

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

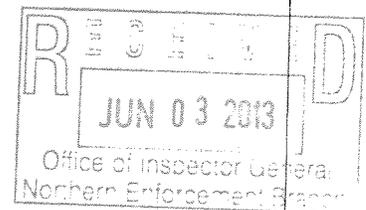
PRINTED: 05/22/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2013
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NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS A standard recertification survey was initiated on 05/13/13 and concluded on 05/15/13 with deficiencies cited at the highest scope and severity of an E. A Life Safety Code survey was initiated and concluded on 05/14/13 with no deficiencies cited. The facility had the opportunity to correct the deficiencies before remedies would be recommended for imposition.	F 000	This plan of correction constitutes Mercy Sacred Heart's credible allegation of compliance for the cited deficiencies. Nothing in this plan of correction should be construed as admission by the facility of any violations of state or federal statutes, regulation, or standards of care. This plan of correction is to demonstrate compliance of the state and federal requirements cited during an annual survey.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	Corrective action for those residents found to have been affected by the deficient practice: 1. The indwelling catheter for Resident # 14 was removed on May 15, 2013.	6/14/13
	This REQUIREMENT is not met as evidenced by:			



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Kim Thelenman TITLE: Executive Director (X6) DATE: 6/1/13

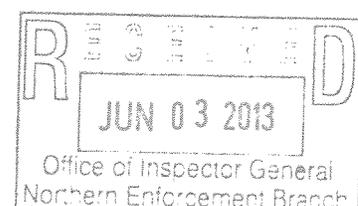
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

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F 280	<p>Continued From page 1</p> <p>Based on observation, interview, record review and facility policy review, it was determined the facility failed to develop a care plan for one (1) of nineteen (19) sampled residents and eight (8) unsampled residents. (Resident #14). The facility staff failed to develop a care plan to address the use of an indwelling catheter for Resident #14.</p> <p>Refer to F315 and F441.</p> <p>The findings include:</p> <p>Review of the facility's Care Plan Policy, revised 04/10, revealed the comprehensive care plan was based on a thorough assessment that included, but was not limited to, the Minimum Data Set (MDS). Assessments of residents were on going and care plans were revised as information about the resident and the resident's condition changed.</p> <p>Review of Resident #14's clinical record revealed the facility admitted the resident on 11/19/12 with a diagnosis of Urinary Tract Infection (UTI). Further review revealed the facility sent Resident #14 to the hospital on 04/04/13 for 5 hours, related to a fall, the hospital placed an indwelling catheter for a UTI and then sent Resident #14 back to the facility.</p> <p>Observations of Resident #14, on 05/14/13 at 3:44 PM, on 05/14/13 at 4:45 PM and on 05/15/13 at 9:10 AM, revealed Resident #14 had an indwelling catheter that was attached to his/her bed and was placed in a dignity bag.</p> <p>Review of Resident #14's care plan revealed there was no care plan for an indwelling catheter. Review of the 500 Unit Assignment Sheet</p>	F 280	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> 1. An audit of care plans was completed for all residents with indwelling catheters. Updates to the care plans were made as needed. 2. An audit of 100% of all other residents was completed checking that no other residents had indwelling catheters in place. <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. The Readmission Checklist form was revised to include checking for indwelling catheter presence, orders, and care plans updates. (Exhibit A) 2. The "Admission/Readmission of a Resident" policy was reviewed and revised. (Exhibit B) 3. The "Care Plans-Preliminary" and the "Care Plans-Comprehensive" policies were reviewed. (Exhibit C) 	



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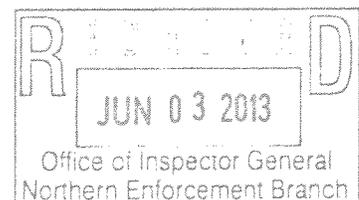
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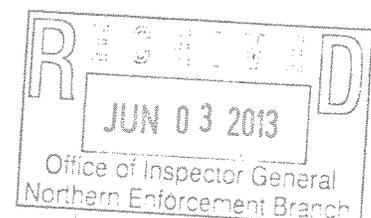
F 280	<p>Continued From page 2 revealed Resident #14 was continent of bladder and bowel and no indwelling catheter was addressed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/15/13 at 2:47 PM, revealed he was the nurse who took report for Resident #14 when he/she came back to the facility on 04/04/13. LPN #2 stated Resident #14 returned with an indwelling catheter in place and did not update the care plan, because the nurse managers always updated the care plan. LPN #2 stated the only care plan he updated was the fall care plan.</p> <p>Continued review revealed there was no assessment of the indwelling catheter completed by LPN #2 when Resident #14 came back to the facility on 04/04/13.</p> <p>Interview with the Unit Manager of the 500 unit, on 05/15/13 at 12:03 PM, revealed she was not aware Resident #14 had an indwelling catheter. The Unit Manager stated she became aware of resident changes by looking at physician orders and talking with the staff. The Unit Manager stated she updated the care plans and all nurses could update the care plan as well.</p> <p>Continued interview with the Unit Manager of the 500 unit, on 05/15/13 at 3:18 PM, revealed it was every ones responsibility to update the care plans.</p> <p>Interview with the Director of Nursing (DON), on 05/15/13 at 3:41 PM, revealed all staff update the care plans, this includes the nurses and the Minimum Data Set (MDS) staff. The DON stated there should have been a care plan for Resident</p>	F 280	<p>4. An "Indwelling Catheters" policy was developed. (Exhibit D).</p> <p>5. All nurses will be educated on the changes to the Readmission Checklist and the "Admission/Readmission of a Resident", "Care Plans-Preliminary", "Care Plans-Comprehensive", and "Indwelling Catheters" policies.</p> <p>6. Orders and care plans of all readmissions and new admissions will be reviewed and audited by the clinical team at morning meetings or by Nurse Manager within 72 hours of admission/readmission.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. The Nurse Manager or Director of Nursing will check orders and care plans of all readmissions and new admissions and document any issues. This audit will be reviewed by the Director of Nursing or Nurse Manager weekly for four weeks, monthly for three months, and quarterly for the remainder of one year.</p>	
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F 280	Continued From page 3 #14. The DON stated they have care plans to direct, monitor and communicate the care of the residents from nurse to staff.	F 280	2. All findings will be reviewed and analyzed then reported to the CQI Committee.	
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to have a medical justification for the use of an indwelling catheter for one (1) of nineteen (19) sampled residents and eight (8) unsampled residents. (Resident #14). The findings include: No policy was provided by the facility. Review of Resident #14's clinical record revealed the facility admitted the resident on 11/19/12 with a diagnosis of Urinary Tract Infection (UTI). Further review revealed the facility sent Resident #14 to the hospital on 04/04/13 for 5 hours, related to a fall, the hospital placed an indwelling catheter for a UTI and then sent Resident #14	F 315	Corrective action for those residents found to have been affected by the deficient practice: 1. The indwelling catheter for Resident # 14 was removed on May 15, 2013. How the facility identified other residents having the potential to be affected by the same deficient practice: 1. An audit of orders was completed for all residents with indwelling catheters. Orders were obtained or clarified as needed. 2. An audit of 100% of all other residents was completed checking that no other residents had indwelling catheters in place.	6/14/13



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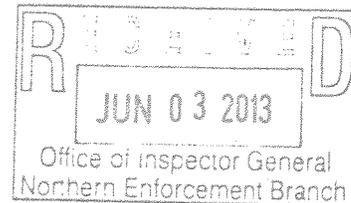
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F 315	<p>Continued From page 4 back to the facility.</p> <p>Observations of Resident #14, on 05/14/13 at 3:44 PM, on 05/14/13 at 4:45 PM and on 05/15/13 at 9:10 AM, revealed Resident #14 had an indwelling catheter that was attached to his/her bed and was placed in a dignity bag.</p> <p>Review of Resident #14's orders, signed 04/30/13, revealed there was no order for an indwelling catheter.</p> <p>Review of the Physicians Progress notes, dated 04/09/13 at 10:37 AM, revealed to the staff were to discontinue the indwelling catheter as soon as there was an overall improvement in the resident.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 05/15/13 to 12:05 PM, revealed she was not aware there was no order for Resident #14 to have an indwelling catheter.</p> <p>Continued interview with LPN #2, on 05/15/13 at 2:47 PM, revealed he was the one who took report when Resident #14 came back to the facility on 04/04/13. LPN #2 stated when Resident #14 came back from the hospital, Resident #14 was screaming when he/she was touched on his/her hip, that was the reason why he thought the catheter was kept in place. LPN #2 stated he did remember the Doctor coming in to see Resident #14 and thought the Doctor would discontinue the indwelling catheter. LPN #2 stated he should have called the Doctor when Resident #14 came back to the facility for an order to remove the indwelling catheter. LPN #2 stated Resident #14 could become dependent on the catheter and could set up an infection if the</p>	F 315	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. The Readmission Checklist form was revised to include checking for indwelling catheter presence, orders, and care plans. (Exhibit A) 2. The "Admission/Readmission of a Resident" policy was reviewed and revised. (Exhibit B) 3. An "Indwelling Catheters" policy was developed. (Exhibit D) 4. All nurses will be educated on the changes to the Readmission Checklist and the "Admission/Readmission of a Resident" and "Indwelling Catheters" policies. 5. Orders and care plans of all readmissions and new admissions will be reviewed and audited by the clinical team at morning meetings or by Nurse Manager within 72 hours of admission/readmission. 6. The Nurse Manager will audit care plans and orders for any in-house resident who has a new order for an indwelling catheter. 	
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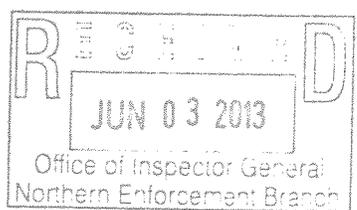
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F 315	<p>Continued From page 5 indwelling catheter remained in place.</p> <p>Interview with the Unit Manager of the 500 hall, on 05/15/13 at 12:03 PM, revealed she was not aware Resident #14 had an indwelling catheter. The Unit Manager stated the Doctor should have wrote the order for Resident #14 to continue to have the indwelling catheter. The Unit Manager stated Resident #14 did not have a diagnosis of Retention, so the indwelling catheter should have been removed.</p> <p>Continued interview with the Unit Manager of the 500 hall, on 05/15/13 at 3:18 PM, revealed she would not want to keep a catheter in a resident without a diagnosis because it was an open access to the body. The Unit Manager stated she had had no concerns with the doctor forgetting to write orders.</p> <p>Interview with the Director of Nursing (DON), on 05/15/13 at 3:41 PM, revealed she was aware Resident #14 had an indwelling catheter on the weekend of 05/11 - 05/12/13. The DON stated she asked the nurse working that weekend to obtain the order to remove the catheter and was shocked when she found out the order was not obtained. The DON stated she would not want a catheter to stay in because it was a source for an infection and it could be uncomfortable for the resident. The DON stated there should have been a clarification with the doctor and there should have been an order for the indwelling catheter.</p>	F 315	<p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <ol style="list-style-type: none"> 1. The Nurse Manager or Director of Nursing will check orders and care plans of all readmissions and new admissions and document any issues. This audit will be reviewed by the Director of Nursing or Nurse Manager weekly for four weeks, monthly for three months, and quarterly for remainder of one year. 2. All findings will be reviewed and analyzed then reported to the CQI Committee. 	
F 368 SS=E	<p>483.35(f) FREQUENCY OF MEALS/SNACKS AT BEDTIME</p> <p>Each resident receives and the facility provides at least three meals daily, at regular times</p>	F 368		



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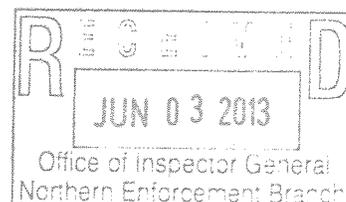
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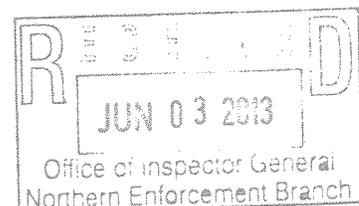
F 368	<p>Continued From page 6</p> <p>comparable to normal mealtimes in the community.</p> <p>There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except as provided below.</p> <p>The facility must offer snacks at bedtime daily.</p> <p>When a nourishing snack is provided at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span, and a nourishing snack is served.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to offer nighttime (HS) snacks to those residents not receiving a physician ordered snack on four (4) of four (4) halls. The 300, 400, 500 and 600 halls.</p> <p>The findings include:</p> <p>Review of the facility's Snack policy, dated 08/17/11, revealed HS snacks would be offered by nursing. Serving Procedure: all snacks, including resident specific, would be served to the residents by nursing.</p> <p>Observation, on 05/14/13 at 3:30 PM, revealed a resident was observed to take a snack from a tray that had another residents name on it. The staff member informed the resident he/she was</p>	F 368	<p>F 368</p> <p>Corrective action for those residents found to have been affected by the deficient practice:</p> <p>1. All residents on the 300, 400, 500, and 600 halls are now being offered snacks at bedtime daily.</p> <p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All residents without a physician ordered snack had the potential to be affected. Snacks are now being offered at bedtime daily to all residents.</p>	6/14/13
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F 368	<p>Continued From page 7 not allowed to eat the snacks on the tray.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 05/14/13 at 4:06 PM, revealed he only passed out snacks to the residents who had orders for the snacks. CNA #3 stated the kitchen was responsible to determine who received snacks. CNA #3 stated he had never walked around and offered snacks to every resident.</p> <p>Interview with the Lead Cook, on 05/15/13 at 3:35 PM, revealed he set up the HS snacks at night for the bedtime snack. The Lead Cook stated that when he placed the HS snacks at the stations, he placed all the ordered snacks and a baggy of cookies. The Lead Cook stated he also placed an extra six drinks out on a tray for additional residents that may ask for a drink. The Lead Cook stated there was not enough snacks put out on the tray to offer all residents a snack at night. The Lead Cook stated he knew there was no staff walking around at night ensuring all residents were offered a snack. There was no cart set up for staff to pass snacks to all the residents at night.</p> <p>Interview with the Dietary Manager, on 05/15/13 at 3:33 PM, revealed she had placed HS snacks out at night before and would come back in the morning and see the same snacks sitting out on the counter, untouched and knew the residents were not offered any snacks. The Dietary Manager stated she knew there was a bag of cookies set out and felt it was not enough to provide all residents on the unit a snack.</p> <p>Interview with Licensed Practical Nurse (LPN) #2,</p>	F 368	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. A bedtime snack program has been implemented to include a spread sheet for documenting offering of a snack. (Exhibit E). 2. All nursing and dietary staff will be educated on the bedtime snack program and "Snacks" policy. 3. The "Snacks" policy was reviewed and revised. (Exhibit F) 		



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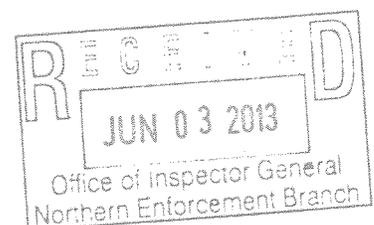
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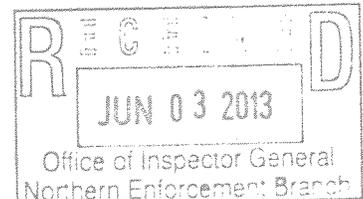
F 368	Continued From page 8 on 05/15/13 at 2:47 PM, revealed he had worked night shift before and HS snacks was not offered to all of the residents, just the residents with ordered snacks were provided by staff. Interview with the Unit Manager of the 500 and 600 hall, on 05/15/13 at 3:18 PM, revealed she was not aware if the staff were offering snacks to the residents. The Unit Manager stated she knew there was no one who walked around offering HS snacks to residents. Interview with the Unit Manager of the 300 and 400 halls, on 05/15/13 at 4:53 PM, revealed there were no staff who walked around to offer HS snacks on the halls. The Unit Manager stated there were snacks available for residents. The Unit Manager stated she was not aware that the facility policy stated the nursing staff would be offering snacks. Interview with the Director of Nursing (DON), on 05/15/13 at 3:41 PM, revealed she was not aware that residents were not being offered HS snacks. The DON stated the facility had snacks that were available. The DON further stated she was not aware their policy stated they were to offer snacks to residents.	F 368	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. The Nurse Manager, Director of Nursing, or Staffing Coordinator will complete a physical audit of bedtime snacks being offered weekly for four weeks, monthly for three months, and quarterly for the remainder of one year. 2. The Nurse Manager or Director of Nursing will audit the bedtime snack spreadsheets weekly for four weeks, monthly for three months, and quarterly for the remainder of one year. 3. All findings will be reviewed and analyzed then reported to the CQI Committee.	
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions	F 371	Corrective action for those residents found to have been affected by the deficient practice: 1. Sampled Residents #11 and #15 and Unsampled Residents A and H are now being served food under sanitary conditions.	6/14/13



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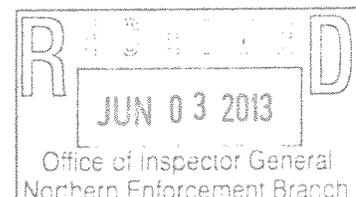
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/15/2013	
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F 371	<p>Continued From page 9</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to distribute and serve food under sanitary conditions for two (2) of nineteen (19) sampled residents and two (2) of eight (8) unsampled residents. Two (2) Certified Nursing Assistants (CNAs) were observed touching food with their bare hands for Sampled Residents #11 and #15, and Unsampled Residents A and H.</p> <p>The findings include:</p> <p>The facility did not provide a copy of a policy for proper handling of food during meal service.</p> <p>Observation, on 05/14/13 at 12:20 PM, revealed CNA #2 delivered the meal tray to Resident #15 and touched the top of the hamburger bun while asking the resident if he/she wanted the sandwich cut in half.</p> <p>Observation, on 05/14/13 at 12:25 PM, revealed CNA #2 delivered the meal tray to Resident #11 and picked up the top portion of the bun with her bare hands to position it over the lettuce and tomato.</p> <p>Observation, on 05/15/13 at 12:20 PM, revealed CNA #1 picked up the slice of bread on Resident #15's tray with her bare hands to apply butter and slice the bread in half.</p>	F 371	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All residents who are served food had the potential to be affected. Food is now served under sanitary conditions.</p> <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <p>1. All staff will be educated on infection control procedures specifically on serving of food to residents under sanitary conditions and the "Proper Handling of Food During Meal Service" policy.</p> <p>2. A skills check will be completed on proper handling of food during meal service for all staff assigned on a routine basis to 600 Unit. The skills check will be completed on other staff on a random basis. (Exhibit G)</p> <p>3. A "Proper Handling of Food During Meal Service" policy was developed. (Exhibit H)</p>	



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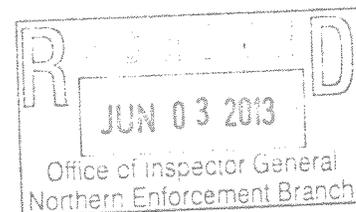
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F 371	Continued From page 10 Observation, on 05/15/13 at 12:25 PM and 12:28 PM revealed CNA #1 again used her bare hands to pick up and prepare the bread slices on the meal trays belonging to Unsampled Residents A and H. Interview, on 05/15/13 at 12:40 PM, with CNA #1 revealed she had not received instruction on not touching residents' food with her bare hands, but she stated touching food with her bare hands could increase the risk of spreading germs to the residents. Interview, on 05/15/13 at 3:05 PM, with the Director of Nursing (DON) revealed it was her expectation that staff would never touch the residents' food with their bare hands. For example, while setting up a meal tray, the staff member(s) should be aware of how to use utensils such as a fork to stabilize the bread while applying butter with a knife. The DON stated that she, along with other administrative staff monitored dining rooms and hallway tray passes weekly to identify potential breaks in infection control.	F 371	How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Nurse Manager, Director of Nursing, Staffing Coordinator or MDS Coordinator will audit meal service during room tray passing weekly for four weeks, monthly for three months, and then quarterly for the remainder of one year. 2. Manager on Duty on the weekends will audit meal service in the dining room weekly for four weeks, monthly for three months and then quarterly for the remainder of one year. 3. All findings will be reviewed and analyzed then reported to the CQI Committee.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections	F 441		



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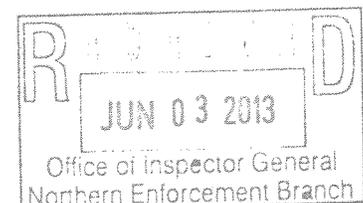
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F 441	<p>Continued From page 11 in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to follow their Infection Control Program to help prevent the development and transmission of disease and infection, for three (3) of nineteen (19) sampled residents and seven (7) of eight (8) unsampled residents. The facility's Certified Nurse Assistant (CNA) did not sanitize her hands between trays passed for sampled</p>	F 441	<p>F 441</p> <p>Corrective action for those residents found to have been affected by the deficient practice:</p> <p>1. Sampled Residents #11 and #15 and Unsampled Residents A, B, C, D, E, F, and G are now being served food following Infection Control protocol to prevent the development and transmission of disease and infection.</p> <p>2. The indwelling catheter for Resident # 14 was removed on May 15, 2013.</p>	6/14/13	



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F 441	<p>Continued From page 12</p> <p>Residents #11 and #15, and Unsampled Residents A,B,C, D, E, F, and G. In addition, the facility staff contaminated the indwelling catheter of Resident #14 during catheter care.</p> <p>The findings include:</p> <p>1. Review of the facility's Handwashing policy (undated), revealed all staff should wash their hands frequently and appropriately, and waterless hand cleaning products such as alcohol based gels and foam rinses were acceptable alternatives in certain instances. The policy further revealed the staff should wash/sanitize hands before/after preparing/serving meals, drinks, etc., before and after having direct physical contact with residents, and after touching dirty equipment.</p> <p>Observation, on 05/14/13 at 12:20 PM, revealed Certified Nursing Assistant (CNA) #2 took meal trays into nine (9) resident's rooms and assisted the residents with tray set up. This involved moving items off over-bed tables, moving a trash can closer to the bed for Unsampled Resident D, and assisting residents with repositioning. CNA #2 did not wash or sanitize her hands after leaving any of the sampled and unsampled residents' rooms or before obtaining the next tray to be passed.</p> <p>Interview, on 05/14/13 at 3:40 PM, with CNA #2 revealed she could not remember any instruction on using hand sanitizer or washing her hands between passing meal trays. She stated she sanitized her hands once before beginning the tray pass, but stated she should have used hand sanitizer after delivering each tray. CNA# 2 stated</p>	F 441	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <p>1. All residents who are served food had the potential to be affected. Food is now served following Infection Control protocol to prevent the development and transmission of disease and infection.</p> <p>2. All residents with indwelling catheters had the potential to be affected. Catheter care is now being provided following Infection Control protocol to prevent the development and transmission of disease and infection.</p>		



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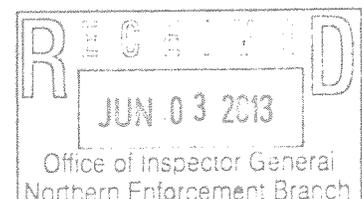
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F 441	<p>Continued From page 13</p> <p>she could not remember exactly when she was last in-serviced on hand hygiene and other infection control procedures, but thought she had received an infection control in-service upon hire, about one year ago.</p> <p>CNA #2 stated the problem with not sanitizing her hands between tray passes or after touching contaminated surfaces would be the potential for cross-contamination and the spread of infections to other residents and staff.</p> <p>Interview, on 05/15/13 at 10:35 AM, with the 600 Hall Nurse Manager revealed she expected staff, at a minimum, to use hand sanitizer to clean their hands between each tray pass and after direct contact with potentially contaminated surfaces. The 600 Hall Nurse Manager further revealed staff should wash their hands with soap and water, when they were visibly soiled and she stated staff hand hygiene/infection control in-services occurred upon hire, at least quarterly, and whenever breaks in infection control were identified. The 600 Hall Nurse Manager further stated the problem with not sanitizing or washing hands between each tray passed would be the potential for transmitting infections.</p> <p>Interview, on 05/15/13 at 3:05 PM, with the Director of Nursing (DON) revealed she expected direct care staff to consistently observe infection control processes which included proper hand hygiene. The DON stated it was common practice to sanitize hands between tray passes, and she, along with other administrative staff monitored dining rooms and hallway tray passes weekly to identify potential breaks in infection control.</p>	F 441	<p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. All staff will be educated on infection control procedures specifically on serving of food to residents under sanitary conditions and the "Proper Handling of Food During Meal Service" policy. 2. All C.N.A.'s will be educated on infection control procedures and proper catheter/perineal care. 3. A skills check will be completed on proper handling of food during meal service for all staff assigned on a routine basis to 600 Unit. The skills check will be completed on other staff on a random basis. (Exhibit G) 4. A skills check will be completed on catheter/perineal care for 25% of all full time C.N.A.'s. (Exhibit I) 5. A "Proper Handling of Food During Meal Service" policy was developed. (Exhibit H) 6. The "Hand Washing" policy was reviewed and revised. (Exhibit J) 	
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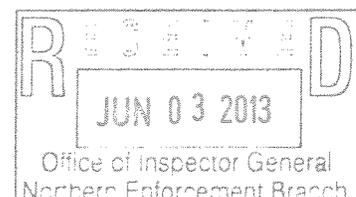
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F 441	Continued From page 14 2. Review of Resident #14's clinical record revealed the facility admitted the resident on 11/19/12 with a diagnosis of Urinary Tract Infection. Observation of Resident #14, on 05/14/13 4:45 PM, revealed the resident had an indwelling catheter bag attached to his/her bed frame. The catheter was noted in a dignity bag. Observation of indwelling catheter care completed by Certified Nursing Assistant (CNA) #4, on 05/15/13 at 11:39 AM, revealed CNA #4 donned gloves and pulled four perineal care wipes from the package. CNA #4 then applied perineal wash to Resident #14's perineal area. CNA #4 dropped the perineal wipes onto the floor, picked them up with the same gloved hands and discarded the perineal wipes in the garbage can. CNA #4 then pulled more perineal wipes and proceeded to clean Resident #14 from front to back. CNA #4 did not remove her gloves or wash her hands after she picked up the perineal wipes from the floor. Interview with CNA #4, on 05/15/13 at 2:50 PM, revealed she did not recognize she had not washed her hands or changed her gloves after picking up the wipes from the floor. CNA #4 stated she had had no hands-on education since she was hired two (2) years ago. CNA #4 stated	F 441	7. The "Perineal Care" policy which addresses catheter care was reviewed. (Exhibit K) How the facility plans to monitor its performance to ensure that solutions are sustained: 1. Nurse Manager, Director of Nursing, Staffing Coordinator or MDS Coordinator will audit meal service during room tray passing weekly for four weeks, monthly for three months, and then quarterly for the remainder of one year. 2. Manager on Duty on the weekends will audit meal service in the dining room weekly for four weeks, monthly for three months and then quarterly for the remainder of one year. 3. Nurse Manager, Director of Nursing or Staffing Coordinator will audit catheter/perineal care on 25% of C.N.A.'s monthly for three months and then quarterly for the remainder of one year. 4. All findings will be reviewed and analyzed then reported to the CQI Committee.	
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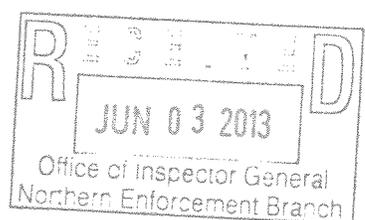
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F 441	Continued From page 15 she should have washed her hands and changed her gloves to prevent the spread of infection to the resident. Interview with Licensed Practical Nurse (LPN) # 2, on 05/15/13 at 2:47 PM, revealed picking up wipes off the floor would be considered dirty and CNA #4 should have washed her hands and donned new gloves when providing perineal care to Resident #14. LPN #2 stated nursing staff wash their hands to prevent the spread of infection. Interview with the Unit Manager, on 05/15/13 at 3:18 PM, revealed it was her expectation that CNA #4 should have washed her hands. The Unit Manager stated she did not have a system for monitoring her staff; however, when she helped with providing care she monitored the staff then. The Unit Manager further stated the nursing staff wash their hands to prevent the spread of infection.	F 441		
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing	F 463	F 463 Corrective action for those residents found to have been affected by the deficient practice: 1. Emergency call light system will be added to the two bathrooms accessible to all residents in the main Chapel lobby on the second floor.	6/28/13



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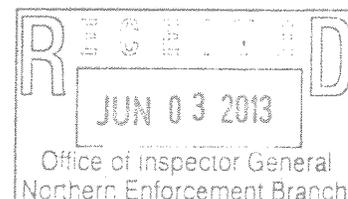
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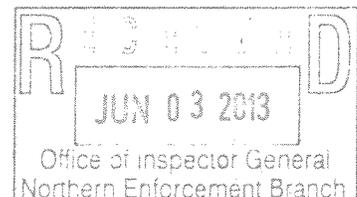
F 463	<p>Continued From page 16 facilities.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and facility policy review, it was determined the facility failed to provide an emergency call light system in two (2) of two (2) bathrooms accessible to all residents in the main Chapel lobby on the second (2nd) floor.</p> <p>The findings include: The facility did not provide a policy for emergency call lights.</p> <p>Observation, on 05/15/13 at 11:00 AM, revealed one (1) unidentified female resident exit the women's bathroom located on the second (2nd) floor main Chapel lobby.</p> <p>Observation, on 05/15/13 at 2:45 PM, of the second (2nd) floor main Chapel lobby revealed it had resident accessible bathrooms. The bathrooms were not equipped with an emergency call light systems. The two bathrooms were identified as one for men and one for women.</p> <p>Interview with the Director of Maintenance, on 05/15/13 at 3:00 PM, during the Environmental tour of the second (2nd) floor of the main Chapel lobby revealed the emergency call system was not installed in the bathrooms. He reported an emergency call light system was not installed when the bathrooms were opened for resident use.</p>	F 463	<p>How the facility identified other residents having the potential to be affected by the same deficient practice:</p> <ol style="list-style-type: none"> 1. All residents who use the bathrooms in the main Chapel lobby on the second floor had the potential to be affected. Emergency call light system will be added to the two bathrooms accessible to all residents in the main Chapel lobby on the second floor. 2. An audit of all bathrooms accessible to residents was completed to identify any others without emergency call light systems. No other issues found. <p>Measures put into place or systemic changes made to ensure the deficient practice will not recur:</p> <ol style="list-style-type: none"> 1. Emergency call light system will be added to the two bathrooms accessible to all residents in the main Chapel lobby on the second floor. 	
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F 463	Continued From page 17 Interview with the Administrator, on 05/15/13 at 3:50 PM, during the Environmental tour of the second (2nd) floor main Chapel lobby revealed the emergency call system was not installed in the bathrooms. She stated she was not aware the bathrooms did not have an emergency call system. She stated they opened these bathrooms when they closed the other set of bathrooms closer to the main Chapel. She reported there was not a policy on the call lights located in the bathrooms.	F 463	<p>2. Residents will be informed of addition of emergency call light system in these bathrooms at Resident Council meetings in June.</p> <p>3. Staff will be informed of addition of emergency call light system in these bathrooms at Staff and/or Town Hall meetings in June.</p> <p>How the facility plans to monitor its performance to ensure that solutions are sustained:</p> <p>1. Maintenance staff will check proper working condition of the emergency call light system in the bathrooms in the main Chapel lobby on the second floor weekly for four weeks, monthly for three months, and quarterly for the remainder of one year.</p> <p>2. All findings will be reviewed and analyzed then reported to the CQI Committee.</p>		



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185442	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/14/2013	
NAME OF PROVIDER OR SUPPLIER SACRED HEART VILLAGE		STREET ADDRESS, CITY, STATE, ZIP CODE 2120 PAYNE STREET LOUISVILLE, KY 40206		
(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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1999, 2008</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type V Protected.</p> <p>SMOKE COMPARTMENTS: Ten (10) smoke compartments.</p> <p>FIRE BARRIER: The non-certified facility and the Skilled Nursing Facility were separated by a two-hour fire barrier.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic sprinkler systems. Dry System in the attic space and exterior and a Wet System in the interior..</p> <p>GENERATOR: Two (2) Type II generators. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 05/14/13. Sacred Heart Village was found to be in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire).</p>	K 000		

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

TITLE

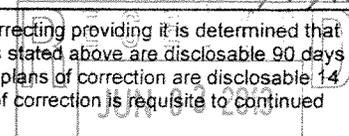
(X6) DATE

Ken T. [Signature]

EO

6/1/13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that the 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.



Office of Inspector General

Not a continuation sheet Page 1 of 2

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

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