

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

PRINTED: 01/30/2014  
FORM APPROVED  
OMB NO. 0938-0391

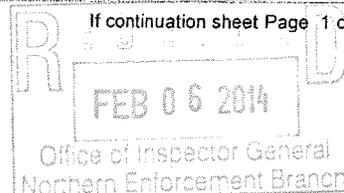
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/16/2014
NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A standard health survey was initiated on 01/14/14 and concluded on 01/16/14 with deficiencies cited at the highest scope and severity of an "F". KY21155 was investigated during the standard survey and was unsubstantiated with no deficiency cited. A Life Safety Code survey was conducted on 01/14/14 with no deficiencies cited.	F 000	F000 This plan of correction is prepared and executed because it is required by the provisions of State and Federal law and not because Summerfield Health and Rehabilitation Center agrees with the citations noted on the pages of this Statement of Deficiencies.		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain twelve (12) of forty-eight (48) wheelchairs used by residents in a sanitary and safe manner. Wheelchair arm coverings were observed frayed, torn, or missing during lunch meal service on 01/15/14.  The findings include:  The facility did not provide a policy specific for maintaining wheelchairs. The facility utilized work order forms to request repairs of the maintenance department whenever a wheelchair was in need of repair.  Observation of wheelchair arms during lunch service on 01/15/14 at 11:50 AM revealed twelve (12) of forty-eight (48) wheelchairs with arms	F 253	F 253  1. The Director of Maintenance and Senior Maintenance Assistant have serviced the 12 chairs referenced for with this deficiency, including replacement of the arm pads, to ensure they are fit for use in a sanitary and safe manner.  2. The facility has 125 wheelchairs available for service. All of these will be inspected by the Director of Maintenance and the Senior Maintenance Assistant. All needed repairs will be completed to ensure the wheelchairs are fit for use in a sanitary and safe manner and will be completed by February 17, 2014. On February 5, 2014, the Director of Maintenance, Director of Housekeeping, and Administrator will review the previous month's room inspections, safety checklists, preventative maintenance program, Are You Ready for Company checklist,	February 18, 2014	

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

TITLE

(X6) DATE

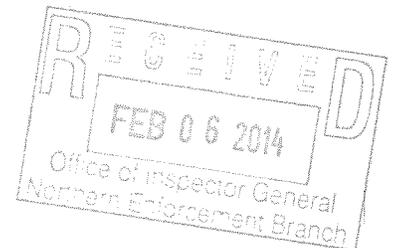
X *[Signature]* X *Adm. v. st. int.* X 2/6/14  
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



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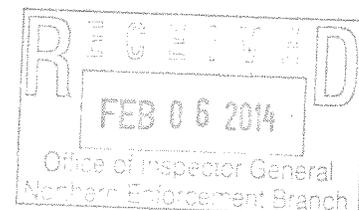
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F 253	Continued From page 1 which were torn, frayed or missing in the main dining room of the facility.  Interview with Physical Therapy Assistant #1 on 01/16/14 at 3:05 PM revealed the therapy department did not keep count of wheelchairs used by residents in the facility. Physical Therapy Assistant #1 stated all facility staff had the responsibility to report equipment in need of repair to maintenance and she further stated a maintenance log was not kept in the therapy department.  Interview with the Maintenance Director on 01/16/14 at 3:15 PM revealed it was his responsibility to repair the wheelchairs in the facility. The Maintenance Director stated he did not know how many wheelchairs were in use in the facility. He further stated he did not keep documents for past repairs of resident equipment nor did he have a system to audit resident equipment for maintenance purposes.  Interview with the Director of Nursing (DON) on 01/16/14 at 3:20 PM revealed she did not know how many resident wheelchairs were in use in the facility. The DON stated resident equipment was checked by the third shift nursing staff but any facility staff could report to maintenance the need for resident equipment repair. She further stated frayed and torn wheelchair arms could not be cleaned properly and could increase the risk of infection to the residents. Frayed, torn or missing wheelchair arms could increase the risk of skin tears to residents.	F 253	F 253 Continued from page 1  housekeeping cleaning schedules and Maintenance logs to identify where other maintenance or housekeeping services may be needed to maintain a sanitary, orderly, and comfortable environment.  3. On February 5, 2014, the Administrator distributed a memo to all staff detailing the requirements of this regulation and assigning responsibility to all staff for keeping the facility in compliance. All employees signed an attestation confirming comprehension of memo context. The memo reviewed the procedure for reporting/requesting housekeeping or maintenance services and it empowered all associates to resolve issues that could lead to non compliance. In addition, the form used to document when wheelchairs are being washed has been revised and now includes a section for requesting wheelchair service. On February 12, 2014, the Assistant Director of Nursing will inform the C.N.A.'s of this change. In addition to signing off the chair cleaning is complete, the C.N.A.'s will be able to document the need for a wheelchair to be serviced on the same form.		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323			



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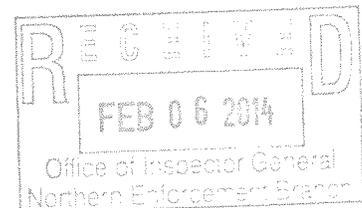
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F 323	<p>Continued From page 2</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of a Material Safety Data Sheet (MSDS) facility policy it was determined the facility failed to ensure the residents' environment remained free from accident hazards. Observation on 01/14/14 revealed one housekeeping staff left (1) of eight (8) housekeeping carts, which contained a mop bucket filled with water and chemicals, unattended and out of sight.</p> <p>The findings include:</p> <p>Review of the facility's policy Policy For Carts/ Storage of Chemicals, undated, revealed all chemicals should be locked in housekeeping carts at all times when the carts were unattended.</p> <p>Review of the MSDS sheet for the disinfectant cleaner 2.0 dated 03/27/13 revealed the cleaner contained hazardous ingredients including alcohols, ethoxylated Didecyle dimethyl ammonium chloride and dimethyl benzyl ammonium chloride which could cause harm to the skin, serious eye irritation and could be harmful if swallowed.</p> <p>Review of training records revealed Housekeeper #2 had reviewed an in-service on housekeeping</p>	F 323	<p>F 253 Continued from page 2</p> <p>The Director of Maintenance will receive a copy of this form and transfer maintenance requests to the maintenance job log for completion.</p> <p>4. The Unit Manager, Assistant Unit Manager, or ADON will inspect a total of 10 wheelchairs on each unit each week for 4 weeks, then each month for 3 months, and then quarterly until the QA Committee has determined substantial compliance for 2 consecutive quarters. They will compare the findings of the inspection with the wheelchair cleaning/maintenance request documentation form submitted by the C.N.A.'s. If a discrepancy is noted, in addition to documenting the need for maintenance, the Unit or Assistant Unit Manager will re-instruct the C.N.A.(s) involved on the system for reporting need for maintenance. Inspection and variances will be reported to the QA Committee so a revised action plan can be developed and implemented. For the next year, the Director of Maintenance will provide a monthly report of wheelchair repairs completed to the Safety Committee to identify any trends indicating a reduction in the number of service requests that may require further investigation by the QA Committee.</p>	



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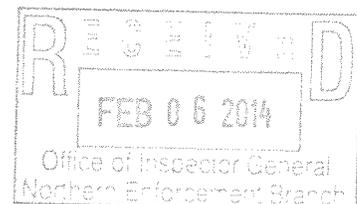
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F 323	<p>Continued From page 3</p> <p>carts on 08/13/13. The in-service included keeping a watchful eye on your cart, never leaving a cart while taking out garbage, taking a break, going to get linens from laundry room etc. The in-service also included information regarding confused residents and stressed the possible harm of dangerous housekeeping chemicals to residents.</p> <p>Observation of Housekeeper #2 on 01/14/14 at 12:25 PM - 12:29 PM revealed he was spraying room deodorizer while walking down the 300 unit hallway with his back to his housekeeping cart located at the nursing station for units 100, 200, 300, and 400. Observation on 01/14/14 between 12:25 PM - 12:29 PM further revealed Housekeeper #2's housekeeping cart, which held a water bucket with chemicals, unlocked and unobserved by Housekeeper #2. Housekeeper #2 on 01/14/14 at 12:30 PM retrieved a broom with a hand held dust pan from his housekeeping cart and left the cart unattended again as he walked back down to the end of the 300 unit sweeping in the hallway.</p> <p>Interview with Housekeeper #1, on 01/16/14 at 3:00 PM, revealed her housekeeping cart was to be in her sight at all times if unlocked. She stated the risk of an unattended housekeeping cart was a resident could be exposed to mop water with dangerous chemicals which could harm the resident. Housekeeper #1 further stated leaving a housekeeping cart at the end of a hallway while working at the other end of the hall and not in sight meant the cart was unattended.</p> <p>Interview with the Housekeeping Director, on 01/16/14 at 2:25 PM, revealed leaving a housekeeping cart unattended with mop water</p>	F 323	<p>F 323</p> <ol style="list-style-type: none"> <li>1. No residents were affected by this alleged deficient practice. On January 20, 2014, the Director of Housekeeping re-inserviced Housekeeper #2 on the correct procedures for safeguarding the housekeeping cart. The Housekeeping Director observed Housekeeper #2 on January 31st and February 3rd and 5th, There were no violations of cart control procedures observed.</li> <li>2. On February 4, 2014, a review of the previous month's incident reports was completed by the facility's QA nurse. There were no incidents of accidental exposure or calls to poison control. There were no changes in resident condition or unknown injury that could be attributed to chemical exposure. There were also no incidents or injuries that could be attributed to other hazards in the resident environment.</li> <li>3. The Director of Housekeeping has revised the procedure for controlling Housekeeping carts. Carts will be placed in the doorway of rooms being cleaned to allow the housekeeper to maintain sight of the cart while in a resident room.</li> </ol>	February 12, 2014	



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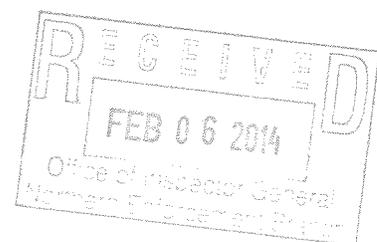
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F 323	Continued From page 4 and chemicals accessible to residents placed residents at risk.  Interview with the Administrator, on 01/16/14 at 3:40 PM, revealed housekeeping carts should not be left unattended by housekeepers.	F 323	F 323 Continued from page 4  Additionally, when not in direct control of the cart or in the processing of mopping the floor, the mop buckets will be covered to prevent accidental exposure. On February 7, 2014, the Director of Housekeeping completed education for all Housekeeping staff on the procedural change. As of February 11th, the Housekeeping Director will complete observations of each Housekeeper to confirm the revised procedure was being followed. An additional systemic change will be that the QA nurse will forward any resident incidents resulting from hazardous environmental, physical plant, or equipment condition to the safety committee.	
F 371 SS=F	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  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review it was determined the facility failed to store and distribute food in a sanitary manner. The facility failed to ensure leftover cheese in the two-door and walk-in refrigerators was labeled and dated. The facility failed to ensure the dry storage bins were free of a sticky substance and clean. The facility failed to ensure cleanliness of the toaster, the two-door oven and the handwashing sink.  The findings include:  Review of the the kitchen storage policy 7.1 and 7.2, undated, on 01/16/14 revealed items of food which had been opened and resealed must be	F 371	4. As part of its regular monthly activities, the facility Safety Committee will review the safety checklist, which requires review and discussion of chemical storage and cart control. For the next two quarters, the Director of Housekeeping will report to the Safety Committee any violations of cart control observed during her daily quality inspection rounds which will include an elevation of proper cart safeguarding by the housekeeping staff.	



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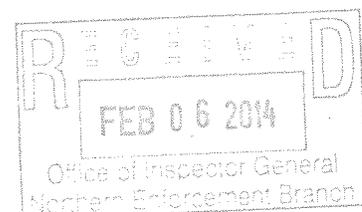
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F 371	Continued From page 5 dated.  Review of the recommended kitchen cleaning schedule dated 2006 on 01/16/14 revealed flour, sugar, and corn meal storage containers should be cleaned after each use.  Observation in the kitchen, on 01/14/14 at 10:40 AM, revealed the toaster had a brown greasy substance on its upper portion and a brown substance on the glass of the two-door oven. Observation further revealed the bins which held flour, sugar, and corn meal had brown and gray substances on the lids and the handles were sticky. The four (4) burner cook top had a thick black crust on the burner surface and the hand washing sink had grayish white stains on the sides and bottom. Continued observation in the kitchen revealed a package of cheese and a package of roast beef opened, resealed and undated in the 2-door refrigerator. The walk in refrigerator revealed two (2) blocks of American cheese that had been opened and resealed with no dates.  Interview with the Dietary Kitchen Manager #9 on 01/16/14 at 9:20 AM, revealed kitchen staff were instructed to resealed and date food items when they were opened and all of the item was not used. The Dietary Kitchen Manager #9 stated the bins in which the flour, sugar, and cornmeal were stored should not have been sticky and residue should not have been visible. The Dietary Kitchen Manager #9 confirmed the hand washing sink had a white substance and she was unable to provide documentation that the sink was cleaned daily. In addition, she had a recommended cleaning schedule from the facility kitchen vendor which indicated kitchen equipment should be	F 371	F 323 Continued from page 5  The committee will also review incident reports provided by the QA nurse. The committee will take corrective action to abate identified hazards. Trends or unresolved hazards will be referred to the full QA Committee for further investigation and resolution.		



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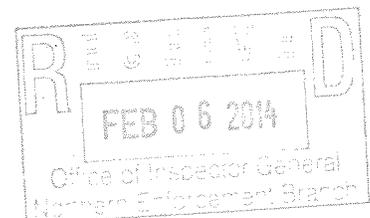
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F 371	<p>Continued From page 6</p> <p>cleaned according to a specific cleaning schedule. The current kitchen cleaning schedule was limited to weekly cleaning only of kitchen equipment.</p> <p>Review of the facility policy Environmental Sanitation/Infection Control, dated 2006, revealed ice was to be dispensed with scoops and ice dispensing utensils were to be stored in clean containers.</p> <p>Observation of a Dietary Assistant (DA) on 01/14/14 at 8:40 AM during the kitchen initial tour revealed the DA scooping ice from the icemaker using a blue plastic container. Continued observation of the DA revealed he took an ice scoop from another employee when he was prompted to use the ice scoop instead of the blue container to scoop the ice. Further observation of the DA revealed he placed the ice scoop on top of the icemaker when he completed the task and not in a clean container.</p> <p>Review of an inservice record dated 01/10/13 revealed the signature of the DA as having attended the inservice for infection control to include cross-contamination. Further review of that inservice did not reveal a post-test or documentation of return demonstration to ensure knowledge of the inservice.</p> <p>Interview with the DA on 01/16/14 at 3:10 PM revealed he repeated several times he did not understand English very well and he had worked at the facility for nine (9) years in the kitchen. He stated his duties were to sweep and clean in the kitchen and to wash plates before placing them into the dish cleaning machine. He further stated</p>	F 371	<p>F 371</p> <p>1. No residents have been affected by this alleged deficient practice. The undated cheese and roast beef referenced with this deficiency were discarded during the survey. The toaster, convection oven, and 4 burner stove will be thoroughly cleaned per the procedures outlined by department policy. This will be completed by the kitchen manager and cooks on February 11, 2014. The ice machine and bin was sanitized on February 7, 2014. The flour, sugar, and corn meal bins are being cleaned daily by the shift cook. Daily cleaning of the hand washing sink has been added to the daily cleaning schedule. Additional ice scoops have been ordered and the scoop holder has been mounted so it can't be mistakenly used to remove ice from the ice maker. Both the scoops and scoop holder are being sanitized on a daily basis. On February 6, 2014, the Dietary Assistant, Kitchen Manager, Dietary Manager, and Administrator met to review the aide's job description, sanitation policies, and answer any questions he may have about his duties.</p>	February 12, 2014	



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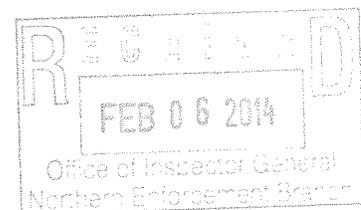
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F 371	Continued From page 7 he had never scooped ice in the kitchen before 01/14/14 but did so because another staff asked him. The DA could not define the meaning of cross-contamination during the interview.  Interview with Dietary Manager #9 on 01/16/14 at 3:25 PM revealed she thought the DA did understand English. She stated the DA's job duties included wrapping foods for the resident trays with cellophane and scooping ice when required. She revealed the blue container the DA was using to scoop ice on 01/14/14 was the ice scoop holder. Dietary Manager #9 stated the DA had been trained on cross-contamination and she was assured he understood the training because he signed his name to an attendance sheet. She stated she did not know if there was a post-test to the last training on cross-contamination or any return demonstration of knowledge.  Interview with Dietary Manager #17 revealed she was assured the DA understood trainings because he did a return demonstration of tasks taught with her but she did not have documentation of that return demonstration.	F 371	F 371 Continued from page 7  2. The facility has had no outbreaks of food borne related illnesses. On February 4, 2014, the Administrator, Kitchen Manager, and consultant Dietician reviewed the results of the previous Health Department Sanitation inspection and the previous 3 month's sanitation audits, completed by the consultant Dietician, to identify other areas where the storing, preparing, distributing, and serving food may be compromised. In addition, our consulting Dietician's manager toured the kitchen on January 24th for the same purpose. All identified concerns will be corrected by February 11, 2014.  3. The dietary cleaning schedule has been completely revised. There is now a daily and weekly cleaning schedule. The Kitchen Manager will verify completion every week by signing and providing the Administrator with a copy. On February 7 and 11, 2014, the facility's consultant Dietician will provide in-service training to all dietary staff. The content of the in-service will include review of the facility policies related to storing, preparing, distributing and serving food under sanitary conditions.		
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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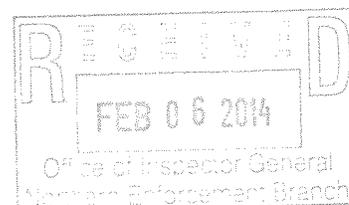
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F 441	Continued From page 8 in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record and policy reviews, it was determined the facility failed to maintain an infection control program that ensured a safe, sanitary and comfortable environment for the prevention and transmission of disease. During the medication pass observation, two (2) Licensed Practical Nurses (LPNs) did not properly wash/sanitize their hands, and a blood glucose meter was not properly disinfected after it was removed from a room	F 441	F 371 Continued from page 8  The in-service will emphasize the importance of following the cleaning schedule and cross contamination. On February 7 and 11, 2014, the Kitchen Manager will review the specific cleaning procedures for deep cleaning of the toaster, convection oven, and four burner stove. Following both trainings, all associates will complete a post test. The test results reviewed by the Dietary Manager to ensure understanding of the training concepts was achieved.  4. To supplement the monthly sanitation audits completed by the consulting Dietician, each week for the next quarter the Administrator and Kitchen Manager will complete a weekly sanitation audit. For the following 3 quarters, the Administrator and Kitchen Manager will conduct monthly sanitation audits. The findings from these audits will be presented to the QA Committee so that compliance or need for system modification or staff change may be determined.		



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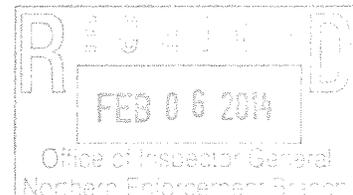
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  01/16/2014
NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSLEY RD. LOUISVILLE, KY 40216		
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F 441	Continued From page 9 where contact isolation was in effect. In addition, proper hand washing technique was not maintained during a skin assessment for sampled Resident #5, and the same LPN broke technique while performing foley catheter care for sampled Resident #5.  The findings include:  Review, on 01/16/14, of the facility's policy titled Hand Hygiene, (dated 08/01/2102), revealed all personnel shall follow the outlined hand washing/hand hygiene procedures to help prevent the spread of infections to residents, other personnel, and visitors. The policy also revealed hand washing/hand hygiene should be performed after direct care of residents and after handling contaminated equipment. A step-by-step process for hand washing was outlined in the policy which specifically stated after completion of the hand scrub at the sink, hands should be rinsed, dried with a paper towel and the sink faucet(s) would be turned off with a clean paper towel.  Observation, on 01/15/14 at 8:55 AM, during the medication pass for Unsampled Resident A, LPN #1 picked up a glove she had dropped on the floor beside the medication cart. She placed the glove in the trash and did not sanitize her hands before proceeding to crush a medication. After administering medication to Unsampled Resident A, LPN #1 washed her hands at the sink in the resident's room and turned off the faucets using her bare hands.  Observation, on 01/15/14 at 9:27 AM, during a medication pass for Unsampled Resident B, revealed LPN #6 washed her hands in the resident's room and turned off the faucet with her	F 441	F 441  1. Resident #5, and unsampled residents A and B have had no change in condition that can be attributed to this alleged deficient practice. Unsampled resident C no longer resides in the facility. On February 5, 2014, the Assistant Director of Nursing reviewed the facility hand hygiene policy and catheter care policy/procedure checklist with LPN #5. Following this review, the ADON observed LPN #5 follow correct hand hygiene practice for 3 residents, one of which was in isolation. On February 5, 2014, the Assistant Director of Nursing reviewed the hand hygiene policy and procedure for correctly disinfecting equipment that must be shared between residents with LPN #6. The ADON showed LPN #6 where the proper cleaning products are located as well as the written instructions for disinfecting equipment found in the Medication Administration Record binder on every med cart. Following this review, the ADON observed LPN #6 follow correct hand hygiene and equipment disinfection practice for 3 residents. LPN #1 is no longer employed at this facility.	February 18, 2014	



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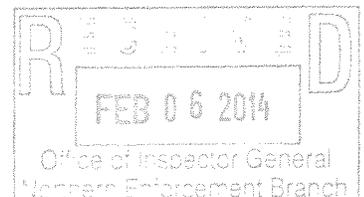
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F 441	<p>Continued From page 10 bare hands.</p> <p>Interview, on 01/16/14 at 11:17 AM, with LPN #1, revealed turning off the faucet with a clean paper towel after washing one's hands was a step in proper hand washing technique. LPN #1 stated she remembered picking up the glove from the floor during the medication pass and stated she should have sanitized her hands before continuing to set up Unsampled Resident A's medications. LPN #1 stated the problem with not properly washing and sanitizing her hands while passing medications would be the potential for spreading infection to the residents.</p> <p>Review, on 01/16/14, of the facility's policy/procedure (undated) for cleaning a blood glucose meter, revealed the blood glucose meter would be cleaned between each use, with either a Gluco-Chlor pre-saturated towelette or a clean lint-free cloth dampened with 10% household bleach and water. The policy also stated alcohol was not to be used to clean the blood glucose meter.</p> <p>Observation, on 01/15/14 at 11:10 AM, LPN #6 carried a blood glucose meter from Unsampled Resident C's room. LPN #6 placed the glucose meter on the surface of the medication cart (med. cart) without first placing a barrier underneath to protect the med. cart's surface. LPN #6 took a small 2 x2 inch wipe and cleaned the glucose meter. She then took the glucose meter into Unsampled Resident D's room and placed it on the resident's bed.</p> <p>Interview, on 01/15/14 at 11:30 AM, with LPN #6 revealed she cleaned the glucose meter with an alcohol saturated pad after exiting Unsampled</p>	F 441	<p>F 441 Continued from page 10</p> <p>2. On February 5, 2014, the Director of Nursing and Medical Director reviewed the facility's infection reports, generated through surveillance of lab/culture results, antibiotic usage and weekly wound reports to identify any other residents who could have been affected by these alleged deficient practices. Physician notification will occur for any resident identified.</p> <p>3. By February 17, 2014, the Assistant Director of Nursing will re-educate all licensed staff on infection control policies. The reeducation will emphasize hand hygiene techniques for routine hand washing, dressing changes, treatment administration, and catheter care. A post test will be administered to verify comprehension of the training topics. On February 11, 2014, the Director of Nursing will meet with the administrative nursing staff to review their role in ensuring the facility's infection control policies are being followed. These nurses will be assigned responsibility for making weekly focused reviews of infection control practices on specific hallways;</p>		



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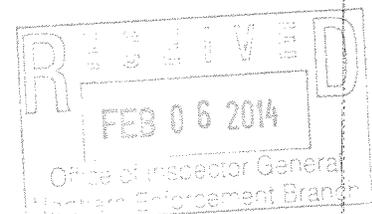
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F 441	<p>Continued From page 11</p> <p>Resident C's room. LPN #6 stated she cleaned the glucose meter with alcohol because Unsampld Resident C was in contact isolation precautions for Clostridium Difficile (C.diff.) and a glucose meter had not been dedicated for testing this resident's blood glucose.</p> <p>Interview, on 01/16/14 at 11:28 AM with LPN #6, revealed she remembered placing the glucose meter on the med. cart after bringing it out of Unsampld Resident C's room, and stated she should have placed a barrier under the meter before placing it on the med. cart's surface. LPN #6 stated the facility trained her that alcohol was an acceptable agent for cleaning equipment removed from a contact isolation room. LPN #6 stated bleach wipes were kept in the Green Unit's medication room and she typically used them to clean the med. cart at the end of her shift. LPN #6 stated she broke technique by not properly disinfecting the blood glucose meter.</p> <p>Review, on 01/16/14, of the facility's procedure checklist titled, Catheter Care (undated), revealed a step-by-step procedure as follows: give perineal care; apply soap and water to a clean, wet, washcloth; hold catheter near meatus; cleanse catheter from the meatus down the catheter about four (4) inches; clean downward, away from the meatus with one (1) stroke, and repeat if necessary with a clean area of the washcloth; and dry with a towel from the meatus down the catheter about 4 inches.</p> <p>Review, on 01/16/14, of the facility's policy titled Urinary Catheter Care (revised and updated 01/06/05), revealed the area at the catheter insertion site was to be cleansed taking care not to pull on the catheter, remove any debris, and</p>	F 441	<p>F 441 Continued from page 11</p> <p>correcting any observed lapses in infection control practice, and documenting their findings on an infection control surveillance audit tool. The reviews will include observation of hand hygiene during treatments and catheter care as well as glucose monitor cleaning.</p> <p>4. To verify proper infection control techniques are being utilized, by February 17, 2014, the Assistant Director of Nursing, Unit Managers, Assistant Unit Managers, Weekend House Supervisor, Third Shift House Supervisor, Director of Staff Development, and Director of Nursing will observe every nurse demonstrate proper hand hygiene techniques. An infection control QA subcommittee, consisting of the DON, ADON, Unit Managers, and other staff as needed, will meet monthly for the remainder of the year to review the facility's infection control policy compliance, infection surveillance, isolation procedures, linen handling, and findings of the weekly infection control audit tool. Non compliance will be referred to the full QA Committee for further investigation and resolution.</p>		



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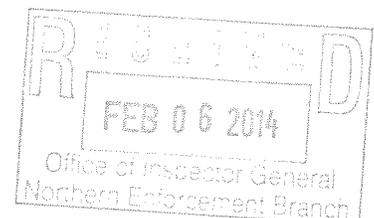
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F 441	Continued From page 12 then proceed to clean the rest of the catheter tubing, moving outward.  Observation, on 01/15/14 at 12:20 PM, during the skin assessment for Resident #5, the resident had a bowel movement (BM). LPN #5 began to clean the resident before beginning the skin assessment. After removing Resident #5's soiled brief, LPN #5 removed her gloves, deposited them and the brief in the trash, obtained a clean pair of gloves from a dispenser in the resident's bathroom, placed them on the sink's counter top, washed her hands, turned off the faucet with her bare hands, and then donned the gloves from the counter top. In the process, the left glove tore. She replaced it, but kept the same glove on her right hand. During the Foley catheter care for Resident #5, LPN #5 cleaned the catheter tubing with a wet, soapy wash cloth, moving from the urinary meatus outward. Then, she cleaned Resident #5's left labial fold with the same washcloth, without refolding the cloth to a clean area or obtaining another clean wash cloth. Upon completion of the catheter care, LPN #5 removed a sheet from beneath the resident that was soiled with BM, and placed it in a plastic bag. LPN #5 then removed her gloves, washed her hands, turned off the faucet with her bare hands, and donned a clean pair of gloves. LPN #5 returned to the resident's bedside and applied barrier cream to blistered areas on the resident's buttocks. After applying the barrier cream, LPN #5 removed her gloves, tossed them in the trash, and again obtained a clean pair of gloves from the dispenser in the resident's bathroom before washing her hands. LPN #5 washed her hands, and turned off the faucet with her bare hands. She donned the gloves that were placed on the counter top, and then returned to the resident's	F 441			



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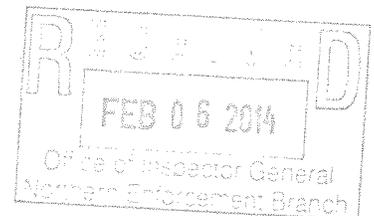
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F 441	<p>Continued From page 13</p> <p>bedside. Using her gloved hand, LPN #5 applied a small amount of barrier cream to small pink area on Resident #5's right inner, upper thigh.</p> <p>Interview, on 01/16/14 at 1:05 PM with LPN #5, revealed she should have turned off the faucet with a clean paper towel after completing hand washing during Resident #5's skin assessment. Further, LPN #5 stated she should have washed her hands prior to obtaining clean gloves that were worn when she returned to complete Resident #5's care. LPN #5 stated she broke proper hand washing technique during the skin assessment and she should have used a clean cloth with each step in the Foley catheter care. The problem not maintaining proper hand washing and catheter care technique was the potential for spreading infection to Resident #5, other residents, and staff members.</p> <p>Interview, on 01/16/14 at 1:50 PM with the Unit Manager (UM) for the Green Unit, revealed non-dedicated equipment, such as a blood glucose meter, should be sanitized with bleach wipes after use. He stated bleach wipes were available on the Green Unit, and it was the responsibility of the hall nurses to ensure that bleach wipes were on the medication carts for use. The UM stated his staff should wash their hands using proper technique as listed in the facility's policy, which included turning off faucets with a clean paper towel after the staff member washed his/her hands. The UM stated he did not conduct random spot checks to ensure infection control practices were consistently followed, but if a compromise in infection control was identified, a stand up in-service would be conducted, immediately. Planned, facility-wide infection control in-services for clinical staff were held at</p>	F 441			



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NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216		
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F 441	Continued From page 14 least annually, and/or whenever it was determined additional instruction was needed.  Interview, on 01/16/14 at 2:25 PM with the Director of Nursing (DON), revealed new staff received infection control education upon hire, annually, and whenever supervisors determined it was needed. Random walk-about observations were conducted by the Assistant Director of Nursing (ADON) who was also responsible for tracking and trending infections. The DON stated the ADON did not keep a log that documented the dates, times, locations, and staff observed during the random walk about. Further, the DON stated she expected the Unit Coordinators/Managers to conduct one on one (1:1) infection control education with staff members on their units whenever breaks in infection control technique were observed.	F 441			



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NAME OF PROVIDER OR SUPPLIER  <b>SUMMERFIELD HEALTH AND REHABILITATION CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1877 FARNSELY RD.</b> <b>LOUISVILLE, KY 40216</b>
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{F 000}	<p><b>INITIAL COMMENTS</b></p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 02/18/14 as alleged.</p>	{F 000}		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185300	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  01/14/2014
NAME OF PROVIDER OR SUPPLIER  SUMMERFIELD HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1877 FARNSELY RD. LOUISVILLE, KY 40216	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1979, 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic, dry sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 01/14/14. Summerfield Health and Rehabilitation Center 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 *New Food* TITLE Administrator DATE 2/6/14

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

If continuation sheet Page 1 of 1  
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Northern Enforcement Branch