

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

PRINTED: 01/08/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185335	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 12/19/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF SOUTH LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 1120 CRISTLAND ROAD LOUISVILLE, KY 40214	
(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 health survey was initiated on 12/17/13 and concluded on 12/19/13 with deficiencies cited at the highest scope and severity of a "E". A Life Safety Code Survey was initiated and concluded on 12/17/13 with deficiencies cited at the highest scope and severity of a "D".	F 000	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.	
F 167 SS=C	483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility. The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability. This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the survey results were provided in a readily accessible location for the residents. The findings include: The facility did not provide a policy related to the access of a survey binder to residents or visitors. Observation, of the front lobby, on 12/17/13 at 8:15 AM, revealed a sign located on the wall, near the entrance with directions to ask for the	F 167	F 167 Effective 1/14/14 the facility has posted within ten (10) feet of the front reception desk, east wing entrance and west wing entrance in a prominent place easily seen by residents, employees, and visitors a printed sign at least eight (8) inches by eleven (11) inches in size, with letters at least one (1) inch high, that states: State Law (KRS 216.547) requires state inspection reports on this facility to be made available to you upon request. ASK A REPRESENTATIVE OF THIS FACILITY. A new Administrator became effective on 12/27/13. The Receptionist	2/1/14

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

TITLE

(X6) DATE

X Kara M. Meredith, RNHA

X Administrator X

1-29-14

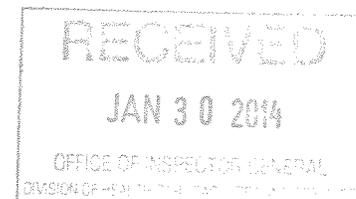
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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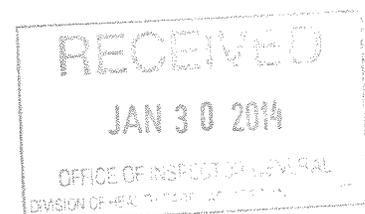
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F 167	<p>Continued From page 1</p> <p>survey results; however, the receptionist area was unattended. The survey results binder was located in the back of the receptionist area. The binder was not readily accessible to the residents or visitors in the unattended lobby.</p> <p>Observation of the front lobby, on 12/17/13 at 3:00 PM, revealed the lobby was again unattended and the survey binder was not readily accessible in the unattended lobby.</p> <p>Observation of the front lobby, on 12/18/13 at 9:45 AM, revealed the binder containing the survey results remained behind the receptionist area and not readily accessible to persons in the lobby.</p> <p>Observation, of the east entrance lobby, on 12/18/13 at 9:47 AM, revealed there was no survey binder available to the residents or visitors.</p> <p>Observation, of the west entrance lobby, on 12/18/13 at 9:53 AM, revealed there was no survey binder available for review.</p> <p>Interview with the Receptionist, on 12/18/13 at 10:20 AM, revealed the receptionist area was staff 8:30 AM through 5:00 PM each day. She stated, the east and west entrances were used after hours and on weekends for families, residents and visitors. She indicated the manual was kept behind the desk and it must be requested. She stated everyone knows where it was located and they could just come behind the desk and get it.</p> <p>Interview and observation with the Administrator, on 12/19/13 at 10:45 AM, revealed the purpose of</p>	F 167	<p>F 167 (continued)</p> <p>was re-educated by the Director of Nursing on 12/18/13 that the survey results were to be posted by the facility in a readily accessible area for residents, employees and visitors. The new Administrator re-educated the Receptionist on 1/14/14 that the facility must post within ten (10) feet of the front reception desk, east wing entrance and west wing entrance in a prominent place easily seen by residents, employees, and visitors a printed sign at least eight (8) inches by eleven (11) inches in size, with letters at least one (1) inch high, that states: State Law (KRS 216.547) requires state inspection reports on this facility to be made available to you upon request. ASK A REPRESENTATIVE OF THIS FACILITY.</p> <p>All residents have the potential to be affected by the deficient practice.</p> <p>The Administrator will audit two (2) times a month for the first month, monthly for 6 months and then quarterly to ensure that the front reception area, west wing entrance and east wing entrance to determine if the required posting and accessibility is observed.</p>	



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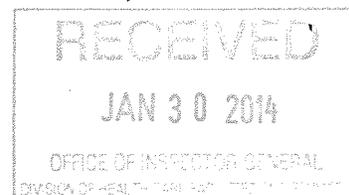
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F 167	Continued From page 2 the binder was to ensure the residents and family members had access to the prior surveys. He reported the survey binder was located on the desk behind the receptionist. He stated it might be intimidating for a resident or family to have to go behind the receptionist desk to get the survey binder.	F 167	F 167 (continued) All staff will be re-educated regarding posting and accessibility requirements by 1/31/14 by the Administrator, Director of Nursing (DON) or the Staff Development Director (SDC)—any staff not completing the education by 1/31/14 will complete the training prior to returning to work. Any identified concerns will be addressed and corrected immediately.		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to properly maintain four (4) of thirty-three (33) resident rooms on the 100 Hall. The facility failed to ensure caulking around the sinks were maintained and securely attached to the walls in resident rooms 122, 123, 126 and 128. In addition, the facility failed to prevent odors in one (1) of seventeen (17) sampled residents room. Resident #14's mattress emitted an odor of urine. The findings include: 1. Review of the facility's policy regarding Soiled Laundry and Bedding, not dated, revealed the Environmental Services Staff would clean and disinfect the mattresses. After review by the Environmental Services Director and/or the Administrator, the staff would discard the mattresses that were significantly damaged, stained or had been wet for prolonged periods.	F 253	The results of the Administrator's audits will be brought to the Quality Assurance Quality Improvement (QAQI) Committee monthly for review and further recommendations from the Medical Director and the QAQI Committee. F 253 The sink in room 123 was repaired, secured and re-caulked on 12/19/13 by the Maintenance Assistant. Additional equipment/parts were ordered and the sinks in rooms 122, 126 and 128 were repaired, re-enforced and re-caulked on 1/6/14. Resident # 14's mattress was immediately replaced on 12/18/13 by the Maintenance Assistant.	2/1/14	



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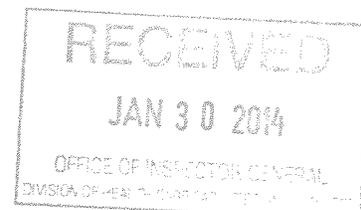
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F 253	<p>Continued From page 3</p> <p>Observation of room 227, on 12/18/13 at 11:17 AM, revealed Certified Nurse Aide (CNA) #1 carried out linens from the room and the bed was left unmade. Upon entering room 227 of Resident #14, the room had a pervasive odor of the smell of urine. The bare mattress had a round, depressed area that was wet in the center. Continued observation outside of room 227 until CNA #1 returned with linens revealed the CNA did not wipe the mattress before it was made up with the clean linens.</p> <p>Interview with CNA #1, on 12/19/13 at 11:50 AM, revealed he quickly made the bed so the surveyor would not see how bad the bed was. He reported the bed was made and the wetness came through the linens and that was why he changed the bed. He stated the bed had been reported to the housekeepers to be cleaned.</p> <p>Interview with Housekeeper #2 assigned to room 227, on 12/18/13 at 11:20 AM, revealed she had only cleaned one room requested by staff. She reported the room she cleaned was room 231.</p> <p>Interview and tour of Resident #14's room with the Director of Nursing, on 12/18/13 at 11:50 AM, revealed the room smelled of urine. She pulled the linens back and stated the mattress needed to be changed. She stated, they change the mattresses all the time and that one should have been changed out. She indicated she was not aware this bed needed to be changed and no system in place to track the mattresses.</p> <p>2. Review of the facility's Maintenance Service policy, dated January 2005, revealed the Maintenance Services would be provided to all</p>	F 253	<p>F 253 (continued)</p> <p>CNA # 1 was re-educated regarding following proper infection control policy and immediately informing house-keeping staff of needing to clean mattresses or if a mattress needs to be discarded.</p> <p>All facility sinks were audited and any identified concerns in need of repair were repaired at the time identified by the Maintenance Director and/or Maintenance Assistant to ensure that they were secure and caulked (if appropriate) on or by 1/7/14. The Maintenance Assistant and the Director of Nursing completed a 100 % audit of all facility mattresses on 12/18/13 to determine if any mattresses needed immediate replacement. Any identified mattresses were replaced on 12/18/13 by the Maintenance Assistant and the Director of Environmental Services.</p> <p>All staff will be re-educated by the Maintenance Director, Maintenance Assistant and or Director of Environmental Services on or by 1/31/14 on how to utilize the Maintenance Log and how to reach Maintenance</p>		



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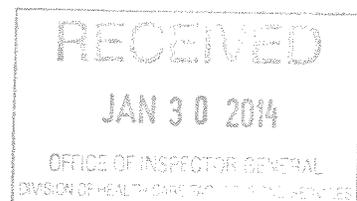
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F 253	<p>Continued From page 4</p> <p>areas of the building, grounds and equipment. The building was to be maintained in good repair and free from hazards.</p> <p>Review of the facility's policy regarding Maintenance Schedules, dated January 2005, revealed the preventive maintenance schedules would be implemented to assure the building and equipment were maintained in a safe and operable manner.</p> <p>Review of the facility's monthly maintenance inspection checklist for resident rooms, which included the sink, revealed no completed monthly inspection checklist for resident rooms 122, 123, 126 and 128 was provided.</p> <p>Observation of the 100 Hall, on 12/18/13 at 10:06 AM, revealed the bathroom sink in rooms 122, 123, 126 and 128 were separated from the wall, including the caulking around the sink.</p> <p>Review of the maintenance work book located at the 100 Hall nurses station, on 12/18/13, revealed the work book did not have any repair orders related to loose sinks or sinks with loose, cracked caulking located in resident rooms 122, 123, 126 or 128.</p> <p>Interview with Housekeeper #1 assigned to the 100 Hall, on 12/18/19 at 10:25 AM, revealed she logged the needed resident room repairs at the nurses station in the binder for maintenance. She stated she would log such things as loose sinks or slow running water. She reported she had not logged any concerns with the resident rooms this week.</p> <p>Interview with Director of Maintenance, on</p>	F 253	<p>F 253 (continued)</p> <p>Personnel when staff identify equipment or physical plant needs during and after normal business hours. Any staff member not completing the education by 1/31/14 will complete the training prior to returning to work.</p> <p>The Maintenance Director, Maintenance Assistant and/or Director of Environmental Services will perform monthly facility audits to ensure that housekeeping and maintenance services necessary to ensure that equipment/physical plant items (i.e. sinks, mattresses, beds, toilets, etc...) are in proper working condition and not in need of repairs or replacement. Any identified mattresses or other equipment/physical plant items identified as needing repair or replacement will be repaired or replaced by the Maintenance Director, Maintenance Assistant or Director of Environmental Services at the time identified.</p>	



Page 5A
F 253 (continued)

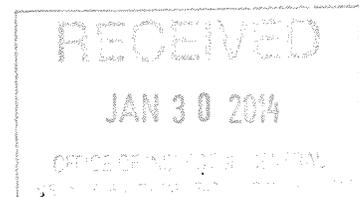
The results of Director of Environmental Services, Maintenance Director/Maintenance Assistant audits will be brought to the Quality Assurance Quality Improvement (QAQI) Committee monthly for review and further recommendations from the Medical Director and the QAQI Committee.



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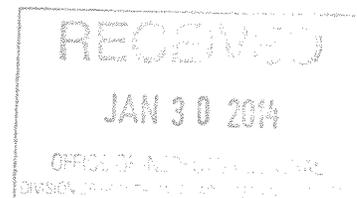
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F 253	Continued From page 5 12/19/13 at 2:10 PM, revealed the work log at the nurses station was checked each day for needed repairs; however, he did not have any work request related to bathroom sink repairs on the 100 Hall.	F 253	F 441 Resident #1 was assessed by COTA and ADON for colostomy care, isolation precautions and C-diff on 12/19/13 and 12/20/13. Resident #1 was re-tested on 1/01/14 for C-diff with negative findings. Resident #1 was educated on colostomy care and hand washing prior to discharge on 1/6/13. Resident #1's wife was reeducated on 12/19/13 on C-Diff and isolation precautions and voiced the understanding. Resident #1's wife was also offered colostomy education and declined. COTA with Resident #1 was re-educated by SDC on Isolation Precautions and C-Diff and voiced understanding on 12/19/13. All therapist present and full-time therapists on 12/19/13, 12/20/13 and 1/7/13 were educated by SDC on Isolation Precautions, Infection Control and C-Diff Control and C-Diff. Rehab manager will inform all PRN therapist of mandated education provided by the Staff Development Coordinator. Resident #5 was assessed on 12/20/13 by the DON and at this time the DON changed dressing. Resident #5 is also followed by Louisville Wound Care	2/1/14	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (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.	F 441			



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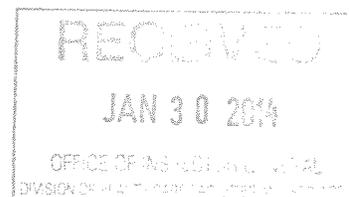
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F 441	Continued From page 6 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to establish and maintain an Infection Control Program and prevent development and transmission of diseases and infections for two (2) of seventeen (17) sampled residents (Resident #1 and #5). The staff provided care for Resident #1 without appropriate Personal Protective Equipment (gown) and failed to wash their hands. In addition, the staff were observed to have poor hand hygiene during a skin assessment and dressing change for Residents #1 and #5. The findings include: 1. Review of the facility's Infection Control Policy regarding Clostridium Difficile (C-Diff), revised August 2012, revealed preventive measures would be taken to prevent the occurrence of C-Diff infections among residents and precautions would be taken while caring for residents with C-Diff (to prevent the transmission of C-Difficile to others and residents with diarrhea associated with C-Diff, i.e. residents who are colonized and symptomatic) would be placed on Contact Precautions for the duration of the illness. Healthcare workers and visitors would don gloves and gowns when entering the room of a resident with C-Diff infection.	F 441	F 441 (continued) and in-house wound nurse for reoccurring vascular wound. LPN#6 was reeducated by the Staff Development Coordinator on 12/22/13 in isolation precautions, infection control and clean dressing changes. LPN#3 was reeducated on 12/19/13 on isolation precautions, C-diff and proper skin assessment by the Staff Development Coordinator and the Director of Nursing. On 12/22/13 LPN # 3 was observed by the Director of Nursing performing skin assessment without difficulty. LPN#3 will have observation/check off on skin assessment twice monthly for the next 3 months performed by the Staff Development Coordinator or Assistant Director of Nursing(s). All nurses will check off on skin assessments by 1/31/14/ by the Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing(s) and annually. Resident #5 was assessed on 12/20/13 and observed for clean dressing change by DON. The Staff Development Coordinator observed and assisted LPN#6 during a skin assessment and clean dressing change on 12/22/13.		



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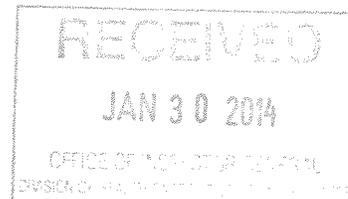
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F 441	Continued From page 7 Observation, on 12/18/13 at 9:30 AM, revealed Certified Occupational Therapy Assistant (COTA) #1 in Resident #1's room instructing the resident on new colostomy care. COTA #1 was observed wearing gloves, and sitting beside the resident; however, she was not wearing a gown, only gloves. Interview with COTA #1, on 12/19/13 at 10:00 AM, revealed she should have worn a gown in the room, and stated she left the room earlier and did have a gown on at that time; however, did not reapply the gown when she came back into the room. COTA #1 stated she had been trained on the procedure for contact precautions; however, did not wash her hands. COTA #1 revealed she should have come back into the room and put on a gown. Observations, on 12/17/13 at 11:25 AM, revealed the wife of Resident #1 sitting in the room beside the resident approximately two (2) feet away and talking with the resident. The wife was not wearing a gown or gloves and continued to sit in the room with the door open. At 3:00 PM, the wife remained in the room sitting beside the resident without any gown or gloves on. Interview at this time with the wife revealed the hospital informed her of the C-Diff diagnosis. The wife denied any education by the facility staff regarding the use of PPE for the prevention of the spread of the C-Diff. There was no gown, glove or hand washing observed during the interview. Interview with LPN #1 who cared for Resident #1, on 12/19/13 at 10:30 AM, revealed gowns and gloves should always be worn with hand washing before and after procedures when residents are	F 441	F 144 (continued) All licensed nursing staff will receive re-education and perform clean dressings by 1/31/14 by Staff Development Coordinator, Director of Nursing or Assistant Director of Nursing(s). All staff members present on 12/19/13, 12/20/13 and 12/22/13 and 1/8/14 were reeducated on isolation precautions, infection control and C-Diff. All staff members will receive education on or by 1/31/14 by the Director of Nursing, Staff Development Coordinator and Assistant Director of Nursing(s) on or by 1/31/14—any staff not completing the education by 1/31/14 will complete the training prior to returning to work. The Staff Development Coordinator will audit 10% of each department monthly for three months then quarterly to ensure all staff and all departments are adhering to infection control policy ensuring proper hand washing and personal protective equipment are utilized when warranted. All findings in deficient practice will be addressed immediately by the SDC and brought to the QAQI by the SDC for further review and recommendations.	



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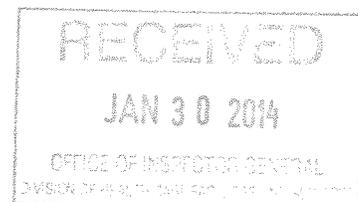
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F 441	<p>Continued From page 8</p> <p>in contact isolation. The LPN stated she had explained to wife of #1 about the C-Diff infection, and the concern with spreading the infection. The wife told them if she was going to get it, she would already have it, and had refused to wear a gown when visiting her husband; however, LPN #1 stated she did stay in the room and had been seen washing her hands.</p> <p>Interview with the 100 Hall Unit Manager (UM), on 12/19/13 at 9:50 AM, revealed any Therapy staff should be wearing gowns and gloves, and washing their hands when caring for residents with infections. She stated they don't always wear a gown when working with residents in their rooms, and revealed they had so many PRN (as needed) therapists, sometimes it was not consistent. The Unit Manager revealed they had been trained to wear gowns and gloves, and to wash hands their hands. The UM stated the potential of not wearing gowns could be the spread of infection to others.</p> <p>Interview with the Director of Nursing, on 12/19/13 at 10:30 AM, revealed the staff had been trained on isolation precautions, and should know what Personal Protective Equipment to use. She stated hand washing should be observed more frequently and completed between each area assessed. In addition, staff should be washing their hands instead of using hand sanitizer when dealing with C-Diff infections.</p> <p>2. Review of the facility's policy regarding Handwashing and Use of Gloves, dated December 2010, revealed hand washing would be performed before and after resident care was rendered and after handling contaminated articles. Hand Washing would be done between</p>	F 441	<p>F 144 (continued)</p> <p>All new hires will check off on skin assessments and dressing changes during first week on orientation and. All staff will check off annually Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing(s). The Staff Development Coordinator will audit 10% of licensed nursing staff monthly for three months then quarterly to ensure all compliance. All findings in deficient practice addressed immediately and brought to QA/QI for further review and recommendations.</p>		



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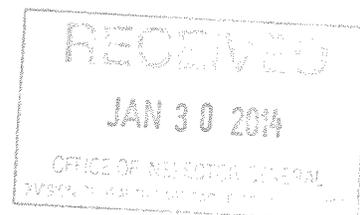
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F 441	<p>Continued From page 9</p> <p>residents. Before caring for a resident who is susceptible to infection. Before or after touching wounds. After contact with surfaces or items contaminated with blood, body fluids, secretions, excretions, mucous membranes, and non-intact skin.</p> <p>Observation of LPN #3, during the skin assessment for Resident #1, on 12/19/13 at 10:00 AM, revealed the LPN put on her gloves and gown and proceeded to conduct a skin assessment. The buttocks area was assessed first, and the LPN proceeded to inspect the front of the resident, without changing her gloves, or washing her hands. The LPN then assessed the colostomy area, adjusted the colostomy bag with the same gloves, and did not remove the bag since it had just been changed. Further, the LPN proceeded to remove the large abdominal wound dressing, without changing her gloves or washing her hands. She picked up the Silver Alginate strip, that was laying on the abdominal wound, then replaced the same alginate strip and dressing back over the wound. The LPN failed to change her gloves or wash her hands throughout the skin assessment.</p> <p>Interview with LPN #1, on 12/19/13 at 10:30 AM, revealed she should not have touched the abdominal wound without washing her hands, and stated she did the entire assessment with one (1) pair of gloves and did not wash her hands. The LPN stated she did get nervous if someone watched her, and did not know that hand sanitizer would not kill the C-Diff infection, or that hand washing was required per policy.</p> <p>Interview with the DON, on 12/19/13 at 10:30 AM, revealed staff had been trained on isolation</p>	F 441			



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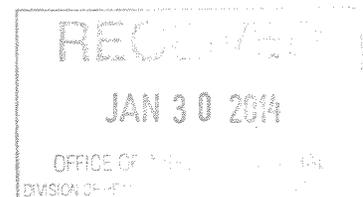
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F 441	<p>Continued From page 10</p> <p>precautions, and should know what PPE to use. She stated LPN #3 should have washed her hands between each area that was assessed. Everyone should be wearing gowns, gloves and washing hands frequently, instead of using hand sanitizer for C-Diff.</p> <p>3. Review of Resident #5's clinical record revealed the facility admitted the resident on 02/27/13 with diagnoses of Cellulitis, Edema, Venous Insufficiency, Diastolic Heart Failure and Diabetes Mellitus II. Review of the Significant Change Assessment, dated 10/17/13, revealed Resident #5 had a BIM score of fourteen (14) which meant the resident was interviewable.</p> <p>Observation of Resident #5's dressing change, on 12/08/13 at 11:09 AM, revealed Licensed Practical Nurse (LPN) #6 donned gloves and removed the dirty dressing from the wound. LPN #6 then removed the dirty gloves and placed on clean gloves without washing hands in between. LPN #6 cleaned the wound with saline and 4 x 4s. LPN #6 applied Mupirocin cream to the wound on Resident #5's calf and shin and wrapped with Kerlix. LPN #6 then removed her gloves and washed her hands.</p> <p>Interview with LPN #6, on 12/18/13 at 11:20 AM, revealed she was not aware she was to wash her hands when changing gloves and moving from dirty to clean. LPN #6 stated she could not remember having any education or training on infection control. LPN #6 stated the Staff Development Nurse educated the nursing staff. LPN #6 stated if you do not wash your hands you could spread infection.</p> <p>Interview with the Staff Development Coordinator,</p>	F 441			



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F 441	<p>Continued From page 11</p> <p>on 12/19/13 at 3:07 PM, revealed the last time she had training on infection control and dressing changes was in August and September 2013. The Staff Development Coordinator stated staff were educated that when they moved from dirty to clean to remove their gloves and wash their hands. The Staff Development Coordinator stated staff should wash their hands to prevent the spread of infection.</p> <p>Review of the Nursing Competencies Assignments, revealed training's were provided on 08/22/13, 08/27/13 and 09/04/13. The training was about Infection Control and Glove Changes. Further review of the training on Infection Control: Isolation and Hand Washing, revealed LPN #6 signed that she attended the course.</p> <p>Interview with the Director of Nursing (DON), on 12/19/13 at 3:27 PM, revealed LPN #6 should have washed her hands between dirty to clean dressing changes. The DON stated staff should wash their hands every time staff removed their gloves because this was standard precautions. The DON stated they washed their hands to prevent the spread of infection.</p>	F 441			



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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1974, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Unprotected</p> <p>SMOKE COMPARTMENTS: Six (6) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system.</p> <p>GENERATOR: Type II generator, installed new in 2009. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/17/13. Signature Healthcare of South Louisville was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility is certified for one-hundred (100) beds with a census of eighty-two (82) 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>The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated.</p> <p>K 046 The battery operated light located in the kitchen was replaced by the Maintenance Director on 12/23/13. The Maintenance Director replaced the batteries in the West Hall/North battery operated emergency light on 12/23/13.</p> <p>The Maintenance Director and Maintenance Assistant completed an audit on 12/23/13 to determine that emergency lighting is provided in accordance with NFPA standards. Any concerns identified during the audit</p>	2/1/14

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

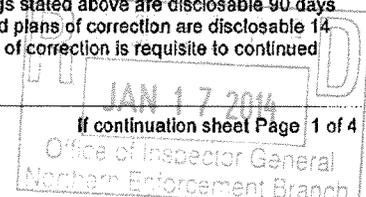
TITLE

(X8) DATE

Kara M. [Signature]

Administrator X 1-17-14

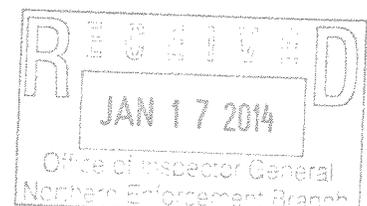
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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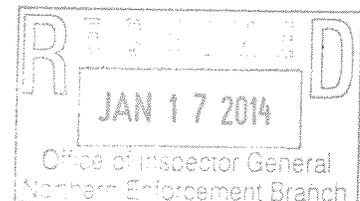
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K 000	Continued From page 1 (Fire).	K 000	conducted on 12/23/13 were immediately corrected on 12/23/13 by the Director of Maintenance and the Maintenance Assistant.	
K 046 SS=D	<p>Deficiencies were cited with the highest deficiency identified at "D" level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect two (2) of six (6) smoke compartments, residents, staff and visitors. The facility has one-hundred (100) certified beds and the census was eighty-two (82) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 12/17/13 at 1:22 PM, with the Administrator, the Assistant Administrator, and the Regional Plant Operations Supervisor, revealed the battery-operated emergency light, located in the Kitchen, did not function when tested.</p> <p>Interview, on 12/17/13 at 1:22 PM, with the Regional Plant Operations Supervisor revealed he had recently tested the battery-operated emergency light during his routine facility inspection. However, the test button had malfunctioned on the day and time of our testing.</p> <p>Observation, on 12/17/13 at 2:27 PM, with the</p>	K 046	<p>The Maintenance Director and/or Maintenance Assistant will conduct a test on every required emergency lighting system at 30 day intervals for no less than 30 seconds and an annual test shall be conducted on every required battery-powered lighting system for not less than 90 minutes to ensure that equipment is fully operational for the duration of the tests. Any concerns identified during the tests will be corrected immediately.</p> <p>The results of the Maintenance Director and Maintenance Assistants tests will be brought to the Quality Assurance Quality Improvement (QAQI) Committee monthly for review and further recommendations from the Medical Director and the QAQI Committee.</p>	



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K 046	<p>Continued From page 2</p> <p>Regional Plant Operations Supervisor and the Maintenance Director, revealed the battery-operated emergency light, located in the West Hall / North, did not function when tested. When the test button was pushed, the light slowly illuminated, instantly dimmed and stopped functioning.</p> <p>Interviews, on 12/17/13 at 2:27 PM, with the Regional Plant Operations Supervisor and the Maintenance Director revealed they were not aware of the battery-operated emergency light not functioning properly and acknowledged it was incapable of providing the required level of illumination and the required time of duration.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>7.9.2.1* Emergency illumination shall be provided for not less than 1 1/2 hours in the event of failure of normal lighting. Emergency lighting facilities shall be arranged to provide initial illumination that is not less than an average of 1 ft-candle (10 lux) and, at any point, not less than 0.1 ft-candle (1 lux), measured along the path of egress at floor level. Illumination levels shall be permitted to decline to not less than an average of 0.6 ft-candle (6 lux) and, at any point, not less than 0.06 ft-candle (0.6 lux) at the end of the 1 1/2 hours. A maximum-to-minimum illumination uniformity ratio of 40 to 1 shall not be exceeded.</p> <p>7.9.3 Periodic Testing of Emergency Lighting Equipment. A functional test shall be conducted on every required emergency lighting system at 30-day intervals for not less than 30 seconds. An annual test shall be conducted on every required battery-powered emergency lighting system for</p>	K 046		



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K 046	Continued From page 3 not less than 11/2 hours. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept by the owner for inspection by the authority having jurisdiction. Exception: Self-testing/self-diagnostic, battery-operated emergency lighting equipment that automatically performs a test for not less than 30 seconds and diagnostic routine not less than once every 30 days and indicates failures by a status indicator shall be exempt from the 30-day functional test, provided that a visual inspection is performed at 30-day intervals.	K 046		

