they need and that all elements are being met (temperatures, serving sizes, diet cards, etc)

Rounding during the meal is to understand if the needs of the residents are being met, food is being eaten, temperatures are holding, trays are promptly delivered, service is appropriate.

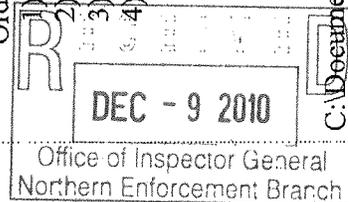
Rounding includes completion of the observation form, two times per month per manager

FACTing:

All staff expected to attend : Supervisors, Production Team, Wait Staff, Dishroom

Order:

- 1) Talk the menu
- 2) FACTing
- 3) Showtime
- 4) CHAT, HATS or other education items: Trish will do when there



RECEIVED
DEC - 9 2010
Office of Inspector General

10/7/2010 1:40:23 PM
Organization: ECH
Entry Date: 10/7/2010
Date Range: 10/7/2010 - 10/7/2010
Discipline(s): All Staff

Care Plan Report

1 of 18

F309

Care Plan for NEWITT, MARGARET A

Diagnosis	10/7/2010 1:40:22 PM	Stratification	10/7/2010 - Present
ALZHEIMER'S DISEASE, JOINT PAIN-LEG, OSTEOARTHRITIS NOS, OROPHARYNGEAL DYSPHAGIA, HYPERTENSION NOS, OSTEOPOROSIS NOS			
Diagnosis			
Notes			
Strengths, Long/Short Term Goals and Other Comments: supportive family/long term placement, no discharge plans, no mood or behaviors this and P Hand BSW			
Health Care Surogates, Living Will, Hospital Preference, Do Not Resuscitate			
Allergies			
No Known Allergies			
Potential for deterioration in comfort or safety: Having a history of Adminis and osteoporosis and receiving glucosamine chondroitin and tylenol arthritis on a daily basis. She also has a diagnosis of colitis and was treated with steroids in the past. No sis of colitis at this time and resident does continue with intermittent sis of pain/discomfort with facial grimacing and tearfulness which could potentially be related to pain. Pain controlled at this time.			
Resident will be free to sis of pain or discomfort w/ arthritis, osteoporosis, and colitis.			
STATUS: Active (Current)			
GOAL DATE: 10/20 11			
Primary/Physician	Furman, Christine	ADN/BSW	9/28/2009
Primary/Nurse		Registered Nurse	
Observe for non verbal and/or verbal sis of pain such as grimacing, rubbing body parts, restlessness, or resident expressing pain, difficulty walking or moving. Report ongoing sis of pain/discomfort or uncontrolled pain/discomfort to me/kern.			
STATUS: Active (Current)			
Nursing			
Administer tylenol arthritis as ordered and prn. Glucosamine chondroitin administered for h/o arthritis.			
STATUS: Active (Current)			
Licensed Practical Nurse			
Registered Nurse			
Observe for sis of abdominal pain, such as grabbing at stomach and grimacing, observe for ongoing diarrhea and/or blood in the stool. Notify MD/RN/PA as indicated for abnormalities.			
STATUS: Active (Current)			
Nursing			
Consult therapy as indicated for treatment.			
STATUS: Active (Current)			
Resident Name	Resident ID	Staff Name	Staff ID
Res #16	1593*	ECHNFD Wang12AD	5867

11-16-10
① PT eval for w/c positioning
② PT to see Sx1 link v 7 links for w/c positioning
11-16-10
OP/CPT
b. directive to see 4-7 link for w/c positioning

R. Shepherd (RN)

10/7/2010 1:40:23 PM

Problems	Goals	Interventions	Diagnoses	Responsible
<p>At risk for alteration in skin integrity r/t being incontinent of her B&B and requiring assistance with her feet mobility. She does have an altered sensory perception and is unable to detect pain or pressure and notify others of pain or pressure. She has a diagnosis of vascular dementia which impairs her ability to notify others of elimination needs and requires staff to anticipate her toileting needs. No skin problems noted at this time. She does have a history of UTI in July '10 and was treated at that time. She does continue to be incontinent and this checked and changed routinely which also increases her risk for UTI. She is unable to make request and relies on staff for her fund and daily care needs.</p> <p>STATUS: Active (Current)</p>	<p>Resident will remain free of undetected sites of UTI.</p> <p>STATUS: Active (Current)</p> <p>GOAL DATE: 1/8/2011</p>	<p>Provide good perineal care with warm soap and water or wet wipes after incontinence. Wipe front to back with perineal care.</p> <p>STATUS: Active (Current)</p>	Nursing	
<p>At Risk For Falls R/T has has a history of falls r/t her lack of safety awareness, poor decision making, and not using her walker. She requires the use of a total body lift for her transfers. She is currently non ambulatory at this time. She continues to be at risk for falling related to her altered safety awareness and inability to make decisions r/t vascular dementia. She does continue to attempt to sit up and lean forward in her chair which can place her at risk for falling as well. She also utilize antidepressant medication for her history of depression. She also has a history of arthritis.</p> <p>STATUS: Active (Current)</p>	<p>Resident will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day review period.</p> <p>STATUS: Active (Current)</p> <p>GOAL DATE: 1/8/2011</p>	<p>Observe for non verbal needs when resident is restless and or making attempts to position/reposition herself in her chair such as leaning forward. Observe for hunger, thirst, and toileting needs and assist as needed.</p> <p>STATUS: Active (Current)</p>	Nursing	
<p>Resident Name: _____</p>	<p>Resident ID: 1593*</p>	<p>Location: ECHINRD Wing12D</p>	<p>Room: 5867</p>	

Res. #116

11-11-10
Observe for positioning in w/c for

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Res # 16

Resident Name	Room	Location	Case #	Staff	Notes
Resident Name	15933	ECHMFLD Wing 172AD	5867	All Staff	<p>Goals</p> <p>At Risk For Falls R/T <i>[redacted]</i> has a history of falls of her lack of safety awareness, poor decision making, and not using her walker. She requires the use of a total body lift for her transfers. She is currently non ambulatory at this time. She continues to be at risk for falling related to her altered safety awareness and inability to make decisions of vascular dementia. She does continue to attempt to sit up and lean forward in her chair which can place her at risk for falling as well. She also utilize antidepressant medication for her history of depression. She also has a history of arthritis.</p> <p>STATUS: Active (Current)</p> <p>Resident will demonstrate the ability to ambulate/transfer without fall related injuries over the next 90 day review period.</p> <p>STATUS: Active (Current)</p> <p>GOAL DATE: 10/2011</p> <p>Interventions</p> <p>TABS alarm for safety.</p> <p>STATUS: Active (Current)</p> <p>Observe for posturing in her chair and/or for attempts to stand without assistance. Provide assistance with repositioning when needed.</p> <p>STATUS: Active (Current)</p> <p><i>use tilt position w/c. on posturing</i></p> <p>Pharmacy</p> <p>Behavior management committee to review psychotropic medications on a quarterly basis and make referrals/recommendations for dosage reduction or appropriateness of psychotropic medication.</p> <p>STATUS: Active (Current)</p>

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Problem	Goal	Intervention	Justification	Priority
<p>Potential for Social Isolation re Decrease conversation abilities. " " as she prefers to be called, at times does not reflect signs of comprehension or understanding during activities. Manager needs recreational programs such as reading stories, musicals, card and balloon games and food social outings.</p> <p>STATUS: Active (Current)</p>	<p>" " will show attention to programs at hand as evidenced by looking forward program leader eye contact and attempts to follow direction during activity at least 3-4x a week by next review.</p> <p>STATUS: Active (Current)</p> <p>GOAL DATE: 1/8/2011</p>	<p>Provide regular diet</p> <p>STATUS: Active (Current)</p>	<p>Activities</p> <p>Volunteer</p>	
<p>" " is at risk for alteration in nutrition due to high risk nutritional dx of vascular dementia, and depression. Resident does require assistance with meals.</p> <p>STATUS: Active (Current)</p>	<p>" " will maintain current nutrition status with no significant weight changes or signs of dehydration.</p> <p>STATUS: Active (Current)</p> <p>GOAL DATE: 1/7/2011</p>	<p>Allow resident to eat in preferred location, which is the neighborhood dining room at this time.</p> <p>STATUS: Active (Current)</p> <p>Honor food preferences</p> <p>STATUS: Active (Current)</p> <p>Monitor at meals and provide cues as needed.</p> <p>STATUS: Active (Current)</p> <p>Monitor weights per MD order and PRN</p> <p>STATUS: Active (Current)</p> <p>Document % meal intake at each meal.</p> <p>STATUS: Active (Current)</p> <p>Dietitian to evaluate nutritional status at least quarterly</p> <p>STATUS: Active (Current)</p> <p>Honor beverage preferences at each meal.</p> <p>STATUS: Active (Current)</p>	<p>Certified Nurse Aide</p> <p>All Staff</p> <p>Nursing</p> <p>Nursing</p> <p>Dietary</p> <p>Nursing</p> <p>Dietary</p> <p>Certified Nurse Aide</p> <p>Dietary</p>	
<p>Resident Name: Res # 16</p>	<p>Residence ID: 15932</p>	<p>Location: ECHINPD Wing12D</p>	<p>Case # 5867</p>	

11-11-0
sit strength & during
sit all meals etc

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RESTORATIVE NURSING PROGRAM

PROBLEM LIST: Balance posture d/c
impaired mobility

EXPECTED OUTCOME - GOALS: Maintain present level of
function d/c
Prevent contracture

RESTORATIVE PROGRAM (CIRCLE)

- PROM
- AROM
- SPLINT OR BRACE ASSISTANCE
- BED MOBILITY
- TRANSFER
- WALKING d/c
- DRESSING OR GROOMING
- EATING OR SWALLOWING
- AMPUTATION/PROSTHESIS CARE
- COMMUNICATION

amb. c. from 100' COA. mind
as tolerated.

PRECAUTIONS: Impulsive Pt has tendency
when turning to sit, sits too quickly.

FREQUENCY OF TREATMENT: 4-7x/wk

[Signature]
SIGNATURE OF PERSON ESTABLISHING PLAN OF CARE

5/27/10
DATE

D/C DATE OF POC

D/c quit 9/21/10
add ROM

- REASON FOR D/C FROM POC:
- PATIENT INDEPENDENT WITH OWN PROGRAM
 - CARE TURNED OVER TO NURSING MAINTENANCE PROGRAM
 - REVISION OF POC
 - NONPARTICIPATION/COOPERATION
 - OTHER

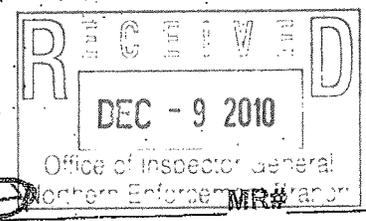
Res # 16

RESIDENT'S NAME

RM#

D

MR#



F309

RESTORATIVE NURSING PROGRAM

PROBLEM LIST: decreased positioning in wlc

EXPECTED OUTCOME - GOALS: improve wlc positioning

RESTORATIVE PROGRAM (CIRCLE)

- PROM
- AROM
- SPLINT OR BRACE ASSISTANCE
- BED MOBILITY
- TRANSFER
- WALKING
- DRESSING OR GROOMING
- EATING OR SWALLOWING
- AMPUTATION/PROSTHESIS CARE
- COMMUNICATION

wlc positioning

reposition and change angle of wheelchair twice a day

PRECAUTIONS: leaning / sliding

FREQUENCY OF TREATMENT: 4-7 x 1wk

[Signature] SIGNATURE OF PERSON ESTABLISHING PLAN OF CARE 11/16/10 DATE

D/C DATE OF POC

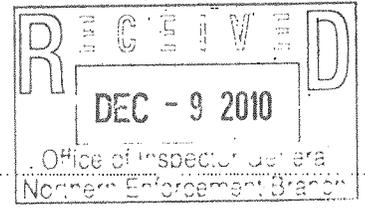
- PATIENT INDEPENDENT WITH OWN PROGRAM
- CARE TURNED OVER TO NURSING MAINTENANCE PROGRAM
- REVISION OF POC
- NONPARTICIPATION/COOPERATION
- OTHER

Res # 16

PATIENT'S NAME

RM# D

MR#



F307

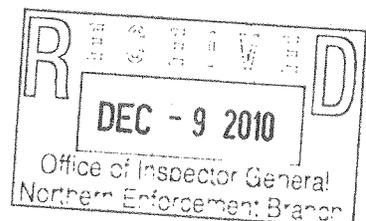
THE EPISCOPAL CHURCH HOME LOUISVILLE, KENTUCKY	INDEX NUMBER:	PAGES:
CHAPTER: Nursing FUNCTION: DESKTOP REFERENCE: Swallowing Precautions	EFFECTIVE DATE: 11/12/2010 SUPERSEDES: RELATED STANDARDS/POLICIES: REVISED DATE: 11/12/2010	

INTRODUCTION: The following are "safe swallowing/feeding" precautions and strategies to use with all residents who are experiencing problems with swallowing. These precautions will increase safety of the swallow during meal times and should be used consistently at all times.

INSTRUCTIONS:

1. Be sure to have the resident in an upright position, preferably in a chair, or bed during all meals. Use cushions or pillows to make sure head is in as close to midline position as possible.
2. Do not try to feed a resident who is not alert enough to elicit a swallow.
3. It is very important to check the resident's tray to make sure it is the correct diet consistency.
4. Cue/feed the resident slowly.....allowing breaks as needed between bites.
5. Make it a regular practice to serve small bites....one at a time...allowing the resident to chew thoroughly and clear mouth.
6. Alternate every few bites with a sip of liquid.
7. Check to see that the resident has cleared mouth before giving another bite/sip. Provide oral hygiene after all meals.
8. Please follow specific safe strategies as instructed by the Speech Pathologist. Examples include:
 - double swallows
 - head turn/tilt
 - chin tuck head position
 - adaptive utensils/cups
 - throat clear
 - mixing consistencies

*****It is very important that all staff follow the same guidelines when feeding and/or supervising residents during meals.



Date: 11-18-2010

Episcopal Church Home
Chart Audit- Dysphagia

Positioning

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#16

Room	Resident	Dysphagia present	Spec instructs: CNA Assignmt	SI on ResCNA Flow Sht	Positioned well on observation
D 1		No			
D 2		No			
D 3		No			
D 4		No			
D 5		No			
D 6		No			
D 7		No			
D 8		No			
D 9		No			
D 10		No			
D 11		No			
D 12		No			
D 12		Yes	Yes		
D 13		No			
D 14		No			
D 15		No			
D 15		No			
D 16		No			
D 17		No			
D 18		No			
D 18-2		No			
D 19-3		No			
D 20-1		No			
D 21-3		No			
D 22-3		No			
D 23-3		No			
D 24-1		No			
D 24-2		No			
D 25-3		No			
D 26-3		No			
D 27-1		No			
D 27-2		No			

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Date: 1-1-18-2010

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Chart Audit-Dysphagia

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Room	Resident	Dysphagia present	Spec Instructs: CNA Assignmt	SI on ResCNA Flow Sht	Positioned well on observation
D-28-1		No			
D-28-2		No			
D-29-2		No			

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Date: 11-22-10

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Chart Audit- Restorative *Positioning*

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Room	Resident	Dysphagia present	Spec instructs: CNA Assignmt	SI on ResCNA Flow Sht	Positioned well on observation
C-3-3		No			
C-4-3		Yes	Puree/NTL	Y Y	Yes
C-5-1		NO			
C-5-2		NO			
C-6-1		NO			
C-6-2		NO			
C-7-3		No		Y Y	Yes
C-8-1		NO	Swallow precautions		
C-8-2		No			
C-9-1		Yes	precautions double Swallows	Need to (F)	Yes
C-9-2		Yes	Ringo / Room - Swallows prec.	Need to (F)	Yes
C-10-1		Yes	Swallow prec.		Yes
C-10-2		NO			
C-11-3		NO			
C-12-1		NO			
C-12-2		NO			
C-13-1		NO			
C-13-2		Yes		Y Y	Yes
C-14-1		Yes	Mech soft		Yes
C-14-2		Yes	waiver to reg. diet		Yes
C-15-1		Yes	Mech soft		Yes
C-15-2		Yes	Puree/LHTL		Yes
C-17-1		NO			
C-17-2		Yes	Puree		
C-18-1		Yes	Mech soft / NTL		
C-18-2		NO			
C-19-1		Yes	Mech soft / NTL		
C-19-2		NO			
C-20-1		Yes	Mech soft		
C-20-2		NO			
C-21-1		NO			
C-21-2		NO		Y	Yes
C-22-1		NO	NFB		
C-23-3		NO		Y	Yes
C-24-1		NO	Y	Y	Yes

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NO - attempted repositioning
NO - achieved

Date:

Episcopal Church Home
Chart Audit - Restorative

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C 24-2	ND				
C 25-3	yes	mechanical	n	n	yes
C 26-1	yes	mechanical/sep basins	n	n	yes
C 26-2	yes	plumber	n	n	yes
C 27-1	ND				
C 27-2	ND				
C 28-1					
C 28-2	yes	plumber/HTL	n	n	yes
C 29-3	ND				
C 30-3					

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Date:

Episcopal Church Home
Chart Audit- Restorative

Room	Resident	Dysphagia present	Spec Instructors: CNA Assignmt	SI on ResCNA Flow Sht	Positioned well on observation
A 1-3					
A 2-3		✓			
A 3-3			✓- 26. log		
A 4-3					
A 5-3					
A 6-3					
A 7-3					
A 8-3					
A 9-3					
A 10-3					
A 11-3					
A 12-3					
A 13-3					
A 14-3					
A 15-3					
A 17-3		✓			
A 18-3			✓		
A 19-3					✓ Position only
A 20-3					
A 21-3					
A 22-3					
A 23-3					
A 24-3					
A 25-3					
A 26-3					
A 27-3					
A 28-3		✓			
A 29-3					
A 30-3					
A 31-3					
A 32-3					
A 33-3					
A 34-3					
A 36-1		✓	26. log	✓	✓

Room 14

#12

#2

not open
Pena file
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