

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

PRINTED: 10/20/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 10/19/2015
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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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{F 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 10/19/15 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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.

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 185237	(Y2) Multiple Construction A. Building _____ B. Wing _____	(Y3) Date of Revisit 10/19/2015
Name of Facility SIGNATURE HEALTHCARE OF CHEROKEE PARK		Street Address, City, State, Zip Code 2100 MILLVALE RD. LOUISVILLE, KY 40205

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix F0441 Reg. # 483.65 LSC _____	Correction Completed 10/19/2015	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <u> 17 </u>	Reviewed By <u> 18 </u>	Date: <u>10/20/15</u>	Signature of Surveyor: <u>Willie Zimmerman</u>	Date: <u>10/20/15</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 9/17/2015	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
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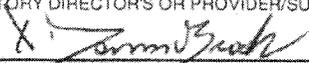
PRINTED: 09/29/2015
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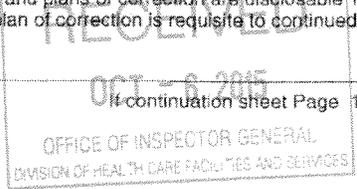
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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F 000	INITIAL COMMENTS	F 000	Preparation and execution of this allegation of compliance does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This allegation of compliance is prepared and/or executed solely because it is required by the provisions of Federal and State Law.	
F 441 SS=D	<p>A Recertification Survey was initiated on 09/15/15 and concluded on 09/17/15 and found the facility not meeting the minimum requirements for recertification with deficiencies cited at the highest scope and severity of an "D".</p> <p>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>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.</p> <p>(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.</p> <p>(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.</p>	F 441	<p>F441</p> <p>1) <i>What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>On 9/15/2015 SDC re-educated SRNA #3 on handwashing techniques. On 9/15/15 and 9/16/2015 the SDC initiated training to licensed nurses, SRNA's, and administrative staff on handwashing techniques.</p> <p>On 9/16/2015 the Director of Clinical Risk Management re-educated SRNA #3 on the facilities policy and procedure for donning and doffing PPE and handwashing techniques.</p> <p>2) <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X Administrator	(X6) DATE X 10/6/15
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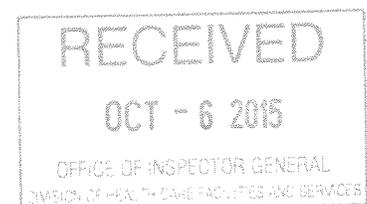
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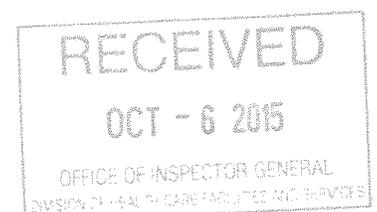
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F 441	Continued From page 1 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to ensure evidence based hand hygiene was performed according to current standards of practice and Centers for Disease Control (CDC) guidelines for one (1) of seventeen (17) sampled residents, Resident #17 who required Transmission Based Precautions. The findings include: Review of the facility's policy titled Isolation - Categories of Transmission-Based Precautions, revised August 2012, revealed Standard Precautions would be used when caring for residents at all times regardless of their suspected or confirmed infection status. Transmission Based Precautions would be used when caring for residents who were documented or suspected of having a communicable disease or infections that could be transmitted to others. Transmission Based Precautions, according to the facility's policy, included Airborne Precaution, Contact Precaution and Droplet Precaution. Contact Precaution detailed in addition to Standard Precautions, staff was to implement Contact Precautions for residents known or	F 441	DON, ADON, SDC, and UM made observations on 9/15/2015, 9/16/2015, and 9/17/2015 of employees entering and exiting isolation rooms. Observations did not note any deficient practice with donning and doffing PPE and handwashing. DON, ADON, SDC, or UM will conduct an infection control audit on 10/6/2015 utilizing IDT Infection Control Audit Tool <i>3) What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i> The SDC, DON, or UM will provide infection control education to the following departments: Nursing, Dietary, Environmental Services and Administration. The infection control training will include the facilities infection control program and preventing the spread of infection including but not limited to donning and doffing PPE and handwashing. All employee will be required to complete a post-test with a score of 80% or higher. The education and testing will be completed by 10/12/2015. The SDC, DON, or UM will conduct competency check-offs for donning and doffing PPE and handwashing to the following departments: Nursing and Housekeeping. The competencies will be completed by 10/12/2015.		



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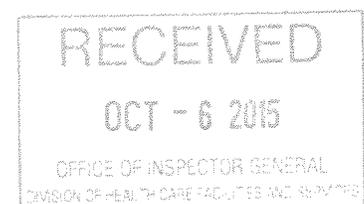
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F 441	<p>Continued From page 2</p> <p>suspected to be infected with microorganisms that could be transmitted by direct contact with the resident or indirect contact with the environmental surfaces or resident-care items in the resident's environment. The decision if precautions were necessary would be evaluated on a case by case basis.</p> <p>Review of Resident #17's clinical record revealed the facility admitted the resident on 06/16/15 with diagnoses of Senile Dementia, Alzheimer's, Hypertension, Gastroesophageal Reflux Disease, Anemia, Depression, Insomnia, Dysphagia and Malnutrition.</p> <p>Review of Resident #17's Comprehensive Minimum Data Set (MDS) completed on 06/23/15 revealed the facility assessed the resident with a Brief Interview for Mental Status (BIMS) of four (4), meaning a severe cognitive impairment and not interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #17 revealed the facility developed a care plan on 06/29/15, with updated goals and a target date of 10/21/15. Problems on the care plan included Infection Clostridium Difficile (C-Diff) as of 09/10/15 (Clostridium Difficile is a bacterium that causes diarrhea and more serious intestinal conditions and complications caused by its toxin-producing bacteria). Infection control and prevention was implemented by facility staff and the Comprehensive Plan of Care was updated accordingly on 09/10/15.</p> <p>Observation, on 09/15/15 at 9:27 AM, on the A-Wing of the facility revealed State Registered Nurse Aide (SRNA) #3 took off Personal Protective Equipment (PPE) and exited the room</p>	F 441	<p>The SDC will provide infection control education upon hire and at least annually.</p> <p>The SDC will conduct competency for donning and doffing PPE and handwashing upon hire and at least annually.</p> <p>4) How will the facility monitor its performance to ensure that solutions are sustained?</p> <p>SDC, DON, or UM will conduct a weekly audit on infection control practices for 4 weeks, then every 2 weeks for 4 weeks and then monthly thereafter. The results of this audit will be presented by the DON or SDC to the QAPI team monthly for review and recommendations based upon the results.</p> <p>5) Compliance Date: 10/19/2015</p>		



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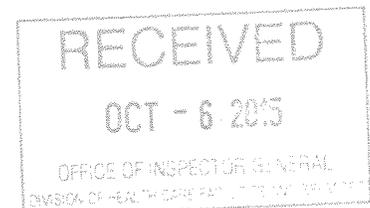
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F 441	<p>Continued From page 3 without washing her hands.</p> <p>Review of the Medication Administration Record (MAR), on 09/17/15 at 9:18 AM, revealed Resident #17 was receiving Flagyl (antibiotic) 500 mg, by mouth, three (3) times daily, for fourteen (14) days to end on 09/27/15.</p> <p>Review of Daily Skilled Nurse's Notes, dated 09/14/15 at 4:15 PM, revealed Resident #17 was compliant with hand hygiene.</p> <p>Interview with SRNA #3, on 09/17/15 at 8:47 AM, revealed it was her understanding, that contact precautions required hand hygiene as stipulated in the facility's policy. SRNA #3 stated she knew the facility's contact precaution protocol was to wear a gown and gloves for a resident in contact precautions, remove the gown and gloves before leaving the room and dispose of them in the red bag. SRNA #3 stated she should wash her hands before leaving the resident's room and she was aware she failed to do so for Resident #17.</p> <p>Interview with Housekeeper #1, on 09/17/15 at 10:00 AM, revealed a specific procedure was to be used to clean resident rooms identified by Contact Precautions signage. He stated he would use PPE as indicated and would use a specific wipe sanitizer to wipe down the bathroom, door handles and the sink. The Housekeeper further stated he would remove his PPE and dispose of it in the red bag container in the room and wash his hands before exiting the room.</p> <p>Interview with the Staff Development Coordinator (SDC), on 09/17/15 at 10:27 AM, revealed a sign would be placed on the door of a resident who</p>	F 441			



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F 441	<p>Continued From page 4</p> <p>needed to be placed in Contact Precautions which stated "Contact the Nurse" before entering the room. In addition, the SDC stated a container with PPE would be placed outside the resident's door as an indication the resident was in isolation and a bin with a red biohazard bag would be placed inside the room for disposal of PPE. The SDC further stated the staff should wash their hands, performing effective hand hygiene as delineated via the Contact Precaution Policy and Procedure Protocol. He stated all staff received training in orientation for infection control plus re-training on infection control one (1) to two (2) times a year.</p> <p>Interview with the Director of Nursing (DON), on 9/17/15 at 10:35 AM, revealed she was unsure if all staff had recently been in-serviced on infection control outside of the annual scheduled training. The DON stated it was necessary to practice correct hand hygiene which would include soap and water for a resident infected with C-Diff to prevent the spread of infection. She stated she was responsible for monitoring infections in the facility and the practice and training of her staff.</p>	F 441		



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NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CHEROKEE PARK	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III protected construction.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Two (2) Type II generators, 100KW and 80KW. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted, utilizing the 2786 Short Form, on 09/15/15. The facility was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p>	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>James B. Cook</i>	TITLE Administrator	(X6) DATE 10/6/15
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If continuation sheet Page 1 of 1
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DIVISION OF HEALTH CARE FACILITY AND SERVICES