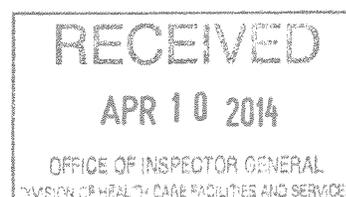


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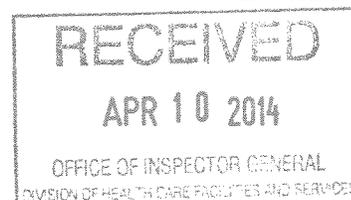
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/26/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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{F 441}	Continued From page 51 2. Review of Resident #17's clinical record revealed the resident's visitor was educated in the proper use of Personal Protective Equipment (PPE) on 03/07/14, as care planned. Reinforcement of that education was documented on 03/08/14 and 03/09/14 in the social services notes by Social Services Director. The Social Services notes revealed the visitor expressed dissatisfaction with having to wear the PPE, but complied with the instructions. During the time Resident #17 remained in Isolation after 03/07/14, a sitter was assigned to be with the resident to assist the visitor with PPE use/compliance. Interview, on 03/25/14 at 3:35 PM, with Certified Nursing Assistant (CNA) #4 revealed she was assigned as the sitter when Resident #17's visitor was in the room, and she validated Resident #17's visitor was educated on use of PPE and proper handwashing, and complied with the instructions during each visit. 3. Record review revealed signage was posted on Resident #17's door, that directed visitors to report to the nurses' station for instructions before entering the resident's room. Nursing Management consisting of the Director of Nursing (DON), Assistant Directors of Nursing (ADONs), and the Regional Vice President (RVP), monitored signage through observations to ensure it stayed on the resident's door throughout the remaining time the resident was in isolation, and that the isolation cart was stocked with PPE and contained directions specific to Droplet Isolation. 4. Review of Resident #17's clinical record	{F 441}	policy and procedure and the policy and procedure for administering eye drops by the DON, SDC, ADON, MDS and RN's on 3/8 and 3/9/2014. Family member #1 was re-educated on the proper use of PPE and educated on the reason for the need of the PPE. All residents had the potential to be affected by this practice. c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Every staff member employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions and the use of PPE by DON, ADON, SDC, RNs, LPN nurse managers. Each licensed nurse was re-educated on the clean dressing change policy and procedure and the policy and procedure for administering eye drops by DON, ADON, SDC, RNs, LPN nurse managers. Family member #1 was re-educated on the proper use of PPE and educated on the reason for the need of the PPE on 3/7/14 by the social worker, 3/8/14, by the nurse, 3/8/14 by the social worker and 3/10/14 by the social worker and documented in the		



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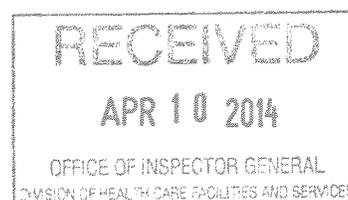
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{F 441}	<p>Continued From page 52</p> <p>revealed his/her visitor was closely monitored, daily, for compliance with PPE use, until an order was obtained to discontinue Droplet Isolation on 03/14/14.</p> <p>Interview, on 03/25/14 at 3:35 PM, with Certified Nursing Assistant (CNA) #4 revealed she received infection control re-education after the identified IJ on 03/07/14, which included instruction in isolation precautions and proper hand washing technique. CNA #4 stated she was assigned to sit with Resident #17 to ensure the resident's visitor donned PPE prior to entering the room, kept it on, appropriately disposed of the PPE, and washed his/her hands before leaving the room. CNA #4 stated the visitor complied with the isolation requirements.</p> <p>5. Review of the Resident #17's clinical record and care plan revealed the 1:1 sitter intervention was removed on 03/14/14 upon discontinuation of the Droplet Isolation for Resident #17, with standard precautions in place thereafter.</p> <p>Observation, on 03/25/14 at 11:07 AM, revealed Resident #17 seated in his/her wheel chair with the visitor seated in a chair in the room. Standard precautions were in effect.</p> <p>6. Interview, on 03/26/14 at 10:22 AM, with LPN #2 revealed he attended several inservices that related to infection control on the weekend after the IJ was announced on 03/07/14.</p> <p>Interview, on 03/26/14 at 10:12 AM, with RN #2 revealed she had received infection control in-service education on 03/12/14 after returning from time off from work.</p>	{F 441}	<p>patient's chart. The education was completed by the SDC, DON, ADON, MDS or RN on 3/8/14 and 3/9/2014.</p> <p>Family member #1 will continue on 1 to 1 supervision as long as Resident #17 is no longer in isolation as of 3/14/14. Family member #1 had been educated, but at times did not remember to don the proper items needed prior to entering the room.</p> <p>The SDC, ADON, DON, RNs, LPN Unit managers will complete an audit on 5 staff members daily x 1 week and then weekly x 12 weeks on the hand washing policy and procedure, changing of gloves policy and procedure and proper cleaning of equipment policy and procedure. The audits will be forwarded to the DON for review. Further education or disciplinary action will be given PRN.</p> <p>The SDC, ADON, DON, RNs, LPN Unit managers or will audit 3 nurses daily x 1 week and then weekly x 12 weeks on the clean dressing change policy and procedure and the administration of eye drops policy and procedure until all nurses have been observed. The audits will be forwarded to the DON for review. Further education or disciplinary action will be given PRN.</p> <p>The housekeeping supervisor, ADON, DON, RNs, LPN Unit</p>		



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{F 441}	Continued From page 53 Interview, on 03/26/14 at 10:31 AM, with CNA #3 revealed that on 03/08/14 she received re-education on infection control including isolation precautions. CNA #3 stated if she saw a visitor about to enter an isolation room, she would ask them to speak to a unit's nurse before visiting the resident. 7. Observation, on 03/25/14 at 8:25 AM, on tour of (Rosemont Street Hall) revealed an Isolation Cart at the Doorway of one room. Two residents resided in the room. The cart outside the door contained disposable gowns, disposable gloves, red bags, and a laminated instruction card with contact isolation instructions. Signage was posted on the resident's door that read, "Visitors, report to the nurse before entering the room." Interview, on 03/25/14 at 9:30 AM, with the ADON for the 200 Hall revealed Resident #26 had been transferred from the facility on 03/22/14 for evaluation/treatment at an acute care hospital. Review of Resident #26's clinical record revealed he/she had been transferred to the hospital on 03/22/14 for evaluation of a change in mental status. Review of Resident #25's clinical record revealed he/she had been transferred to the hospital for evaluation of itching and pain/with a diagnosis of possible shingles on 03/24/14. Upon return to the facility, later that same day, the resident's physician ordered Contact Isolation Precautions. Further review of the clinical record (nurses' notes), on 03/25/14, revealed Resident #25's, daughter was notified by phone on, 03/25/14, of the resident's change in status, received further education in isolation precautions and PPE use	{F 441}	managers will audit 2 laundry aides daily x 1 week, then weekly x 12 weeks to ensure the proper handling of soiled linen until all are completed. The audits will be forwarded to the Administrator for review. Further education or disciplinary action will be given PRN. d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place; The QA committee met on 3/14/14 & 3/18/14 to review the compliance. The next QA meeting will be 3/28/14 to evaluate the effectiveness of the POC. The audits by the SDC, ADON, DON, RNs, Housekeeping supervisor will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.	



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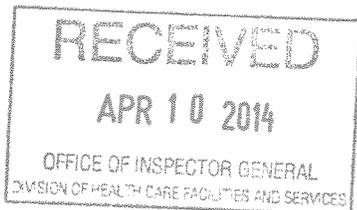
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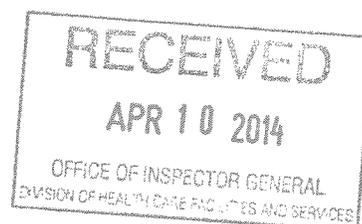
{F 441}	<p>Continued From page 54</p> <p>when she came to visit that same day, and that the daughter voiced understanding of the instructions. Record review, on 03/25/14 at 11:00 AM, revealed logs at the 200 hall nurses' station that documented hourly monitoring of Resident #25's room/staff for adherence to infection control practice.</p> <p>Observation, on 03/25/14 at 8:30 AM, during tour of the Kentucky Pride Hall, revealed an Isolation Cart outside Resident #27's doorway. The cart contained disposable gowns, disposable gloves, red bags, and a laminated instruction card for contact isolation precautions. Signage posted at the door read, "Visitors, report to the nurse before entering the room."</p> <p>Review, on 03/25/14, of the clinical record revealed Resident #27 was placed in Contact Isolation on 03/17/14 for potential Clostridium Difficile (C. diff), with a positive C. diff lab report on 03/18/14. Further review, of Resident #27's clinical record (nurses' notes) revealed the resident's daughter and grandson were educated on 03/18/14, regarding PPE use and the disease requiring Resident #27 to be in Contact Isolation. Nurses' notes revealed the family members voiced understanding of the information. Record review, on 03/25/14 at 8:35 AM revealed logs at the 300 hall nurses' station, that documented hourly monitoring of Resident #27's room/staff for adherence to infection control practice.</p> <p>8. Review, of sign in sheets, training binders, and the post-tests completed by employees revealed infection control re-education began on 03/07/14, immediately after the IJ was identified. Staff that did not work on 03/07/14 received infection control re-education including instruction on</p>	{F 441}		
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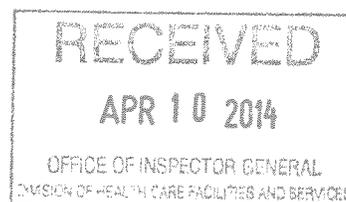
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{F 441}	<p>Continued From page 55</p> <p>isolation precautions, use of PPE, and proper handwashing technique upon reporting to work their next scheduled shift. Each staff member who received infection control in-service training was required to prove competency via a written post test, and a return demonstration of proper hand washing technique. The facility had prepared sub binders that contained documentation of those who attended wound care and medication administration trainings for licensed nurses, and perineal care re-education for licensed nurses, CNAs, and Occupational Therapists (OTs). The binders contained policies and sign-in sheets documenting the attendees.</p> <p>Review of the completed post-tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests fifteen (15) employees received training and were tested on 03/10/14, one (1) staff person was trained/tested on 03/11/14 and one staff person was trained/tested 03/12/14.</p> <p>Interview, on 03/25/14 at 1:30 PM, with the facility's Signature Care RN Consultant, revealed staff that were not trained while on duty on 03/07/14, were required to attend an infection control inservice, take a post test, and perform a return demonstration of proper hand washing technique before reporting to their assigned hallway to work. The Signature Care RN Consultant stated additional in-services were conducted later in the shift for employees which included re-education in proper wound care techniques, perineal care, medication administration, and safe handling of soiled linen.</p>	{F 441}	



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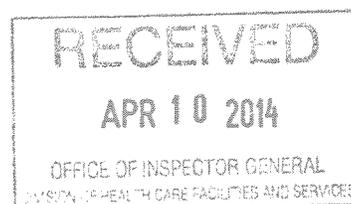
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{F 441}	<p>Continued From page 56</p> <p>Observation, on 03/25/14 at 8:30 AM, revealed CNA #4 sanitized her hands and donned appropriate PPE at Isolation Room 326. CNA #4 knocked on the resident's door before carrying in a paper (disposable) tray of breakfast items.</p> <p>Interview, on 03/25/14 at 3:35 PM, with CNA #4 revealed she received infection control re-education after the identified IJ on 03/07/14, which included instruction in isolation precautions and proper hand washing technique. CNA #4 stated she was assigned to sit with Resident #17 for the two (2) days Resident #17 remained in Droplet Isolation. CNA #4 stated she was to ensure Family Member #1 donned PPE on entering the resident's room, kept it on, appropriately disposed of the PPE and washed her/his hands before leaving the room. CNA #4 stated Family Member #1 complied with the isolation requirements.</p> <p>Review, on 03/26/14 at 11:05 AM, of the clinical record for Resident #28, revealed he/she had been placed in Contact Isolation for potential scabies. Nurses notes revealed the resident had three (3) small pin dot scabs on her upper torso and an order for Contact Isolation had been obtained on 03/25/14.</p> <p>Observation, on 03/26/14 at 11:00 AM, revealed three (3) housekeeping staff persons were wearing PPE while cleaning Room 301 on the Kentucky Pride Hallway where Isolation Precautions had been put into effect.</p> <p>Interview, on 03/25/14 at 3:50 PM, revealed Housekeeper #3 received re-education in infection control about two weeks ago, but could not remember the exact date. She stated she</p>	{F 441}		



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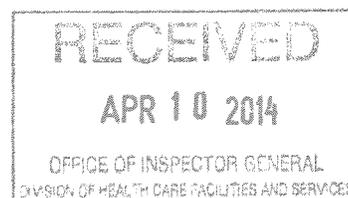
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{F 441}	<p>Continued From page 57</p> <p>would don PPE as indicated on the isolation instruction card in the cart before entering the room. She would knock on the resident's door and clean. After completing the tasks she would remove the PPE, place it in the lined barrel in the room, wash her hands at the resident's sink. Housekeeper #3 stated upon cleaning her hands she used a clean paper towel to touch faucet handles.</p> <p>Interview, on 03/25/14 at 4:32 PM, with Laundry Services/House Keeping Staff #5, revealed she was instructed, in handwashing and proper use of PPE while processing soiled linen in the facility's laundry department, on 03/07/14. Laundry Staff Person #5 stated she was instructed to put on a disposable gown, gloves, and goggles when placing the soiled linen/towels/clothing in the washers.</p> <p>Interview, on 03/26/14 at 10:12 AM, with RN #2, revealed, she received infection control education, including hand washing with a required return demonstration, when she reported to work on 03/12/14, after having time off from work. RN #2 stated she understood her role in educating visitors in proper isolation precautions before and during a visit to a resident in isolation. She stated the sign posted on the resident's door directed the visitor(s) to see a nurse for guidance before entering the isolation room.</p> <p>Interview, on 03/25/14 at 3:45 PM, with LPN #1 revealed she was trained on 03/10/14 upon reporting to work. She stated she was not allowed to work on her unit until she attended the required infection control inservice, completed a post-test, and demonstrated proper hand washing procedure. LPN #1 stated she received additional</p>	{F 441}		



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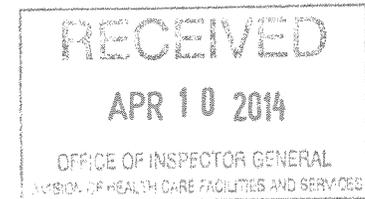
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{F 441}	Continued From page 58 infection control in-service education related to resident care later in that day, which were taught by the MDS nurse. Interview, on 03/25/14 with RN #1, revealed she received re-education on 03/11/14, after returning from time off from work. RN #1 stated she was not allowed to report to her unit to work until she had received re-education in infection control, which addressed Isolation Precautions, hand washing, with a required return demonstration. 9. Review of the completed post-tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests fifteen (15) employees received training and were tested on 03/10/14, one (1) staff person was trained/tested on 03/11/14 and one staff person was trained/tested 03/12/14. Interview, on 03/25/14 at 1:30 PM, with the facility's Signature Care RN Consultant, revealed staff that were not trained while on duty on 03/07/14, were required to attend an infection control inservice, take a post test, and perform a return demonstration of proper hand washing technique before reporting to their assigned hallway to work. The Signature Care RN Consultant stated additional in-services were conducted later in the shift for employees which included re-education in proper wound care techniques, perineal care, medication administration, and safe handling of soiled linen. Review of the sign in sheets and curriculum in the sub-binder for medication administration training revealed from 03/07/14-03/09/14, Licensed	{F 441}			



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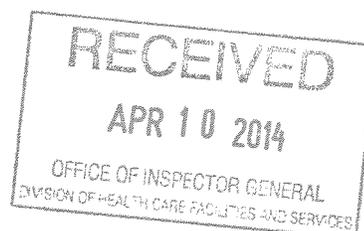
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{F 441}	Continued From page 59 Nurses received medication administration and wound care re-education that included observance of infection control practices. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work. Interview, on 03/25/14 at 1:30 PM, with the facility's Signature Care RN Consultant, revealed staff that were not trained while on duty on 03/07/14, were required to attend an infection control inservice, take a post test, and perform a return demonstration of proper hand washing technique before reporting to their assigned hallway to work. The Signature Care RN Consultant stated additional in-services were conducted later in the shift for employees which included re-education in proper wound care techniques, perineal care, medication administration, and safe handling of soiled linen. Review, of the Care 2 Learn Online Education Infection Control Tests completed by staff revealed infection control re-education began on 03/07/14, immediately after the IJ was identified. Each test revealed the name of the employee and date the test was taken. Staff that did not work on 03/07/14 received infection control re-education including instruction on isolation precautions, use of PPE, and proper handwashing technique upon reporting to work their next scheduled shift. Each staff member who received infection control in-service training was required to prove competency via completion of the multiple choice test questions. A return demonstration of proper hand washing technique was also required before the employees could return to their assigned units. Further review, on 03/25/14, of the dated post	{F 441}			



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{F 441}	<p>Continued From page 60</p> <p>tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests, fifteen (15) employees received training and were tested on 03/10/14 and two (2) staff were trained/tested after 03/10/14, due to their scheduled time off from work. None of these employees were allowed to report to their units to work before completing the required training, testing, and return demonstration.</p> <p>10. Review of the Employee Listing/Signature Payroll Services list provided by the administrator, revealed the facility employed 194 staff members.</p> <p>Interview, on 03/25/14 at 10:15 AM, with the facility's administrator revealed the facility did not employ agency staff.</p> <p>11. Interview, on 03/25/14 at 1:30 PM, with the Signature Care RN Consultant revealed after the IJ was announced on 03/07/14, and prior to reporting to their assigned units to work, all staff members were required to attend an infection control in-service, complete the Care 2 Learn Infection Control Multiple Choice Test, and demonstrate competency in proper hand washing technique.</p> <p>12. Interview, on 03/26/14 at 1:00 PM, with the Administrator revealed the facility had no new staff hired from 03/11/14 to 03/26/14.</p> <p>Review of the Employee Listing/Signature Payroll Services list provided by the administrator, revealed the facility employed 194 staff members.</p>	{F 441}		



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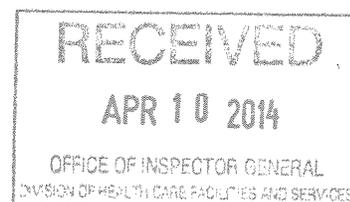
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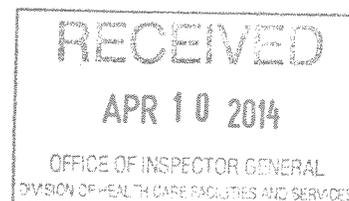
{F 441}	<p>Continued From page 61</p> <p>Interview, on 03/25/14 at 10:15 AM, with the facility's administrator revealed the facility did not employ agency staff.</p> <p>13. Review, of the Infection Control Monitoring Checklists revealed administrative staff were assigned to monitor infection control compliance three (3) times daily after the identified IJ of 03/07/14. Staff were monitored for observance of Isolation Precautions, skin/wound treatment technique, peri care technique, observance of proper hand hygiene across all facility departments and disciplines, linen handling by nursing and laundry staff, and hand hygiene and eye drop administration during med pass.</p> <p>Review of the Allegation of Compliance book, on 03/25/14 at 11:00 AM, revealed the Infection Control Monitoring Checklists had been completed three (3) times daily on each unit.</p> <p>Observation, on 03/25/14 at 8:30 AM, during tour of the facility, revealed The Staff Development Nurse was observing and assisting CNA #4 as she donned PPE before carrying a paper tray of breakfast items into Resident #27's room, who was in Contact Isolation.</p> <p>Observation, on 03/26/14 at 11:05 AM, revealed a Corporate Staff Person observing housekeepers who were cleaning Resident #28's room, who was in Contact Isolation. All housekeeping staff in the room appropriately donned PPE prior to entering the room.</p> <p>Record review, on 03/25/14 and 03/26/14, revealed logs at the 200 and 300 hall nurses' stations, that documented hourly monitoring of Resident #25, Resident #27 and Resident #28 for</p>	{F 441}		
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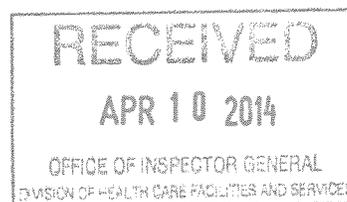
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{F 441}	Continued From page 62 staff adherence to infection control practice. Record review revealed as of 03/27/14 the facility had provided 110 nursing staff with the required infection control in-service education with five (5) nursing staff members who still needed this required in-service education. Four (4) Certified Nursing Assistants (CNAs) had not received the infection control in-service. A registered letter was mailed on 03/21/14 to all who had not received the training to make them aware of this requirement. Review of the sign in sheets and curriculum in sub binder for perineal (peri) care revealed from 03/07/09- 03/09/14, Licensed Nurses, CNAs, and Occupational Therapists (OTs) were re-educated in peri care. Training was conducted by Nursing Administration and Signature Care RN Consultant. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work. Interview, on 03/25/14 with RN #1, revealed she received re-education on 03/11/14, after returning from time off from work. RN #1 stated she was not allowed to report to her unit to work until she had received re-education in infection control, which addressed Isolation Precautions, hand washing (with a required return demonstration). RN #1 stated she was also required to demonstrate competency via a written post test, RN #1 stated she also attended perineal, wound care, and medication administration training later during her shift. Interview, on 03/26/14 at 10:22 AM with LPN #3, revealed he received re-education in infection control immediately upon reporting to work on	{F 441}			



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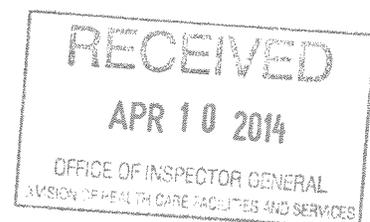
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{F 441}	<p>Continued From page 63</p> <p>03/08/14. LPN #3 stated as soon as he clocked in to work his shift, the DON provided infection control training that included hand washing, linen handling, proper use of PPE, how to treat potentially biohazardous waste, properly sanitizing a glucometer, and other medication pass procedures.</p> <p>Interview, on 03/26/14 at 10:31 AM with CNA #3, revealed she received re-education in infection control on 03/08/14. CNA #3 stated she was not allowed to report to her unit to work until she had an in-service on infection control which included hand-washing with a required return demonstration. CNA #3 stated she noticed many administrative staff were in the building, and she was required to attend other in-services later that day that related to infection control and resident care.</p> <p>Interview, on 03/25/14 at 3:45 PM, with LPN #1 revealed when she entered the door of the facility on 03/10/14 to work the first shift, she was met by the DON, and told she was not to work on her unit until she received infection control training and demonstrated proper hand washing technique. LPN #1 stated she received additional in-service education related to peri care, med pass, and wound care later in the shift.</p> <p>14. Infection control audits for handwashing, glove changes, cleaning of equipment, eye medication administration, and infection control in the laundry services department were conducted daily for one week after identification of the IJ on 03/07/14 and were to continue weekly for 12 weeks to ensure staff's adherence to policies.</p> <p>15. Review of sign in sheets for Quality</p>	{F 441}			



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{F 441}	Continued From page 64 Assurance meeting held 03/08/14, after the IJ was idenetified on 03/07/14. The documentation revealed the purpose of this meeting was to activate processes to remove the IJ with particular emphasis on ensuring the faciltiy adhered to all of its infection control policies and procedures. Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed the facility had a Quality Assurance meeting on 03/08/14 to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures, and met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures.				
{F 464} SS=E	483.70(g) REQUIREMENTS FOR DINING & ACTIVITY ROOMS The facility must provide one or more rooms designated for resident dining and activities. These rooms must be well lighted; be well ventilated, with nonsmoking areas identified; be adequately furnished; and have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide sufficient space in the Restorative Dining Room, or Gold Room to accommodate fourteen (14) residents, eight (8) staff members, and two (2) visitors. Fourteen (14) residents, four (4) sampled (Residents #1, 2, 3, and 5) and ten (10)	{F 464}	a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The change in the dining program was to assess residents based upon their need for assistance and any resident that required only verbal cueing or follow up feeding were graduated to a transition table in the main dining. Four residents were involved in this change. All dining and nursing staff was educated by staff development coordinator Dining Services manager or Director of Nursing and ADONs and RNs on proper meal service, feeding assistance and regarding timeliness of meal service on 3/17/14. Post test will be performed by educated staff members on the change in the dining program and importance of timeliness of meal service on 3/28/14. The administrator, DON or RN's will audit the dining rooms daily for the first week and then weekly x 12 for timeliness of meal service and timeliness of assistance provided to residents requiring assistance with eating utilizing a Dining Audit tool.		3/29/14



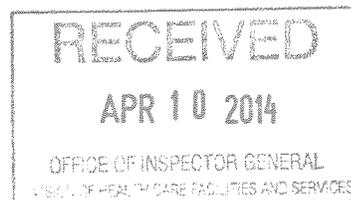
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{F 464}	<p>Continued From page 65</p> <p>unsampled residents (Unsampled Residents #B, C, D, E, F, G, H, I, J, and K) were observed sitting in their wheelchairs around the five (5) tables provided, and did not have the ability to exit the room without staff first moving another resident.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing (DON), on 03/06/14, at 3:00 PM, revealed there was not a specific policy for Restorative Dining space.</p> <p>Observation of the evening meal, on 03/04/14 at 6:00 PM, in the Restorative Dining Room, and the lunch observation, on 03/05/14 at 12:00 PM, revealed Sampled Residents #1, 2, 3, and 5, and Unsampled Residents B, C, D, E, F, G, H, I, J, and K required staff for assisting with dining, feeding or cueing. Observation of the five (5) round tables in the Gold Room, on 03/04/14 at 5:55 PM, revealed the space was very crowded and staff had to move residents away from the table, in order to allow another resident to leave the table. Eight (8) staff members and two (2) family members were also observed in the room assisting residents with either cueing or feeding.</p> <p>Interview with the Quality of Life Director, on 03/06/14 at 2:45 PM, revealed last year all residents requiring feeding or cueing were served in the main Dining Room; however, she stated the Restorative Dining area was changed to the Gold Room last year, which was much smaller, and sometimes there was a space problem.</p> <p>Interview with the Director of Nursing, on 03/06/14, at 3:00 PM, revealed the Restorative Dining Room sometimes gets crowded, and</p>	{F 464}	<p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents dining in the Gold room have the potential to be affected by this practice. All residents that dine in the Gold room were assessed on 3/27/14 by the Restorative nurse related to their dining needs. No corrective action was needed.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Nursing Staff has been educated by the Director of Nursing, Staff Development Coordinator, Assistant Director of Nursing, on 3/18/14 on proper meal service, feeding assistance, and timeliness of meal service. Post test completed 3/28/14 on meal service and timeliness of meal service. The administrator, DON, ADON, Dietician on RN's will audit the dining rooms daily (Monday through Friday) to assure that the residents have appropriate space for meal service. This will be audited every day for the first week and then weekly x 12.</p>	



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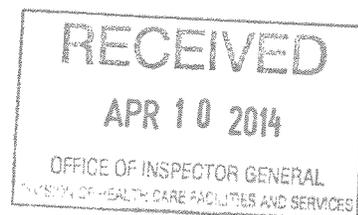
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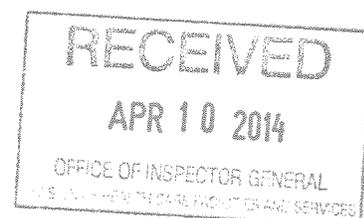
<p>{F 464}</p> <p>{F 490}</p> <p>SS=E</p>	<p>Continued From page 66 stated they tried to keep the double doors open. The DON stated they had looked at different ways to help with the crowded room; however, had not implemented anything to date.</p> <p>483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING</p> <p>A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, policy review, and the facility's Allegation of Compliance (AOC), it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/07/14, had been removed related to the Administration's failure to have an effective infection control program as evidenced by ineffective monitoring of a visitor to the facility who was non-compliant with use of Personal Protective Equipment (PPE); inconsistent availability of PPE; improper hand hygiene by staff; lack of glove use during eye medication administration; breaks in clean technique during perineal and wound care; and lack of PPE utilization during laundry processing.</p> <p>An acceptable AOC was received on 03/20/14 alleging removal of the IJ on 03/10/14. Based on the findings of the revisit, it was determined the IJ was removed on 03/10/14, as alleged, with remaining noncompliance at a scope and severity</p>	<p>{F 464}</p> <p>F 490</p>	<p>d.) How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance program will be put into place; The audits by the administrator, DON, ADONs, RD or RNs will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p> <p>a.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Education was provided for the staff identified. Proof of education was reviewed by the Administrator.</p> <p>1. Family member #1 was placed on 1 to 1 supervision with a staff member on 3/8/2014 when visiting to insure that PPE was donned appropriately prior to entering Resident #17's room and to insure that Family member #1 continued to follow the isolation precautions while in the room to prevent the</p>	<p>3/28/14</p>
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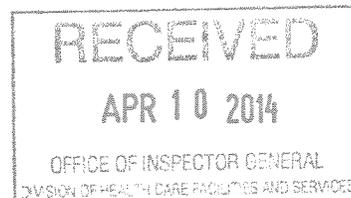
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{F 490}	<p>Continued From page 67 of an "E" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>The facility provided an Allegation of Compliance (AOC) on 03/20/14 alleging Immediate Jeopardy (IJ) was removed on 03/10/14; the facility took the following immediate steps to remove the IJ:</p> <ol style="list-style-type: none"> 1. Education was started on 03/07/13 and was concluded on 03/09/14, which included infection control, use of personal protective equipment (PPE), hand washing, linen/laundry handling, cross-contamination, isolation precautions for specific infections, quality assurance and care plans. This education, was taught to all staff by Nursing Administration, RN Supervisors, Social Services, Dietary Administration, Signature Care Consultant and the Administrator. 2. Medication and wound care trainings were provided from 03/07/14-03/09/14 to Licensed Nurses by Administrative Nursing Personnel and the Signature Care Consultant. 3. Licensed nurses, Certified Nursing Assistants (CNAs), and Occupational Therapists (OTs) were educated on peri care from 03/07/14 to 03/09/14. Training was conducted by Nursing Administration and The Signature Care Consultant. 4. Post education testing and skills competencies (hand washing, linen handling, wound care, peri care, med pass, and donning of PPE) were started with all staff on 03/07/14 with 	{F 490}	<p>potential spread of infection.</p> <p>The resident was removed from droplet precautions on 3-14-14 per the MD orders. The RT was re-educated on proper infection control practice related to droplet precautions and cleansing of equipment properly on 3/8/2014 by the DON.</p> <ol style="list-style-type: none"> 2. RN#2 was re-educated on the policy and procedure for administering eye drops to a resident and the policy and procedure for hand washing on 3/5/2014 by the SDC. 3. Laundry Aide #2 was not specifically identified but all were educated on the proper use of PPE when handling soiled linen on 3/9/2014 by the ADON, DON, RNs, LPN Unit managers and housekeeping supervisor. 4. RN#1 was re-educated on the clean dressing change policy and procedure on 3/4/2014 by the DON. 5. RN#1 was re-educated on the hand washing policy and procedure on 3/5/2014 by the DON. 6. CNA#2 was not specifically identified, but all CNAs were re-educated on the hand washing policy and procedure on 3/9/2014 by the SDC, RNs, ADON, DONs, and LPN unit managers. 	



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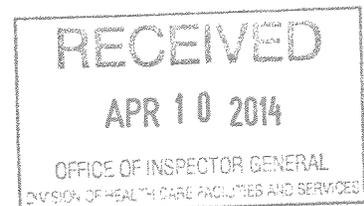
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{F 490}	<p>Continued From page 68 completion on 03/09/14.</p> <p>5. Signature East Louisville currently employees 197 staff members, one staff currently on leave, and with no agency staff.</p> <p>6. No staff were allow to return to work without the mandated education listed above.</p> <p>7. Newly hired staff will be educated during the orientation process by the Staff Development Nurse.</p> <p>8. Compliance observations of staff occurred three times daily via an Infection Control Monitoring Checklist, in order to ensure adherence to infection control policies and procedures. Checklists will be kept in the AOC book in the Administrator's office.</p> <p>9. Quality Assurance (Ad Hoc) Meeting held on 03/08/14. The purpose of meeting was to ensure all infection control policies were adhered to for removal of the Immediate Jeopardy (IJ) Status. Actions taken: Discussed infection control policies/procedures; investigated root cause of infection control policy infraction; identified tasks necessary to prevent future infection control infractions; and, Department Directives/Assignments made for tasks/interventions to address the current infection control infraction and to prevent future infractions. The Performance Improvement (PI) Plan was reviewed for further recommendations. The PI plan was approved by the QA committee and the Medical Director.</p> <p>10. The Administrator was to oversee the QA committee meetings in conjunction with the DON,</p>	{F 490}	<p>7. LPN#1 was re-educated on the hand washing policy and procedure and the changing of gloves policy and procedure on 3/4/2014 by the DON.</p> <p>8. CNA #6 was re-educated on the hand washing policy and procedure and the changing of gloves policy and procedure on 3/6/2014 by the SDC.</p> <p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents have the potential to be affected by this practice. Every staff member employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions and the use of PPE by the DON, ADONs, SDC, Transitional Care Nurse, RN Supervisors, MDS Nurses from 3-7-14 to 3-8-14. Each licensed nurse was re-educated on the clean dressing change policy and procedure and the policy and procedure for administering eye drops by the DON, ADONs, SDC, Transitional Care Nurse, RN Supervisors, and MDS Nurses from 3-7-14 to 3-8-14. Family member #1 was re-educated on the proper use of</p>	



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{F 490}	<p>Continued From page 69</p> <p>the IDT, the Medical Director, and the VP of Operations. The Regional Nurse Consultant will provide oversight daily x 5 days for one week, then once weekly for 4 weeks, and then monthly for 3 months.</p> <p>11. The Administrator and DON received in-service education from the VP of Operations on 03//08/14 regarding the requirements for the quality assurance process. In addition, the DON, Staff Development Nurse, ADON, Unit Manager, MDS Nurse, Medical Records, Signature Care Consultant, the RD, and the Certified Dining Manager received training for the QA process, with the identified concerns, on 03/08/14.</p> <p>12. On 03/08/14, The Administrator met with the administrative team and initiated a process to introduce, develop, and implement plans for the identified concerns. Concerns were to be addressed daily in the morning meetings, plans were developed, and teams were assigned to correct the concerns. Infection control check lists and monitoring audits were assigned to the DON, ADON, Licensed Nurses, Admissions Director, and the Assistant Administrator, with subsequent evaluation of the plan's effectiveness.</p> <p>13. Findings would be discussed with the QA Committee to determine the need for further recommendations and additional follow-up. The DON would ensure completion of the audits, and follow up as needed. The Administrator would review the findings of the daily infection control audits Sunday through Saturday.</p> <p>On 03/26/14 the State Survey Agency (SSA) verified through observation, interview and record review, removal of Immediate Jeopardy (IJ) on</p>	{F 490}	<p>PPE and educated on the reason for the need of the PPE by the SDC and the DON on 3/8 and 3/9/2014. Proof of education was reviewed by the Administrator.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur;</p> <p>The Administrator and DON received in-service education provided by the VP of Operations on 3/8/14 regarding the requirements of the quality assurance process. The administrator will oversee the QA committee meeting in conjunction with the Director of Nursing, IDT team and Medical Director.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place;</p> <p>Facility administrator will oversee the all of the audits. If issues are identified during the audits, facility will put into place a plan of action or if needed have an additional QA meeting to address trends. The medical director has reviewed all of our audit tools, education and is participating in QA meetings</p>	



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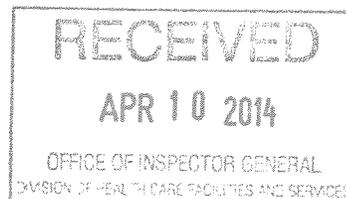
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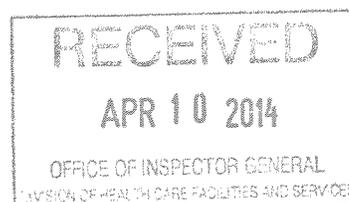
{F 490}	Continued From page 70 03/10/14, as alleged by the facility. 1. Review of the facility's care plan in-service sign in sheets and curriculum for that in-service revealed care plan implementation/revisions training was conducted on 03/09/14 by the facility's Regional Registered Nurse (RN) Consultant. A copy of the sign-in sheet (attendees) was provided which included names of the ADONs, the Staff Development/Infection Control Nurse, and other licensed nurses. Copies of the curriculum included the following policies: Interdisciplinary team care planning process (Dated 12-2010); Interdisciplinary Team Care Assessments (Dated 12-2010); Daily Review of Physician's Orders (Dated 12-2010); and At Risk Meetings (Dated 12-2010). Content of the At Risk Meetings Policy stated the meetings were conducted to focus the Interdisciplinary Team (IDT) on care standards, problem solving, care planning, intervening upon a change in a resident's condition, and communication across the IDT. Further review of documentation from this training revealed care plans of residents with changes in status would be reviewed daily in clinical meetings by the IDT. Any changes deemed necessary would be completed and then care plans would be monitored by the DON, ADONs, and the Minimum Data Set (MDS) nurses. Review, of sign in sheets, training binders, and the post-tests completed by employees revealed infection control re-education began on 03/07/14, immediately after the IJ was identified. Staff that did not work on 03/07/14 received infection control re-education including instruction on isolation precautions, use of PPE, and proper	{F 490}	with the facility weekly. VP of Operations, or the Regional Nurse Consultant will provide oversight daily, Monday - Friday, starting 3/8/14 for one (1) week; then, once per week for four (4) weeks, then monthly for three (3) months and quarterly thereafter. The administrator will oversee the QA process, auditing results and seeking trends that may require additional actions by the QA team.	
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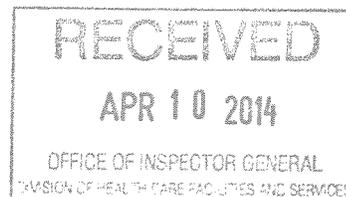
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{F 490}	<p>Continued From page 71</p> <p>handwashing technique upon reporting to work their next scheduled shift. Each staff member who received infection control in-service training was required to prove competency via a written post test, and a return demonstration of proper hand washing technique.</p> <p>The facility had prepared sub-binders that contained documentation of those who attended wound care and medication administration trainings for licensed nurses, and perineal care re-education for licensed nurses, CNAs, and Occupational Therapists (OTs). The binders contained policies and sign-in sheets documenting the attendees.</p> <p>Review of the completed post-tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests fifteen (15) employees received training and were tested on 03/10/14, one (1) staff person was trained/tested on 03/11/14 and one staff person was trained/tested 03/12/14.</p> <p>Interview, on 03/25/14 at 1:30 PM, with the facility's Signature Care RN Consultant, revealed staff that were not trained while on duty on 03/07/14, were required to attend an infection control inservice, take a post test, and perform a return demonstration of proper hand washing technique before reporting to their assigned hallway to work. The Signature Care RN Consultant stated additional in-services were conducted later in the shift for employees which included re-education in proper wound care techniques, perineal care, medication administration, and safe handling of soiled linen.</p>	{F 490}		



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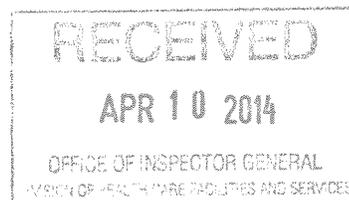
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{F 490}	Continued From page 72 Interview, on 03/26/14 at 10:22 AM, with LPN #2 revealed he attended a care plan inservice 03/08/14-03/09/14 along with several other inservices that related to infection control on the weekend after the IJ was announced on 03/07/14. Interview, on 03/26/14 at 10:12 AM, with RN #2 revealed she had received care plan and infection control in-service education on 03/12/14 after returning from time off from work. RN #2 stated licensed nurses were responsible for educating visitors in consistent use of PPE. Interview, on 03/26/14 at 10:31 AM, with CNA #3 revealed that on 03/08/14 she received re-education on infection control including isolation precautions. CNA #3 stated if she saw a visitor about to enter an isolation room, she would ask them to speak to a unit's nurse before visiting the resident. Observation, on 03/25/14 at 8:30 AM, revealed CNA #4 sanitized her hands and donned appropriate PPE at Isolation Room 326. CNA #4 knocked on the resident's door before carrying in a paper (disposable) tray of breakfast items. Interview, on 03/25/14 at 3:35 PM, with CNA #4 revealed she received infection control re-education after the identified IJ on 03/07/14, which included instruction in isolation precautions and proper hand washing technique. Observation, on 03/26/14 at 11:00 AM, revealed three (3) housekeeping staff persons were wearing PPE while cleaning Room 301 on the Kentucky Pride Hallway where Isolation	{F 490}			



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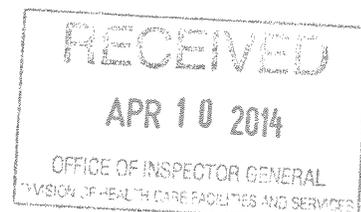
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{F 490}	Continued From page 73 Precautions had been put into effect. Interview, on 03/25/14 at 3:50 PM, revealed Housekeeper #3 received re-education in infection control about two weeks ago and she would don PPE as indicated on the isolation instruction card in the cart before entering the room. She would knock on the resident's door and clean. After completing the tasks she would remove the PPE, place it in the lined barrel in the room, wash her hands at the resident's sink. Housekeeper #3 stated upon cleaning her hands she used a clean paper towel to touch faucet handles. Interview, on 03/25/14 at 4:32 PM, with Laundry Services/House Keeping Staff #5, revealed she was instructed, in handwashing and proper use of PPE while processing soiled linen in the facility's laundry department, on 03/07/14. Laundry Staff Person #5 stated she was instructed to put on a disposable gown, gloves, and goggles when placing the soiled linen/towels/clothing in the washers. Interview, on 03/26/14 at 10:12 AM, with RN #2, revealed, she received infection control education, including hand washing with a required return demonstration, when she reported to work on 03/12/14, after having time off from work. RN #2 stated she understood her role in educating visitors in proper isolation precautions before and during a visit to a resident in isolation. She stated the sign posted on the resident's door directed the visitor(s) to see a nurse for guidance before entering the isolation room. Interview, on 03/25/14 at 3:45 PM, with LPN #1 revealed she was trained on 03/10/14 upon	{F 490}			



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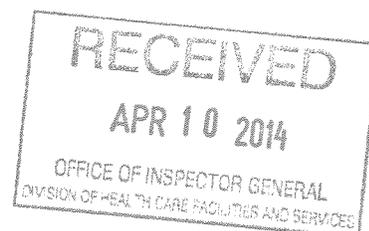
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{F 490}	<p>Continued From page 74</p> <p>reporting to work. She stated she was not allowed to work on her unit until she attended the required infection control inservice, completed a post-test, and demonstrated proper hand washing procedure. LPN #1 stated she received additional infection control in-service education related to resident care later in that day, which were taught by the MDS nurse.</p> <p>Interview, on 03/25/14 with RN #1, revealed she received re-education on 03/11/14, after returning from time off from work. RN #1 stated she was not allowed to report to her unit to work until she had received re-education in infection control, which addressed Isolation Precautions, hand washing, with a required return demonstration.</p> <p>2. Review of the sign in sheets and curriculum in the sub-binder for medication administration training revealed from 03/07/14-03/09/14, Licensed Nurses received medication administration and wound care re-education that included observance of infection control practices. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work.</p> <p>3. Review of the sign in sheets and curriculum in sub binder for perineal (peri) care revealed from 03/07/09- 03/09/14, Licensed Nurses, CNAs, and Occupational Therapists (OTs) were re-educated in peri care. Training was conducted by Nursing Administration and Signature Care RN Consultant. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work.</p> <p>Interview, on 03/25/14 with RN #1, revealed she received re-education on 03/11/14, after returning</p>	{F 490}			



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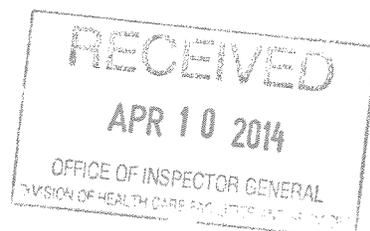
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{F 490}	Continued From page 75 from time off from work. RN #1 stated she was not allowed to report to her unit to work until she had received re-education in infection control, which addressed Isolation Precautions, hand washing (with a required return demonstration). RN #1 stated she was also required to demonstrate competency via a written post test, RN #1 stated she also attended perineal, wound care, and medication administration training later during her shift. Interview, on 03/26/14 at 10:22 AM with LPN #3, revealed he received re-education in infection control immediately upon reporting to work on 03/08/14. LPN #3 stated as soon as he clocked in to work his shift, the DON provided infection control training that included hand washing, linen handling, proper use of PPE, how to treat potentially biohazardous waste, properly sanitizing a glucometer, and other medication pass procedures. Interview, on 03/26/14 at 10:31 AM with CNA #3, revealed she received re-education in infection control on 03/08/14. CNA #3 stated she was not allowed to report to her unit to work until she had an in-service on infection control which included hand-washing with a required return demonstration. CNA #3 stated she noticed many administrative staff were in the building, and she was required to attend other in-services later that day that related to infection control and resident care. 4. Review, of the Care 2 Learn Online Education Infection Control Tests completed by staff revealed infection control re-education began on 03/07/14, immediately after the IJ was identified. Each test revealed the name of the employee and	{F 490}			



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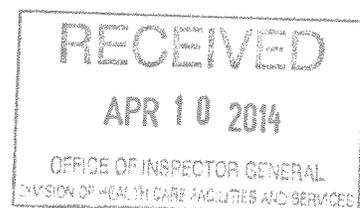
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{F 490}	Continued From page 76 date the test was taken. Staff that did not work on 03/07/14 received infection control re-education including instruction on isolation precautions, use of PPE, and proper handwashing technique upon reporting to work their next scheduled shift. Each staff member who received infection control in-service training was required to prove competency via completion of the multiple choice test questions. A return demonstration of proper hand washing technique was also required before the employees could return to their assigned units. Further review, on 03/25/14, of the dated post tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests, fifteen (15) employees received training and were tested on 03/10/14 and two (2) staff were trained/tested after 03/10/14, due to their scheduled time off from work. None of these employees were allowed to report to their units to work before completing the required training, testing, and return demonstration. 5. Review of the Employee Listing/Signature Payroll Services list provided by the administrator, revealed the facility employed 194 staff members. Interview, on 03/25/14 at 10:15 AM, with the facility's administrator revealed the facility did not employee agency staff. 6. Interview, on 03/25/14 at 1:30 PM, with the Signature Care RN Consultant revealed after the IJ was announced on 03/07/14, and prior to reporting to their assigned units to work, all staff	{F 490}			



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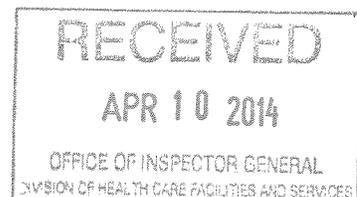
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{F 490}	Continued From page 77 members were required to attend an infection control in-service, complete the Care 2 Learn Infection Control Multiple Choice Test, and demonstrate competency in proper hand washing technique. 7. Interview, on 03/26/14 at 1:00 PM, with the Administrator revealed the facility had no new staff hired from 03/11/14 to 03/26/14. 8. Review, of the Infection Control Monitoring Checklists revealed administrative staff were assigned to monitor infection control compliance three (3) times daily after the identified IJ of 03/07/14. Staff were monitored for observance of Isolation Precautions, skin/wound treatment technique, peri care technique, observance of proper hand hygiene across all facility departments and disciplines, linen handling by nursing and laundry staff, and hand hygiene and eye drop administration during med pass. Review of the Allegation of Compliance book, on 03/25/14 at 11:00 AM, revealed the Infection Control Monitoring Checklists had been completed three times daily on each unit. 9. Review of attendance sheets for the Quality Assurance (QA) inservice training was conducted on by Corporate Vice President on 03/08/14 with the Administrator and DON in attendance. A second QA inservice was held on 03/10/14 by The Regional RN Consultant. The Sign In Sheet revealed twenty-one (21) staff persons were in attendance at this session, which included staff who would be conducting audits and monitoring for infection control policy adherence across all units in the facility. Signatures of the The Staff Development/Infection Control Nurse, the	{F 490}			



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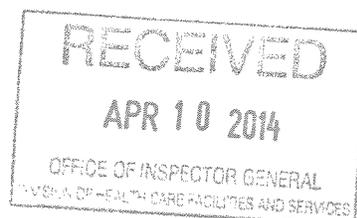
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED R 03/26/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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{F 490}	<p>Continued From page 78</p> <p>Assistant Administrator, the ADON/Unit Managers, other Licensed Nurses, the facility's Registered Dietician (RD), and the Administrator were listed.</p> <p>Review of the AOC revealed the purpose of these meetings was to implement processes for removal of the IJ identified on 03/07/14 during the standard survey, and included implementing procedures to ensure staff adherence to infection control policies and procedures.</p> <p>Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed there was a Quality Assurance (QA) inservice training conducted by Corporate Vice President on 03/08/14 with the Administrator and DON in attendance. He stated a second QA inservice was held on 03/10/14 by The Regional RN Consultant. He further stated the purpose of these meetings was to implement processes for removal of the IJ identified on 03/07/14 during the standard survey, and included implementing procedures to ensure to ensure staff adherence to infection control policies and procedures.</p> <p>10. Review of sign in sheets for Quality Assurance meeting held 03/08/14, after the IJ was identified on 03/07/14. The documentation revealed the purpose of this meeting was to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures. See Item #17 for a list of staff in attendance.</p> <p>In addition, the QA committee met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures. The next QA</p>	{F 490}		



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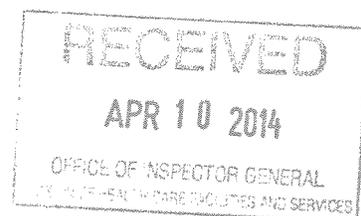
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{F 490}	<p>Continued From page 79 meeting was scheduled for 03/28/14.</p> <p>Interview with the Administrator on 03/26/14 at 1:00 PM revealed the facility had a Quality Assurance meeting on 03/08/14 to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures, and met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures.</p> <p>Interview, on 03/25/14 at 1:30 PM with the facility's Regional RN Consultant revealed she had conducted a QA Process in-service with additional facility staff members on 03/10/14, and a Sign-In Sheet documented members in attendance. In addition, the RN Consultant stated she was in the process of monitoring the QA committee's work per the schedule outlined in the AOC.</p> <p>11. Review of the Quality Assurance Process Training sign in sheet revealed this inservice was held on 03/08/14, and conducted by the the Corporation's Regional Vice President. Copies of the policies reviewed during this meeting were attached and reviewed.</p> <p>12. Review of the facility's Performance Improvement Plan with Abaqis curricula, provided as part of the QA training of 03/08/14, revealed the Administrator was a required member of the facility's Performance Improvement (PI) Committee. The PI Committee would be comprised of the Administrator, along with other administrative staff, and at least two other facility employees. The facility would identify and monitor activities that focus on processes that significantly</p>	{F 490}	



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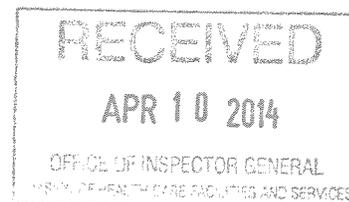
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{F 490}	Continued From page 80 affect resident outcomes. This ongoing monitoring by the Administrator and The Signature Care Consultant would establish the facility's baseline and the predictability of various outcomes. Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed he and The Signature Care Consultant would identify and monitor activities that focus on processes that significantly affect resident outcomes which would establish a baseline and the predictability of various outcomes. Review, on 03/25/14 of the facility's AOC revealed the Administrator met with the administrative team on 03/08/14 to plan for removal of the IJ called on 03/07/14. Persons in attendance included the Medical Director (by phone), the Administrator, the DON, the Staff Development Coordinator, the Nurse Practitioners, the RVP, and The Signature Care Consultant. The AOC revealed infection control check lists and monitoring audits were assigned to the DON, ADONs, other licensed nurses, the Admissions Director, and the Assistant Administrator. Time parameter for re-educating staff on infection control and ensuring competency in the topic was 03/07/13-03/09/13 with alleged compliance on 03/10/14.	{F 490}			
{F 502} SS=D	483.75(j)(1) ADMINISTRATION	{F 502}			



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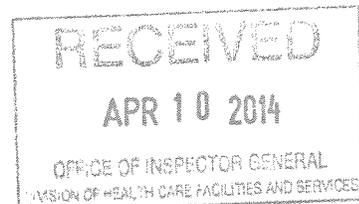
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{F 502}	<p>Continued From page 81</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure a urinalysis was obtained timely for one (1) of twenty-four (24) sampled residents (Resident #20). The staff failed to obtain a urinalysis with culture and sensitivity for Resident #20 on 02/14/14 upon return from the hospital.</p> <p>The findings include:</p> <p>Review of Resident #20's clinical record revealed the facility admitted the resident, on 03/28/13, with the diagnoses of Atrial Fibrillation, Coronary Artery Disease, Hypertension, Angina, Pacemaker, Dementia, and Chronic Obstructive Pulmonary Disease. Review of the Nurse Practitioner notes, dated 02/13/14, revealed the resident continued with complaints of fatigue and weakness. Review of the physician orders written on 02/13/14 revealed an order for a urinalysis (UA) and a culture and sensitivity. However, results of the ordered tests were not in the chart.</p> <p>Interview with the 200 Unit Manager, on 03/06/14 at 2:43 PM, revealed the resident went to the hospital, on 02/14/14, the day after the order was written for complaints of chest pain and he did not think the UA was ever completed.</p> <p>Further review of the clinical record revealed the</p>	{F 502}	<p>F502</p> <p>a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #20 had a urine C&S on 3/7/14 as ordered by physician. Care plan was updated on 3/7/14 by the MDS nurse. Results were reported to the physician on 3/10/14 with new orders noted and care plan updated by MDS nurse.</p> <p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected by this citation. All labs back to 2/1/14 were audited to ensure completion.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Licensed nursing staff has been educated on proper lab</p> <p>3/28/14</p>



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{F 502}	<p>Continued From page 82</p> <p>resident did go out to the hospital on 02/14/14. However, the resident returned to the facility, on 02/14/14 at 2:10 PM. The Urinalysis was not obtained at the hospital.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 03/07/14 at 9:30 AM, revealed the physician should have been notified when the resident returned to the facility to see if they were to still obtain the UA. The LPN revealed although the resident had no symptoms of a UTI, there was a potential for a Urinary Tract Infection (UTI) to go untreated by not collecting the ordered UA.</p> <p>Interview with the Nurse Practitioner, on 03/07/14 at 10:03 AM, revealed she was not notified the UA was never collected. The Nurse Practitioner revealed the facility normally wrote cultures in the lab book and were flagged when resulted.</p> <p>Further interview with LPN #2, on 03/07/14 at 10:04 AM, revealed the facility had a lab log to keep track of what was ordered, for which resident, when the lab was ordered, when the lab was sent, and when the lab was resulted. The LPN revealed the Unit Manager was responsible to monitor the lab log.</p> <p>Interview with the 200 Unit Manager, on 03/07/14 at 10:10 AM, revealed the nurse taking off the orders was responsible to place the order into the lab book and put it into the computer. However, the 200 Unit Manager revealed the order was never put into the computer or in the lab book by the nurse taking off the orders.</p> <p>Interview with the DON, on 03/07/14 at 2:06 PM, revealed all orders were reviewed in the daily clinical meeting. The DON revealed the resident</p>	{F 502}	<p>completion by the staff development coordinator, DON, ADON or RN's on 3/18/14.</p> <p>The director of nursing, Nursing Supervisors and/or Assistant Directors of Nursing will audit the physician orders daily to assure proper lab completion for the first week and then weekly x 12. If any errors are noted, the facility will notify the physician and responsible party. Re-education with the staff member responsible up to termination will occur.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place;</p> <p>The audits by the DON, ADONs, and RNs, will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	



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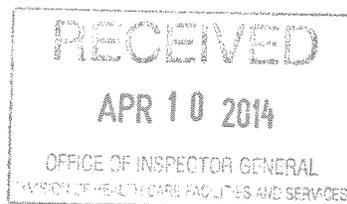
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{F 502}	Continued From page 83 went out to the hospital and they should have made sure the orders for the UA were still current. The DON revealed the lab also did its own review every month and she was not always notified of any concerns discovered during the review. The DON revealed the Nurse Practitioner still wanted a UA on Resident #20 and wrote a new order to ensure it was collected.	{F 502}		
{F 514} SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure physician orders were transcribed accurately to the medical record for one (1) of twenty-four (24) sampled residents (Residents #10). The staff transcribed a duplicate order for Loratadine 10 mg dose daily from 02/24/14 until 03/06/14 on the Medication Administration	{F 514}	F514 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #10 was assessed by the DON on 3/5/14 and no concerns identified. The resident care plan was reviewed and updated for observation of potential side effects. On 3/5/14 the DON notified the physician of resident #10 of the medication duplication and order clarification received. Resident is receiving medication per order. Family notified was notified on 3/5/14 by resident's nurse. b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected by this practice.	3/28/14



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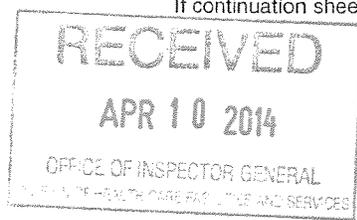
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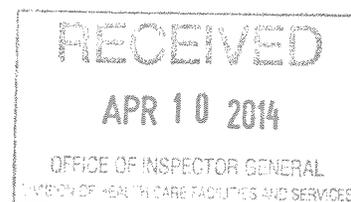
{F 514}	Continued From page 84 Record (MAR). The findings include: Review of the facility's policy titled, Physician's Orders At-A-Glance, not dated, revealed new orders received from the physician or nurse practitioner would be placed on the Medication Administration Record (MAR) by the designated nurse. In addition, copies of new orders were taken to a daily clinical meeting for review. Following the clinical meeting, the DON or designee reviewed the MARs daily for accuracy. Any identified medication administration errors or omissions would be investigated by the DON to determine the root cause of the error or omission. During monthly change over the new MAR was received from pharmacy and compared to the existing MAR by the Director of Nursing (DON) or designate. 1. Review of Resident #10's clinical record revealed the facility admitted the resident, on 05/10/11, with the diagnoses of Hypertension, Reflux, Ureter Stricture, Dementia, Chronic Obstructive Pulmonary Disease, and Atrial Fibrillation. Observation, on 03/05/14 during the morning medication pass on the facility's 200 Hall, revealed Loratadine (antihistamine) 10 milligrams (mg) daily was listed twice on Resident #10's MAR. Registered Nurse (RN) #2 did not open the blister packs for each of the medications she pulled for the resident, but placed them in a small plastic cup. One 10 mg dose of Loratadine was already in the cup, and when RN #2 reached the end of Resident's #10's list of morning medications, Loratadine 10 mg was again listed	{F 514}	c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Licensed nursing staff audited all physician orders and MARs on 3/17/14 for accuracy in transcription and any variances were addressed with physician family notified and care plans updated as appropriate. The Medical Records LPN was reeducated by the corporate nurse on 3/18/14 on critical importance for accuracy when inputting physician orders with emphasis on triple checking each medication entered for accuracy. Licensed nursing staff has been educated on medication administration by the staff development coordinator, DON, ADON or RN on 3/18/14. The director of nursing, SDC, ADON, or RN will audit all new physician orders against the medication administration records daily for accurate transcription daily x 1week and then weekly x 12.	
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{F 514}	<p>Continued From page 85</p> <p>on Resident #10's MAR. RN #2 proceeded to get out another Loratadine 10 mg tab and placed it in the med cup. Two (2) doses of Loratadine 10 mg were now in the medication cup. RN #2 reviewed the MAR, after surveyor intervention, and removed the second blister pack of Loratadine 10 mg from the cup. She stated this was probably an accidental repeat order on the MAR. RN #2 then wrote the word 'repeat' in capital letters out to the side of the second Loratadine 10 mg order. RN #2 stated she would review Resident #10's MD orders to determine the correct dosage of Loratadine to administer to the resident. RN #2 administered only the one dose of the Loratadine 10 mg.</p> <p>Review, on 03/05/14, at 8:35 AM, of Resident #10's MAR revealed that each block of both the Loratadine orders were marked with nurses initials making it appear that Resident #10 had received a double dose of the medication on 03/01/14, 03/02/14, 03/03/14, and 03/04/14.</p> <p>Interview with RN #2, on 03/05/14 at 10:25 AM, revealed she was not aware if the resident received a double dose on the above dates as this was her first time on this medication cart. She reviewed Resident #10's physician orders, spoke to the ADON for 200 Hall and the DON. The RN revealed it was determined Resident #10 had a duplicate order for Loratadine 10 mg daily, and according to the MAR the resident may have been receiving 20 mg of Loratadine daily, instead of the ordered 10 mg daily dose. However, RN #2 did not know if Loratadine 10 mg was originally ordered on 07/16/13, and was again ordered by the Advanced Registered Nurse Practitioner (ARNP) on 02/24/14. The medication was listed twice on the MAR. RN #2 stated upon learning of</p>	{F 514}	<p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place;</p> <p>The audits by the DON, ADON or RNs will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	



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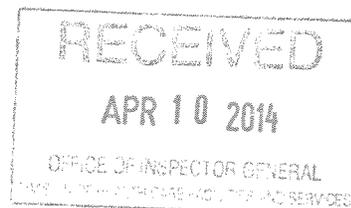
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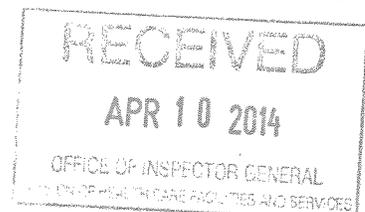
{F 514}	<p>Continued From page 86</p> <p>the duplicate order, the DON assessed Resident #10, the physician was notified, and a clarification order for Loratadine 10 mg was obtained on 03/05/14 at 9:30 AM.</p> <p>RN #2 stated when she sets up a resident's medications, she always double checked the meds against the MAR before administering the medications. She stated she felt she would have caught the duplicate dose of Loratadine before actually administering it to Resident #10.</p> <p>Interview with the 200 Unit Manager, on 03/06/14 at 10:41 AM, revealed new orders were faxed to the pharmacy. A copy of the order was put into the Medical Record's box to be picked up and input the order into the computer system. The 200 Unit Manager revealed he was responsible to compare the old MAR with the new MAR during the monthly change over each month.</p> <p>Interview, on 03/07/14 at 11:50 AM, with the Registered Pharmacist for the facility revealed if a second identical order was faxed to the pharmacy, the computer software would automatically alert the pharmacy staff of the duplication. According to the records he retrieved, he stated the pharmacy discontinued Resident #10's order for Loratadine 10 mg written 07/16/13, when the second order for Loratadine 10 mg was written and sent on 02/24/14.</p> <p>Interview with the Medical Records, on 03/07/14 at 9:42 AM, revealed the pharmacy did not print the MARs, she received the medication orders for all residents and put them into the facility's computer system to print out on the electronically generated MARs. The Medical Records revealed she was able to see all the medications a resident</p>	{F 514}		
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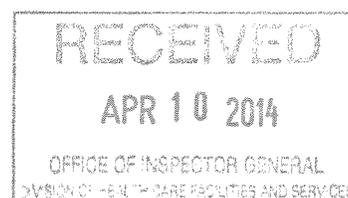
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{F 514}	Continued From page 87 was on at the time the orders were entered. Medical Records personnel revealed she should have noticed the Loratadine 10 mg order for Resident #10 was a duplicate, and should not have put it into the system a second time. Further interview with the 200 Unit Manager, on 03/07/14 at 11:30 AM, revealed she was responsible for checking Resident #10's MAR during the monthly change over and should have caught the duplicate order.	{F 514}		
{F 520} SS=E	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.	{F 520}	F 520 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The Administrator and DON received in-service education provided by the VP of Operations on 3/8/14 regarding the requirements of the quality assurance process. The administrator will oversee the QA committee meeting in conjunction with the Director of Nursing, IDT team and Medical Director. Facility staff across all departments received education on the Quality Assurance process by the SDC, DON, ADON, transitional care nurse or social service director on 3/9/14. As of 3/27/14, facility has inserviced 182 employees with 9 still to be inserviced. A registered letter was mailed to them on 3/21/14 to make them aware of the required training.	3/28/14



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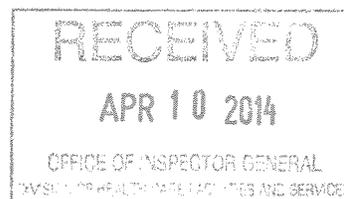
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{F 520}	<p>Continued From page 88</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, review of facility's policy, and the facility's Allegation of Compliance (AOC), it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/07/14, had been removed related to the facility's Quality Assurance (QA) Committee failure to identify quality deficiencies and develop and implement appropriate plans of action to correct identified quality deficiencies. During the 03/07/14 annual survey it was determined the facility received the findings of the mock survey, conducted in January 2014, the third week of February 2014 which identified deficiencies with hand hygiene and wearing of Personal Protective Equipment (PPE). However, the facility had not developed or implemented action plans to correct the identified quality deficiencies.</p> <p>An acceptable AOC was received on 03/20/14 alleging removal of the IJ on 03/10/14. Based on the findings of the revisit, it was determined the IJ was removed on 03/10/14, as alleged, with remaining noncompliance at a scope and severity of an "E" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>The facility provided an Allegation of Compliance (AOC) on 03/20/14 alleging Immediate Jeopardy (IJ) was removed on 03/10/14; the facility took the</p>	{F 520}	<p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents have the potential to be affected by this practice. Every staff member employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions and the use of PPE by the DON, ADONs, SDC, Transitional Care Nurse, RN Supervisors, MDS Nurses on 3/9/14. As of 3/27/14, facility has inserviced 182 employees with 9 still to be inserviced. A registered letter was mailed to them on 3/21/14 to make them aware of the required training. Each licensed nurse was re-educated on the clean dressing change policy and procedure and the policy and procedure for administering eye drops by the DON, ADONs, SDC, Transitional Care Nurse, RN Supervisors, and MDS Nurses</p>



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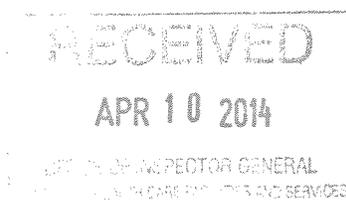
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{F 520}	Continued From page 89 following immediate steps to remove the IJ: 1. Quality Assurance (Ad Hoc) Meeting held on 03/08/14. The purpose of meeting was to ensure all infection control policies were adhered to for removal of the Immediate Jeopardy (IJ) Status. Actions taken: Discussed infection control policies/procedures; investigated root cause of infection control policy infraction; identified tasks necessary to prevent future infection control infractions; and, Department Directives/Assignments made for tasks/interventions to address the current infection control infraction and to prevent future infractions. The Performance Improvement (PI) Plan was reviewed for further recommendations. The PI plan was approved by the QA committee and the Medical Director. 2. The Administrator was to oversee the QA committee meetings in conjunction with the DON, the IDT, the Medical Director, and the VP of Operations. The Regional Nurse Consultant will provide oversight daily x 5 days for one week, then once weekly for 4 weeks, and then monthly for 3 months. 3. The Administrator and DON received in-service education from the VP of Operations on 03/08/14 regarding the requirements for the quality assurance process. In addition, the DON, Staff Development Nurse, ADON, Unit Manager, MDS Nurse, Medical Records, Signature Care Consultant, the RD, and the Certified Dining Manager received training for the QA process, with the identified concerns, on 03/08/14. 4. On 03/08/14, The Administrator met with the administrative team and initiated a process to	{F 520}	from 3-7-14 to 3-8-14. Family member #1 was re-educated on the proper use of PPE and educated on the reason for the need of the PPE by the SDC and the DON on 3/8 and 3/9/2014. Proof of education was reviewed by the Administrator. c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; The Quality Assurance Committee will meet weekly for 4 weeks, and then resume monthly meetings. The QA committee has met 3/8/14, 3/14/14 and 3/18/14. The next meeting is scheduled for 3/28/14. The QA committee and all staff (As of 3/27/14, facility has inserviced 182 employees with 9 still to be inserviced. A registered letter was mailed to them on 3/21/14 to make them aware of the required training) have been reeducated on the QA process on 3/9/14. The results of the mock survey were addressed in the 3/26/14 QA meeting. The areas identified in the mock survey were discussed with the QA team and subsequent plans were established.	



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{F 520}	<p>Continued From page 90</p> <p>introduce, develop, and implement plans for the identified concerns. Concerns were to be addressed daily in the morning meetings, plans were developed, and teams were assigned to correct the concerns. Infection control check lists and monitoring audits were assigned to the DON, ADON, Licensed Nurses, Admissions Director, and the Assistant Administrator, with subsequent evaluation of the plan's effectiveness.</p> <p>5. Findings would be discussed with the QA Committee to determine the need for further recommendations and additional follow-up. The DON would ensure completion of the audits, and follow up as needed. The Administrator would review the findings of the daily infection control audits Sunday through Saturday.</p> <p>On 03/26/14 the State Survey Agency (SSA) verified through observation, interview and record review, removal of Immediate Jeopardy (IJ) on 03/10/14, as alleged by the facility.</p> <p>1. Review of sign in sheets for Quality Assurance meeting held 03/08/14, after the IJ was identified on 03/07/14. The documentation revealed the purpose of this meeting was to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures.</p> <p>In addition, the QA committee met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures. The next QA meeting was scheduled for 03/28/14.</p> <p>Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed the facility had a Quality</p>	{F 520}	<p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place;</p> <p>VP of Operations, or the Regional Nurse Consultant will provide oversight daily, Monday – Friday, starting 3/8/14 for one (1) week; then, once per week for four (4) weeks and then monthly for three (3) months to include oversight of the Quality Assurance Committee meetings. QA minutes will then be sent to the RVP monthly x 6 months or until deemed in compliance by the RVP through review of the QA minutes and process.</p>		



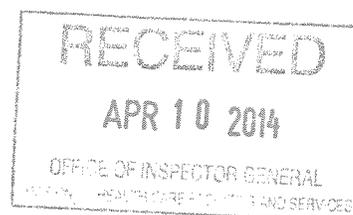
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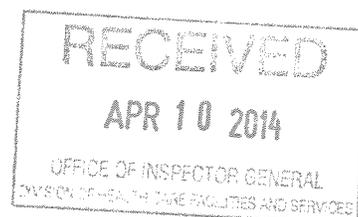
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{F 520}	<p>Continued From page 91</p> <p>Assurance meeting on 03/08/14 to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures, and met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures.</p> <p>Interview, on 03/25/14 at 1:30 PM with the facility's Regional RN Consultant, revealed she had conducted a QA Process in-service with additional facility staff members on 03/10/14, and a Sign-In Sheet documented members in attendance. In addition, the RN Consultant stated she was in the process of monitoring the QA committee's work per the schedule outlined in the AOC.</p> <p>2. Review of sign in sheets for Quality Assurance meeting held 03/08/14, after the IJ was identified on 03/07/14. The documentation revealed the purpose of this meeting was to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures.</p> <p>In addition, the QA Committee met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures. The next QA meeting was scheduled for 03/28/14.</p> <p>The Administrator is to oversee the infection control policy adherence and care plan audit processes to ensure results are forwarded to the QA Committee for weekly then monthly review and assure continued compliance during identified time frames. Interview, on 03/26/14 at 1:00 PM, with the facility's Administrator revealed</p>	{F 520}		



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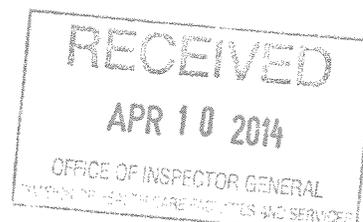
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{F 520}	Continued From page 92 he received the infection control audits and reviewed them with the DON, daily, to ensure proper follow up occurred as indicated. Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed the facility had a Quality Assurance meeting on 03/08/14 to activate processes to remove the IJ with particular emphasis on ensuring the facility adhered to all of its infection control policies and procedures, and met on 03/14/14 and 03/18/14 to review the facility's documentation of compliance with infection control policies and procedures. Interview, on 03/25/14 at 1:30 PM with the facility's Regional RN Consultant, revealed she had conducted a QA Process in-service with additional facility staff members on 03/10/14, and a Sign-In Sheet documented members in attendance. In addition, The RN Consultant stated she was in the process of monitoring the QA committee's work per the schedule outlined in the AOC. 3. Review of the Quality Assurance Process Training sign in sheet revealed this inservice was held on 03/08/14, and conducted by the Corporation's Regional Vice President. Copies of the policies reviewed during this meeting were attached and reviewed. The DON and Administrator attended this inservice. 4. Review of the facility's Performance Improvement Plan with Abaqis curricula, provided as part of the QA training of 03/08/14, revealed the Administrator was a required member of the facility's Performance Improvement (PI) Committee. The PI Committee would be comprised of the Administrator, along with other	{F 520}			



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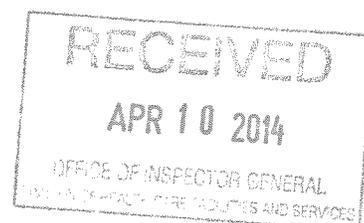
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{F 520}	Continued From page 93 administrative staff, and at least two other facility employees. The facility would identify and monitor activities that focus on processes that significantly affect resident outcomes. This ongoing monitoring by the Administrator and The Signature Care Consultant would establish the facility's baseline and the predictability of various outcomes. Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed he and The Signature Care Consultant would identify and monitor activities that focus on processes that significantly affect resident outcomes which would establish a baseline and the predictability of various outcomes. Interview with Registered Nurse (RN) Consultant, on 03/25/14 at 1:30 PM, revealed she conducted a QA process in-service on 03/10/14 for additional facility employees, and was in the process of monitoring the QA Committee's work by the schedule defined in the AOC. Review, on 03/25/14 of the facility's AOC revealed the Administrator met with the administrative team on 03/08/14 to plan for removal of the IJ called on 03/07/14. Persons in attendance included the Medical Director (by phone), the Administrator, the DON, the Staff Development Coordinator, the Nurse Practitioners, the RVP, and The Signature Care Consultant. The AOC revealed infection control check lists and monitoring audits were assigned to the DON, ADONs, other licensed nurses, the Admissions Director, and the Assistant Administrator. Time parameter for re-educating staff on infection control and ensuring competency in the topic was 03/07/13-03/09/13 with alleged compliance on	{F 520}		



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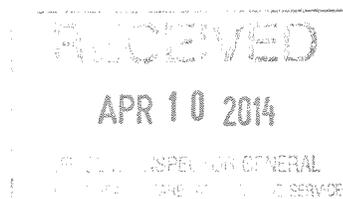
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{F 520}	Continued From page 94 03/10/14. Review of employees' re-education post tests regarding infection control which began on 03/07/14 revealed most staff were trained by 03/09/14. Review of the employees' post tests revealed fifteen (15) employees were trained on 03/10/14, one employee on 03/11/14, and one employee on 03/12/14. None of the employees were allowed to work on their assigned units until they attended the infection control in-service and proved their competency via a written post test and a return demonstration of proper hand washing technique. 5. Review of attendance sheets for the Quality Assurance (QA) inservice training was conducted on by Corporate Vice President on 03/08/14 with the Administrator and DON in attendance. A second QA inservice was held on 03/10/14 by the Regional RN Consultant. The Sign In Sheet revealed twenty-one (21) staff persons were in attendance at this session, which included staff who would be conducting audits and monitoring for infection control policy adherence across all units in the facility. Signatures of the Staff Development/Infection Control Nurse, the Assistant Administrator, the ADON/Unit Managers, other Licensed Nurses, the facility's Registered Dietician (RD), and the Administrator were listed. Review of the AOC revealed the purpose of these meetings was to implement processes for removal of the IJ identified on 03/07/14 during the standard survey, and included implementing procedures to ensure to ensure staff adherence to infection control policies and procedures.	{F 520}			



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{F 520}	<p>Continued From page 95</p> <p>Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed there was a Quality Assurance (QA) inservice training conducted by the Corporate Vice President on 03/08/14 with the Administrator and DON in attendance. He stated a second QA inservice was held on 03/10/14 by the Regional RN Consultant. He further stated the purpose of these meetings was to implement processes for removal of the IJ identified on 03/07/14 during the standard survey, and included implementing procedures to ensure to ensure staff adherence to infection control policies and procedures.</p> <p>Review of the Infection control audits for handwashing, glove changes, cleaning of equipment, eye medication administration, and infection control in the laundry services department revealed they were conducted daily for one (1) week after identification of the IJ on 03/07/14. The audits were to continue weekly for twelve (12) weeks to ensure policy adherence.</p> <p>Review of the audits of the staff members' compliance with the Interdisciplinary Team (IDT)/CNA care plans revealed they were conducted during provision of resident care, daily for thirty (30) days. Any variance to care as planned was addressed immediately with re-education or disciplinary action. Licensed staff completed post-test competency training on IDT and CNA care plans. As of 03/27/14 ninety-five (95) staff had completed the post-test with twenty (20) staff remaining who had not completed the post-test competency.</p> <p>Care plan adherence audits were to continue after the initial daily audits for thirty (30) days, weekly for thirty (30) days, and then as</p>	{F 520}		



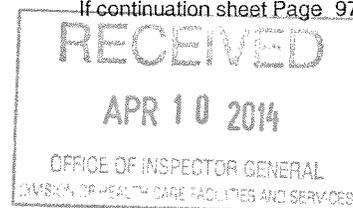
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{F 520}	<p>Continued From page 96 determined by the QA Committee to ensure compliance.</p> <p>The Administrator is to oversee the infection control policy adherence and care plan audit processes to ensure results are forwarded to the QA Committee for weekly then monthly review and assure continued compliance during identified time frames.</p> <p>Interview, on 03/26/14 at 1:00 PM, with the facility's Administrator revealed he received the infection control audits and reviewed them with the DON, daily, to ensure proper follow up occurred as indicated.</p>	{F 520}		



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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: 1973, 1985</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (200)</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 dry sprinkler system.</p> <p>GENERATOR: Type II generator, installed in 1984. Fuel source is Natural Gas.</p>	K 000	<p>Signature HealthCARE of East Louisville does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p> <p>K 029</p> <p>What corrective action will be accomplished for those residents found to have been affected?</p>	3/20/14
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	<p>A standard Life Safety Code survey was conducted on 03/05/14. Signature Health Care of East Louisville was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The facility is certified for one-hundred and twenty-eight (128) beds and the census was one-hundred and eighteen (118) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>		<p>1) Closure device installed on Janitor Closet in kitchen on 3/7/2014.</p> <p>2) Closure device installed on door in outpatient area by 100 hall on 3/7/2014.</p> <p>How will the facility identify other residents that have the potential to be affected?</p> <p>An audit was conducted, by the Regional Director of Plant Operations, on 3/10/2014, for fire door ratings and doors requiring being self closing.</p>	
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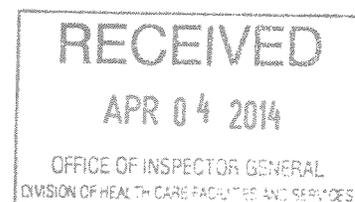
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Administrator	(X6) DATE 4/3/14
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it 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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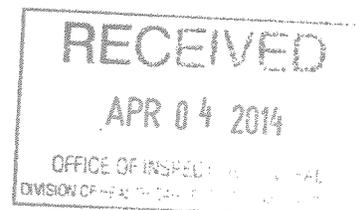
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED 03/05/2014
NAME OF PROVIDER OR SUPPLIER SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000	What measures will be put into place to ensure that the deficient practice will not recur?		
K 029 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of nine (9) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has one-hundred and twenty-eight (128) certified beds and the census was one-hundred and eighteen (118) on the day of the survey. The findings include:	K 029	Education was provided by the Administrator on 3/10/2014, to the Maintenance Director and Maintenance Assistant about the requirement regarding fire rated doors and self closing devices. How the facility will monitor its performance to ensure solutions are sustained. Monthly, the Maintenance Director will audit doors requiring self closures and document on a log. Results from this audit will be presented monthly to the Safety committee for six months. After this time, the audit will be conducted quarterly and results taken to the Safety committee quarterly.		



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K 029	<p>Continued From page 2</p> <p>Observation, on 03/05/14 at 8:57 AM, with the Maintenance Director revealed a room leased by an outpatient facility sharing space within the building, did not have a self-closing device installed on the door. The room was being used to store combustible materials requiring the door to be equipped with a self-closing device. The ceiling had an opening where the sprinkler piping hanger penetrated and was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Interview, on 03/05/14 at 8:57 AM, with the Maintenance Director revealed he was not aware of the room being used to store combustible materials and the penetration in the ceiling.</p> <p>Observation, on 03/05/14 at 9:23 AM, with the Maintenance Director revealed the Janitor Closet located within the Kitchen, did not have a self-closing device installed on the door.</p> <p>Interview, on 03/05/14 at 8:57 AM, with the Maintenance Director revealed he was not aware of the door to the Janitor Closet not being equipped with a self-closing device. The door did display signage for employees to keep the door closed at all times.</p> <p>Interview, on 03/05/14 at 1:45 PM, with the Administrator revealed he was not aware of the room being leased by the outpatient facility sharing space within the building was being used for the storage of combustible materials and the door to the Janitor Closet within the Kitchen not being equipped with a self-closing device.</p> <p>Reference:</p>	K 029		



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K 029	Continued From page 3 NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be	K 029			

