

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

PRINTED: 07/15/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CHEROKEE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A Recertification Survey was initiated on 06/29/14 and concluded on 07/02/14 with deficiencies cited at the highest scope and severity of a "D". This was a Nursing Home Initiative Survey with entrance to the facility on Sunday 06/29/14 at 3:00 PM.	F 000	Signature Healthcare of Cherokee Park (Facility) does not believe and does not admit that any deficiencies existed before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 160 SS=C	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate. This REQUIREMENT is not met as evidenced by: Based on interview, record review, review of the facility's resident account statements, and the facility's policy Conveyance of Funds upon a Resident's Death, it was determined the facility failed to ensure resident funds were conveyed to the resident's designee within thirty (30) days of their death for four (4) of the four (4) unsampled residents (Unsampled A, B, C, and D). The findings include: Review of the facility's policy regarding Conveyance of Funds upon a Resident's Death, dated June 2007, revealed upon a resident's death, a representative of the business office would determine if the resident had any funds on	F 160		

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

TITLE

(X8) DATE

* Nicole Meade LHA

* Administrator

* 7/23/14

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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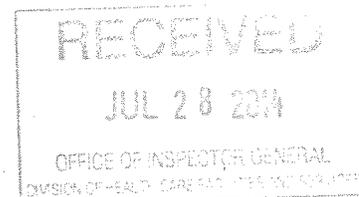
JUL 28 2014

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE PROGRAMS AND SERVICES

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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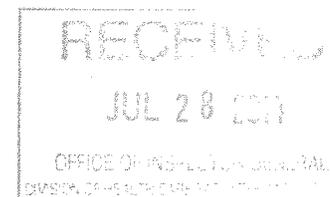
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F 160	<p>Continued From page 1</p> <p>deposit with the facility. The resident's records would be reviewed and the business office would make a final accounting and a transfer of funds to the resident's representatives or probate jurisdiction administering the resident's estate within thirty (30) days.</p> <p>Review of Unsampld Resident A's account revealed the resident expired on 05/08/14. The resident's funds were not dispersed until 06/24/14, which was 47 days after the residence's death.</p> <p>Review of Unsampld Resident B's account revealed the resident expired on 01/30/14. The facility transferred the resident's balance of sixty (60) dollars into the facility's account on 02/11/14 and did not convey the funds to the resident's power of attorney.</p> <p>Review of Unsampld Resident C's account revealed the resident expired on 04/23/14. The facility transferred the resident's account balance of forty (40) dollars into a facility account instead of conveying the funds to resident's power of attorney.</p> <p>Review of Unsampld Resident D's account revealed the resident expired on 10/02/13. The facility closed the account and wrote a check to deceased Unsampld Resident D for the remaining amount in the account on 11/04/14, which was 33 days after the resident's death.</p> <p>Interview with the Business Office Manager, on 07/01/14 at 2:15 PM, revealed the remaining balance of a resident's account should be closed upon death and a check for the remaining balance should be written to the person the</p>	F 160	<p>F 160 C</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Unsampled resident A and D funds were dispersed but later than 30 days after expiration. Unsampld residents B and C had resident funds used to pay their outstanding debt for care and services to the facility; this money was refunded to the residents estate by 8/1/14.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents who have resident trust accounts with the facility have the potential to be affected. The administrator will audit all resident trust accounts of residents who have passed away in the last year (June 2013-July 2014) to validate refunds were issued timely and not applied to outstanding bills. If any funds were used for outstanding bills, these will be refunded by 8/1/14. This audit was completed by 7/28/2014.</p>	



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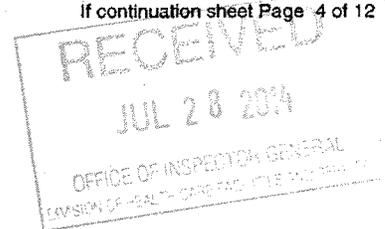
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F 160	Continued From page 2 resident had designated as the responsible person. The Business Office Manager revealed the balance from Unsampled Resident B and C had been used to go towards the outstanding bill. Continued interview, on 07/02/14 at 1:23 PM, revealed she was aware resident trust accounts should be closed within thirty (30) days and it was an error that the accounts were closed late. The Business Office Manager revealed she had always used a remaining balance to pay outstanding bills and had never been informed that could not be done. Interview with the Administrator, on 07/02/14 at 3:08 PM, revealed she had reviewed the policy for Conveyance of Funds and felt it was vague. The Administrator revealed the corporate office had just completed an audit of the resident trust accounts and did not find a problem. The Administrator revealed it was discussed that the facility was using the money to pay themselves if there was an outstanding balance; however, the corporate office was not aware the facility did not have authorization from the residents or their power of attorney to do so.	F 160	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Administrator will educate the BOM and ABOM on the conveyance of resident funds upon death to adhere to the appropriate time frame and appropriate refund to the jurisdiction of the resident's estate per our current policy by 7/22/14. 4. How will the facility plan to monitor its performance to ensure that solutions are sustained? The Administrator will complete an audit of any deceased residents who had a resident trust account with the facility to ensure proper refunds were issued and timely, this will occur weekly x 4 weeks, then monthly x 3 months, then quarterly x 3 quarters. The results of the audits will be presented to the QAPI committee monthly x 4 months then quarterly x 3 quarters for review and further recommendations based on the results.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Comprehensive Care	F 282		8/6/14



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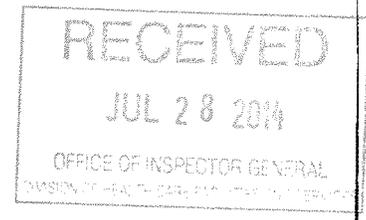
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F 282	<p>Continued From page 3</p> <p>Plan Policy, it was determined the facility failed to follow the care plan for one (1) of sixteen (16) residents, Resident #2. The staff failed to place the heel boots on Resident #2 as care planned.</p> <p>The findings include:</p> <p>Review of the Comprehensive Care Plan Policy, revised October 2010, revealed each residents comprehensive care plan was designed to reflect currently recognized standards of practice for problem areas and conditions.</p> <p>Review of Resident #2's clinical record revealed the facility admitted the resident on 04/24/14, with diagnoses of Dementia, Fracture of the Femur, Orthopedic Aftercare and Vascular Disease. Review of Resident #2's skin assessment, dated 04/24/14, revealed the facility assessed Resident #2 with an unstageable pressure ulcer to the right heel.</p> <p>Review of Resident #2's care plan titled at risk for developing additional skin breakdown, dated 05/06/14, revealed staff was to place a heel boot to Resident #2's foot.</p> <p>Observations of Resident #2, on 06/30/14 at 9:50 AM and 10:05 AM, revealed Resident #2 was sitting in the television room with no heel boots on either foot. Observation of Resident #2, on 07/01/14 at 12:05 PM, revealed Resident #2 did not have the heel boots on his/her feet, though the resident was observed to have non-skid socks on his/her feet. Continued observation of Resident #2, on 07/01/14 at 1:52 PM, revealed Resident #2 was lying down in bed with a pillow under Resident #2's knees. However, both heels of the feet were observed to be touching the bed</p>	F 282		



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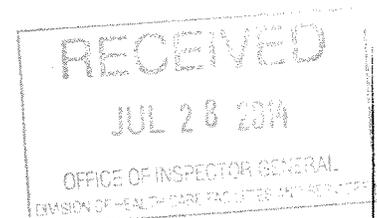
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F 282	<p>Continued From page 4</p> <p>mattress. Observation of Resident #2, on 07/01/14 at 2:59 PM, revealed Resident #2 was lying down in bed with both feet elevated on pillows. There were no heel boots on Resident #2's feet.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/02/14 at 12:59 PM, revealed she did not initiate or update care plans. LPN #1 stated she was expected to follow the care plans. If Resident #2 did not have on his/her heel boots as care planned, then the care plan was not being followed.</p> <p>Interview with the Minimum Data Set (MDS) Coordinator, on 07/02/14 at 1:19 PM, revealed nurses were responsible to complete the initial care plans and the MDS Coordinator was responsible to complete the comprehensive care plans. The MDS Coordinator stated she had not witnessed Resident #2 kicking off the heel boots. The MDS Coordinator stated if the heel boots were care planned she expected the staff to follow the care plan as outlined.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 07/02/14 at 1:42 PM, revealed nurses completed initial care plans upon admission and the MDS Coordinator and Nurse Managers could follow up with the care plan a few days from admission to ensure all aspects of care were present. The ADON stated she was not aware Resident #2 did not wear her heel boots as care planned. The ADON stated she felt the staff were following the care plan if they replaced the heel boot as care planned to Resident #2's foot, though the heel boot was not on at all times as ordered. The ADON stated it was important for Resident #2 to keep his/her heel boots on as care</p>	F 282	<p>F 282 D</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The heel boot was placed on the resident's right foot on 7-2-14 by the LPN per the care plan and the physician's order.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>Implementation of care plan interventions on current residents were reviewed and checked by the 2 ADONs and 2 MDS Nurses on 7-22, 7-23, 7-24 and 7-25-14. Any identified issues were immediately corrected.</p>	



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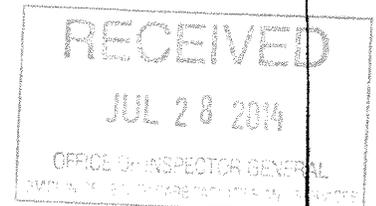
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F 282 F 309 SS=D	Continued From page 5 planned to prevent further breakdown. 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow Physician Orders for one (1) of sixteen (16) sampled residents, Resident #2. The staff failed to place heel boots on Resident #2 as ordered by the Physician. The findings include: No policy could be provided by the facility for following Physician Orders. Review of Resident #2's clinical record revealed Resident #2 was admitted on 04/24/14, with diagnoses of Dementia, Fracture of the Femur, Orthopedic Aftercare and Vascular Disease. Review of Resident #2's skin assessment, dated 04/24/14, revealed an unstageable pressure ulcer to Resident #2's right heel. Review of Louisville Wound Care Notes, dated 06/10/14, revealed Resident #2 was admitted to	F 282 F 309	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Staff Development Nurse provided education to the Licensed Nurses and Nursing Assistants for providing or arranging services by qualified persons in accordance with each resident's written plan of care from 7-22-14 to 8-1-14. Additionally 10% of current residents' care plans will be audited for implementation by the 2 ADONs weekly x4 weeks, monthly x3 months and then quarterly x3 quarters with results given to the DON for review. 4. How will the facility plan to monitor its performance to ensure that solutions are sustained? Results from the care plan audits will be presented by the DON monthly for 4 months, and then quarterly for 3 quarters to the QAPI team for review and recommendations based upon the results.	8/6/14	



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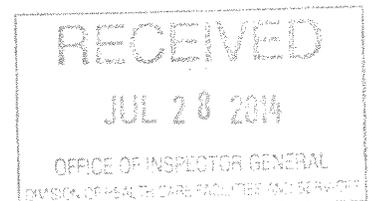
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F 309	<p>Continued From page 6</p> <p>their services with an Arterial Ulcer to the right heel with a high grade stenosis (abnormal narrowing of blood vessels). Review of Resident #2's Physician Orders, dated 06/24/14, revealed an order for heel lift boot on at all times.</p> <p>Observations of Resident #2, on 06/30/14 at 9:50 AM and 10:05 AM, revealed Resident #2 was sitting in the television room without heel boots in place on either foot. Observation of Resident #2, on 07/01/14 at 12:05 PM, revealed Resident #2 had non-skin socks on; however, he did not have the heel boots on his/her feet. Continued observation of Resident #2, on 07/01/14 at 1:52 PM, revealed Resident #2 was lying down in bed with a pillow under Resident #2's knees. Both heels of the feet were observed to be touching the bed mattress. Observation of Resident #2, on 07/01/14 at 2:59 PM, revealed Resident #2 was lying down in bed, both feet elevated on pillows. Resident #2 did not have heel boots on feet.</p> <p>Interview with Certified Nursing Assistant (CNA) #1, on 07/02/14 at 1:58 PM, revealed she worked with Resident #2, on Monday, Tuesday and Wednesday of the survey and revealed she had been looking for the heel boots but could not find them. CNA #1 stated she was aware that Resident #2 was to have them on his/her feet, but did not inform nursing staff that she could not find the heel boots. CNA #1 stated she could not recall the resident having the boots on when she came in to start her shift. CNA #1 stated she had known the heel boots would displace on Resident #2's feet, but had not known the resident to kick off the heel boots.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/02/14 at 12:59 PM, revealed she was</p>	F 309	<p>F 309 D</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The heel boot was placed on the resident's right foot on 7-2-14 by the LPN per the care plan and the physician's order.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>Implementation of active physician orders on current residents were reviewed and checked by the 2 ADONs and 2 MDS Nurses on 7-22, 7-23, 7-24 and 7-25-14. Any identified issues were communicated to the physician or nurse practitioner and immediately corrected.</p>	



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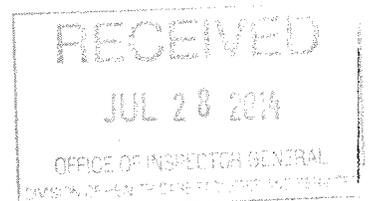
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F 309	Continued From page 7 aware Resident #2 was to wear a boot to keep Resident #2's heel a float. LPN #1 stated she was not aware that Resident #2 did not have his/her boots on at times. LPN #1 stated the CNA's should inform her when Resident #2's boots were off. LPN #1 stated Resident #2's wound had stayed about the same and had not gotten any worse. LPN #1 stated if the heel boot was an order, staff were expected to follow the orders. Interview with Assistant Director of Nursing, on 07/02/14 at 1:42 PM, revealed she was not aware Resident #2 did not have his/her heel boots on. Resident #2 was cognitively impaired and would not remember if he/she was wearing the heel boots. Resident #2 had an arterial wound to his/her heel since admission and was being followed by the wound Doctor. The ADON stated the Doctor did not expect the wound to get better, but it was important that staff place the heel boots on Resident #2 as ordered.	F 309	3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur? The Staff Development Nurse provided education to the Licensed Nurses and Nursing Assistants for providing 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 care plan, including following the physician orders from 7-22-14 to 8-1-14. Additionally 10% of current residents active physician orders will be audited	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 431	for implementation by the 2 ADONs weekly x4 weeks, monthly x3 months and then quarterly x3 quarters with results given to the DON for review.	



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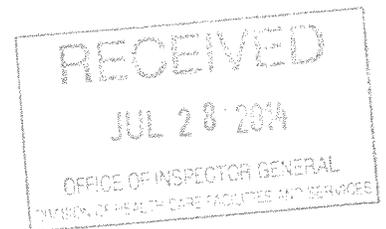
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F 431	Continued From page 8 applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Storage of Medication, it was determined the facility failed to ensure medications remained secured and locked for one (1) of five (5) facility medication carts. The staff failed to ensure an unlocked medication cart was monitored while sitting in the A Hallway of the facility. The findings include: Review of the facility's policy titled, Storage of Medication 4.1 (dated September 2010), revealed access to prescription medications would be limited to licensed nurses, pharmacy staff, and those lawfully authorized to administer medications. Medication rooms, cabinets, and	F 431	4. How will the facility plan to monitor its performance to ensure that solutions are sustained? Results from the physician order audit will be presented by the DON monthly for 4 months, and then quarterly for 3 quarters to the QAPI team for review and recommendations based upon the results.	8/6/14



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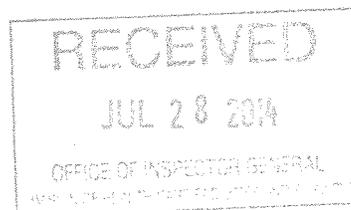
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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F 431	<p>Continued From page 9</p> <p>medication supplies should remain locked when not in use or attended by personnel with authorized access.</p> <p>Observation, on 07/01/14 at 11:37 AM, revealed a medication cart (med cart) was stationed on the A Hallway near Room 133. The cart was unlocked and unattended by the nurse assigned to the cart. The cart was observed to be unlocked and unattended for at least three (3) minutes before Registered Nurse (RN) #1 returned to the cart.</p> <p>Interview with RN #1, on 07/01/14 at 11:40 AM, stated he had been in room (127), administering one medication to the resident, and he thought he had been away from the cart for about 30 seconds. RN #1 stated upon returning to the med cart, he realized it was unlocked. RN #1 revealed a potential problem for residents who were possibly confused, and others to have access to medications stored in the cart. RN #1 stated there was one (1) resident who resided in a room on that particular hallway who self-propelled in his/her wheelchair, and was known to exhibit confusion. RN #1 stated during his new employee orientation, he received training on locking the med cart when he was away from from the cart.</p> <p>Interview, on 07/02/14 at 9:55 AM, with the Assistant Director of Nursing (ADON) for the A Hallway, revealed med carts were to be locked when the nurses assigned were not physically at the carts. The ADON further stated, regardless of how brief the time away might be, it was not acceptable for a med cart to be unlocked when the nurse was away from the cart. The ADON stated the problem was the potential for residents to have access to medications that were not prescribed for them. The ADON revealed this had</p>	F 431	<p>F 431D</p> <p>1. <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>On 7-1-14 RN #1 locked his medication cart upon returning to the cart. On 7-1-14 The ADON re-educated RN #1 on the facility's Storage of medication policy which includes securing and locking the medication cart.</p> <p>2. <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>Observations of unattended medication carts were conducted by the DON on 7-1-14, 7-2-14, and 7-3-14 on the 6a and 6p shifts. No medication carts were observed unlocked.</p>	



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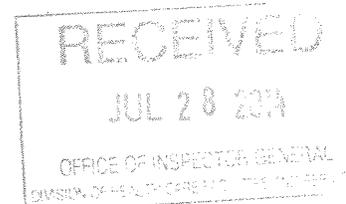
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F 431	<p>Continued From page 10</p> <p>not been a problem on the unit, but upon learning the med cart was observed unlocked, RN #1 was immediately re-educated regarding safe storage of the residents' medications and keeping the med cart locked when he was not standing beside it. The ADON stated, upon hire, and at least annually, licensed nurses were trained in safe management of the residents' medications and that included ensuring the med carts were locked when they were not standing by them.</p> <p>Interview, on 07/02/14 at 10:15 AM with the facility's Director of Nurses (DON), revealed there were currently five (5) med carts in use at the facility, and those med carts should be locked any time they were not attended by the assigned nurse.</p> <p>The DON stated the problem with leaving a med cart in the facility's hallway unattended and unlocked was the potential for residents and other persons moving through the hallway to access medications that were not prescribed for them. The DON revealed during new employee orientation, licensed nurses were trained to keep the residents' medications securely stored and that included ensuring med carts were locked every time they had to step away from the cart. The DON stated RN #1, who was responsible for the med cart that was discovered unlocked on the A Hallway on 07/01/14, had been re-educated on secure storage of the residents' medications, and that she and the ADON's for each unit were in the process of re-educating every licensed nurse responsible for administering medications on the necessity of locking their assigned med carts every time they had to step away from them. The DON further stated this re-education process started on 07/01/14 and was ongoing. The DON stated med carts stationed in the facility's</p>	F 431	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Staff Development Nurse provided education on the Storage of Medication facility policy to the Licensed Nurses starting on 7-1-14 through 7-25-14. The Storage of Medication facility policy includes storage, labeling, dating, and securing and locking of medication carts. Additionally the facility management team (Administrator, DON, 2 ADONs, SDC, Chaplin, Admissions, Social Services, 2 Maintenance, 2 MDS, Activities, Medical Records, and Business Office Manager) will conduct daily observations of each medication cart during at least 2 shifts per day (but will include all 3 shifts) for 4 weeks. Any identified issues will be immediately corrected. The results will be given to the DON for review and follow-up.</p>		



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F 431	Continued From page 11 hallways were monitored seven (7) days per week, when either she or the ADONs for each unit made rounds to ensure staff followed the facility's policies/procedures for safe storage (lockage) of the residents' medications.	F 431	4. How will the facility plan to monitor its performance to ensure that solutions are sustained? The Staff Development Nurse will audit each medication cart monthly for storage, labeling, dating, and securing and locking. The results of this audit will be presented by the SDC to the QAPI team monthly for review and recommendations based upon the results.		8/16/14



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III protected construction.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators, 100KW and 80KW. Fuel source is diesel.</p> <p>A Life Safety Code Survey was conducted on 07/02/14. The Survey began using the 2786S, short form. Concerns were identified effecting complete sprinkler coverage and the survey was then changed to the 2786R standard form. The facility was found not in compliance with the requirements for participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>Signature Healthcare of Cherokee Park (Facility) does not believe and does not admit that any deficiencies existed before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	

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

x *Nicole Meade WHA*

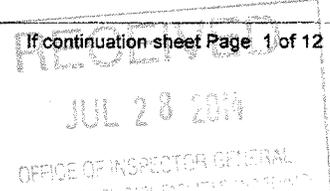
TITLE

x *Administrator*

(X6) DATE

x *7/23/14*

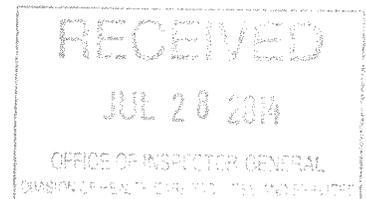
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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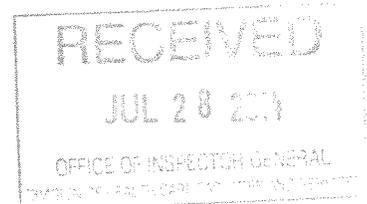
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K 000	Continued From page 1 Fire)	K 000		
K 038 SS=D	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the illumination of the means of egress was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficient practice had the potential to affect one (1) of nine (9) smoke compartments, residents, staff and visitors. The facility has the capacity for eighty-four (84) beds and at the time of the survey, the census was sixty-eight (68). The findings include: Observation, on 07/02/14 at 11:40 AM, with the Maintenance Director revealed the facility did not provide egress lighting for the sidewalk leading from the basement exit door by the Beauty Shop around the building to the public way. Interview, on 07/02/14 at 11:41 AM, with the	K 038	K 038 D 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The egress lighting on the sidewalk from the basement exit door to the public way was installed by the Maintenance Director by 8/1/2014. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected. The Plant Operations Director will complete a facility grounds observation for all paths of egress and the use of appropriate lighting by 7/22/2014. The results will be presented to the Administrator for review by 7/23/2014.	



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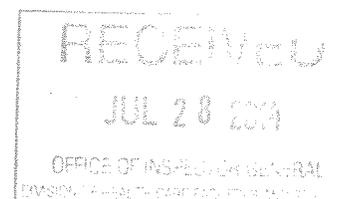
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K 038	<p>Continued From page 2</p> <p>Maintenance Director revealed he was not aware of the requirements for egress lighting.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 101 (2000 Edition) 7.8 ILLUMINATION OF MEANS OF EGRESS</p> <p>7.8.1 General.</p> <p>7.8.1.1*</p> <p>Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2</p> <p>Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3*</p> <p>The floors and other walking surfaces within an exit and within the portions of the exit access and</p>	K 038	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Administrator will educate the plant operations director on Kentucky LSC Tips for K38-Exits and Egress monitoring for compliance by 7/22/14. The plant ops director will audit the exits and egress areas for compliance monthly x 3 months, then quarterly x 3 quarters and report results to the QAPI committee.</p> <p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>The Plant Operations Director will complete an audit of the exits and egress areas for compliance monthly x 3months, then quarterly x 3quarters with results reported to the monthly x3months and then quarterly x 3 quarters to the QAPI committee for review and recommendations.</p> <p style="text-align: right;">8/15/14</p>



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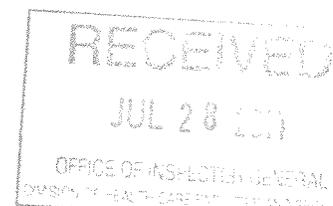
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K 038	Continued From page 3 exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels. 7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area. 7.8.1.5 The equipment or units installed to meet the requirements of Section 7.10 also shall be permitted to serve the function of illumination of means of egress, provided that all requirements of Section 7.8 for such illumination are met. 7.8.2 Sources of Illumination. 7.8.2.1* Illumination of means of egress shall be from a source considered reliable by the authority having jurisdiction. 7.8.2.2 Battery-operated electric lights and other types of portable lamps or lanterns shall not be used for primary illumination of means of egress. Battery-operated electric lights shall be permitted to be used as an emergency source to the extent permitted under Section 7.9.	K 038		
K 056 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard	K 056		



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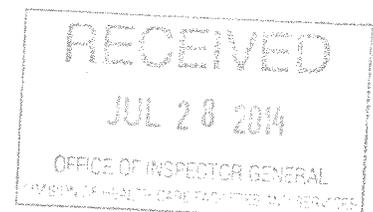
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K 056	<p>Continued From page 4</p> <p>for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure the building had a complete sprinkler system, in accordance with National Fire Protection Agency (NFPA) Standards. The deficient practice had the potential to affect three (3) of nine (9) smoke compartments, thirty-four (34) residents, staff and visitors. The facility has the capacity for eighty-four (84) beds and at the time of the survey, the census was sixty-eight (68). According to CMS S&C 13-55-LSC the enforcement implication would be a fully sprinklered facility with major problems.</p> <p>The findings include:</p> <p>1. Observation, on 07/02/14 at 10:33 AM, with the Maintenance Director revealed the sprinkler heads located in the Linker Wing Corridor and Pedway to be blocked by newly installed ceiling mount light fixtures.</p> <p>Interview, on 07/02/14 at 10:34 AM, with the</p>	K 056	<p>K 056 D</p> <p>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</p> <p>The sprinkler heads identified on the Linker wing and pedway that were obstructed by the light fixtures and the front entrance and rehab entrance awnings/porches will be replaced or added as specified in the BID received and approved on 7/22/2014. The BID indicates all work to be completed by 8/31/2014.</p> <p>The two awnings outside the basements doors by the activity room and the end stairwell were removed on 7/2/14.</p> <p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>All residents have the potential to be affected.</p>	



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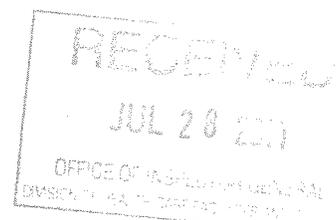
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K 056	<p>Continued From page 5</p> <p>Maintenance Director revealed the light fixtures had been recently updated by the company's road crew. The previous light fixtures were of the recessed type.</p> <p>2. Observation, on 07/02/14 at 10:54 AM, with the Maintenance Director revealed an exterior porch roof extending out greater than four (4) feet that was constructed of combustible wood framing and did not have sprinkler protection installed. The porch roof was located outside the exit doors in the front hall of the Rehabilitation Wing.</p> <p>Interview, on 07/02/14 at 10:55 AM, with the Maintenance Director revealed he was not aware the exterior roofs were to be sprinkler protected due to being constructed of combustible wood materials.</p> <p>3. Observation, on 07/02/14 at 11:10 AM, with the Maintenance Director revealed an exterior porch roof extending out greater than four (4) feet that was covered in combustible canvas material connected to a combustilbe structure over the driveway that did not have sprinkler protection installed. The porch roof was located outside the exit door of the Main Entrance</p> <p>Interview, on 07/02/14 at 11:11 AM, with the Maintenance Director revealed he was not aware the exterior roofs were to be sprinkler protected due to being covered in combustible canvas material.</p> <p>4. Observation, on 07/02/14 at 11:29 AM, with the Maintenance Director revealed an exterior porch roof extending out greater than four (4) feet that was covered in combustible canvas material that did not have sprinkler protection installed. The</p>	K 056	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>The Plant Operations Director with Century Fire and Sprinkler Company completed a full facility audit on 7/16/14 to ensure no other areas were out of compliance with NFPA 25 and NFPA 13. Any identified areas were added to the BID for repairs or additions.</p> <p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>The facility will continue with quarterly sprinkler inspections for routine monitoring of compliance and function. These results will be presented quarterly x 4 quarters to the QAPI committee for review and recommendations.</p>	7/13/14



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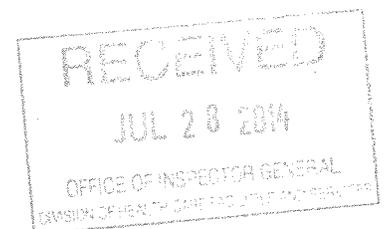
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - BUILDING 0202 B. WING _____	(X3) DATE SURVEY COMPLETED 07/02/2014
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K 056	<p>Continued From page 6</p> <p>porch roof was located outside the exit doors next to the stairwell in the basement of the Linker Wing.</p> <p>Interview, on 07/02/14 at 11:30 AM, with the Maintenance Director revealed he was not aware the exterior roofs were to be sprinkler protected due to being covered in combustible canvas material.</p> <p>5. Observation, on 07/02/14 at 11:38 AM, with the Maintenance Director revealed an exterior porch roof extending out greater than four (4) feet that was covered in combustible canvas material that did not have sprinkler protection installed. The porch roof was located outside the exit door of the Activity Room in the basement of the Linker Wing.</p> <p>Interview, on 07/02/14 at 11:39 AM, with the Maintenance Director revealed he was not aware the exterior roofs were to be sprinkler protected due to being covered in combustible canvas material.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 07/02/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/02/14.</p> <p>Actual NFPA Standard:</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Sprinklers shall be installed under exterior roofs or canopies exceeding 4 Ft. (1.2 m) in width. Exception: Sprinklers are permitted to be omitted where the canopy or roof is of noncombustible or limited combustible construction.</p>	K 056		



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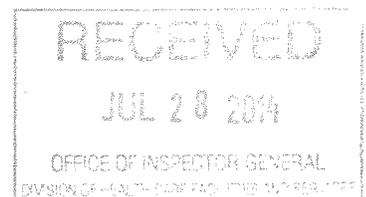
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K 056	Continued From page 7 Reference: NFPA 13 (1999 Edition) 5-5.5.1* Performance Objective. Sprinklers shall be located so as to minimize obstructions to discharge as defined in 5-5.5.2 and 5-5.5.3, or additional sprinklers shall be provided to ensure adequate coverage of the hazard. Reference: NFPA 13 (1999 Edition)2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. hydraulic design basis, the system area of operation shall be permitted to be reduced without revising the density as indicated in Figure 7-2.3.2.4 when all of the following conditions are satisfied: (1) Wet pipe system (2) Light hazard or ordinary hazard occupancy (3) 20-ft (6.1-m) maximum ceiling height The number of sprinklers in the design area shall never be less than five. Where quick-response sprinklers are used on a sloped ceiling, the maximum ceiling height shall be used for determining the percent reduction in design area. Where quick-response sprinklers are installed, all sprinklers within a compartment shall be of the quick response type.	K 056		



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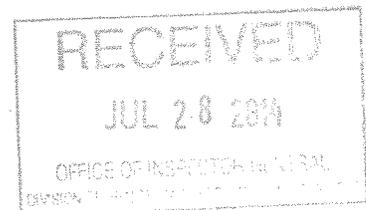
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K 056	<p>Continued From page 8</p> <p>Exception: Where circumstances require the use of other than ordinary temperature-rated sprinklers, standard response sprinklers shall be permitted to be used.</p> <p>Reference: NFPA 13 (1999 Edition) 5-13 8.1 Actual NFPA Standard: NFPA 101, Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility. Actual NFPA Standard: NFPA 101, 19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7. Actual NFPA Standard: NFPA 101, 9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. Actual NFPA Standard: NFPA 13, 5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles: (1) Sprinklers installed throughout the premises (2) Sprinklers located so as not to exceed maximum protection area per sprinkler (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.</p> <p>Reference: NFPA 13 (1999 edition) 5-6.3.3 Minimum Distance from Walls. Sprinklers shall be located a minimum of 4 in. (102 mm) from a wall.</p> <p>Reference: NFPA 13 (1999 Edition) 5-5.5.2.2</p>	K 056		



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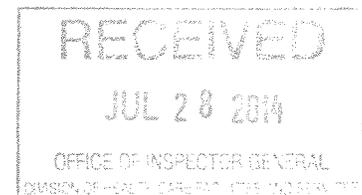
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K 056	Continued From page 9 Sprinklers shall be positioned in accordance with the minimum distances and special exceptions of Sections 5-6 through 5-11 so that they are located sufficiently away from obstructions such as truss webs and chords, pipes, columns, and fixtures. Table 5-6.5.1.2 Positioning of Sprinklers to Avoid Obstructions to Discharge (SSU/SSP) <table border="0"> <thead> <tr> <th colspan="2">Maximum Allowable Distance</th> </tr> <tr> <th>Distance from Sprinklers to above Bottom of Side of Obstruction (A)</th> <th>of Deflector Obstruction (in.)</th> </tr> </thead> <tbody> <tr> <td>(B)</td> <td></td> </tr> <tr> <td>Less than 1 ft</td> <td>0</td> </tr> <tr> <td>1 ft to less than 1 ft 6 in.</td> <td>21/2</td> </tr> <tr> <td>1 ft 6 in. to less than 2 ft</td> <td>31/2</td> </tr> <tr> <td>2 ft to less than 2 ft 6 in.</td> <td>51/2</td> </tr> <tr> <td>2 ft 6 in. to less than 3 ft</td> <td>71/2</td> </tr> <tr> <td>3 ft to less than 3 ft 6 in.</td> <td>91/2</td> </tr> <tr> <td>3 ft 6 in. to less than 4 ft</td> <td>12</td> </tr> <tr> <td>4 ft to less than 4 ft 6 in.</td> <td>14</td> </tr> <tr> <td>4 ft 6 in. to less than 5 ft</td> <td>161/2</td> </tr> <tr> <td>5 ft and greater</td> <td>18</td> </tr> </tbody> </table> For SI units, 1 in. = 25.4 mm; 1 ft = 0.3048 m. Note: For (A) and (B), refer to Figure 5-6.5.1.2(a). Reference: NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	Maximum Allowable Distance		Distance from Sprinklers to above Bottom of Side of Obstruction (A)	of Deflector Obstruction (in.)	(B)		Less than 1 ft	0	1 ft to less than 1 ft 6 in.	21/2	1 ft 6 in. to less than 2 ft	31/2	2 ft to less than 2 ft 6 in.	51/2	2 ft 6 in. to less than 3 ft	71/2	3 ft to less than 3 ft 6 in.	91/2	3 ft 6 in. to less than 4 ft	12	4 ft to less than 4 ft 6 in.	14	4 ft 6 in. to less than 5 ft	161/2	5 ft and greater	18	K 056		
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K 144 K 144 SS=F	Continued From page 10 NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on an interview and record review, the facility failed to maintain the generator set by National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect nine (9) of nine (9) smoke compartments, all residents, staff and visitors. The facility has the capacity for eighty-four (84) beds with a census of sixty-eight (68) on the day of the survey. The findings include: 1. Observation, on 07/02/14 at 11:49 AM, with the Maintenance Director revealed the emergency battery-powered light identified as #4, installed in the area where the transfer switch for the emergency generator was located failed to illuminate when tested. Interview, on 07/02/14 at 11:50 AM, with the Maintenance Director revealed the emergency battery-powered light was tested routinely and he was not aware it had stopped working.	K 144 K 144	K 144 F 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The emergency battery powered lights identified as #4, #13 and #2 had the batteries replaced and lights were fully functioning by 7/5/14. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected.	



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K 144	<p>Continued From page 11</p> <p>2. Observation, on 07/02/14 at 12:00 PM, with the Maintenance Director revealed the emergency battery-powered light identified as #13 and #2, installed in the area where the transfer switch for the emergency generator was located failed to illuminate when tested.</p> <p>Interview, on 07/02/14 at 12:01 PM, with the Maintenance Director revealed the emergency battery-powered light was tested routinely and he was not aware it had stopped working.</p> <p>The census of sixty-eight (68) was verified by the Administrator on 07/02/14. The findings were acknowledged by the Administrator and verified by the Maintenance Director at the exit interview on 07/02/14.</p> <p>Reference: NFPA 110 (1999 Edition).</p> <p>5-3.1 The Level 1 or Level 2 EPS equipment location shall be provided with battery-powered emergency lighting. The emergency lighting charging system and the normal service room lighting shall be supplied from the load side of the transfer switch.</p>	K 144	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p><i>The administrator will educate the Plant ops director on Kentucky Top LSC Tips on K144 and monitored for compliance that battery powered lights are functioning by 7/22/14. The plant ops director will complete a 30 second test of all battery powered lights in all mechanical rooms weekly x 4 weeks then monthly going forward.</i></p> <p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>The Plant Ops Director will complete a 30 second test of all battery powered lights in all mechanical rooms weekly x 4 weeks then monthly going forward. Results of the testing will be presented to the QAPI meeting monthly for review and recommendations for 12 months.</p>	8/15/14

