

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

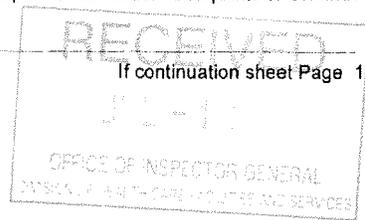
PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard recertification survey was conducted 06/04/13 through 06/06/13 and a Life Safety Code survey was conducted on 06/04/13. Deficiencies were cited with the highest scope and severity of an "D" with the facility having the opportunity to correct the deficiencies before remedies would be cited.	F 000	"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."	
F 160 SS=B	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, and review of the facility's policy, it was determined the facility failed to convey resident funds promptly within 30 days of death for three (3) of the five (5) discharged records reviewed (Unsampled Resident A, B, and C). The findings include: Review of the facility's policy Accounts Receivable Policies and Procedures, revised 05/22/13, revealed refunds must be made via check within five (5) business days of the transfer of funds to petty cash checking account. If there is no family or responsible party, make the checks payable to the state's unclaimed properties department.	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *Administrator* (X6) DATE *6/28/13*

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

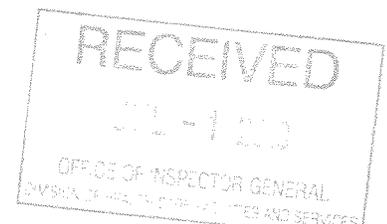
KH



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 160	Continued From page 1 1. Reveiw of Unsampled Resident A's personal fund records revealed the resident expired on 01/21/13. However, the final conveyance of funds totaling \$100.76 was written in Pay to order of Klondike Care Center and not the person in charge of the resident's estate. 2. Review of Unsampled Resident B's personal fund records revealed the resident expired on 04/19/13. However, the final conveyance of funds totaling \$912.07 was not sent to the person in charge of the resident's estate. 3. Review of Unsampled Resident C's personal fund records revealed the resident expired on 04/14/13. However, the final conveyance of funds totaling \$1177.11 was not sent to the person in charge of the resident's estate. Interview with the Business Office Manager, on 06/06/13 at 10:00 AM, revealed that if a resident owed money to the facility at the time of their death, the money in the resident's account was then paid to the facility. The Business Office Manager revealed the facility admission contract stated that if money was owed, any money in the account would go towards payment for services. The Business Office Manager revealed she was not familiar with regulations regarding the conveyance of resident funds. Interivew with the Administrator, on 06/06/13 at 4:57 PM, revealed she was not aware how funds were being handled and was also not aware of regulations pertaining to conveyance of funds.	F 160	F160 1. For Resident A- \$100.76 was refunded to the residents responsible party on 07/01/13 by the Business Office Manager. For Resident B- \$912.07 was refunded to the residents responsible party on 07/01/13 by the Business Office Manager. For Resident C- \$1177.11 was refunded to the residents responsible party on 07/01/13 by the Business Office Manager. 2. An audit of resident financial files for the past 30 days was completed by the Business Office Manager and Administrator on 06/28/2013 to determine if funds had been returned timely. Any residents identified had funds returned to their estate/responsible party. 3. The Business Office Manager and Administrator were re-educated to the Accounts Payable Policy regarding refunds must be made via check within five (5) business days of the transfer of funds to petty cash checking account and if there is no family or responsible party, make the checks payable to the state's unclaimed properties department by the Regional Accounts Payable Manager on 06/28/2013. 4. The Business Office Manager and/or Administrator will complete an audit of all discharged residents financial files to determine that funds have been refunded within 5 days as per policy weekly x 8 weeks and then monthly x 4. Any concerns will be addressed at the time identified. A summary of findings will be submitted to the Performance Improvement Committee by the Business Office Manager or Administrator monthly x 6 months for review and further recommendation.	07/02/13	
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS	F 164			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

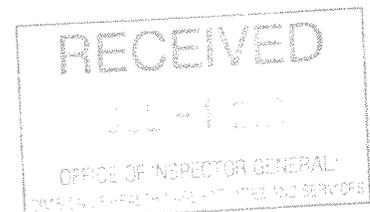
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 2 The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to provide privacy during personal care for two (2) of seventeen (17) sampled residents and six (6) unsampled residents, Residents #7 and #13. Window blinds were not closed during a	F 164	F164 1. A privacy curtain was hung in resident #13 room by a housekeeper on 6-6-13. Resident #7 was assessed by a licensed nurse and denies any distress related to the blinds not being closed during care on 6-6-13. 2. An audit of all resident rooms was conducted by the Administrator, Director of Nursing and MDS Nurse on 6-6-13 to determine that privacy curtains were in place and that privacy was provided for residents during care ie blinds closed etc. No additional concerns were identified. 3. Nursing staff were re-educated by the Administrator, Director of Nursing, and MDS nurse to provide privacy during resident care including shutting blinds, use of privacy curtain, shutting doors etc. as of 06/06/2013. Housekeeping and nursing staff were re-educated on the expectation that all residents have a privacy curtain in their room and where additional curtains are stored in case the curtain presently in the room needs to be changed. Inservice completed by the Administrator, Director of Nursing and MDS Nurse as of 06/11/2013. 4. The Administrator, Director of Nursing, and/or designee will complete an audit of resident rooms to determine that privacy curtains are in place and that staff are providing privacy during care weekly x4 weeks and then monthly x 5. Any concerns will be addressed when identified. A summary of findings will be submitted to the Performance Improvement Committee by the Administrator monthly x 6 months for further review and recommendation.	07/02/13

RECEIVED
JUL - 1 2013
OFFICE OF INSPECTOR GENERAL

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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

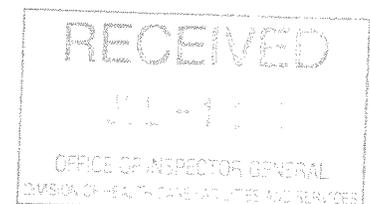
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	<p>Continued From page 3</p> <p>skin assessment for Resident #7, and a privacy curtain was not provided for several days for Resident #13.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Care And Services CL-676-000 (Dated 01/08), revealed the facility's Interdisciplinary Care Team (IDT) provided care and services within reasonable accommodations of each resident's individual needs and preferences, and interacted with residents in a manner that enhanced the resident's self-esteem and self worth.</p> <p>The facility did not provide a policy specific to assuring the resident's privacy during personal care.</p> <p>Review of Resident #13's clinical record, revealed the facility admitted the resident on 09/12/12 with diagnoses of Multiple Sclerosis, Schizophrenia, Impulse Control Disorder, Metabolic Encephalopathy, Contractures of his/her hands and feet, and a history of Urinary Tract Infections.</p> <p>Review of Resident #13's Comprehensive Care Plan revealed the resident was dependent on staff for most care needs including bathing, incontinence care, and two staff person transfers which included use of a Hoyer lift. Resident #13 was also care planned for colostomy care.</p> <p>During the group interview, on 06/04/13 at 10:30 AM, Resident #13 revealed he/she did not have a privacy curtain in their room between bed 1 and bed 2, which prevented the resident from having privacy during personal care. The resident</p>	F 164		



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

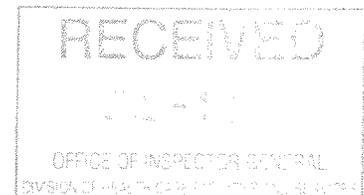
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	<p>Continued From page 4</p> <p>revealed he/she did inform several staff members, but did not reveal how long the curtain had been missing.</p> <p>Observation, on 06/04/13 at 11:40 AM and 12:00 PM, revealed a privacy curtain in Room 31 for the resident in Bed #1, but there was no privacy curtain hanging from the ceiling track between beds #1 and #2. Resident #13 resided in Bed #2. Continued observations, on 06/05/13 at 11:35 AM and 5:00 PM, and on 06/06/13 at 11:00 AM, revealed a privacy curtain was not in place.</p> <p>Interview, on 06/06/13 at 11:30 AM, with Resident #13 revealed he/she remembered having a privacy curtain at one time. Resident #13 could not remember exactly when the curtain had been taken down, but stated he/she would like to have one hung to provide privacy from the resident in Bed #1 and from persons passing in the hallway.</p> <p>Interview, on 06/06/13 at 1:00 PM, with Certified Nursing Assistant (CNA) #1, revealed she thought a privacy curtain had recently been in place for Resident #13 because she remembered pulling the curtain before performing care for Resident #13. To provide residents privacy during care, CNA #1 said she typically closed the resident's door leading to the hallway, pulled the curtain, and closed the window blinds if the resident was in the bed closest to a window.</p> <p>Interview, on 06/07/13 at 12:01 PM, with Licensed Practical Nurse (LPN) #1 revealed a privacy curtain had been in place for Resident #13, but she had not noticed it was missing. LPN #1</p>	F 164		



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

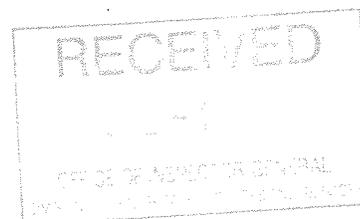
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	<p>Continued From page 5</p> <p>stated Resident #13 sometimes exhibited a behavior of throwing cups, food items, and other personal items, and this behavior had occurred the previous Sunday and was documented. If the curtain had become soiled from debris, it may have been taken down for cleaning, but that was the only reason LPN #1 stated she could think of for removal of the curtain.</p> <p>Interview, on 06/06/13 at 1:25 PM, with the Director of Housekeeping revealed extra privacy curtains (at least 8-10) were available for use and stored in the laundry department, and Housekeeping staff would hang a clean curtain anytime, when requested.</p> <p>Interview, on 06/06/13 at 2:40 PM, with the Director of Nursing (DON) revealed anytime a skin assessment or other personal care was given, the direct care staff should assure the resident's privacy by closing the room's door and pulling the privacy curtain. If the resident's bed was near a window, the blinds should be closed. The DON stated if Resident #13's privacy curtain was taken down for any reason, it should have been promptly replaced. Upon notification, Environmental Services staff would be responsible for replacing the privacy curtain. The DON stated the missing privacy curtain concerned her because Resident #13 should be assured privacy during personal care. In addition, the DON stated Environmental Services staff was responsible for ensuring privacy curtains were hung wherever needed, but she would hope the direct care staff would have noticed the missing curtain, and would have reported it. The DON said she was not aware there was a surplus of privacy curtains in the laundry department for</p>	F 164		



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

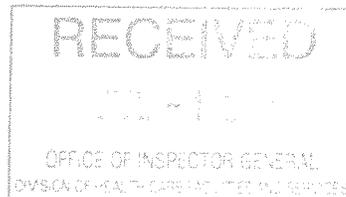
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 164	Continued From page 6 use. Observation of Resident #7's skin assessment, on 06/05/13 at 9:45 AM, revealed both Certified Nursing Assistant (CNA) #3 and Licensed Practical Nurse (LPN) #1 entered the resident's room and began the skin assessment without closing the window blinds. Interview with CNA #3, on 06/06/13 at 2:00 PM, revealed she did not notice the blinds were open and should have checked to ensure they were closed before uncovering and disrobbing the resident. Interview with LPN #1, on 06/06/13 at 2:05 PM, revealed she did not notice the blinds were open during the skin assessment. The LPN revealed the blinds should have been closed to ensure privacy and dignity to the resident during the assessment.	F 164		
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, facility policy review, it was determined the facility failed to follow one (1) of the seventeen (17)	F 282		



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

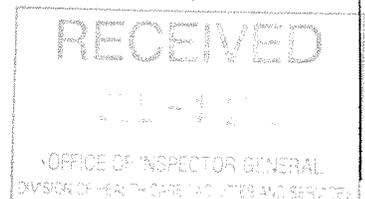
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	Continued From page 7 sampled residents and six (6) unsampled residents (Resident #17) comprehensive plan of care regarding incontinence care. The findings include: Review of the facility's policy regarding Care Plan-Interdisciplinary, dated 01/2008, revealed the facility developed an individualized plan of care for each resident utilizing the information gathered during each assessment. The Interdisciplinary Team developed care plans addressing the resident's most acute problems. The care plan is comprehensive for each resident including measurable objectives and timetable to meet resident's medical, nursing, mental, and psychosocial needs. Review of the clinical record for Resident #17 revealed the facility admitted the resident on 03/09/13 with diagnoses of Quadriplegia, Hypertension, Depression, and Anemia. The Minimum Data Set (MDS) assessment tool, dated 05/21/13, revealed the facility assessed the resident as being cognitively intact with a Brief Interview for Mental Status score of 15. The facility assessed the resident as having functional limitation in range of motion to both upper and lower extremities, requiring a two (2) person assist with transfers, and a one (1) per assist with toileting and hygiene. Review of the Resident's Comprehensive plan of care revealed the resident had a recurring pressure ulcer to the coccyx area and right heel which was being followed by the wound clinic and being treated with daily dressing changes. Further review of the resident's Plan of care revealed the resident's self care deficit related to Quadriplegia resulted in	F 282	F282 1. Incontinence care was provided for resident #17 by nursing staff on 6-6-13 and then checked every 2 hours for incontinence thereafter as directed by the resident plan of care. The Care Card for resident #17 was updated by the Director of Nursing on 6-6-13 to include checking for incontinence every 2 hours. 2. An audit of current residents care plans, care cards, and care provided was completed by the Director of Nursing, Unit Manager, and MDS nurse on 06/28/2013 to determine that care is provided per the residents plan of care. No other concerns were identified. 3. The Director of Nursing, Administrator, and MDS nurse were re-educated by the Regional Manager of Clinical Operations regarding bringing/updating resident care cards during the Interdisciplinary Team meetings on 6-27-13. Nursing staff were re-educated to following resident plans of care by the Director of Nursing, Unit Manager, and Nurse Supervisor as of 06/11/2013. 4. The Director of Nursing, Unit Manager, and or Nurse Supervisor will complete an audit of 5 residents per week x8 weeks to determine that care is provided as directed by the plan of care and that the care cards reflect interventions on the care plan and then 5 residents per month x4 months. Any concerns identified will be addressed at that time. The Director of Nursing will submit a summary of findings to the Performance Improvement Committee monthly x6 months for further review and recommendation.	07/02/13	



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

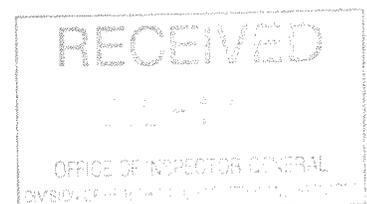
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 282	<p>Continued From page 8</p> <p>required assistance with grooming, hygiene, and urinary incontinence with occasional use of an external urinary catheter when leaving the facility. The facility determined the following interventions to keep the resident clean and dry and prevent complications with the external urinary: change the catheter as needed; check for incontinence every 2 hours and as needed, observe for signs of leakage, and provide incontinent care as needed.</p> <p>Interview with Resident #17, on 06/06/13 at 10:45 AM, revealed the resident had an external urinary catheter placed for an appointment which the resident had felt come loose during the previous evening. The resident revealed a Certified Nursing Assistant (CNA) checked the outside of the resident's incontinence brief and said everything was fine without actually removing the brief to ensure the catheter was in place. The resident revealed Registered Nurse (RN) #1 and CNA #5 completed wound care to the residents sacral area, on 06/06/13 at 10:15 AM, and informed the resident he/she was soiled. However, the two (2) staff members did not provide the resident with incontinence care at the time of the dressing change, and told the resident they would have someone else come back and clean the resident, which left the resident lying in a soiled brief. During the resident interview, at 10:55 AM, CNA #6 entered the resident's room and asked the resident if they were in need of incontinence care, which was forty (40) minutes after the resident was first discovered they were soiled.</p> <p>The Assistant Director of Nursing (ADON) and CNA #6 return to the Resident's room, on</p>	F 282	



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

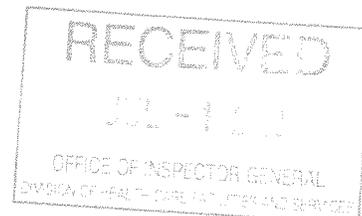
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 9</p> <p>06/06/13 at 11:05 AM, to provide the resident with incontinent care. Observation revealed the external urinary catheter was not in place and a strong urine odor was noted. The incontinence brief was completely saturated to the point the blue outer coating appeared green in color. The lift sheet underneath the resident was wet with a visible ring from the resident's mid back down the the resident's mid thigh.</p> <p>Interview with CNA #6, on 05/06/13 at 11:30 AM, revealed the CNA did not make routine rounds and monitor for incontinence, but only provided care when called for by the resident. The CNA revealed the resident was continent of bladder unless the resident was having spasms which then resulted in incontinence, therefore routine rounds were not completed. In addition, the CNA revealed the resident was not checked to ensure the external urinary catheter was intact and connected.</p> <p>Review of the Nursing Assistant Care Card for Resident #17 revealed the resident was not marked for every 2 hour incontinent management.</p> <p>Interview with RN #1, on 06/06/13 at 11:55 AM, revealed she completed Resident #17's sacral dressing change after she was finished with her medication pass on the unit. The RN revealed she did notice the resident was soiled at the time of the dressing change and asked the CNA that was assisting her to let the resident's assigned CNA know the resident was in need of incontinent care. The RN revealed she left the resident's room without telling him/her why or when someone would be returning to perform</p>	F 282			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

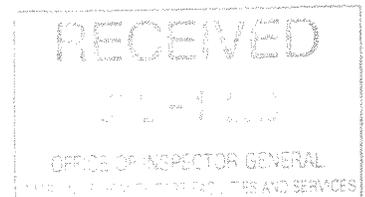
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 282	<p>Continued From page 10</p> <p>incontinent care. The RN revealed the resident did have episodes of incontinence and should be checked routinely by the CNA's to ensure he/she was clean and dry. The RN was not aware what information was on the CNA care card.</p> <p>Interview with the MDS Coordinator, on 06/06/13 at 2:45 PM, revealed Resident #17 did have episodes of incontinence and should be checked every 2 hours. The MDS Coordinator revealed the care plans and CNA care cards were reviewed quarterly and the discrepancy should have been caught at that time. The MDS Coordinator revealed the CNA care cards are not actually brought to the Interdisciplinary team meeting, but stated the Unit Managers were responsible to ensure they were updated accordingly.</p> <p>Interview with the ADON, on 06/06/13 at 3:30 PM, revealed the facility staff should have assisted the resident with incontinence care at the time of the wound care. The ADON revealed the CNA's should be making routine rounds for incontinence management. After reviewing the CNA care card, the ADON revealed she was not aware the care card was not updated to reflect the resident's incontinence status. The ADON revealed she was not monitoring to ensure the CNA care cards reflect interventions determined on the nursing comprehensive plan of care.</p> <p>Interview with the Director of Nursing (DON), on 06/06/13 at 4:07 PM, revealed Resident #17 should be checked every 2 hours for incontinence care and as needed to ensure the external urinary catheter was in place. The DON revealed the purpose of the care plan was to know what</p>	F 282	
(X5) COMPLETION DATE			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

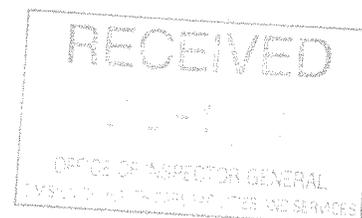
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 282	Continued From page 11 type of care was needed for each individual person. The DON revealed care cards are not brought to the care meetings, but changes were written down, then the cards were updated at a later time by the Unit Manager. The DON revealed she does audit charts and compared the care cards, but does not use a rubric or document who or when completed.	F 282	
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and the review of the facility's policy, it was determined the facility failed to provide the necessary services to maintain personal hygiene on one (1) of the seventeen (17) sampled residents (Resident #17). The facility knowingly left Resident #17 soiled after discovering the dependant resident was in need of incontinence care during a wound treatment. The findings include: Review of the facility's policy regarding Skin Integrity Care Delivery Process: Incontinence Skin Care, dated 10/01/10, revealed staff should protect the wound from further trauma, contamination, or drying, monitor for risk/potential	F 312	F312 1. Incontinence care was provided to resident #17 on 6-6-13 by nursing staff. The Director of Nursing completed a skin assessment of resident #17 on 6-6-13 with no changes in skin condition identified. RN #1, CNA's #4, #5, and #6 were re-educated by the Director of Nursing on 06/06/2013 regarding providing timely incontinence care. 2. An audit of current incontinent residents was completed by the Director of Nursing, Unit Manager, and Nurse Supervisor on 06/28/2013 to determine that Incontinence care was provided as per the plan of care and that the care cards reflected each residents incontinence care needs. No additional concerns were identified. 3. Nursing staff were re-educated to providing Incontinence care per the plan of care on 06/06 /13 by the Director of Nursing, Unit Manager, and Nurse Supervisor. 4. The Director of Nursing, Unit Manager, or Nurse Supervisor will complete an audit of 5 residents per week x 8 weeks to determine that incontinence care is provided timely as per the plan of care and then 5 residents monthly x 4 months. Any concerns will be addressed at the time identified. A summary of findings will be submitted to the Performance Improvement Committee monthly x 6 months for further review and recommendation.



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

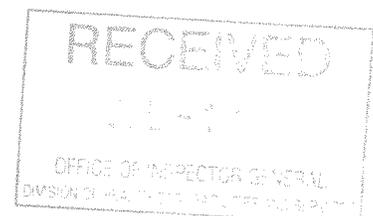
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	<p>Continued From page 12</p> <p>risk of exposure to fecal or urinary incontinence. The guideline revealed moisture caused by urine, feces, wound exudate, or perspiration leads to skin maceration, and breakdown. The guideline further explained, because of this, the perineal area of incontinent individuals rapidly breaks down if not protected.</p> <p>Review of the clinical record for Resident #17 revealed the facility admitted Resident #17 on 03/09/10 with diagnoses of Quadriplegia, Hypertension, Depression, and Anemia. The Minimum Data Set (MDS) assessment tool, dated 05/21/13, revealed the facility assessed the resident as being cognitively intact with a Brief Interview for Mental Status score of 15. The facility assessed the resident as having functional limitation in range of motion to both upper and lower extremities, requiring a two (2) person assist with transfers, and a one (1) per assist with toileting and hygiene. Review of the Resident's Comprehensive plan of care revealed the resident had a recurring pressure ulcer to the coccyx area and right heel which was being followed by the wound clinic and being treated with daily dressing changes. Further review of the resident's Plan of care revealed the resident's self care deficit related to Quadriplegia required assistance with grooming and hygiene, and urinary incontinence with occasional use of an external urinary catheter when leaving the facility. The facility determined the following interventions to prevent complications with the external urinary catheter and to keep the resident clean, dry, and odor free: change catheter as needed; check for incontinence every 2 hours and as needed, observe for signs of leakage, and provide incontinent care as needed.</p>	F 312		



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

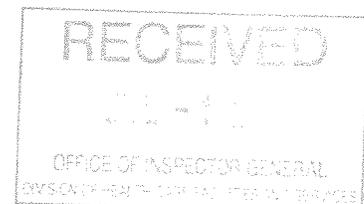
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 13 On 06/06/13, Resident #17 requested to speak to a state surveyor. Interview with Resident #17, on 06/06/13 at 10:45 AM, revealed the resident had an external urinary catheter placed for an appointment with the wound care physician. The resident revealed he/she began to feel wet during the evening and notified a Certified Nursing Assistant (CNA). The resident revealed the CNA checked the outside of the incontinence brief and said everything was fine without actually removing the brief to ensure the catheter was in place. The resident revealed Registered Nurse (RN) #1 and CNA #5 completed wound care to the residents sacral area, on 06/06/13 at 10:15 AM, and informed the resident he/she was soiled. However, the two (2) staff members did not provide the resident with incontinence at the time of the dressing change, and told the resident they would have someone else come back and clean the resident, which left the resident lying in a soiled brief. During the resident interview, at 10:55 AM, CNA #6 entered the resident's room and asked the resident if they were in need of incontinence care, which was forty (40) minutes after being discovered the resident was soiled. After seeing the state surveyor, the CNA leaves the room and states she will return. The Assistant Director of Nursing (ADON) and CNA #6 return to the Resident's room, on 06/06/13 at 11:05 AM, which was 50 minutes after the resident was found incontinent. Observation of the incontinence and pericare revealed the external urinary catheter was not in place and a strong urine odor was noted. The incontinence brief was completely saturated to the point the blue outer coating appeared green in	F 312			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

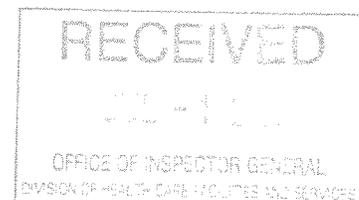
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
F 312	<p>Continued From page 14</p> <p>color. The lift sheet underneath the resident was wet with a visible ring from the resident's mid back down the the resident's mid thigh.</p> <p>Interview with CNA #6, on 05/06/13 at 11:30 AM, revealed she was not told the Resident was soiled and in need of incontinence care until 10:55 AM and immediately came to the resident's room. The CNA revealed she does not go into the resident's room unless called for by resident. The CNA revealed she did make a morning round, but only looked in the resident's room to ensure the resident was safe and did not check to make sure the resident was clean and dry. The CNA revealed the resident was continent of bladder unless the resident was having spasms which then resulted in incontinence. The CNA revealed the resident was not routinely checked for incontinence. The CNA revealed the resident was not checked to ensure the external urinary catheter was intact and connected.</p> <p>Review of the Nursing Assistant Care Card for Resident #17 revealed the resident was continent, and had either an external catheter or used urinal. The resident was not marked for the every 2 hour incontinent management.</p> <p>Interview with RN #1, on 06/06/13 at 11:55 AM, revealed she completed Resident #17's sacral dressing change after she was finished with her medication pass on the unit. The RN revealed she did notice the resident was soiled at the time of the dressing change and asked the CNA that was assisting her to let the resident's assigned CNA know the resident was in need of incontinent care. The RN revealed she left the room because she was told by CNA #4 another</p>	F 312	
(X5) COMPLETION DATE			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

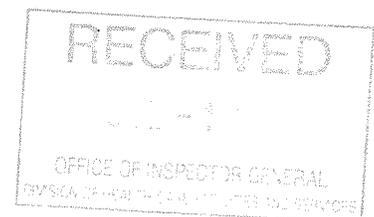
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	<p>Continued From page 15</p> <p>resident was having shortness of air. The RN revealed she left the resident's room without telling him/her why or when someone would be returning to perform incontinent care. The RN revealed the resident did have episodes of incontinence and should be checked routinely by the CNA's to ensure he/she was clean and dry.</p> <p>Interview with CNA #4, on 06/06/13 at 2:13 PM, revealed she did not interrupt the resident's dressing change and tell the RN someone was having shortness of air. The CNA revealed she told the RN a resident was holding their chest and said they felt dizzy early that morning when the nurse entered the room to give the resident their medications. The CNA revealed she was told the resident had been complaining of this since 06/04/13 and had already had a chest x-ray.</p> <p>Further interview with RN #1, on 06/06/13 at 2:30 PM, revealed the other resident's complaints were not a new concern or urgent and she should have cleaned the resident while she was in Resident #17's room. The RN revealed she should not have changed a wound dressing while the resident was soiled with urine and should not have laid the resident back down into a saturated brief after performing wound care and applying a new dressing due to the potential for an infection or worsening wounds.</p> <p>Interview with the MDS Coordinator, on 06/06/13 at 2:45 PM, revealed Resident #17 did have episodes of incontinence and should be checked every 2 hours. The MDS Coordinator revealed the care plans and CNA care cards were reviewed quarterly and the discrepancy should have been caught at that time. The MDS</p>	F 312			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 312	Continued From page 16 Coordinator revealed the CNA care cards are not actually brought to the Interdisciplinary team meeting, but states the Unit Managers were responsible to ensure they were updated accordingly. Interview with the ADON, on 06/06/13 at 3:30 PM, revealed the facility staff should have assisted the resident with incontinence care at the time of the wound care, and should never have completed a dressing change over a soiled brief and then leave the resident to lay in it. The ADON revealed the CNA's should be making routine rounds for incontinence management. After reviewing the CNA care card, the ADON revealed she was not aware the care card was not updated to reflect the resident's incontinence status. The ADON revealed she was not monitoring to ensure the CNA care cards reflect interventions determined on the nursing comprehensive plan of care. Interview with the Director of Nursing (DON), on 06/06/13 at 4:07 PM, revealed Resident #17 should be checked every 2 hours for incontinence care and as needed to ensure the external urinary catheter was in place. The DON revealed care cards are not brought to care meetings, but changes were written down, then the cards were updated at a later time. The DON revealed she does audit charts and compared the care cards, but does not use a rubric or document who or when completed.	F 312			
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a	F 441			



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441 Continued From page 17
safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.

(a) Infection Control Program
The facility must establish an Infection Control Program under which it -
(1) Investigates, controls, and prevents infections in the facility;
(2) Decides what procedures, such as isolation, should be applied to an individual resident; and
(3) Maintains a record of incidents and corrective actions related to infections.

(b) Preventing Spread of Infection
(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.
(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.

(c) Linens
Personnel must handle, store, process and transport linens so as to prevent the spread of infection.

F 441

F441

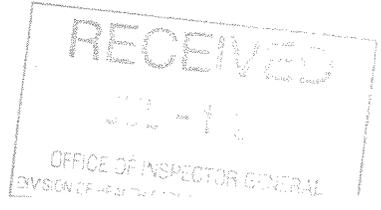
1. Contact isolation was implemented for Resident #4 on 6-6-13.
The lancet was retrieved from the trash and discarded in a sharps container by a licensed nurse on 6-5-13. LPN #1 was re-educated to proper disposal of sharps in sharps containers and Precautions necessary for MDRO's (multi-drug resistant organisms) on 6-5-13 by the Assistant Director of Nursing.

2. An audit was completed of in-house residents current labs to determine the presence of other MDRO's or other infectious process that require additional precautions and that those precautions are in place by the Assistant Director of Nursing and Unit Manager on 06/28/13. No other concerns were identified.
An audit of resident trash cans was completed on 6-6-13 by the Assistant Director of Nursing to determine that no sharps had been discarded inappropriately with no additional concerns identified.

3. Licensed nurses were re-educated by the Director of Nursing, Unit Manager, and Nurse Supervisor related to the proper disposal of sharps, including lancets, and precautions necessary for MDRO organisms and that a reference listing of Infections and Precautions indicated has been posted at each nursing station to assist nursing staff in determining precautions indicated on 06/28/13. A copy of Precautions Necessary for Common Infections that includes the MDRO's, ie ESBL was posted by the Director of Nursing at each nurses station on 06/28/13 for staff to reference.

07/02/13

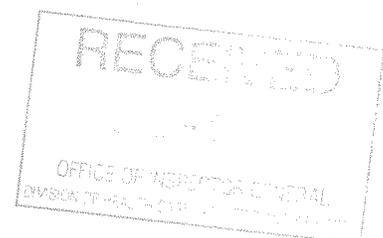
This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record and



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 18 facility policy reviews, it was determined the facility failed to provide a safe, sanitary and comfortable environment for the prevention of disease transmission for one(1) of seventeen (17) sampled and one (1) of six (6) unsampled residents. Contact Isolation precautions were not initiated for Resident # 4. In addition, a nurse failed to properly dispose of a lancet used to prick Resident F's finger for blood glucose monitoring. The Findings Include: Review of the facility's policy titled Medication Administration: Injectable (IM, Sub-Q, Z-track) revised 05/01/11, revealed syringes and needles were to be discarded in appropriate sharps containers. The facility did not provide a policy specific to disposal of lancets used for blood glucose monitoring. Observation, on 06/05/13 at 11:45 AM, revealed Licensed Practical Nurse (LPN) #1 pricked Resident F's finger to obtain a blood sample for glucose monitoring and disposed of the lancet in a small lined trash can next to the sink in the resident's room. A sharps container was affixed to the medication cart that was positioned outside the door of Resident F's room. Interview, on 06/05/13 at 12:35 PM with LPN #1, revealed her normal process was to dispose of any sharps (lancets, needles, etc.) in a sharps container in the resident's room (if available) or in the sharps container on the med cart, but LPN #1 stated she realized she wrapped the lancet in her used glove and threw it in the regular trash after testing Resident F's blood sugar.	F 441	F441 4. The Director of Nurses, Unit Manager, and or Nurse Supervisor will audit culture results of current residents weekly x 2 weeks and then monthly x 4 months to determine that precautions are implemented as directed by the Infection Control Policy. The Director of Nurses, Unit Manager, and Nurse supervisor will complete an audit of resident trash cans weekly x 2 weeks and then monthly x4 months to determine that sharps, including lancets, are discarded in sharps containers. Any concerns will be addressed when identified. The Director of Nurses will submit a summary of findings to the Performance Improvement Committee monthly x 6 months for review and further recommendation.	07/02/13



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441

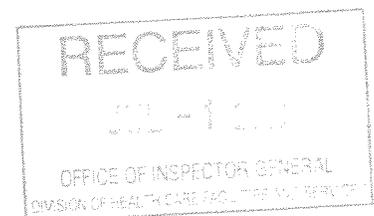
Continued From page 19

Interview, on 06/06/13 at 11:10 AM with the Director of Nursing (DON) revealed lancets used to perform finger sticks should always be placed in a sharps container and should never be discarded in the regular trash. The problem with discarding sharps in regular trash cans would be the potential for a blood borne pathogen exposure that involved another resident or a staff member. The DON stated the staff was in-serviced in infection procedures quarterly and whenever breaks in infection control were identified.

2. Review of the facility's policy Multi-Drug Resistant Organisms (MDROs), revised 05/13/13, revealed contact precautions will be followed when there was a high risk for transmission, such as patients who have urinary or fecal incontinence uncontained by usual methods/products.

Review of the clinical record for Resident #4 revealed the facility admitted the resident on 05/13/13 with diagnoses of Mental Status changes, Anemia, Bipolar, Hypertension, Stroke, Sleep Apnea, and Narcolepsy. The Minimum Data Set (MDS) assessment tool, dated 05/20/13, revealed the facility assessed the resident as being cognitively intact with with a Brief Interview for Mental Status score of thirteen (13), independent with personal hygiene, and requiring supervision with toileting. The MDS identified the resident as always continent; however, interview with Resident #4, on 06/04/13 at 11:45 AM, revealed the resident had frequent incontinence

F 441



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

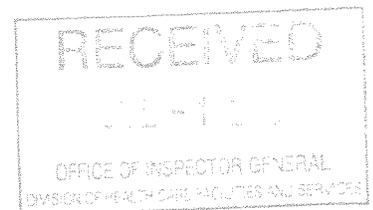
PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441	<p>Continued From page 20</p> <p>and sometimes used incontinent pads. Review of the Comprehensive Plan of Care did not reflect the resident's reported incontinence; however, review of the Nursing Assistant Care Card revealed the resident was incontinent and used pads/briefs. Review of the resident's urinalysis, collected 06/03/13, revealed bacteria levels were too numerous to count and the resulting culture and sensitivity, dated 06/05/13, revealed the bacteria Escherichia Coli which was Extended-Spectrum Beta-Lactamases (ESBL) positive which was a type of MDRO. The resident's physician was notified and the resident was started on an antibiotic.</p> <p>Observations, on 06/05/13 at 4:00 PM, and 06/06/13 at 9:00 AM and 3:15 PM, revealed the resident was not placed in contact isolation.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 06/06/13 at 3:20 PM, revealed she was aware of the urine culture results and stated ESBL was not normally placed in isolation. The LPN revealed the resident was already in a private room so universal precautions was all that was necessary.</p> <p>Interview with Housekeeping, on 06/06/13 at 3:25 PM, revealed people with ESBL would be in isolation, which was identifiable by signage and an isolation cart. The Housekeeper revealed extra precautions would be taken, they would use Personal Protective Equipment (PPE) while in the room, and change the mop water once the floor was mopped to prevent the spread of infection to other rooms. The Housekeeper revealed he was not aware of any resident's in the facility in need of isolation.</p>	F 441		
-------	---	-------	--	--



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

PRINTED: 06/20/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/06/2013
--	--	--	--

NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 441

Continued From page 21

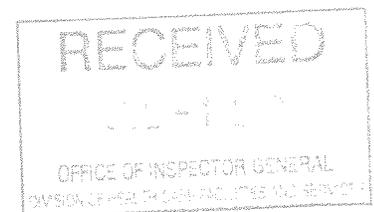
F 441

Interview with the Assistant Director of Nursing (ADON), on 06/06/13 at 3:30 PM, revealed she was in charge of the infection control program. The ADON revealed ESBL should be placed in contact precautions. The ADON revealed she was not notified of Resident #4's urine culture results.

Interview with LPN #1, on 06/06/13 at 4:00 PM, revealed she did not notify the Director of Nursing (DON) the resident had a positive urinalysis. The LPN revealed she did not think ESBL was contagious or as resistant as other types of MDRO's that would require the resident to have an indwelling urinary catheter.

Interview with Certified Nursing Assistant (CNA) #2, on 06/06/13 at 4:05 PM, revealed she was not aware that Resident #4 was incontinent or that they had any type of infection.

Interview with the DON, on 06/06/13 at 4:07 PM, revealed Resident #4 was incontinent and that she was informed that the resident had a positive urine culture but not of what type of bacteria. The DON revealed she should have asked for more specifics and notified the corporate representative for guidance. The DON revealed lab results were normally discussed in the morning meetings; however, the facility was not having the meeting during the health care survey. Therefore, the result should have been investigated further once informed of it being abnormal. The DON revealed a potential for other people becoming infected by not placing the resident in contact isolation.



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

PRINTED: 06/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two (2) stories, Type V Protected. Offices are located on the partial second floor.</p> <p>SMOKE COMPARTMENTS: Five (5) smoke compartments on the ground floor.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>GENERATOR: Type II, 100KW generator. Fuel source is diesel. Upgraded in 1999.</p> <p>A standard Life Safety Code survey was conducted on 06/04/13. Klondike Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility has sixty-two (62) certified beds and the census was fifty-eight (58) on the day of the survey.</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>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Klondike Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X Jamie Cunningham* TITLE: *X Administrator* (X6) DATE: *6/28/13*

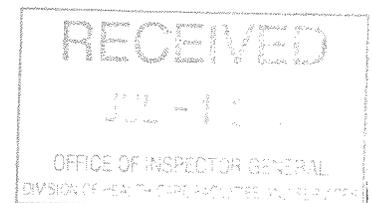
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

JA

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

PRINTED: 06/07/2013
FORM APPROVED
OMB NO. 0938-0391

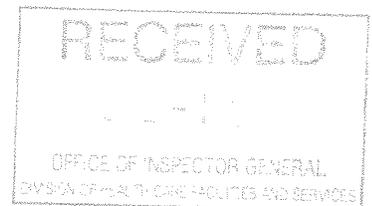
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 Fire)	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at D level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiencies had the potential to affect one (1) of five (5) smoke compartments, residents, staff and visitors. The facility has sixty-two (62) certified beds and the census was fifty-eight (58) on the day of the survey.</p> <p>The findings include:</p> <p>1. Observation, on 06/04/13 at 9:10 AM, with the</p>	K 029	<p>K029</p> <ol style="list-style-type: none"> 1. The Maintenance Director sealed the penetrations in the Chemical Closet located within the laundry room on 06/04/13. A self-closing device was installed on the Medical Records Room door by the Maintenance Director on 06/11/13. 2. The Maintenance Director and Administrator completed an audit of the center to determine the Protection of Hazards in accordance with NFPA standards on 06/10/13. No concerns were identified. 3. The Maintenance Director was re-educated to the Protection of Hazards requirement in accordance with the NFPA standards by the Administrator on 06/10/13 4. The Maintenance Director and or Administrator will complete an audit of the center to determine that the protection of hazards, in accordance with NFPA standards, is in place monthly x 6 months. Any concerns will be addressed at the time identified. A summary of findings will be submitted to the Performance Improvement Committee monthly x 6 months for further review and recommendation. 	07/02/13



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

PRINTED: 06/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	<p>Continued From page 2</p> <p>Maintenance Director revealed the Chemical Closet located within the Laundry Room, had two small, unsealed penetrations in the ceiling.</p> <p>Interview, on 06/04/13 at 9:10 AM, with the Maintenance Director revealed he was not aware of the two (2) penetrations in the ceiling in the Chemical Closet. The ceiling mounted light fixture had recently been replaced with a smaller fixture; the two (2) small penetrations remained unsealed.</p> <p>2. Observation, on 06/04/13 at 9:40 AM, with the Maintenance Director revealed the door to the Medical Records Room, located in the partial, second floor office area, did not have a self-closing device installed on the door.</p> <p>Interview, on 06/04/13 at 9:40 AM, with the Maintenance Director revealed he was not aware of the Medical Records Room being categorized as a hazardous storage area, and the requirement for the door to be equipped with a self-closing device.</p> <p>Reference:</p> <p>NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards.</p> <p>19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler</p>	K 029		



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

PRINTED: 06/07/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185333	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 06/04/2013
NAME OF PROVIDER OR SUPPLIER KLONDIKE CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 3802 KLONDIKE LANE LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 029	Continued From page 3 option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		

