

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

PRINTED: 09/26/2013
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 09/13/2013
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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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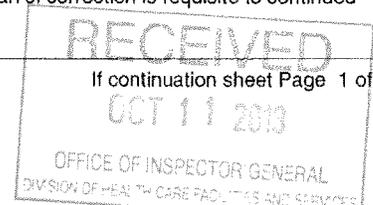
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F 000	INITIAL COMMENTS A standard health survey was initiated on 09/10/13 and concluded on 09/13/13 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code Survey was conducted on 09/11/13 with deficiency cited at the highest scope and severity of an "F" with the facility having the opportunity to correct deficiencies before remedies would be recommended for imposition.	F 000	Signature Healthcare of Cherokee Park (Facility) does not believe and does not admit that any deficiencies existed before, during or after the survey. The Facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.	
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's resident handbook, it was determined the facility failed to promote care for residents in a respectful manner and in an environment to maintain the residents' dignity for four (4) of sixteen (16) sampled residents and three (3) of four (4) unsampled residents. Resident #6, #7, #12, #13 and Unsampled Residents A, B and C. Resident #6 and #7 complained the staff was not compassionate, Resident #12 stated a Certified Nursing Assistant (CNA) spoke in a mean tone to him/her after putting the call lite on at night, Resident #13 stated a CNA told him/her to "roll your own wheelchair" when the resident was tired, Resident A reported a CNA was curt with him/her when inquiring about the shower he/she was supposed to have gotten, Unsampled	F 241		10/21/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Nicole Meade</i> LNHA	TITLE <i>X CED Administrator</i>	(X6) DATE <i>X 10/4/2013</i>
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

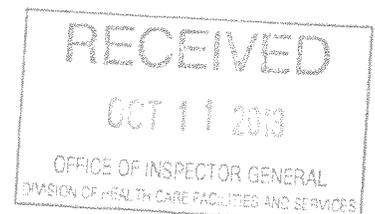
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F 241	<p>Continued From page 1</p> <p>Resident B stated a CNA talked to him/her in a disrespectful manner and with a smart mouth and Unsampld Resident C reported a CNA said she would get him/her some necessary bathing equipment and did not return for an hour.</p> <p>The findings include:</p> <p>Review of the facility's Kentucky Resident Handbook & Admissions Information revealed it was the resident's right to a dignified existence.</p> <p>1. Interview with Resident #7, on 09/10/13 at 9:00 AM, during the entrance tour revealed the resident felt some of the staff (un-named) were not compassionate. The resident stated she felt bad when having to ask for assistance from the staff to transfer from the recliner chair to the wheelchair because they would complain it was too difficult. Also, it would take up to an hour sometimes after the initial answer to the call lite to return with the lift to transfer him/her.</p> <p>Review of Resident #7's record revealed the facility admitted the resident on 08/03/13, assessed the resident on the MDS dated 08/10/13 as being interviewable with a score of fifteen (15) and also assessed the resident on the MDS as needing extensive assist by staff to transfer from the chair to the bed or the wheelchair. Further review of the record revealed Resident #7 had diagnoses to include Chronic Obstructive Pulmonary Disease, Hypertension and Morbid Obesity.</p> <p>2. Interview with Resident #6, on 09/10/13 at 9:20 AM, during the entrance tour revealed the resident felt some of the staff (un-named) were not compassionate. Resident #6 indicated</p>	F 241	<p>F 241E</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>Residents #6 and #7 discharged from the facility. Residents #12, 13, A, B, and C were interviewed by the Social Service Director on 10-4-13. The Social Service Director explained the grievance process to these residents and completed grievances on current issues. These issues were addressed by the Administrator and Director of Nursing.</p> <p>2. <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>The Social Service Director, Director of Admissions, Dining Services Director, Chaplin, and Activities interviewed all residents between 10-7-13 and 10-11-13. Grievances were completed on current concerns.</p>	10/21/13	



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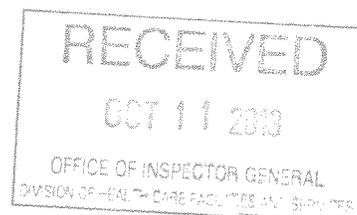
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F 241	<p>Continued From page 2</p> <p>he/she had felt hurt when his/her temperature was taken as the staff was rough with him/her and although it made the resident angry, they did not feel it was intentional. Resident #6 further indicated he/she had told the facility he/she preferred other staff.</p> <p>Review of Resident #6's record revealed the facility assessed the resident on the Minimum Data Set (MDS) as being interviewable with a score of fourteen (14) on 07/24/13. The admission nursing assessment, dated 07/07/13, revealed the facility admitted the resident on 07/07/13 for rehabilitation with diagnoses to include Post Cerebrovascular Accident (stroke) with a Left Sided Weakness and Hypertension.</p> <p>Review of the past three (3) months of Resident Council Meeting minutes did not reveal any concerns about staff treating residents in an undignified manner.</p> <p>3. Interview with Unsampled Resident B and C during the Quality of Life Assessment Group Interview, on 09/10/13 at 3:30 PM, revealed they each had a complaint about how the staff treated them and talked to them at the facility. Unsampled Resident B stated a CNA talked very disrespectfully and with a 'smart' mouth about two (2) weeks ago, but she/he could not remember the staff name as the turnover rate was high. Unsampled Resident C stated a CNA did not get the items he/she needed to shower for over an hour after the resident had requested the items and the CNA told the resident he/she would 'just have to wait' for the items in a mean tone of voice.</p> <p>Record review for Unsampled Resident B</p>	F 241	<p>These grievances were addressed by the Administrator and the Director of Nursing.</p> <p>3. <i>What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</i></p> <p>Staff training for all departments was conducted by the Administrator and Director of Nursing between Oct 1 and Oct 10-11-13. Education included promoting care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>4. <i>How will the facility plan to monitor its performance to ensure that solutions are sustained?</i></p> <p>The facility department positions (Social Services, Activities, Chaplin, Dining Services, Admissions, Central Supply) will conduct interviews and observations with a minimum of 10 random residents each month utilizing</p>	10/21/13	

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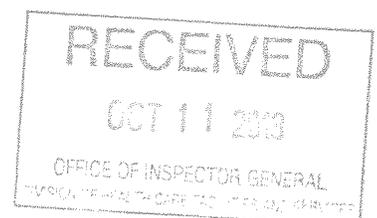
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F 241	<p>Continued From page 3</p> <p>revealed the facility assessed the resident as being interviewable with a score of nine (9) on the MDS. Record review for Resident C revealed the facility assessed the resident as being interviewable with a score of fifteen (15) on the MDS.</p> <p>Interview with the facility Ombudsman, on 09/11/13 at 3:15 PM, revealed she had just been in the facility Resident Council meeting and received complaints from Residents #12, #13 and Unsampld Resident A regarding not being treated with dignity.</p> <p>4. Interview with Resident #12, on 09/12/13 at 8:30 AM, revealed the resident slept late on 09/11/13. The resident received a cold breakfast tray and when the resident requested the tray be reheated he/she was told over the call lite system "don't call again". Resident #12 stated the incident made him/her feel bad about being at the facility.</p> <p>Review of Resident #12's record revealed the facility admitted the resident on 07/19/13 with diagnoses of Renal (kidney) Failure and Hypertension. Further review of Resident #12's record revealed the facility assessed the resident as being interviewable with a score of fifteen (15) on the MDS dated 07/25/13</p> <p>5. Interview with Resident #13, on 09/12/13 at 9:20 AM, revealed he/she was self-propelling the wheelchair in the hallway last week, became tired and asked a CNA for assistance. Resident #13 stated the CNA told him/her to "roll yourself" in a smart way and it made the resident feel bad.</p> <p>Review of Resident #13's record revealed the</p>	F 241	<p>the Abaqis system(includes staff treatment of residents and resident rights). This monthly process will remain in effect for a minimum of 12 months. Results will be presented monthly to the QAPI team for review and recommendations based upon the results.</p>	10/2/13	



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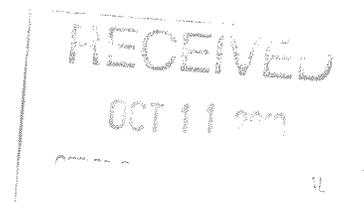
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F 241	<p>Continued From page 4</p> <p>facility admitted the resident on 11/11/10 with diagnoses of Hypertension and Post CVA. Further review of Resident #13's record revealed the facility assessed the resident as being interviewable with a score of fifteen (15) on the MDS dated 07/28/13.</p> <p>6. Interview with Unsampled Resident A, on 09/12/13 at 9:30 AM, revealed a CNA told him/her last week on the shower day "you don't ask when you get a shower, I will tell you when you get a shower". Unsampled Resident A could not remember the CNA's name, but did state it made him/her feel bad at the time.</p> <p>Record review for Unsampled Resident A revealed the facility assessed the resident as being interviewable on the MDS with a score of fourteen (14).</p> <p>Interviews with Resident #12, #13, #7, #6, and Unsampled Residents A, B and C, on 09/13/13 between 9:00 AM and 4:00 PM, revealed they felt safe in the facility and were not afraid of the staff. They all stated they were no lingering concerns from the treatment by the facility.</p> <p>Interview with CNA #13, on 09/13/13 at 5:20 AM, revealed she was trained on resident rights at the facility and she had not heard any staff be disrespectful to the residents.</p> <p>Interview with CNA #14, on 09/13/13 at 9:00 AM, revealed she was trained on resident rights at the facility and she had not heard any staff be disrespectful to the residents.</p> <p>Interview with CNA #1, on 09/13/13 at 1:50 PM, revealed she had never heard staff speak</p>	F 241		



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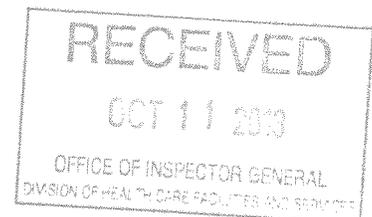
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F 241	Continued From page 5 disrespectfully to residents and she had been trained on resident rights by the facility and knew that would be wrong. Interview with CNA #12, on 09/13/13 at 5:40 AM, revealed Unsampled Resident C had filed a grievance against her about being disrespectful, but the resident had the wrong CNA and CNA #12 denied having been disrespectful to the resident. Interview with ADON #1, on 09/13/13 at 3:30 PM, revealed she was not aware the staff ever talked disrespectfully to any of the residents. She further stated staff were trained on resident rights on hire and at least yearly. ADON #1 did state she was aware Resident #6 did not appear to like some of the staff and when the staff he did not like were working, that staff would be switched or the nurse would answer his/her call lite. She indicated that was not written on the resident's comprehensive plan of care but it would be done by verbal information sharing. She further indicated it should probably be part of the resident's comprehensive plan of care in order for all of the staff to be aware of his/her staff preferences.	F 241	F 279 D <i>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i> Residents #6 discharged from the facility. Infection care plans were developed for residents #5 and #10 by the interdisciplinary Team on 10-4-13. <i>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</i> Current resident care plans were reviewed revised or developed based on their current status from 10-7-13 to 10-11-13 by the MDS Nurses, DON, ADONS, Medical Record Nurse and Transitional Care Nurse.	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive	F 279		10/21/13



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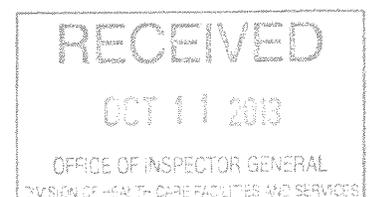
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F 279	<p>Continued From page 6 assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to develop a care plan for three (3) of sixteen (16) sampled residents, Resident #5, #6 and #10. The facility failed to develop an infection care plan for Residents #5 and #10 and failed to develop a care plan for Resident #6 as it pertained to his/her personal preferences.</p> <p>The findings include:</p> <p>Review of the Care Plan Policy, effective 12/2010, revealed all residents would have a care plan. The residents care plan would provide guidance to all staff caring for the residents and communicate changes in care to all direct care staff. An interdisciplinary approach to identify problems and develop solutions and goals individualizing and coordinating resident care.</p> <p>1. Record review of Resident #5's record, revealed the facility admitted the resident on 07/24/13 with diagnoses of Clostridium Difficile, Dementia and Renal Dialysis. Resident #5's</p>	F 279	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Training was provided to the Interdisciplinary team by the Director of Nursing on 10-7-13 to include guidance to staff caring for the residents and communicating changes in care to direct care staff per the Care Plan.</p> <p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>Ten percent of current resident care plans will be audited by the MDS Nurses monthly for 3 months then quarterly for 3 quarters. Results will be presented monthly for 3 months, and then quarterly for 3 quarters to the QAPI team for review and recommendations based upon the results.</p>	10/21/13	



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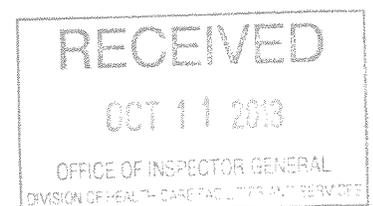
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F 279	<p>Continued From page 7</p> <p>Minimum Data Set (MDS) Admission assessment, dated 08/03/13 revealed the facility assessed the resident with a BIMS score of fifteen (15) which was considered interviewable. The facility also identified the resident as having a C-Diff infection.</p> <p>Observation made during tour, on 09/10/13 at 8:20 AM, revealed the Assistant Director of Nursing (ADON) #1 entering Resident #5's room, an isolation room for C-Diff (admitted with the organism), without sanitizing hands or applying PPE, when she entered or washing hands when she exited the room.</p> <p>Observation of the lunch meal pass, on 09/10/13 at 11:52 AM, revealed CNA #1 entered Resident #5's room (a resident with C-Diff) with out sanitizing hands or putting on PPE, and placed Resident #5's tray on his/her bedside table. CNA #1 was then observed to not wash hands as she exited Resident #5's room.</p> <p>Interview with Resident #5, on 09/12/13 at 10:19 AM, revealed he/she had noticed the staff members at times not coming in the room with PPE. Resident #5 stated sometimes the staff had PPE on and some times they do not.</p> <p>Review of Resident #5's care plan, revealed no care plan was provided for the C-Diff infection.</p> <p>2. Review of Resident #10's record, revealed the facility admitted the resident on 09/03/13 with diagnoses of UTI, Leukocytosis and C-Diff. Resident #10's MDS revealed one was not completed and was still within fourteen (14) days of admission.</p>	F 279			



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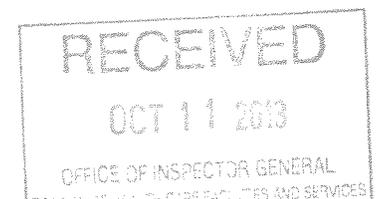
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F 279	<p>Continued From page 8</p> <p>Observation of Occupational Therapist Assistant (OTA) in Resident #10's room, on 09/12/13 at 8:50 AM, revealed the OTA was working with Resident #10 and maneuvering the wheelchair trying to get Resident #10 positioned with no PPE on. The OTA came out of Resident #10's room to sanitize his hands and apply PPE on. Resident #10 was on contact isolation for C-Diff.</p> <p>Review of Resident #10's interim care plan, revealed C-Diff infection was not documented.</p> <p>Interview with Licensed Practical Nurse (LPN) #6, on 09/13/13 at 9:57 AM, revealed nursing staff could update the care plan. LPN #6 stated she updated the care plan when there was a change in condition. LPN #6 stated she would also add infections to the interim care plan.</p> <p>Interview with the MDS Coordinator, on 09/13/13 at 9:57 AM, revealed the admitting nurse was responsible to complete the temporary care plan. The infection should have been documented on the care plan if the resident was admitted with the infection. Staff could also add on to the interim care plan if needed. Looking at Resident #5's care plan the MDS Coordinator stated she would have placed the infection on the bowel care plan. The MDS Coordinator stated she would have added for staff to wear PPEs on the care plan as well. The MDS Coordinator stated the care plan was the blueprint for staff to follow.</p> <p>Interview with the Assistant Director of Nursing (ADON) #1, on 09/13/13 at 9:34 AM, revealed she updated care plans and the care plans were updated manually. The ADON #1 stated the MDS Coordinator updated the care plans in the computer and the nursing staff updated paper</p>	F 279		



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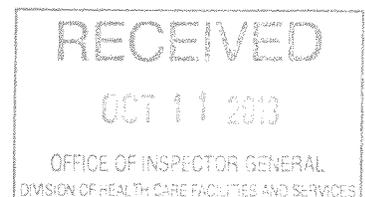
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
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F 279	<p>Continued From page 9</p> <p>care plan. The Care plan for Resident #5 and #10 should have been updated to reflect the residents status, because the care plan was the plan of care for each resident.</p> <p>3. Interview with Resident #6, on 09/10/13 at 9:20 AM, during the entrance tour revealed the resident felt some of the staff (un-named) were not compassionate. Resident #6 indicated he/she had felt hurt when his/her temperature was taken as the staff was rough with him/her and it made the resident angry. Resident #6 further indicated he/she had told the facility he/she had preferred certain staff.</p> <p>Review of Resident #6's record revealed the facility assessed the resident on the Minimum Data Set (MDS) as being interviewable with a score of fourteen (14) on 07/24/13. The admission nursing assessment dated 07/07/13 revealed the facility admitted the resident on 07/07/13 for rehabilitation with diagnoses of Post Cerebrovascular Accident (stroke) with a Left Sided Weakness and Hypertension. Review of Resident #6's comprehensive plan of care revealed no plan for the resident's staff preferences.</p> <p>Interview with CNA #6, on 09/13/13 at 6:00 AM, revealed she knew Resident #6 and she knew he/she did not like certain staff and had staff preferences but she only knew this by word-of-mouth from other CNA's. She stated she did have an assignment sheet and a CNA plan of care, but the information about Resident #6's staff preferences was not on either of those</p>	F 279			



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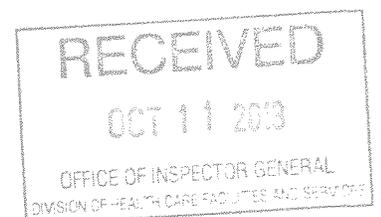
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F 279	Continued From page 10 documents.	F 279			
F 431 SS=E	<p>Interview with ADON #1, on 09/13/13 at 3:30 PM, revealed she was aware Resident #6 did not appear to like some of the staff and when the staff he/she did not like were working, the staff would be switched or the nurse would answer his/her call lite. She indicated that was not written on the resident's comprehensive plan of care, but it would be done by verbal information sharing. She further indicated it should probably be part of the resident's comprehensive plan of care in order for all of the staff to be aware of Resident #6's staff preferences.</p> <p>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p>	F 431	<p>F 431 E</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>The 3 medication carts identified were cleaned by the ADON/UMs on 9-13-2013. The 2 identified vials of Tuberculin Purified Protein Derivative were destroyed by the ADON/UMs on 9-13-2013.</p> <p>2. <i>How will the facility identify other residents having the potential to be affected by the same deficient practice?</i></p> <p>The facility currently uses 4 medication carts. The medication carts were reviewed by the ADON/UMs. Multi dose vials were checked by the ADON/UMs to ensure opened vials were dated. Corrections were made at the time of review by the ADON/UMs on 10-7-13.</p>	10/21/13	



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F 431	<p>Continued From page 11</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to ensure sanitation was maintained for three (3) of four (4) medication carts and failed to ensure and two (2) of two (2) opened multidose vials of Tuberculin Purified Protein Derivative were labeled for date opened.</p> <p>The finding include:</p> <p>Review of the facility's policy regarding Injectable Vials and Ampules dated 12/12, revealed the date opened and the initials of the first person to use the vial are recorded on multidose vials.</p> <p>The facility did not provide a policy on maintaining medication carts.</p> <p>Observation of four medication carts, on 09/12/13 at 10:30 AM and 11:55 AM, revealed the medication cart for Linker Front Hall had a yellow sticky substance in the top drawer, a bottle of liquid Potassium Chloride had a white substance on the outside of the bottle and a bottle of</p>	F 431	<p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>Training was provided to the Licensed Nurses by the ADON between 9-18-13 and 10-11-13 to include drug and biological labeling and storage and medication cart cleanliness.</p> <p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>2 Medication Carts and 1 Medication room will be audited weekly for 4 weeks then monthly for 3 months, then quarterly for 3 quarters by the ADON/UMs. Results will be presented monthly for 4 months, and then quarterly for 3 quarters to the QAPI team for review and recommendations based upon the results.</p>	10/21/13



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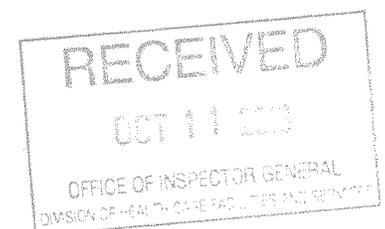
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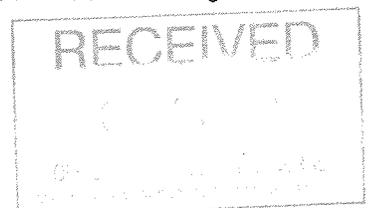
F 431	<p>Continued From page 12</p> <p>Probufen had clear sticky substance on the outside, as well as, a white substance on the side of the bottle. Linker Back Hall medication cart had a bottle of liquid Potassium Chloride with a clear sticky substance on the outside of the bottle. The Excelerated Wing A medication cart had a clear sticky substance in the bottom of the liquids drawer.</p> <p>Observation of the facility's two medication rooms, on 09/12/13 at 10:45 and 12:05 PM, revealed there was a bottle of Tuberculin Purified Protein Derivativ in each medication refrigerator that had been opened but neither was dated as to when it had been opened.</p> <p>Interview with LPN #4, on 09/12/13 at 10:45 AM, revealed sticky stuff in a medication cart drawer collects dust, bacteria and gross stuff. It was not good infection control to have the medications carts in that shape. She stated you can spread infection. LPN #4 stated all the carts were cleaned over the weekend and she was not sure why they were dirty now. She stated it was the responsibility of each nurse that used the carts to ensure they were clean. She stated all multidose vials should be dated when they were opened and first used. She stated sometimes a medication was only good for a certain period of time after it was opened and you would not know if the medication was good if the vials were not dated.</p> <p>Interview with LPN #3, on 09/12/13 at 12:05 PM, revealed the spills in a medication cart drawer should be cleaned up at the time they occurred. She stated dirt and grime would collect into the sticky substance and become an infection control problem.</p>	F 431		
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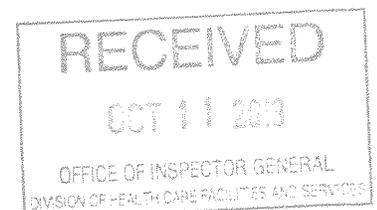
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F 431	Continued From page 13	F 431		
F 441 SS=E	<p>Interview with the Director of Nursing (DON), on 09/12/13 at 1:20 PM, revealed it was the responsibility of all nurses to clean the medication carts. They should be wiped down at the end of each shift. The nursing staff on night shift was supposed to ensure the drawers were clean. The problem was dirt can get stuck in the sticky substance and then it becomes an infection control problem. The DON stated there was a policy on dating multi-dose vials when opened for the first use. She stated some medications had an expiration date after they were opened and you must know the date opened to ensure the medication was still effective.</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</p>	F 441	<p>F 441</p> <p><i>1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</i></p> <p>The medical record of Resident #5 was reviewed by the DON on 9/13/13 to identify isolation precautions needed. The medical record of Resident #10 was reviewed by the DON on 9/13/13 to identify isolation precautions needed. The medical record of Resident #11 was reviewed by the DON on 9/13/13 to identify isolation precautions needed. The medical record of Resident D was reviewed by the DON on 9/13/13 to identify isolation precautions needed.</p> <p>After chart reviews completed, the ADON (Staff Development Nurse) verified proper infection control precautions were in place and in use on 9/13/13.</p>	10/21/13



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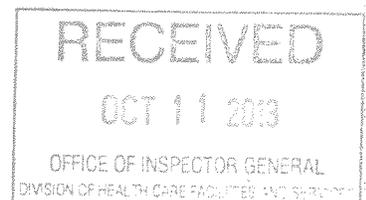
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F 441	<p>Continued From page 14</p> <p>isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review it was determined the facility failed to follow an infection control program for three (3) of sixteen (16) sampled residents, Residents #5, #10 and #11 and one (1) of four unsampled residents, Unsampled Resident #D all observed to live on one (1) of four (4) halls. Observations revealed the Assistant Director of Nursing (ADON) was observed entering and leaving Resident #5's isolation room without sanitizing/washing hands or applying Personal Protective Equipment (PPE). A staff member was observed removing milk from Resident #11's room, who had a diagnosis of Methicillin-Resistant Staphylococcus Aureus (MRSA), and placed the milk carton into the community refrigerator. A CNA was observed making a bed in Resident #D room, Resident #D had a diagnosis of MRSA of a (Ventricular Assistive Device (VAD) system. A therapy</p>	F 441	<p>2. How will the facility identify other residents having the potential to be affected by the same deficient practice?</p> <p>Infection control precautions for residents with infections were reviewed by the ADON and DON on 9-16-13. Any issues identified were immediately corrected.</p> <p>3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?</p> <p>DON/ADON(Staff Development Nurse) and ADON/UM were educated by Dr. Xia (Infectious Disease MD Consultant) on 9/12/13 on Infection Control isolation procedures including when and how to use PPE. Staff training for all departments was provided by the ADON(Staff Development Nurse) between Oct 1 and Oct 11, 2013 on Infection control including isolation, PPE procedures, hand washing, linen handling, tray delivery and contact with environment in isolation rooms(including sitting on furniture).</p>	10/21/13



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F 441	<p>Continued From page 15</p> <p>assistant was observed in Resident #10's room providing care with no PPE, Resident #10 had a diagnosis of Clostridium Difficile (C-Diff) of the stool. Staff were observed delivering trays to isolation rooms and not donning PPE. The Social Worker was observed sitting on Resident #11's bedside chair with no PPE on, Resident #11 had MRSA of the wound.</p> <p>The findings include:</p> <p>Review of the Isolation- Categories of Transmission Based Precautions, revised 08/2009, revealed contact precautions, in addition to standard precautions, implemented contact precautions for residents known or suspected to be infected or colonized with microorganisms that could be transmitted by direct contact with the resident or indirect contact with environmental surfaces or resident-care items in the residents environment.</p> <p>Review of the facility's education on Isolation Precautions, dated 04/23/13 and 04/24/13 revealed infection control was everyone's responsibility. It further revealed transmission could occur with contact of fluids, cuts, lacerations, cracked skin, splashes of mucous membranes, eyes and hangnails. To reduce the risk of exposure staff should wear appropriate personal protective equipment; gloves, mask, gowns and goggles and to use standard precautions (universal precautions).</p> <p>Observations made during tour, on 09/10/13 at 8:20 AM, revealed infections were isolated to one (1) of four (4) halls.</p> <p>1. Observations, on 09/10/13 at 8:20 AM,</p>	F 441	<p>4. How will the facility plan to monitor its performance to ensure that solutions are sustained?</p> <p>The ADON will review residents in isolation precautions and observe staff procedures weekly for 4 weeks then monthly for a minimum of 12 months. This will include observation of a minimum of ten employees across all shifts including ancillary staff. Results will be presented monthly to the QAPI team for review and recommendations based upon the results.</p>		



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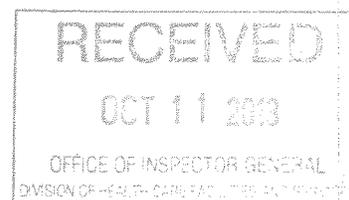
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F 441	<p>Continued From page 16</p> <p>revealed the Assistant Director of Nursing (ADON) #1 entered Resident #5's room, an isolation room for C-Diff (admitted with the organism), without sanitizing hands or applying PPE when she entered or washing hands when she exited the room.</p> <p>Interview with Resident #5, on 09/12/13 10:19 AM, revealed he/she had noticed the staff members at times not coming in the room with PPE. Sometimes the staff have PPE on and some times they do not.</p> <p>Interview with Resident #11, on 09/12 at 11:48 AM, revealed for the most part staff put on PPE when they enter the room.</p> <p>Interview with the ADON #1, on 09/13/13 at 9:34 AM, revealed when staff enter an isolation room for C-Diff, the staff member should use sanitizer when entering the room and wash hands when they leave the room. ADON #1 stated staff should always use gowns and gloves at all times when entering a C-Diff room. ADON #1 revealed she did not remember walking into Resident #5's room with no PPE or sanitizing her hands when she entered or exited. ADON #1 stated they wash their hands and place PPE on to prevent the spread of infection.</p> <p>2. Observation of the lunch meal, on 09/10/13 11:58 AM, revealed Certified Nursing Assistant (CNA) #1 entered Resident #11's room who was on contact precautions for MRSA of the wound and placed a lunch tray on Resident #11's table. Per Resident #11's request the CNA removed milk from resident #11's tray and placed the milk in the community refrigerator which served one (1) of four (4) halls.</p>	F 441		
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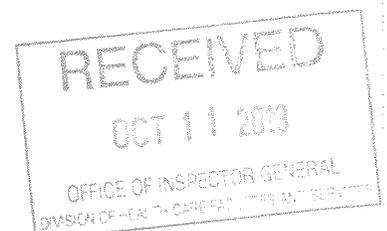
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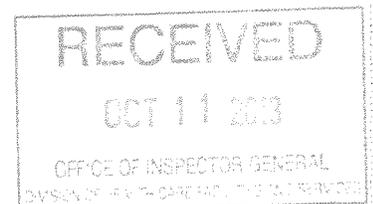
F 441	<p>Continued From page 17</p> <p>Interview with CNA #1, on 09/10/13 12:03 PM, revealed she should have removed the milk and poured the milk out instead of placing the milk in the refrigerator. CNA #1 stated the milk was considered dirty and could cause an infection control concern.</p> <p>Interview with Registered Nurse (RN) #2, on 09/12/13 at 4:43 PM, revealed the milk should not come out of the isolation room and be placed in the community refrigerator. They do not want to pass the infection to other residents.</p> <p>3. Observation of CNA #2, on 09/12/13 at 9:09 AM, revealed CNA #2 was making Resident #D's bed, who had MRSA of the Ventricular Assistive Device and did not have any PPE on.</p> <p>Interview with CNA #2, on 09/12/13 at 10:00 AM, revealed CNA #2 thought if he did not come in direct contact of Resident #D, he would not have to put on PPE. CNA #2 stated if he did not come in direct contact of Resident #D's wound he would not need to put on PPE. CNA #2 stated he was educated on contact precautions upon hire.</p> <p>Interview with ADON #1, on 09/13/13 at 9:34 AM, revealed CNA's should place PPEs on when touching resident items in the room.</p> <p>4. Observation of Occupational Therapist Assistant (OTA) in Resident #10's room, on 09/12/13 at 8:50 AM, revealed the OTA was working with Resident #10 and maneuvering the wheelchair trying to get Resident #10 positioned with no PPE on. The OTA came out of Resident #10's room to sanitize his hands and apply PPE. Resident #10 was on contact isolation for C-Diff.</p>	F 441		
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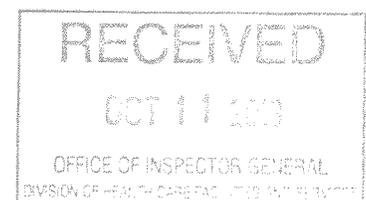
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185237	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/13/2013
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF CHEROKEE PARK			STREET ADDRESS, CITY, STATE, ZIP CODE 2100 MILLVALE RD. LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	Continued From page 18 Interview with OTA, on 09/12/13 at 9:13 AM, revealed he was placing the wheelchair in Resident #10's room. The OTA stated he wanted to place the wheelchair in Resident #10's room and then gown and glove up. The OTA stated he should sanitize his hands before entering the room and wash hands as he exited Resident #10's room. The OTA stated you have to don gloves and PPE to ensure prevention of the spread the infection. Interview with the Therapy Manager, on 09/12/13 at 4:21 PM, revealed staff should sanitize their hands and apply PPE before entering contact isolation rooms. Staff members should not be in isolation rooms without PPE. The Therapy Manager stated she monitored staff a couple of times a week and had not observed any staff not putting on PPE appropriately. 5. Observation of the lunch meal tray pass, on 09/10/13 at 11:52 AM, revealed CNA #1 entered Resident #5's room (a resident with C-Diff) with out sanitizing hands or putting on PPE. The CNA placed Resident #5's tray on his/her bedside table. CNA #1 was then observed to not wash hands as she exited Resident #5's room. Observation of the lunch meal tray pass, on 09/10/13 at 11:55 AM, revealed CNA #2 entering Resident #D's room, whom had MRSA, without sanitizing hands before entering the room. Interview with CNA #2, on 09/12/13 at 10:00 AM, revealed he should have sanitized his hands before entering Resident #D's room. Interview with ADON #1, on 09/13/13 at 9:34 AM,	F 441			



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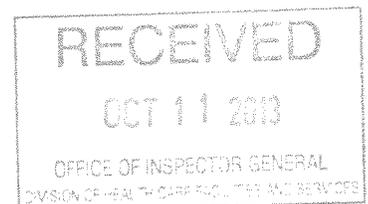
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F 441	<p>Continued From page 19</p> <p>revealed she expected the staff to wash/sanitize their hands as they entered and left a room with a patient on MRSA contact isolation. ADON #1 stated she expected the staff to sanitize their hands and don PPE as they entered a residents room and wash hands as they exited a residents room who was on C-Diff precautions.</p> <p>6. Observation of the Social Worker entering Resident #11's room (on contact isolation for MRSA of the wound), on 09/12/13 at 11:08 AM, revealed the Social Worker entered Resident #11's room without sanitizing her hands. The Social Worker then sat down in Resident #11's recliner with no PPE on.</p> <p>Interview with the Social Worker, on 09/12/13 at 11:10 AM, revealed she did not know what Resident #11 was in isolation for. The Social Worker stated she knew she should have sanitized her hands as she entered the room and as she exited the room. The Social Worker stated she did sit in the residents recliner and was not sure if Resident #11 had sat in the recliner. The Social Worker stated she started three weeks ago and was trained by Human Resource and the Staff Development Coordinator.</p> <p>Interview with the ADON #3, on 09/13/13 at 1:53 PM, revealed she educated the staff on infection control and standard precautions. ADON #3 stated she educated the staff upon hire and annually. ADON #3 stated she used a power point to educate the staff. The ADON stated she taught what was provided from the CDC and monitored what the staff did while providing care. ADON #3 stated it was frustrating when she educated the staff to apply PPE when entering rooms and the task was not being completed by</p>	F 441			



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F 441	<p>Continued From page 20</p> <p>staff. ADON #3 stated she was also responsible to assist the Director of Nursing (DON) with monitoring the infections in the facility. The ADON stated there was no increase in infections in the facility.</p> <p>Interview with the DON, on 09/13/13 at 2:12 PM, revealed staff should be washing hands, wearing gloves, putting on PPE as they enter resident rooms and touching the residents environment. The DON stated they put on PPE to prevent infections. The DON stated she had been monitoring the infections in the building and there had been no spikes in the number of infections in the building.</p> <p>Interview with the Administer, on 09/13/13 at 3:15 PM, revealed she monitored the infections in the building through Quality Assurance (QA) through a mapping process. The Administrator stated there had not been an increase in infections. The Administrator stated most of the residents were admitted with the infections when they come to the facility. The Administrator stated she did understand there needed to be more education provided to staff. The Administrator stated she expected the DON and the ADON to be monitoring staff to ensure the staff followed infection control practices.</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 Continued From page 1
deficiency identified at F level.

K 056 **NFPA 101 LIFE SAFETY CODE STANDARD**
SS=F

If there is an automatic sprinkler system, it is installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, to provide complete coverage for all portions of the building. The system is properly maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. It is fully supervised. There is a reliable, adequate water supply for the system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5

This STANDARD is not met as evidenced by:
Based on observation and interview, it was determined the facility failed to ensure the building had a complete sprinkler system in accordance with NFPA Standards. The deficiency had the potential to affect each of the seven (7) smoke compartments on the Ground floor and each of the two (2) smoke compartments in the basement, all residents, staff and visitors. The facility has eighty-four (84) certified beds and the census was seventy-one (71) on the day of the survey.

The findings include:

Observations, on 09/11/13 between 10:57 AM and 12:54 PM, with the Plant Operations and Environmental Services Director revealed the

K 000

K 056

K 056

K 056

1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice?

An accepted BID for installation of the noted missing sprinkler heads was obtained and approved on September 30, 2013. Work to Begin on October 7, 2013 with anticipated work completion date of October 25, 2013.

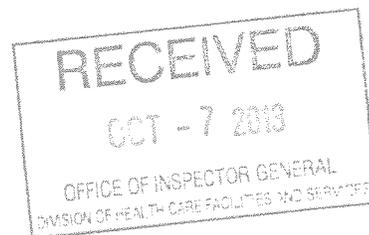
2. How will the facility identify other residents having the potential to be affected by the same deficient practice?

All residents have the potential To be affected.

3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur?

Once all sprinkler heads are installed the facility will be In compliance with 42 CFR 483.70(a) and NFPA 101 Life Safety Code Standard.

10-26-13
10/25/13
pa Nienmeide
by PB 10-8-13



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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 056

Continued From page 2
resident storage closets located in the A Wing Therapy Hall on the Ground Floor and the ten (10) resident rooms located in the basement, were not protected by automatic sprinkler coverage.

Interviews, on 09/11/13 between 10:57 AM and 12:54 PM, with the Plant Operations and Environmental Services Director revealed he was not aware of the storage closets not being protected by automatic sprinkler coverage.

Reference: NFPA 101 (2000 Edition)

Table 19.1.6.2 and 19.3.5.1. Existing healthcare facilities with construction Type V (111) require complete sprinkler coverage for all parts of a facility.

19.3.5.1. Where required by 19.1.6, health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with Section 9.7.

9.7.1.1. Each automatic sprinkler system required by another section of this Code shall be in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems.

Reference: NFPA 13 (1999 Edition)

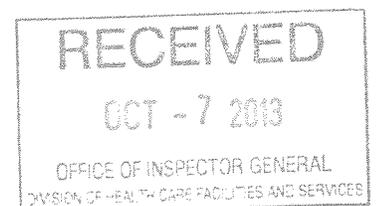
5-1.1. The requirements for spacing, location, and position of sprinklers shall be based on the following principles:
(1) Sprinklers installed throughout the premises
(2) Sprinklers located so as not to exceed maximum protection area per sprinkler

K 056

4. How will the facility plan to monitor its performance to ensure that solutions are sustained?

The facility will continue with quarterly sprinkler inspections for routine monitoring of compliance and function.

10-26-13
10/27/13
per Nicholas
by PB 10-8-13



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K 056	Continued From page 3 (3) Sprinklers positioned and located so as to provide satisfactory performance with respect to activation time and distribution.	K 056		

