

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

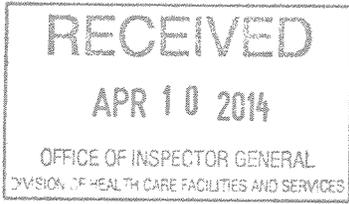
PRINTED: 04/09/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185350	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  R 03/26/2014
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220
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{F 000}	<p>INITIAL COMMENTS</p> <p>On 03/26/14, an on-site revisit for the annual survey completed on 03/07/14 was conducted to determine the removal of Immediate Jeopardy (IJ) at 42 CFR 483.20 Resident Assessment (F282), 42 CFR 483.65 Infection Control (F441), and 42 CFR 483.75 Administration (F490 and F520). The IJ identified during the 03/07/14 annual survey was related to the facility's failure to ensure the infection control program was implemented to prevent the transmission of highly infectious diseases. The facility failed to have an effective infection control program evidenced by ineffective monitoring of a visitor to the facility who was non-compliant with use of Personal Protective Equipment (PPE); inconsistent availability of PPE; improper hand hygiene by staff; lack of glove use during eye medication administration; breaks in clean technique during perineal and wound care; and lack of PPE utilization during laundry processing.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 03/20/14 alleging removal of the IJ on 03/10/14. Based on the findings of the revisit, the State Survey Agency (SSA) determined Immediate Jeopardy was removed on 03/10/14, as alleged, with remaining noncompliance at 42 CFR 483.20 Resident Assessment (F282) at a scope and severity of a "D", and 42 CFR 483.65 Infection Control (F441), and 42 CFR 483.75 Administration (F490 and F520) at a scope and severity of an "E", while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.</p>	{F 000}	<p>Signature HealthCARE of East Louisville does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution, formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the Facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the Facility does not waive and reserves the right to assert in any administrative, civil or criminal claim, action or proceeding. The Facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	
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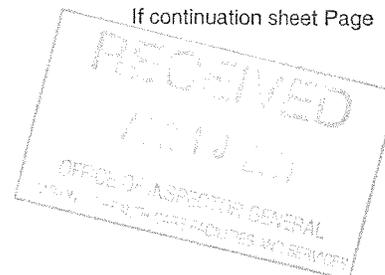
LABORATORY, DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 4/10/14
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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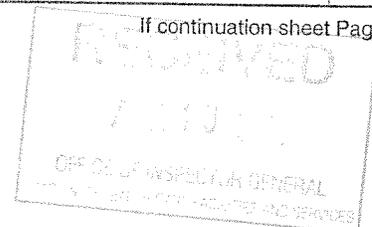
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{F 000}	Continued From page 1 The non-IJ deficiencies cited during the annual survey were not reviewed for compliance during this revisit as the facility had not had an opportunity to submit a Plan of Correction (POC). Therefore the deficiencies detailed in this Statement of Deficiencies for the Health revisit on 03/26/14 include F156, F174, F241, F253, F314, F371, F372, F431, F464, F502, and F514.	{F 000}			
{F 156} SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES  The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.  The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.	{F 156}	F 156 a.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident's #22, #23 and #24 are discharged residents and the charts are closed. Social services mailed out notices on 3/27/14 to residents #22, # 23 and #24.  b.) How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All discharging residents have the potential to be affected. An audit of all Medicare residents from January 1, 2014 discharging to the community were audited by social services 3/27/14. 13 residents were identified as needing coverage letters. Those letters sent to the affected on 3/27/14 by the social worker.	3/28/14	



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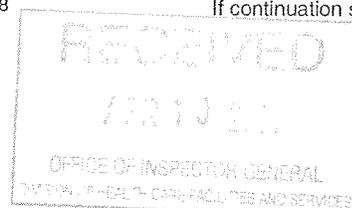
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{F 156}	<p>Continued From page 2</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate.</p> <p>The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;</p> <p>A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels.</p> <p>A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements.</p> <p>The facility must inform each resident of the</p>	{F 156}	<p>c.) What measures will be put into place or what systemic changes will be made to ensure that the deficient practice does not occur;</p> <p>Education was provided to the social service director, assistant and business office manager by the Administrator on 3/19/14 regarding Medicare non-coverage letters and an understanding of Medicare requirements have been voiced. The policy was reviewed on 3/19/14 by Nurse Consultant, Administrator, DON and social services. There were no changes to the policy.</p> <p>An audit was initiated by the Administrator on 3/7/14 and will be completed on all Medicare discharging residents to ensure compliance with Medicare non-coverage guidelines.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur i.e. what quality assurance program will be put into place;</p> <p>The audits by the administrator or administrator in training will continue weekly for three months</p>	



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{F 156}	<p>Continued From page 3</p> <p>name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and closed record review, it was determined the facility failed to ensure Medicare A residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) closed records reviewed. (Residents #22, #23 and #24). The facility failed to issue a non-coverage letter, with information on beneficiary appeal rights for those residents that were discharged from the facility after Medicare Part A services were terminated. The facility only provided that information to those residents who continued to reside in the facility after Medicare Part A services was terminated.</p> <p>The findings include:</p> <p>The facility did not provided a specific policy related to Non-coverage letters. The Business Office Manager provided a scenarios guide provided to her by the corporation. Review of this scenarios list, not dated, revealed instructions when to issue a notice letter. One of the scenarios listed that when a resident goes home</p>	{F 156}	<p>and then monthly thereafter to ensure compliance.</p> <p>The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	



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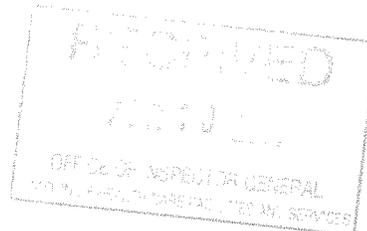
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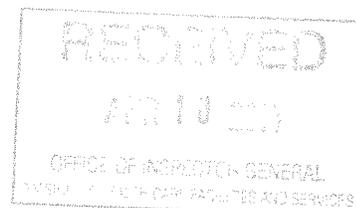
{F 156}	<p>Continued From page 4 to issue letter #10123 no later than two days before services end.</p> <p>Review of the facility's admission/financial agreement revealed the facility provided information on how the resident could apply for benefits under Medicare and Medicaid. A copy of a blank Notice of Medicare Non-coverage letter was included in the admission packet and provided to the resident or responsible party during the admission process.</p> <p>1. A closed record review of Resident #22's clinical record revealed the facility admitted the resident on 01/21/14 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 02/08/14 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>2. A closed record review of Resident #23's clinical record revealed the facility admitted the resident on 02/11/14 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 02/21/14 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>3. A closed record review of Resident #24's clinical record revealed the facility admitted the resident for skilled services under Medicare Part A on 12/12/13. The record revealed the resident was discharged to home on 12/16/13 with skilled days remaining. However, the facility failed to issue a Notice of Medicare Non-coverage letter</p>	{F 156}		
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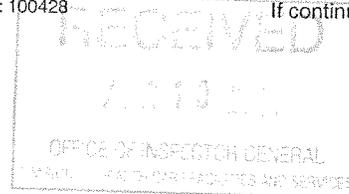
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{F 156}	Continued From page 5 with appropriate beneficiary appeal rights.  Interview with the Business Office Manager, on 03/06/14 at 11:00 AM, revealed notice letters were not issued to discharged residents who chose to go home even if they had Medicare skilled days left. She stated the Social Worker actually issued the letter and she conducted the financial portion. She was not aware those residents were to receive a notice letter. She revealed she received training from the previous Business Office person and she told her the form letters were for those residents who had Medicare days left and remained in the facility. She stated the corporate consultant had never told her to issue a notice when the resident chose to terminate skilled services.  Interview with the Social Service Director, on 03/06/14 at 11:17 AM, revealed she was responsible for Liability Notices & Beneficiary Appeal letters after a resident's Medicare Part A skilled services were terminated. She did not issue to residents who were there for rehab and chose to go home. She stated therapy or family would tell her when the skilled services would end. She stated she only issued those letters to residents who would remain in the facility and she would issue two days prior to when the skilled service would end. She said she had not provided the notice of non-coverage to residents who were discharged from the facility even though the residents had not exhausted all their skilled days. She had been trained by the corporate consultant and that was what she was told to do.	F174	F 174 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; A cordless phone was replaced on the 200 Hall on 3/5/14 and is now available for resident use.  b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents on the 200 hall have a potential to be affected.  c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; All staff has been educated by the Staff Development coordinator, Social worker, DON, RN's or ADON's (Education began on 3/17/14 and as of 3/27/14 we have trained 128 employees with 61 left to complete the training) on proper completion of maintenance work requests for repairs that need to be completed or if one of the resident phones is not working properly or missing. Training will be completed by 3/27/14 with no staff members working until training has been completed. A	3/28/14
{F 174} SS=D	483.10(k),(l) RIGHT TO TELEPHONE ACCESS WITH PRIVACY	{F 174}		



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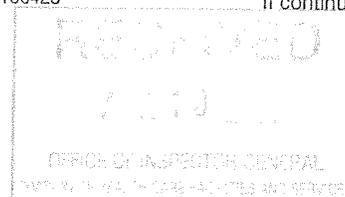
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{F 174}	<p>Continued From page 6</p> <p>§483.10(k) Telephone The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.</p> <p>§483.10(l) Personal Property The resident has the right to retain and use personal possessions, including some furnishings, and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to ensure residents could make telephone calls in private on one (1) of three (3) units. (200 Hall)</p> <p>During group interview on 03/04/14, Unsampled Resident A revealed he/she had to use the desk phone at the 200 nurses station to make telephone calls.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Telephone, Resident Use of, dated June 2007, revealed residents would have easy access to telephones. Designated telephones would be available to residents to make and receive private telephone calls. The telephones at the nursing stations would ordinarily be reserved for staff use, unless no other alternative was available. Residents would use telephones at the nursing stations for as brief a period as possible.</p> <p>Interview with Unsampled Resident A at the</p>	{F 174}	<p>resident council was on held 3/18/14 to notify the residents of the availability of the telephones on the units for their use. The Administrator or administrator in training will conduct audits three times weekly for two weeks, then twice weekly for two weeks, then weekly for three months for availability and functionality of cordless telephones.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur ,i.e. what quality assurance program will be put into place; The audits by the administrator or administrator in training will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	



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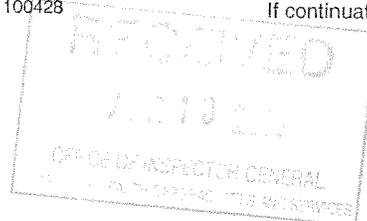
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{F 174}	Continued From page 7 Group Meeting, on 03/04/14 at 4:00 PM, revealed he/she had to use the desk phone at the nurse's station on the 200 Hall, and there was no privacy.  Observation of the 100 and 300 Nurse's station, on 03/04/14 at 5:00 PM, revealed cordless phones were provided for residents to use for private telephone conversations. However, observation of the 200 Hall, on 3/04/14 at 5:15 PM, and again on 03/05/14 at 8:30 AM, revealed no evidence a cordless phone was provided for residents.  Interview with the Unit Manager/ADON on the 200 Hall, on 03/05/14 at 11:00 AM, revealed the cordless phone had been broken at the 200 Hall nurse's station, but was not sure how long. The Unit Manager stated that residents were taken behind the desk to talk.  Interview with the Maintenance Director, on 03/06/14 at 3:30 PM, revealed he was not informed of the broken cordless phone on the 200 Hall until 6:30 PM, on 03/05/14. The Maintenance Director stated that staff was to fill out a maintenance slip and forward to him if anything was broken; however, he had not received anything until yesterday. The Maintenance Director stated there would be a privacy issue with residents using the phone at the nurse's desk.	{F 174}			
{F 241} SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	{F 241}		3/29/14	



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{F 241}	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to promote care for residents in an environment that would enhance each resident's dignity related to dining in the Restorative Dining Room for two (2) of twenty-four (24) sampled residents (Residents #1 and #3). Residents were observed to be sitting for long periods of time before the meal was served and Residents #1 and #3 sat waiting for assistance while the residents at their tables were eating.</p> <p>The findings include: The facility did not provide a policy regarding dignity during dining.</p> <p>1. Observation during the initial tour of the facility, on 03/04/14 at 8:35 AM, revealed the breakfast meal was being served in the Gold Room (Restorative Dining Room). Observation revealed there were twelve (12) residents for this meal sitting at five (5) different tables. Three (3) staff then came into the room and provided assistance to ten (10) of the residents. One table had two (2) residents, Residents #1 and #3, sitting alone with covered plates of food pushed to the center of the table out of the residents' reach. No staff was assisting the residents.</p> <p>Interview with Certified Nursing Assistant (CNA) #3 at 8:40 AM revealed other aides would assist the residents once the room trays were delivered. She stated there was not enough staff to feed all residents in the dining room at the same time.</p>	{F 241}	<p>F 241</p> <p>a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident 1 and 3 were assessed by the DON on 3/18/14 related to their dining needs. Care plans were reviewed by the DON on 3/18/14 and with no updates required. The facility dining program was reassessed on 3/17/14 by the RD, DON, Restorative Nurse, and ADON. A new dining room program was implemented for the facility on 3/17/14 to address timeliness of meal service and assistance provided to the residents during meal service.</p> <p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents dining in the Gold room have the potential to be affected by this practice. All residents that dine in the Gold room were assessed on 3/27/14 by the Restorative nurse related to their dining needs. No corrective action was needed.</p>	3/29/14



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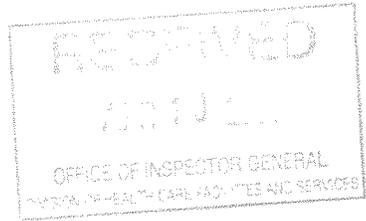
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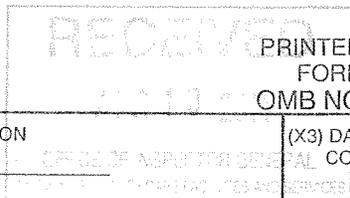
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{F 241}	<p>Continued From page 9</p> <p>She indicated there were usually two (2) restorative aides and two (2) CNAs in the dining room to assist the residents. At 8:42 AM, four (4) staff came into the dining room to assist residents.</p> <p>Observation of the evening meal, on 03/04/14 at 5:40 PM, revealed fourteen (14) residents in the Gold Dining Room for this meal and they were already in place at the tables prior to 5:40 PM. The residents sat from before 5:40 PM until 6:25 PM. Fluids were brought to the room and passed to most residents at approximately 5:45 PM. At 6:25 PM, the food trays were delivered.</p> <p>Observation of the lunch meal, on 03/05/14 at 12:10 PM, revealed fourteen (14) residents in the Gold Dining Room when the first tray pass was delivered. Observation revealed Resident #3 was pushed up to a table with one resident who fed themselves. Observation revealed a food tray was placed in front of Resident #3, but no staff provided assistance. Resident #3 watched while the other resident ate and continued not to receive staff intervention. At 12:35 PM, twenty-five (25) minutes after the other residents were served, Resident #3 was assisted with eating.</p> <p>Interview with the Administrator, on 03/05/14 at 8:50 AM, revealed the facility had changed the schedule for meals and yesterday, 03/04/14, was the first day on the new schedule. He stated the meals for the restorative dining were late and felt the service would improve today. Residents who could understand were made aware of the change in schedule.</p> <p>Interview with the Director of Nursing, on</p>	{F 241}	<p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur;</p> <p>The change in the dining program was to assess residents based upon their need for assistance and any resident that required only verbal cueing or follow up feeding were graduated to a transition table in the main dining. Four residents were involved in this change. All dining and nursing staff was educated by staff development coordinator Dining Services manager or Director of Nursing and ADONs and RNs on proper meal service, feeding assistance and regarding timeliness of meal service on 3/17/14. Post testing was completed on 3/28/14 by educated staff members on the importance of timeliness of meal service.</p> <p>The administrator, DON and RN's will audit the dining rooms daily for the first week and then weekly x 12 for timeliness of meal service and timeliness of assistance provided to residents requiring assistance with eating utilizing a Dining Audit tool.</p>	
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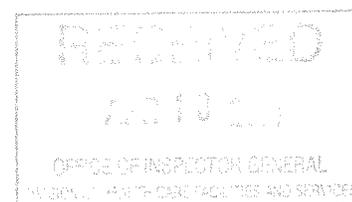
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{F 241}	Continued From page 10 03/06/14 at 3:00 PM, revealed residents should be served at the same time. She acknowledged the dining room was crowded and most residents in the dining room had to be assisted with feeding.	{F 241}	d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur,i.e. what quality assurance program will be put into place;  The audits by the administrator, DON or RNs will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.	
{F 253} SS=E	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, interview, and review of the facility's policy, it was determined the facility failed to have an effective housekeeping and maintenance program to ensure a safe and sanitary environment for eleven (11) of thirty-five (35) rooms observed (Rooms 108, 109, 112, 115, 202, 231, 301, 319, 320, 321, and 323). Ceiling vents were soiled, caulking around sinks were soiled and/or coming off, there were holes in the walls, a door frame was chipped with bare wood exposed, ceiling fans were soiled, privacy curtains were soiled, heater control knobs were soiled, a bathroom floor had wood rot, and an bathroom emergency pull cord was inaccessible.  The findings include:  Review of the facility's policy regarding Plumbing, HVAC and Related Systems, revised August 2011, revealed individual air condition units in resident rooms would be maintained as necessary. Air vents and air handling units would be cleaned annually. Additionally, exhaust fans	F 253	a.) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  All concerns identified within the 2567 have been corrected by maintenance and housekeeping. Specifically Rooms 108, 109, 112, 115, 202, 231, 301, 319, 320, 321, 323 were checked for: caulk around sink/toilets, head walls painted and unscuffed, painted door frames, ceiling fans clean, heater control knobs clean, wood rot on baseboards/floors, emergency pull cords per regulation, vents/exhaust fans, scuffed doors and ceilings. These corrections were made on 3/18/14 by plant operations director and team.	3/29/14

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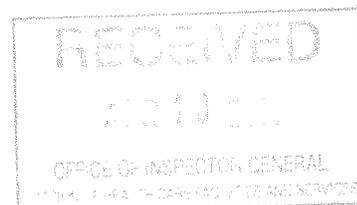
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{F 253}	<p>Continued From page 11 would be maintained every six (6) months.</p> <p>Review of the facility's Building Standards Policy, dated January 2005, revealed the facility would be maintained to ensure safety and the well-being of residents. The physical environment would be maintained in a safe, clean and sanitary manner. Additionally, the building and its heating and cooling systems would be maintained in good repair and clean condition at all times.</p> <p>The facility did not provide a policy for Housekeeping Services.</p> <p>1. Observation, on 03/05/14 at 2:43 PM, of the 100 Unit revealed the ceiling fan over the nurse's station contained dust and/or dirt. Air vents in the hallway in front of the shower room, and near rooms 109 and 112, contained dust and/or dirt. Resident room 108's bathroom vent was soiled and the caulk around the sink was cracked and soiled. Further observation at 2:47 PM, revealed room 115's bathroom sink caulking and air vent were soiled. The door to the bathroom had chipped paint which exposed the bare wood and was rough to touch. The air condition unit was in poor condition. Additionally, two (2) privacy curtains were soiled.</p> <p>Review of the facility Maintenance worksheet, dated 03/02/14, revealed all resident rooms, on the 100 unit, were inspected. Inspections included doors, baseboards, and walls. The doors for room 115 had been checked to indicate they were inspected.</p> <p>Review of the facility Monthly Deep Cleaning Checklist, dated February 2014, revealed air condition units, privacy curtains, baseboards,</p>	{F 253}	<p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected. An audit of all rooms was completed on 3/17/14 for housekeeping and maintenance concerns. All identified concerns from this audit were completed on 3/17/14 for all resident rooms.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Maintenance, laundry and housekeeping staff members were educated on 3/18/14 by the Administrator or Regional Plant operations director on proper maintenance and cleaning. Post test completion by 3/28/14 on will verify the staff member's comprehension of the provided education. The administrator/administrator in training/plant ops director will conduct audits weekly x 12 to ensure that compliance is met for facility housekeeping and maintenance including the following: cleanliness of ceiling vents, fans, privacy curtains, heater control knobs, and holes</p>	



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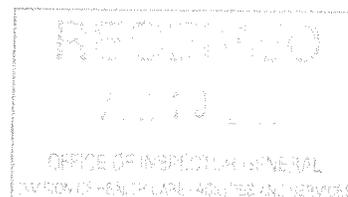
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{F 253}	<p>Continued From page 12</p> <p>walls and doors, and the bathrooms were to be cleaned and included in the monthly duties. Room 115 had been deep cleaned on 02/24 with privacy curtains, doors, and bathroom completed. Room 108 was not deep cleaned in February 2014 as scheduled.</p> <p>On 03/05/14 at 2:52 PM, observation of the 100 unit revealed a soiled utility room with an odor of urine and clean pillows were being stored.</p> <p>On 03/06/14 at 10:12 AM, observation during environmental tour with the Maintenance Director, Environments Services Director (ESD), and the Regional Plant Operations (RPO) Manager revealed on the 100 unit a soiled ceiling fan at the nurse's station, pillows stored in a soiled utility room with odor present, a vacuum cleaner stored in a second soiled utility closet. Resident room 108's bathroom ceiling vent was soiled and the sink caulking was soiled or dis-colored. Room 115 also had a soiled ceiling vent in the bathroom and sink caulking. The bathroom's baseboard had black discoloration under the sink area. In addition, the room's door to the bathroom had exposed wood that was rough to touch and two (2) soiled privacy curtains.</p> <p>Interview, on 03/05/14 at 3:06 PM and 03/06/14 at 10:12 AM and 10:33 AM, with the Maintenance Director revealed the sinks in the bathrooms for rooms 108 and 115 had been recaulked in the last thirty (30) days and looked as if they needed to be recaulked again due to discoloration. He further indicated in room 115 the maintenance department used a spreadsheet to check the doors and the bathroom door was scuffed by a wheelchair.</p>	{F 253}	<p>in walls, caulking around sinks clean and intact, floor damage, chipped door frames and accessibility of emergency pull cords. Any concerns identified will be communicated to the plant operations staff for follow up via maintenance work order. Administrator will audit work orders weekly as well as deep cleaning schedules for completeness. Administrator/ Administrator in training will complete audits of finished work orders and deep cleaning weekly.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur, i.e. what quality assurance program will be put into place;</p> <p>The audits by the administrator or administrator in training will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>		



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{F 253}	<p>Continued From page 13</p> <p>Interview with the ESD, on 03/06/14 at 10:12 AM, during the environmental tour for the 100 hall revealed the housekeeping department was responsible to clean the ceiling fans twice a week. He stated he last checked the fans last week. The ESD indicated the pillows in the soiled utility room were also soiled as they had been stored in the soiled closet. He further indicated the soiled utility closet should be sprayed for odor and disinfectant. The ESD stated the closet smelled liked dirty linen and did not smell like it had been sprayed for odors. He indicated a vacuum cleaner stored in another soiled utility room was a vacuum that was regularly used and was not considered to be soiled. He further indicated the vacuum should not have been stored in the soiled utility closet. The ESD stated the resident room bathroom ceiling vents should be cleaned by housekeeping weekly; however, he was unsure when the last time the vents had been cleaned in rooms 108 and 115. The ESD indicated the privacy curtains were cleaned as a part of the monthly deep cleaning and should be checked daily by the housekeepers. He stated he would not want those soiled curtains in his room.</p> <p>On 03/06/14 at 10:12 AM, interview with the RPO revealed the privacy curtains in room 115 should be changed and cleaned. He stated one (1) curtain had ink stains that would not come out and should be replaced. The RPO indicated the curtains were changed and cleaned once a month.</p> <p>Interview with Housekeeper #2, on 03/07/14 at 10:51 AM, revealed vents in resident rooms should be cleaned twice a week. She stated privacy curtains were checked by housekeeping whenever they were cleaning the room. The</p>	{F 253}			



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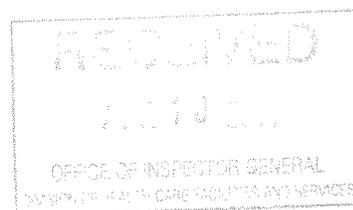
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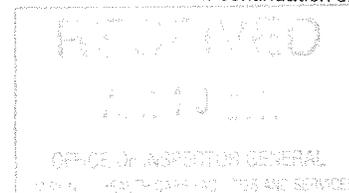
{F 253}	<p>Continued From page 14</p> <p>Housekeeper indicated the pillows stored in the soiled utility closet were both clean and soiled pillows, with the clean pillows stored in a trash liner bag after having been cleaned. She indicated the odor in the closet smelled of urine. She further indicated she had not sprayed for odor on this day. Housekeeper #1 stated if resident rooms and bathrooms were not cleaned properly the rooms would not look good and was not good for resident health.</p> <p>2. On 03/06/14 at 10:12 AM, observation during environmental tour with the Maintenance Director, Environments Services Director (ESD), and the Regional Plant Operations (RPO) Manager revealed on the 200 unit, at 10:44 AM, room 202's bathroom floor was discolored and rotted behind the toilet at the baseboard. At 11:02 AM, observation of room 231's heating unit revealed a soiled control knob with a crusty and stuck substance.</p> <p>Interview with the ESD, on 03/06/14 at 10:12 AM, during the environmental tour revealed the floor and baseboard behind the toilet in room 202 were rotted from moisture damage. He stated he was unaware of the rotting floor. At 11:02 AM, continued interview revealed housekeeping was responsible to clean the heating and cooling temperature knob in room 231.</p> <p>On 03/07/14 at 11:06 AM, interview with Housekeeper #3 revealed housekeeping was responsible to clean the heating and cooling control knobs in resident rooms. She stated the control knob was part of cleaning and should be checked every day.</p> <p>3. Observation during initial tour, on 03/04/14 at</p>	{F 253}		
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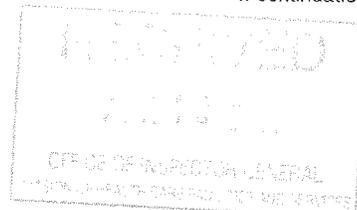
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{F 253}	<p>Continued From page 15</p> <p>8:38 AM, revealed room 301 did not have an emergency pull cord attached in the bathroom. The cord was observed laying on the toilet seat.</p> <p>Observation, on 03/05/14 at 11:31 AM, revealed on the 300 unit rooms 319, 320, 321, and 323 had gouges in the drywall behind the beds.</p> <p>On 03/06/14 at 10:12 AM, observation during environmental tour with the Maintenance Director, Environments Services Director (ESD), and the Regional Plant Operations (RPO) Manager revealed on the 300 Unit revealed room 301's bathroom emergency pull cord was detached from the wall and was wrapped around the toilet assistance bar. Room 320 and 321 had gouges in the wall behind the beds.</p> <p>Interview, on 03/05/14 at 3:06 PM and 03/06/14 at 10:12 AM and 10:33 AM, with the Maintenance Director revealed the walls behind the beds on the 300 unit were an ongoing problem as the beds scraped the wall when being raised or lowered. He indicated the maintenance department was in resident rooms at least once a month to check the walls. The Maintenance Director further indicated, on 03/06/14 at 3:28 PM, there were no work orders requested for baseboards, walls, or any other maintenance issues observed during the environmental tour.</p> <p>Interview with the ESD, on 03/06/14 at 10:12 AM, during the environmental tour revealed the pull cord in the bathroom of room 301 was checked daily by the housekeepers. He indicated if the emergency pull cord was not attached, the resident could not alert staff if something happened.</p>	{F 253}			



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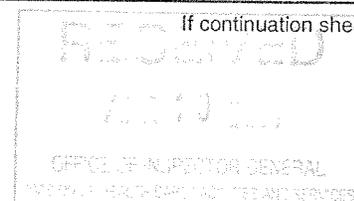
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{F 253}	<p>Continued From page 16</p> <p>On 03/06/14 at 10:12 AM, interview with the RPO revealed he had asked maintenance to repair the emergency pull cord in room 301's bathroom two (2) days ago. He further indicated housekeeping was in the room daily and were responsible to check the emergency cords and to notify the maintenance department of any needed repairs.</p> <p>Interview, on 03/07/14 at 11:22 AM, with the Assistant Director of Nursing (ADON) for the 300 unit revealed maintenance was responsible to maintain the emergency pull cord in resident bathrooms. She indicated the unit had a repair book to make maintenance requests. The ADON indicated if the resident's pull cord was not attached or in reach, the resident would not be able to notify if he/she needed assistance.</p> <p>4. Observation of the resident smoking patio, on 03/05/14 at 2:46 PM, revealed six (6) boxes with maintenance parts and two (2) empty boxes. In addition, three (3) large pipes were observed stored on the patio. Residents were observed utilizing the patio to smoke.</p> <p>On 03/06/14 at 10:12 AM, observation during environmental tour with the Maintenance Director, Environments Services Director (ESD), and the Regional Plant Operations (RPO) Manager revealed eight (8) boxes stored on the patio with maintenance supplies/parts, two (2) of the boxes were empty. In addition, three (3) large pipes were also in the smoking area.</p> <p>Interview, on 03/05/14 at 3:06 PM and 03/06/14 at 10:12 AM and 10:33 AM, with the Maintenance Director revealed the pipes and boxes on the resident smoking patio were parts for the sprinkler system that was currently undergoing</p>	{F 253}		



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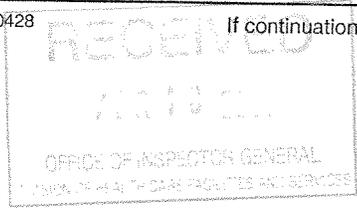
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{F 253}	<p>Continued From page 17</p> <p>repairs. He stated the work had begun in January and was scheduled to be completed by 03/24/14. The Maintenance Director stated the parts were being stored on the patio by the sprinkler company and should be stored elsewhere. He indicated the empty boxes should also have been disposed.</p> <p>On 03/06/14 at 10:12 AM, interview with the RPO revealed on the resident smoking patio the pipes and boxes should be stored in the facility basement. He stated the boxes of parts were a hazard on the patio as the boxes were flammable.</p> <p>Interview with the Director of Nursing (DON), on 03/07/14 at 11:35 AM, revealed she conducted rounds in the facility and if an issue with housekeeping or maintenance was observed she would notify the ESD or Maintenance Director and write the needs in the unit maintenance log book. She stated she had not identified issue with ceiling vents, privacy curtains, sink caulking, or flooring. The DON indicated she had seen where paint had been scraped from the walls behind some beds; however, had not seen gouges in the walls. Additionally, she stated the emergency pull cord in resident bathrooms were the responsibility of housekeeping and maintenance. She indicated if the pull cord was not available or in reach there was potential the resident would be unable to call for any needed assistance.</p> <p>On 03/07/14 at 2:07 PM, interview with the Administrator revealed he conducted facility rounds every day and would check several resident rooms. He stated the RPO would go through the facility monthly with a punch list of items for each resident's room. The Administrator</p>	{F 253}		



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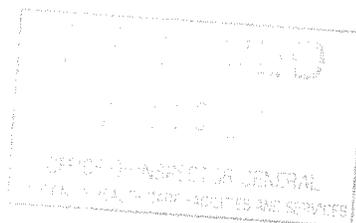
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{F 253}	Continued From page 18 indicated each unit had a maintenance log to request repairs and remain on the log until the repair was completed. He further indicated he monitored maintenance repairs randomly to follow up to ensure the repair was completed.		F 282 – Services by Qualified Persons/Per Ca  What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;		
{F 282} SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of policy and procedures and the facility's Allegation of Compliance (AOC), it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/07/14, had been removed related to implementation of written plans of care affecting two (2) of twenty-four residents (24) sampled residents (Residents #3 and #17). The facility had failed to ensure droplet isolation precautions were consistently implement for Resident #17 who had a diagnosis of Methicillian Resistant Staphylococcus Aureus (MRSA) and failed to ensure skin treatment was provided to Resident #3 per the plan of care.  An acceptable AOC was received on 03/20/14 alleging removal of the IJ on 03/10/14. Based on the findings of the revisit, it was determined the IJ was removed on 03/10/14, as alleged, with remaining noncompliance at a scope and severity of a "D" while the facility develops and	{F 282}	A.1. Family member #1 has been educated on the disease process, the reasons for using the PPE, and how to apply PPE appropriately by the DON on 3/8/14. Family member #1 was also placed on 1 to 1 supervision on 3/8/14 by MD order to ensure support and compliance with isolation standards. CNA was not specifically identified, but all CNAs were re-educated starting on 3/7/14 on the appropriate use of hand washing and application of PPE prior to entering an isolation room by the DON. CNAs have not been able to return to work until this training was provided. The careplan was reviewed and updated by the Interdisciplinary team on 3/8/14.  2. Resident #3 is now receiving barrier cream according to the care plan. CNA #7 was re-educated on providing care according to the care plan on 3/8/2014 by the Unit Manager. LPN # 1 was reeducated by the DON on 3/4/14 regarding the importance of charting the time for medications administered.	3/28/14	



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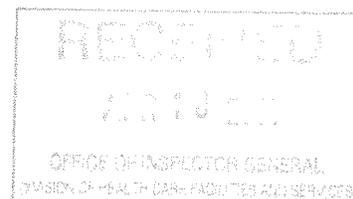
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{F 282}	Continued From page 19 implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.  The findings include:  Review of the facility's Allegation of Compliance (AOC) revealed the facility took the following immediate steps to remove the IJ:  1. Resident #17's care plan was reviewed and updated in daily clinical meetings until an order to discontinue isolation was obtained.  2. Additional residents have been placed in isolation. Care plans for these residents have been reviewed and updated, as needed. These residents were observed every sixty (60) minutes to ensure infection control practices were followed.  3. Care plans were reviewed and updated on 03/07/14 and 03/08/14 by the Interdisciplinary Team (IDT) which included the Administrator, Assistant Administrator, Director of Nursing, The Assistant Director of Nursing, Social Services, Minimum Data Set (MDS) Nurses, Dietary, and the Quality of Life/Transitional Care Nurse.  4. Education was started on 03/07/13 and was concluded on 03/09/14, which included infection control, use of personal protective equipment (PPE), hand washing, linen/laundry handling, cross-contamination, isolation precautions for specific infections, quality assurance and care plans. This education, was taught to all staff by Nursing Administration, RN Supervisors, Social Services, Dietary Administration, Signature Care	{F 282}	b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;  The nursing staff employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions, the use of PPE and providing care according to the care plan and documentation of education provided for visitors by the SDC, DON and social worker on 3/8/14 and 3/9/2014. As of 3/27/14, facility has inserviced 110 nursing staff with 5 still to be inserviced. A registered letter was mailed to them on 3/21/14 to make them aware of the required training. Current resident care plans were reviewed on 3/17/14 and 3/18/14 by the nurse management team and compared to the CNA care plans for accuracy and implementation. The ADONs reviewed and updated the CNA assignment sheets on 3/17/14 and 3/18/14 to ensure that interventions are current and being followed by the CNA's.  All residents had the potential to be affected.		



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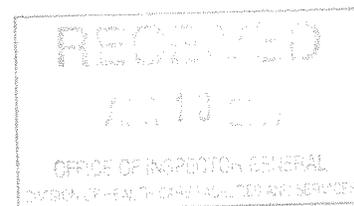
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{F 282}	<p>Continued From page 20 Consultant and the Administrator.</p> <p>5. Medication and wound care trainings related to Resident #3 were provided from 03/07/14-03/09/14 to Licensed Nurses by Administrative Nursing Personnel and the Signature Care Consultant.</p> <p>6. Licensed nurses, Certified Nursing Assistants (CNAs), and Occupational Therapists (OTs) were educated on perineal care from 03/07/14 to 03/09/14. Training was conducted by Nursing Administration and The Signature Care Consultant.</p> <p>7. Post education testing and skills competencies (hand washing, linen handling, wound care, perineal care, medication pass, and donning of PPE) were started with all staff on 03/07/14 with completion on 03/09/14.</p> <p>8. Signature East Louisville currently employees 197 staff members, one staff currently on leave, and with no agency staff.</p> <p>9. No staff was allowed to return to work without the mandated education listed above.</p> <p>10. Newly hired staff will be educated during the orientation process by the Staff Development Nurse.</p> <p>11. Policy and Procedure Revisions, no changes as determined, on 03/08/14, by the Corporate Regional Vice President.</p> <p>12. On 03/08/14, The Administrator met with the administrative team and initiated a process to introduce, develop, and implement plans for the</p>	{F 282}	<p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur;</p> <p>The nursing staff employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions, the use of PPE and providing care according to the care plan by the SDC on 3/7/14, 3/8/14 and 3/9/2014. As of 3/27/14, facility has inserviced 110 nursing staff with 5 still to be inserviced. 56 of the 110 are CNAs and 4 have not received the training. A registered letter was mailed to all that have not had the training on 3/21/14 to make them aware of the required training.</p> <p>Family member #1 was placed on 1:1 supervision by MD order on 3/8/14 to insure that the care plan to be followed.</p> <p>The Unit Managers or ADON will complete an audit on 3 staff members daily x 1 week and weekly x 12 during the provision of care to ensure that all care plan interventions are being followed in accordance with the plan of care. Any variance will be immediately addressed with re-education and or disciplinary action. The results of the audits will be forwarded to the DON for</p>	



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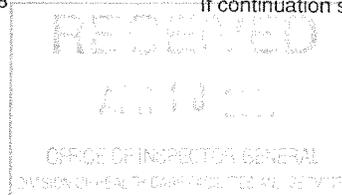
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{F 282}	<p>Continued From page 21 identified concerns. Concerns were to be addressed daily in the morning meetings, plans were developed, and teams were assigned to correct the concerns.</p> <p>13. Care plan adherence audits were to continue after the initial daily audits for thirty (30) days, weekly for thirty (30) days, and then monthly for a period of time to be determined by administration and Quality Assurance (QA) to ensure compliance.</p> <p>14. Findings would be discussed with the QA Committee to determine the need for further recommendations and additional follow-up. The DON would ensure completion of the audits, and follow up as needed.</p> <p>15. Oversight of the Care Plan Competency Audits would be conducted by the Administrator and the QA team.</p> <p>The State Survey Agency (SSA) verified through observation, interview and record review, the removal of Immediate Jeopardy (IJ) on 03/10/14, as alleged by the facility.</p> <p>1. Review of the care plan for Resident #17 revealed the 1:1 sitter intervention was added on 03/08/14. Discontinuation of the Droplet Isolation and the 1:1 sitter occurred on 03/14/14, with resumption of standard precautions during the resident's care.</p> <p>2. Review of the care plans for residents with changes in status revealed they were reviewed daily in clinical meetings by the Interdisciplinary Team (IDT). Any applicable changes deemed necessary were completed and then care plans</p>	{F 282}	<p>review. The audit consists of observing the actual care being provided to the resident by the CNA and comparing this to the CNA care record. The date of the first audit was 3/17/14.</p> <p>Licensed staff has completed post test competency training on care plans/CNA plans on 3/27/14. As of 3/27/14, 95 have completed the post test competency with another 20 to complete.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place;</p> <p>The DON will forward the results of the audits to the monthly Quality Assurance Committee for review and recommendations. The audits will continue daily x 1 week and weekly x 12 weeks. Facility administrator will oversee the all of the audits. If issues are identified during the audits, facility will put into place a plan of action or if needed have an additional QA meeting to address trends. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions. The administrator will oversee the QA process, auditing results and seeking trends that may require additional actions by the QA team.</p>	



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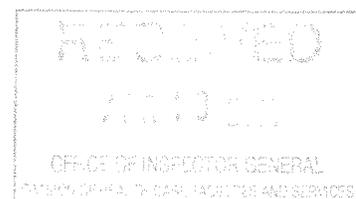
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{F 282}	<p>Continued From page 22 were monitored by the DON, ADONs, and the MDS nurses.</p> <p>3. Review of Resident #17's clinical record/care plan revealed the care plan was reviewed and updated daily, and as needed until the physician discontinued Droplet Isolation Precautions on 03/14/14.</p> <p>Review of the facility's care plan in-service sign in sheets and curriculum for that in-service revealed care plan implementation/revisions training was conducted on 03/09/14 by the facility's Regional Registered Nurse (RN) Consultant. A copy of the sign-in sheet (attendees) was provided which included names of the ADONs, the Staff Development/Infection Control Nurse, and other licensed nurses. Copies of the curriculum included the following policies: Interdisciplinary team care planning process (Dated 12-2010); Interdisciplinary Team Care Assessments (Dated 12-2010); Daily Review of Physician's Orders (Dated 12-2010); and At Risk Meetings (Dated 12-2010). Content of the At Risk Meetings Policy stated the meetings were conducted to focus the Interdisciplinary Team (IDT) on care standards, problem solving, care planning, intervening upon a change in a resident's condition, and communication across the IDT. Further review of documentation from this training revealed care plans of residents with changes in status would be reviewed daily in clinical meetings by the IDT. Any changes deemed necessary would be completed and then care plans would be monitored by the DON, ADONs, and the Minimum Data Set (MDS) nurses. Review of the infection control inservice revealed as of 03/27/14 one hundred and ten (110) nursing staff received the education with five (5) nursing staff who still</p>	{F 282}		



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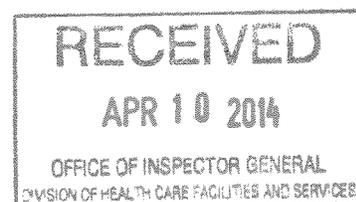
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{F 282}	<p>Continued From page 23</p> <p>needed the required education. Four (4) CNAs had not received the education. A registered letter was mailed on 03/21/14 to all those who had not received the training to make them aware of the requirement.</p> <p>Interview, on 03/26/14 at 10:22 AM, with LPN #2 revealed he attended a care plan inservice 03/08/14-03/09/14 along with several other inservices that related to infection control on the weekend after the IJ was announced on 03/07/14. LPN #2 stated he thought he understood the care planning process and would define the care plan as a plan to care for the resident. New interventions or revisions added to a resident's care plan should be monitored by the nursing staff for implementation and should be recorded via 'hot charting' every shift for a certain number of days. Hot charting should reflect if the new interventions were implemented and if they were effective.</p> <p>Interview, on 03/26/14 at 10:12 AM, with RN #2 revealed she had received care plan and infection control in-service education on 03/12/14 after returning from time off from work. RN #2 stated the primary purpose of the care plan was to provide an individualized plan to guide resident care. RN #2 stated she would expect to see an isolation care plan in place when isolation was ordered, and this information should also be on the CNA care plan. RN #2 stated licensed nurses were responsible for educating visitors in consistent use of PPE.</p> <p>Interview, on 03/26/14 at 10:31 AM, with CNA #3 revealed that on 03/08/14 she received re-education on infection control including isolation precautions. CNA #3 stated she was</p>	{F 282}		



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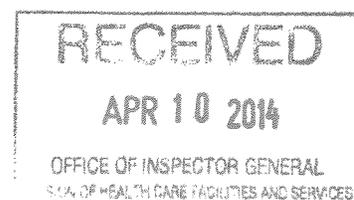
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{F 282}	Continued From page 24 aware CNA care plans were kept at the nurses' station for her review, and she would expect to see isolation precautions on the CNA care plan if a resident had been placed in isolation. CNA #3 stated if she saw a visitor about to enter an isolation room, she would ask them to speak to a unit's nurse before visiting the resident.  4. Review, of sign in sheets, training binders, and the post-tests completed by employees revealed infection control re-education began on 03/07/14, immediately after the IJ was identified. Staff that did not work on 03/07/14 received infection control re-education including instruction on isolation precautions, use of PPE, and proper handwashing technique upon reporting to work their next scheduled shift. Each staff member who received infection control in-service training was required to prove competency via a written post test, and a return demonstration of proper hand washing technique.  The facility had prepared sub binders that contained documentation of those who attended wound care and medication administration trainings for licensed nurses, and perineal care re-education for licensed nurses, CNAs, and Occupational Therapists (OTs). The binders contained policies and sign-in sheets documenting the attendees.  Review of the completed post-tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests fifteen (15) employees received training and were tested on 03/10/14, one (1) staff person was trained/tested on 03/11/14 and	{F 282}			



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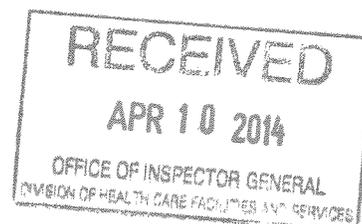
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{F 282}	<p>Continued From page 25 one staff person was trained/tested 03/12/14.</p> <p>Interview, on 03/25/14 at 1:30 PM, with the facility's Signature Care RN Consultant, revealed staff that were not trained while on duty on 03/07/14, were required to attend an infection control inservice, take a post test, and perform a return demonstration of proper hand washing technique before reporting to their assigned hallway to work. The Signature Care RN Consultant stated additional in-services were conducted later in the shift for employees which included re-education in proper wound care techniques, perineal care, medication administration, and safe handling of soiled linen.</p> <p>Observation, on 03/25/14 at 8:30 AM, revealed CNA #4 sanitized her hands and donned appropriate PPE at Isolation Room 326. CNA #4 knocked on the resident's door before carrying in a paper (disposable) tray of breakfast items.</p> <p>Interview, on 03/25/14 at 3:35 PM, with CNA #4 revealed she received infection control re-education after the identified IJ on 03/07/14, which included instruction in isolation precautions and proper hand washing technique. CNA #4 stated she was assigned to sit with Resident #17 for the two (2) days Resident #17 remained in Droplet Isolation. CNA #4 stated she was to ensure Family Member #1 donned PPE on entering the resident's room, kept it on, appropriately disposed of the PPE and washed her/hers hands before leaving the room. CNA #4 stated Family Member #1 complied with the isolation requirements.</p> <p>Review, on 03/26/14 at 11:05 AM, of the clinical record for Resident #28, revealed he/she had</p>	{F 282}		



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{F 282}	<p>Continued From page 26</p> <p>been placed in Contact Isolation for potential scabies. Nurses notes revealed the resident had three (3) small pin dot scabs on his/her upper torso and an order for Contact Isolation had been obtained on 03/25/14.</p> <p>Observation, on 03/26/14 at 11:00 AM, revealed three (3) housekeeping staff persons were wearing PPE while cleaning Room 301 on the Kentucky Pride Hallway where Isolation Precautions had been put into effect.</p> <p>Interview, on 03/25/14 at 3:50 PM, revealed Housekeeper #3 received re-education in infection control about two weeks ago, but could not remember the exact date. She stated she would don PPE as indicated on the isolation instruction card in the cart before entering the room. She would knock on the resident's door and clean. After completing the tasks she would remove the PPE, place it in the lined barrel in the room, wash her hands at the resident's sink. Housekeeper #3 stated upon cleaning her hands she used a clean paper towel to touch faucet handles.</p> <p>Interview, on 03/25/14 at 4:32 PM, with Laundry Services/House Keeping Staff #5, revealed she was instructed, in handwashing and proper use of PPE while processing soiled linen in the facility's laundry department, on 03/07/14. Laundry Staff Person #5 stated she was instructed to put on a disposable gown, gloves, and goggles when placing the soiled linen/towels/clothing in the washers.</p> <p>Interview, on 03/26/14 at 10:12 AM, with RN #2, revealed, she received infection control education, including hand washing with a required</p>	{F 282}			



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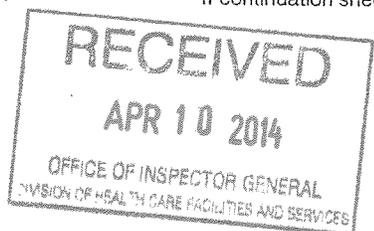
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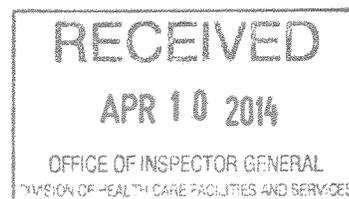
{F 282}	<p>Continued From page 27 return demonstration, when she reported to work on 03/12/14, after having time off from work.</p> <p>RN #2 stated she understood her role in educating visitors in proper isolation precautions before and during a visit to a resident in isolation. She stated the sign posted on the resident's door directed the visitor(s) to see a nurse for guidance before entering the isolation room.</p> <p>Interview, on 03/25/14 at 3:45 PM, with LPN #1 revealed she was trained on 03/10/14 upon reporting to work. She stated she was not allowed to work on her unit until she attended the required infection control inservice, completed a post-test, and demonstrated proper hand washing procedure. LPN #1 stated she received additional infection control in-service education related to resident care later in that day, which were taught by the MDS nurse.</p> <p>Interview, on 03/25/14 with RN #1, revealed she received re-education on 03/11/14, after returning from time off from work. RN #1 stated she was not allowed to report to her unit to work until she had received re-education in infection control, which addressed Isolation Precautions, hand washing, with a required return demonstration.</p> <p>5. Review of the sign in sheets and curriculum in the sub-binder for medication administration training revealed from 03/07/14-03/09/14, Licensed Nurses received medication administration and wound care re-education that included observance of infection control practices. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work.</p>	{F 282}		
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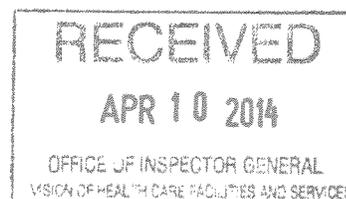
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{F 282}	Continued From page 28 6. Review of the sign in sheets and curriculum in sub-binder for perineal (peri) care revealed from 03/07/09- 03/09/14, Licensed Nurses, CNAs, and Occupational Therapists (OTs) were re-educated in peri care. Training was conducted by Nursing Administration and Signature Care RN Consultant. One licensed nurse received this training on 03/11/14 and one on 03/12/14 when they returned to work.  7. Review, on 03/25/14, of the dated post tests revealed a concern regarding "all training" completed prior to the AOC date of 03/10/14. Copies of the post tests for the employees trained on or after 03/10/14 were obtained. According to dates on the post tests, fifteen (15) employees received training and were tested on 03/10/14 and two (2) staff were trained/tested after 03/10/14, due to their scheduled time off from work. None of these employees were allowed to report to their units to work before completing the required training, testing, and return demonstration.  8. Review of the Employee Listing/Signature Payroll Services list provided by the administrator, revealed the facility employed 194 staff members.  9. Interview, on 03/25/14 at 1:30 PM, with the Signature Care RN Consultant revealed after the IJ was announced on 03/07/14, and prior to reporting to their assigned units to work, all staff members were required to attend an infection control in-service, complete the Care 2 Learn Infection Control Multiple Choice Test, and demonstrate competency in proper hand washing technique.  10. Interview, on 03/26/14 at 1:00 PM, with the	{F 282}		



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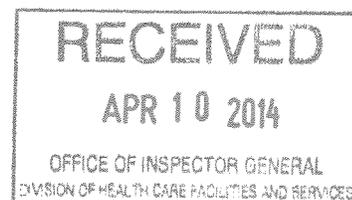
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{F 282}	<p>Continued From page 29</p> <p>Administrator revealed the facility had no new staff hired from 03/11/14 to 03/26/14.</p> <p>11. Review of the Quality Assurance Process Training sign in sheet revealed this inservice was held on 03/08/14 and conducted by the corporation's Regional Vice President. Copies of the policies reviewed during this meeting were attached and reviewed.</p> <p>12. Review of the facility's AOC binder revealed the Administrator met with the administrative team on 03/08/14 to make assignments for the audits. The audits were completed daily and acted upon by the facility.</p> <p>13. Care plan adherence audits were to continue after the initial daily audits for thirty (30) days, weekly for thirty (30) days, and then monthly for a period of time to be determined by administration and Quality Assurance (QA) to ensure compliance.</p> <p>14. Review of the facility's Performance Improvement Plan with Abaqis curricula, provided as part of the QA training of 03/08/14, revealed the Administrator was a required member of the facility's Performance Improvement (PI) Committee. The PI Committee would be comprised of the Administrator, along with other administrative staff, and at least two other facility employees. The facility would identify and monitor activities that focus on processes that significantly affect resident outcomes. This ongoing monitoring by the Administrator and The Signature Care Consultant would establish the facility's baseline and the predictability of various outcomes.</p>	{F 282}		



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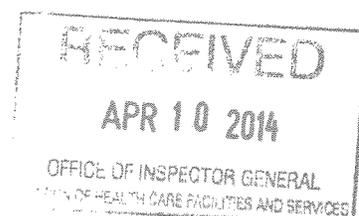
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{F 282}	Continued From page 30 Interview with the Administrator, on 03/26/14 at 1:00 PM, revealed he and The Signature Care Consultant would identify and monitor activities that focus on processes that significantly affect resident outcomes which would establish a baseline and the predictability of various outcomes.	{F 282}			
{F 314} SS=D	15. Interview, on 03/26/14 at 1:00 PM, with the facility's Administrator revealed he received the infection control audits and reviewed them with the DON, daily, to ensure proper follow up occurred as indicated.  483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy, it was determined the facility failed to ensure necessary treatment was provided to promote healing and prevent new pressure ulcer formation for one (1) of seven (7) residents with a pressure ulcer, out of a total sample of twenty-four (24). Resident #3 had healing pressure ulcers on the buttocks and was assessed to be at high risk for the development	{F 314}	F 314 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; Resident #3's skin assessment was completed by the licensed nurse on 3/18/14. -Resident #3 is receiving barrier cream as ordered by the physician. C.N.A. #7 was reeducated by the Unit Manager on 3/4/14 on the importance of reviewing the C.N.A care plan and utilizing the appropriate crême. LPN #1 was educated on 3/4/14 by the DON on the importance of documenting the time of medication administration and a medication competency assessment was completed on 3/12/14 by the Unit Manager.	3/28/14	



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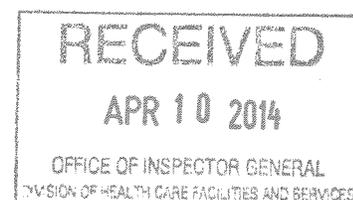
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{F 314}	<p>Continued From page 31 of additional formation of pressure ulcers. The resident's physician ordered skin barrier cream to be applied twice a day and with incontinence/soilage. Observation during a skin assessment revealed the skin barrier cream had not been applied as ordered.</p> <p>The findings include:</p> <p>Review of facility's policy for perineal care, effective date December 2010, revealed after perineal care was provided, apply lotion or barrier cream to the perineal area.</p> <p>Review of facility's policy titled Skin Management and Prevention, not dated, did not include preventive measures such as creams.</p> <p>Review of the skin barrier cream's manufacturer information, provide by the facility, revealed the barrier cream was recommended when skin was at risk or compromised. The cream prevented moisture, urine and fecal matter from contacting skin.</p> <p>Review of the clinical record for Resident #3 revealed the resident was admitted in November 2010. The resident had diagnoses of Dementia and Failure to Thrive. Review of the annual MDS assessment, conducted on 12/05/13, revealed the facility assessed the resident to be dependent on staff for bed mobility, toilet use, and transfers. The resident was assessed to be incontinent of bladder and bowel and was dependent on staff to provide incontinent care. Review of the pressure ulcer care plan, dated 11/25/13, revealed the resident had a pressure ulcer on the left and right buttock with interventions to provide incontinent care and apply barrier cream.</p>	{F 314}	<p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;</p> <p>All residents have the potential to be affected by this practice. An audit of all residents was completed by the licensed staff on 3/25/14 to ensure that the correct barrier ointment is being used on all residents.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not reoccur;</p> <p>Licensed staff and C.N.A.'s have been educated on 3/17/14 and 3/18/14 by the staff development coordinator, Registered Nurses, DON, and ADON on proper wound care protocols and proper treatment completion.</p> <p>A random audit of 5 % of residents receiving skin treatments will be performed by the Director of Nursing, Assistant Director of Nursing, SDC and RN's daily for one week and then weekly for 12 weeks to ensure compliance with proper treatment protocols.</p>	



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{F 314}	<p>Continued From page 32</p> <p>Continued review of the clinical record revealed the resident was under the care of a wound care specialist. The wound care physician was at the facility, on 03/03/14, and observed the resident's wounds. The physician documented in the progress notes that the resident's left buttock wound was superficial with measurements of 0.4 cm x 0.3 cm. The physician documented the right buttock ulcer was resolved with a scar.</p> <p>Review of the physician's order, dated 03/03/14, revealed to clean the buttocks with Normal Saline and apply barrier cream to the buttocks twice a day and as needed for incontinence/soilage. Review of the nurse's note, dated 03/03/14, revealed the nurse had documented the same information in the record.</p> <p>Observation of a skin assessment for Resident #3, with Licensed Practical Nurse (LPN) #1, on 03/04/14 at 3:00 PM, revealed when the nurse removed the disposable brief, the brief was dry without any barrier cream on the brief or on the resident's buttocks. The nurse indicated at this time that the nurse aide had just performed incontinent care. The nurse stated she had applied the barrier cream to the resident's buttocks earlier that day. However, she stated she did not see any barrier cream on the resident's buttocks during the skin inspection. She searched the resident's room and did not find any skin barrier cream.</p> <p>Interview with Certified Nursing Assistant (CNA) #7, on 03/06/14 at 9:40 AM, revealed she was the CNA who was responsible for Resident #3 on 03/04/14. She stated she had not applied skin barrier cream that day, but had applied lotion by</p>	{F 314}	<p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place;</p> <p>The audits by the DON, ADON, SDC and RNs will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	



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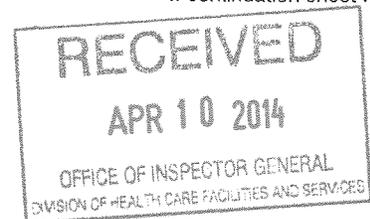
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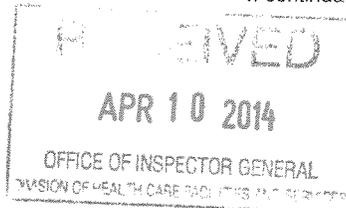
{F 314}	<p>Continued From page 33</p> <p>mistake. She stated she did not know to apply the skin barrier cream and none was available for use in the resident's room. She stated LPN #1 had instructed her on 03/04/13, after the skin assessment with the surveyor, to use the skin barrier cream after each incontinent episode.</p> <p>Interview with the 100 Unit Manager, on 03/06/14 at 9:45 AM, revealed the nurse aides have access to the skin barrier cream from central supply and should have obtained the barrier cream prior to 03/04/14. She stated the facility had recently changed skin products and the lotion that the CNA had used before would not have protected the resident's skin from moisture. She stated the change in treatment for Resident #3 must not have been communicated to CNA #7. However, she stated the CNA care plan had indicated the use of a skin barrier cream prior to the physician ordering the cream. The Unit Manager stated the CNA was responsible for reviewing each resident's care plan prior to caring for the residents and should have applied the barrier cream.</p> <p>Review of the CNA care plan for March 2014, revealed the resident was to be checked and changed every two hours and as needed. The resident's skin was to be cleaned with a cleanser and barrier cream was to be applied after each incontinent episode.</p> <p>Interview with the Director of Nursing (DON), on 03/07/14 at 2:45 PM, revealed when the facility changed the skin products information regarding the products were posted at each nurses' station. When asked if it was a read and sign, the DON revealed the staff was not required to sign if they read the information. In addition, there was no</p>	{F 314}		
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{F 314}	Continued From page 34 follow-up to ensure the direct care staff had read the information and understood the changes.	{F 314}		
{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, and review of the facility's policies, it was determined the facility failed to provide a functional hand washing station, foods were not sealed or dated, foods were expired, equipment was soiled and cans were found dented. In addition, the resident's refrigerator contained items that were not dated when opened and carried an expiration date dependent on the date opened.  The findings include:  Review of the facility's policy regarding Sanitation/Infection Control, not dated, revealed all cooking equipment, door seals, and surfaces of grills, burners and ovens are wiped off daily, and thoroughly cleaned regularly.  Review of the facility's policy regarding Infection Control, not dated, revealed adequate hand	{F 371}	F 371 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The towel dispenser in the hand washing area was repaired on 3/7/14, a garbage can has been placed by the hand washing station (placed on 3/4/14) and the paper towels that were in the canned area have been discarded (3/5/14). The undated items of ground beef, lemon meringue pie, box of waffles, box of beef patties and health shakes have been discarded (discarded on 3/4/14). The mixer, meat slicer, convection oven and all drawers have been cleaned (3/4/14). The expired thickened apple juice and whipping cream were discarded on 3/4/14. The warmer, clean bowl holder and all bowls have been cleaned 3/4/14. The dented cans (were picked up on 3/14/14) of nutrient health shakes were discarded on 3/4/14. The two bags of dried cereal, box of ready care pasta mix, and the partially used bag of pasta were discarded on 3/4/14. Bread tongs are no longer being placed in the bread bin. All dishes are thoroughly	3/28/14



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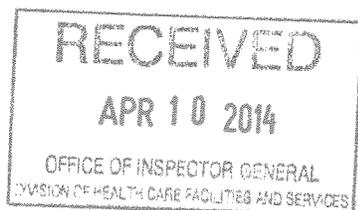
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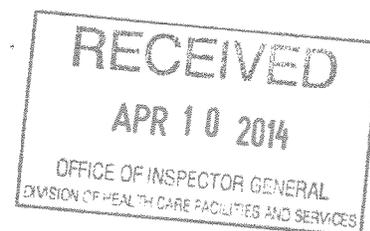
{F 371}	<p>Continued From page 35</p> <p>washing facilities would be available and included hot and cold running water, soap, and individual disposable towels. A trash receptacle with a step-on lid should be available in the hand-washing area.</p> <p>Review of the facility's policy regarding Food Storage, not dated, revealed metal or plastic containers with tight fitting covers must be used for storing cereals, cereal products, flour, sugar, dried vegetables, and broken lots of bulk foods. All containers must be legibly and accurately labeled. Leftover food would be stored in covered containers or wrapped carefully and securely. Each item would be clearly labeled and dated before being refrigerated.</p> <p>Review of the facility's policy regarding Infection Control and Food Handling, revealed efforts would be directed toward assuring that cross-contamination was minimized and hair coverings were worn.</p> <p>1. Observations during the initial tour of the Kitchen, on 03/04/14 at 8:30 AM, revealed a hand washing station with no garbage can. The paper towel dispenser did not work and a roll of paper towels was sitting on the shelf with canned goods in the dry storage area. Observation of the walk-in cooler revealed a box of ground beef with no date, a lemon meringue pie with no date, and a crate of healthshakes not dated. Observation of the walk-in freezer revealed a box of waffles and a box of beef patties opened, not sealed, and not dated. The mixer was found with a yellow substance on the beater mount. The meat slicer had a dried brown substance and was covered with plastic. The convection oven had a dark build up of a substance on the bottom of the</p>	{F 371}	<p>dried prior to use. The soup kettle has been removed from the main dining room on 3/10/14. The peanut butter, prune juice and apple juice found on the 300 hall refrigerator were discarded on 3/7/14. These corrections were made by the certified dietary manager.</p> <p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected by this practice. An audit of refrigerators in the kitchen and on the units was completed on 3/18/14 with no corrective action needed upon inspection.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Dietary staff was educated on 03/21/14 by the dietician and/or Regional Food Services coordinator on proper sanitation and food storage and preparation. Education was provided to the ADONs by the DON on 3/21/14 regarding inspection of the "on unit" refrigerators and their responsibility to monitor. Post training competency was</p>	
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE			STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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{F 371}	<p>Continued From page 36</p> <p>oven. A drawer in the food prep area contained a spoodle and a spatula with large chunks of unidentified debris in the base of the drawer. The reach-in cooler by the tray line contained thickened apple juice dated 12/27, tea dated 12/25, and whipping cream dated 2/26. The warmer had black debris on the tracks. The clean bowl holder had a dried yellow substance smeared down the inside of one of the channels which contained bowls. Two (2) dented cans of nutrient health drinks was found stored on the shelf in the dry storage room. Two (2) partially used bags of dry cereal were not dated. A box of pureed Ready Care pasta mix was expired and stored on the shelf in the dry storage room. A partially used bag of pasta was wrapped in cellophane and not dated.</p> <p>Interview with the Dietary Manager, on 03/04/14 at 9:05 AM, revealed she did not know where the trash can was for the hand washing station. She was aware the paper towel dispenser was not working; however, she did not see a problem with there being a roll of paper towels on the shelf and not individual paper towels. The Dietary Manager revealed the meat slicer was covered and ready for use and should have been properly cleaned and sanitized when last used. The Dietary Manager also revealed the Mixer was used the night before and should have been cleaned after use. The Dietary Manager revealed all food should be properly sealed and marked with a use by date. The Dietary Manager revealed the warmer was supposed to be cleaned nightly and the convection oven was cleaned monthly.</p> <p>Review of the cleaning schedule revealed the mixer and slicer were last cleaned on 03/03/14. The drawers in the prep area were noted as last</p>	{F 371}	<p>completed on 3/27/14 to ensure comprehension of the education. An audit will be completed by the dietician, Administrator or dining services manager weekly x 12 weeks to ensure substantial compliance is met.</p> <p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur,i.e. what quality assurance program will be put into place; The audits by the RD, administrator or Dining Manager will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>		



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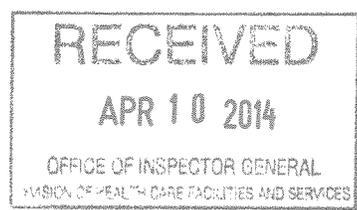
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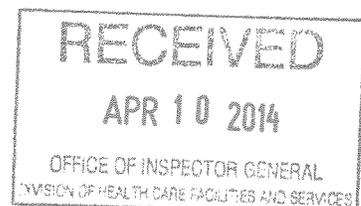
{F 371}	<p>Continued From page 37 cleaned on 03/02/14. The convection oven was not listed for cleaning.</p> <p>Interview with the Dietary Manager on 03/06/14 at 9:10 AM, revealed wet dishes should not be used and serving utensils should not be placed in food to prevent cross contamination. The Dietary Manager revealed she does correct issues identified when she is on the tray line. However, there was not a routine or scheduled time she monitored the tray line and did not remember when last observed. Further interview, on 03/06/14 at 3:00 PM, revealed pies should be used within 3 days of being thawed and health shakes should be used within 10 days of being thawed. The Dietary Manager revealed these items should have had a use by date marked on them and she was not aware when the items were thawed.</p> <p>Observation of the tray line service, on 03/04/14 at 5:05 PM, revealed the hand washing station still did not have a working paper towel dispenser or a garbage can. The bowl holder still contained the dried yellow substance and bowls were being removed for use during tray line. The bread tongs were repeatedly placed in the bread bin on the buns. Four (4) wet plates, wet warmers, and wet plate holders were used and placed on trays to be served. After surveyor intervention, the server found multiple wet dishes stored by the steam table ready for use.</p> <p>Interview with the Dietary Server, on 03/04/14 at 5:40 PM, revealed she was not aware of a potential problem serving food on a wet plate and had not heard of this being a problem before. The Dietary Server revealed serving utensils should not be placed down in the food containers</p>	{F 371}		
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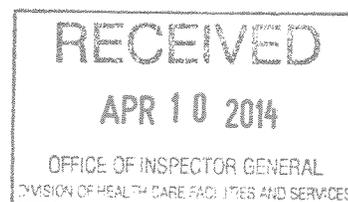
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{F 371}	<p>Continued From page 38 due to a potential for cross contamination.</p> <p>Interview with the Dietary Manager on 03/06/14 at 9:10 AM, revealed she did a walk through several times a week. The Dietary Manager revealed she did not use a rubric or log during rounds to take notes of findings, or of any changes made. The Dietary Manager revealed her last walk through was done 03/03/14.</p> <p>2. Observation of the meal service in the Main Dining Room, on 03/04/14 at 6:40 PM, revealed the Activities Director and multiple Certified Nursing Assistants (CNAs) dispensing soup from the soup pot on the steam table and serving food without wearing a hair covering.</p> <p>Interview with the Activities Director, on 03/06/14 at 9:45 AM, revealed she was never educated to wear hair coverings when dispensing food, was only told to ensure her fingers did not get into the bowl, and to remind the residents if the soup was hot.</p> <p>Interview with Certified Nursing Assistant (CNA) #5, on 03/06/14 at 11:45 AM, revealed she was never told to wear any type of hair covering when dispensing or serving food.</p> <p>Interview with the Dietary Manager on 03/06/14 at 9:10 AM, revealed The Dietary Manager revealed there had never been any discussion of the staff wearing hair coverings while dispensing soup in the main dining room.</p> <p>3. Observation, on 03/04/14 at 2:17 PM and 03/07/14 at 11:14 AM, revealed the refrigerator in the 300 Unit supply room contained a five (5)</p>	{F 371}		



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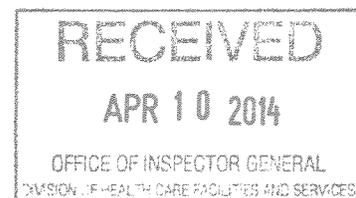
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{F 371}	<p>Continued From page 39</p> <p>pound tub of peanut butter that had been opened and not dated, a carton of prune juice opened and dated 02/11, and apple juice opened and dated 12/23. The carton of apple juice had instructions to refrigerate up to five (5) days after opening.</p> <p>Interview with Registered Nurse (RN) #3, on 03/07/14 at 11:14 AM, revealed food and drink items should be dated when opened. She indicated the dated juices were past use after being opened and the prune juice, apple, juice, and peanut butter should be thrown away. The RN further indicated she was not responsible to monitor the refrigerator and its contents and was unaware who was responsible to ensure items were dated and within date of use. She stated if the peanut butter was not dated when opened, there was no way to know if it was still within the time for use. Additionally, she indicated using expired food and juices could cause residents to become sick.</p> <p>On 03/07/14 at 11:22 AM, interview with the 300 unit Assistant Director of Nursing (ADON) revealed everyone on the unit was responsible to monitor the refrigerator in the storage room. She indicated there was no record indicating the refrigerator had been checked by nursing staff. Additionally, the ADON indicated she did not monitor if the unit staff was checking the refrigerator. She further indicated serving residents expired food and drinks could cause residents to become sick.</p> <p>Interview, on 03/07/14 at 11:35 AM, with the Director of Nursing (DON) revealed everyone was responsible to monitor food and drinks in the refrigerator on the 300 unit. She stated the ADON</p>	{F 371}		



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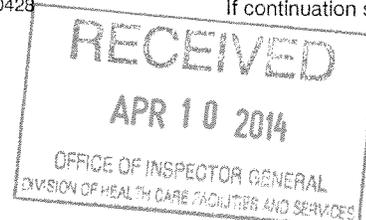
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{F 371}	Continued From page 40 was responsible to monitor the refrigerator on the unit, in addition to herself and the Administrator. The DON indicated she did not monitor if the ADON had checked the refrigerator's contents were dated and within date.	{F 371}		
{F 372} SS=F	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY  The facility must dispose of garbage and refuse properly.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy Infection Control it was determined the facility failed to ensure garbage and used cooking oil was properly disposed and the dumpster area was maintained to prevent the harborage of pests.  The findings include:  Review of the facility's policy Infection Control, not dated, revealed garbage and waste are disposed promptly and properly.  1. Observation of the dumpster area, on 03/06/14 at 8:50 AM, revealed the cardboard dumpster had both side doors open and a chair placed in front of the dumpster. The lid to the grease bin was found open with a large pool of dark colored grease on the ground extending the entire length of the bin and down the side. The snow pile in front of the grease bin was covered in oil and pooled in the center. A wood pallet was found behind the garbage dumpster. A bag of garbage was found lying on the ground next to	{F 372}	F 372 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The chair was removed from around the dumpsters, the grease bin and area around was scrubbed, dumpster doors verified closed and the wooden pallet was relocated away from the dumpster. These corrections were completed on 3/8/14 by the maintenance director and environmental services director.  b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents have the potential to be affected by this practice.  c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; Dietary and maintenance staff has been educated by the administrator and Regional Food	3/28/14



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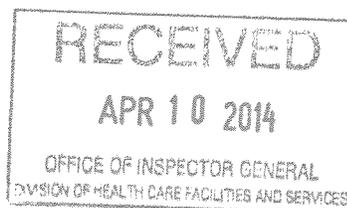
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{F 372}	Continued From page 41 the dumpster.  Interview with the Dietary Manager, on 03/06/14 at 8:50 AM, revealed the Assistant Dietary Manager had emptied the grease on 03/04/14. The Dietary Manager revealed she was told the Assistant Dietary Manager fell over the snow while emptying the grease, but did not know it was on the ground. The Dietary Manager revealed there was a potential for attracting pests and rodents by leaving doors and lids open and having grease pooled on the ground. The Dietary Manager revealed the Maintenance Department was responsible for maintaining the dumpster area.  Interview with the Assistant Dietary Manager, on 03/06/14 at 9:05 AM, revealed he did spill the grease on the ground after falling over the snow that was piled up in front of the grease bin. The Assistant Dietary Manager revealed he did notify the Manager he fell, and assumed she knew it was on the ground. The Assistant Dietary Manager revealed he did not notify the maintenance or housekeeping department of the spill.  Observation, on 03/07/14 at 11:25 AM, during the environmental tour with the Maintenance Director, Environmental Services Director (ESD), and the Regional Planter Operations (RPO) Manager revealed the dumpster area had a chair in front of one (1) of three (3) dumpsters and still had a large amount of cooking oil on the ground in front of the oil waste container.  Interview, on 03/07/14 at 11:25 AM, with the Maintenance Director, ESD, and RPO revealed the Maintenance Director stated he and the ESD	{F 372}	services coordinator on 3/18/14 on dumpster and grease trap policy and procedure. An audit of the dumpsters, grease trap and surrounding area checking for spilled grease, garbage on ground, refuse around the area, will be completed by the Administrator or Administrator in Training weekly x 12 weeks to ensure substantial compliance is met.  d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; The audits by the administrator or administrator in training will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.		



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{F 372}	Continued From page 42 were responsible to clean and maintain the dumpster area, and any cooking oil that had spilled. The ESD indicated the spill of cooking oil should have been cleaned up when the spill occurred. He further indicated an unclean dumpster area was a risk of contamination to others or could cause someone to slip. The RPO stated the maintenance department was responsible to maintain the dumpster area. He indicated uncontained waste was a risk to pest control.  Interview with the Administrator, on 03/07/14 at 2:07 PM, revealed he last checked the dumpster area five (5) days ago. He stated the snow removal company had piled the snow in front of the dumpsters. The Administrator indicated staff had piled garbage in front of the dumpsters. He further indicated at the end of the day, all of the trash had been properly disposed of and the dumpster area had been cleared. He stated the cooking oil was changed four (4) days ago by the Assistant Dietary Manager. The Administrator indicated the person responsible for the spill should be the person responsible to clean the spill. Additionally, he stated housekeeping and maintenance departments were responsible to police the grounds and ensure the area was free of trash and debris.	{F 372}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all	{F 431}	F 431 a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice; The identified cans of enteral feeding were disposed of on 3/4/14 by the Central Supply Clerk.	3/28/14



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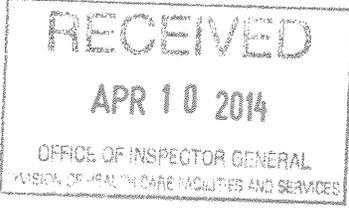
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{F 431}	<p>Continued From page 43</p> <p>controlled drugs is maintained and periodically reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure expired and dented cans of enteral feedings were removed from use from one (1) of the three (3) units, the 300 unit. The enteral feeding storage room for the 300 unit had four (4) cans of Vital 1.5 cal. that had a pre-stamped expiration date of 12/01/13. Additionally one (1) can of Nepro was dented so severely it was flat on one side of the</p>	{F 431}	<p>b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken; All residents who utilize enteral products have the potential to be affected by this practice. An audit of rooms for residents utilizing enteral feeding was completed on 3/4/14 by DON and central supply with no dented or outdated cans noted.</p> <p>c.)What measures will be put into place or what systemic changes will be made to ensure that the deficient does not occur; The central supply clerk was in serviced by the director of nursing on 3/18/14 on proper enteral can storage, need to audit for expiration dates and the intactness of cans of enteral feeding. An audit will be performed daily by the director of nursing or assistant director of nursing of enteral products for one week and then weekly for 12 weeks to ensure compliance with proper enteral feeding storage, container integrity and expiration dates.</p>	
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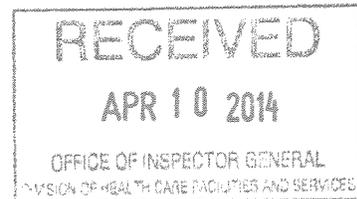
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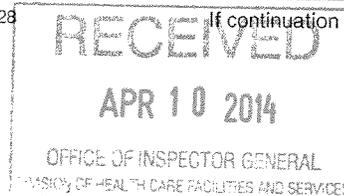
{F 431}	<p>Continued From page 44</p> <p>can. All of the cans were intermingled with the rest of the cans and available for use.</p> <p>The findings include:</p> <p>The facility did not provide a policy related to enteral feeding and storage.</p> <p>Observation, on 03/04/14 at 2:42 PM, of the 300 unit storage closet revealed multiple enteral feedings. Cans available for use included four (4), eight ounce cans of Vital with expiration dates of 12/01/13 and one (1), eight ounce can of Nepro was dented at the seam.</p> <p>Interview with Registered Nurse (RN) #3, on 03/07/14 at 11:14 AM, revealed she was unaware of who was responsible to check the enteral feeding or if any one person was responsible. She indicated all staff who removed enteral feeding cans was responsible to check the cans and ensure they were not dented or expired. The RN further indicated using a dented or expired can of enteral feeding could cause a resident to become sick.</p> <p>On 03/04/14 at 11:22 AM, interview with the 300 Unit Assistant Director of Nursing (ADON) revealed the Central Supply Coordinator (CSC) was responsible to stock and maintain the enteral feeding storage. She indicated the nurses on the unit checked the cans when they used the enteral feedings and would notify the (CSC). The ADON further indicated a resident could become sick if a dented or expired can of enteral feeding was given to a resident.</p> <p>Interview with the CSC, on 03/07/14 at 11:30 AM, revealed she was responsible to check enteral</p>	{F 431}	<p>d.)How the corrective actions(s) will be monitored to ensure the deficient practice will not reoccur,i.e. what quality assurance program will be put into place;</p> <p>The audits by the DON and ADONs will continue weekly for three months and then monthly thereafter to ensure compliance. The audits will be reviewed for trends monthly and reported to the quality assurance committee for the next three months and quarterly thereafter. The committee will re-evaluate the effectiveness of the interventions.</p>	
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NAME OF PROVIDER OR SUPPLIER  SIGNATURE HEALTHCARE OF EAST LOUISVILLE		STREET ADDRESS, CITY, STATE, ZIP CODE 2529 SIX MILE LANE LOUISVILLE, KY 40220		
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{F 431}	<p>Continued From page 45</p> <p>feeding for dented and expired cans and bottles. She indicated she rotated stock so the first in would be the first used. The CSC further indicated if expired or dented cans of enteral feeding were administered to a resident, the feeding could harm the resident and cause the resident to become sick.</p> <p>Interview, on 03/04/14 at 11:35 AM and 2:07 PM, with the Director of Nursing (DON) revealed the CSC was responsible to stock the enteral feedings and should check expiration dates and check for dented cans. She indicated the ADON was also responsible to check enteral feeding storage. The DON stated she was ultimately responsible to ensure dented and expired cans were removed and unavailable for use. She indicated she rounded on the units; however, she had no record of checking the enteral feeding storage. Additionally, she stated the ADON did not submit to her for review any documentation of verifying enteral feedings were monitored. The DON indicated she, the Administrator, and the CSC had worked for three (3) days on the enteral feeding storage on the 300 unit in January 2014. She stated they had reorganized and moved supplies in the storage closet and the cans should have been discovered.</p> <p>On 03/04/14 at 2:07 PM, interview with the Administrator revealed he, the DON, and the CSC had all three (3) just reorganized the enteral feeding storage room on the 300 unit in January 2014. He stated they all should have caught the expired cans of enteral feeding. The Administrator indicated the facility did not have record of monitoring the enteral feedings for dented or expired cans; however, the CSC was usually responsible as she was the person who</p>	{F 431}		



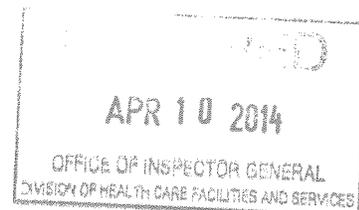
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{F 431}	Continued From page 46 would stock the supply for the units.	{F 431}		
{F 441} SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary 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 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.	{F 441}	F 441  a.)What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;  Resident #17 was assessed on 3/7/2014 by the RN without changes in status noted. Resident #17's spouse was educated on infection control and PPE the RT was re-educated on proper infection control practice related to droplet precautions and cleansing of equipment properly on 3/6/2014 by the DON. Resident #20 was assessed on 3/18/2014 by the DON related to her current treatment for UTI. She is without changes in status. Care plan was reviewed with no changes required. CNA #6 was re-educated on the hand washing policy and procedure and the changing of gloves policy and procedure on 3/6/2014 by the DON. Resident #3's skin was assessed on 3/18/2014 by the unit manager and presents with no skin breakdown or changes in status. Resident #3 continues to receive barrier cream as ordered. Care plan was reviewed with no changes required. LPN#1 was re-educated on the hand washing	3/28/14



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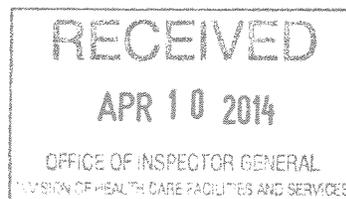
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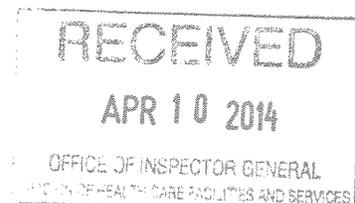
{F 441}	Continued From page 47  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, policy review, and the facility's Allegation of Compliance (AOC), it was determined the Immediate Jeopardy (IJ) identified during the annual survey, concluded on 03/07/14, had been removed related to the facility's failure to maintain an effective infection control program to help prevent the development and transmission of disease and infection for one (1) of two (2) residents in isolation precautions (Resident #17). In addition, multiple breaks in technique were observed during the 03/07/14 annual survey related to hand hygiene, glove use, eye medication administration, laundry process, and use of Personal Protective Equipment (PPE). This had affected five (5) of twenty-four (24) sampled residents (Residents #3, 10, 13, 17, and 20), and two (2) of thirteen (13) Unsampled Residents (Unsampled Residents L and M).  An acceptable AOC was received on 03/20/14 alleging removal of the IJ on 03/10/14. Based on the findings of the revisit, it was determined the IJ was removed on 03/10/14, as alleged, with remaining noncompliance at a scope and severity of an "E" while the facility develops and implements a Plan of Correction and monitors the effectiveness of systemic changes and quality assurance activities.  The findings include:  The facility provided an Allegation of Compliance (AOC) on 03/20/14 alleging Immediate Jeopardy	{F 441}	policy and procedure and the changing of gloves policy and procedure on 3/4/2014 by the DON. LPN #1 on 3/4/14 completed a skin assessment competency with the DON without concerns. Resident #10 was assessed on 3/18/2014 by the DON related to recent course of antibiotic eye drops. Treatment concluded on 3/5/2014 and is currently without changes in status. Care plan was reviewed by the DON with no changes necessary. RN #2 was re-educated on the policy and procedure for administering eye drops to a resident to include hand washing prior to donning gloves and after removal 3/5/2014 by the DON. RN #2 completed a Medication administration competency on 3/8/14 with the Corporate Nurse. Resident #13 was assessed on 3/18/2014 by the ADON and currently is without symptoms of infection. RN#1 was re-educated on the clean dressing change policy and procedure to include hand washing, establishing clean field with wound care competency on 3/4/2014 by the DON without concerns. RN #1 was re-educated on the hand washing policy with a hand washing competency completed by the DON on 3/5/2014 by the DON and on 3/11/14 by the SDC without concerns.	
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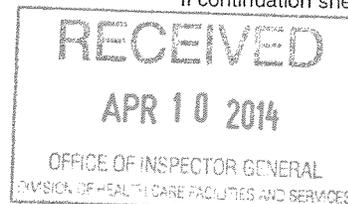
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{F 441}	<p>Continued From page 48</p> <p>(IJ) was removed on 03/10/14; the facility took the following immediate steps to remove the IJ:</p> <ol style="list-style-type: none"> <li>Review of the clinical record revealed a head-to-toe clinical assessment was completed for Resident #17 by a licensed nurse.</li> <li>On 03/07/14, Resident #17's visitor was re-educated on proper use of Personal Protective Equipment.</li> <li>On 03/07/14, The Signature Care Consultant posted signage on Resident #17's door that read, "Visitors- Please report to the nurses station before entering." Nursing management staff was responsible to ensure that signage stayed in place. On 03/07/14 a sign that alerted staff to the specific type of isolation and required personal protective equipment will be placed inside the isolation cart directly located outside of the residents door. The isolation specific instructions will not be visible to the general public.</li> <li>Resident #17's visitor arrived at the facility daily at approximately 9:30 AM and will be met by staff at the facility's entrance. The visitor's personal belongings will be placed in a plastic bag and he/she will be escorted by staff to Resident #17's room, and assisted by nursing, social services, admissions personnel, or the chaplain with donning PPE.</li> </ol> <p>A sitter will stay with Resident #17 during the visit and ensure the visitor adheres to infection control policies and procedures, per the physician's order. When the visitor is ready to leave, he/she will be assisted by nursing, social services, admissions personnel, or the facility's chaplain with proper removal of the PPE and hand</p>	{F 441}	<p>Resident L was assessed on 3/18/2014 by the DON and is currently without symptoms of infection. The facility is unable to determine who CNA #2 is, but all CNA's have been educated on infection control and proper handwashing.</p> <ol style="list-style-type: none"> <li>Family member #1 was placed on 1:1 supervision when she visited Resident #17 by MD order on 3/8/14. A staff member would accompany the resident to the room upon arrival to the facility and assist in the application of isolation apparel, (gloves, gown, mask) and personal belongings were bagged. Staff assistance ensured that hand sanitization was completed prior to entering and leaving the room and proper PPE was donned appropriately before entering Resident #17's room.</li> </ol> <p>Education was provided on 3/8/14 to Family Member #1 by the DON on infection control precautions including use Personal Protective Equipment, hand washing and isolation precautions.</p> <p>The RT was re-educated on proper infection control practice related to droplet precautions and cleansing of equipment properly on 3/6/2014 by the DON.</p>



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{F 441}	Continued From page 49 washing. The visitor's personal belongings will be removed from the bag and returned to him/her.  5. The 1:1 sitter intervention was removed on 03/14/14 when Resident #17 was cleared from Isolation Precautions.  6. Education was started on 03/07/13 and was concluded on 03/09/14, which included infection control, use of personal protective equipment (PPE), hand washing, linen/laundry handling, cross-contamination, isolation precautions for specific infections, quality assurance and care plans. This education, was taught to all staff by Nursing Administration, RN Supervisors, Social Services, Dietary Administration, Signature Care Consultant and the Administrator.  7. Medication and wound care training's were provided from 03/07/14-03/09/14 to Licensed Nurses by Administrative Nursing Personnel and the Signature Care Consultant.  8. Licensed nurses, Certified Nursing Assistants (CNAs), and Occupational Therapists (OTs) were educated on peri care from 03/07/14 to 03/09/14. Training was conducted by Nursing Administration and The Signature Care Consultant.  9. Post education testing and skills competencies (hand washing, linen handling, wound care, peri care, med pass, and donning of PPE) were started with all staff on 03/07/14 with completion on 03/09/14.  10. Signature East Louisville currently employees 197 staff members, one staff currently on leave, and with no agency staff.	{F 441}	2. RN #2 was re-educated on the policy and procedure for administering eye drops to a resident to include hand washing prior to donning gloves and after removal 3/5/2014 by the DON. RN #2 completed a Medication administration competency on 3/8/14 with the Corporate Nurse.  3. Laundry Aide #2 was not specifically identified, but all laundry staff was educated on the proper use of PPE when handling soiled linen on 3/9/2014 by the housekeeping supervisor, ADON, DON, RNs, LPN Unit managers.  4. RN #1 was re-educated on the clean dressing change policy and procedure to include hand washing, establishing clean field with wound care competency on 3/4/2014 by the DON without concerns.  5. RN #1 was re-educated on the hand washing policy with a hand washing competency completed by the DON on 3/5/2014 by the DON and on 3/11/14 by the SDC without concerns.  6. CNA#2 was not specifically identified, but all were educated on the hand washing policy and procedure on 3/9/2014 by the ADON, DON, RNs, LPN Unit managers.	



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{F 441}	Continued From page 50  11. No staff were allow to return to work without the mandated education listed above.  12. Newly hired staff will be educated during the orientation process by the Staff Development Nurse.  13. Compliance observations of staff occurred three times daily via an Infection Control Monitoring Checklist, in order to ensure adherence to infection control policies and procedures. Checklists will be kept in the AOC book in the Administrator's office.  14. Policy and Procedure Revisions, no changes as determined, on 03/08/14, by the Corporate Regional Vice President.  15. Findings would be discussed with the QA Committee to determine the need for further recommendations and additional follow-up. The DON would ensure completion of the audits, and follow up as needed. The Administrator would review the findings of the daily infection control audits Sunday through Saturday.  On 03/26/14 the State Survey Agency (SSA) verified through observation, interview and record review, removal of Immediate Jeopardy (IJ) on 03/10/14, as alleged by the facility.  1. Review of Resident #17's clinical record revealed a head-to-toe assessment was completed by a licensed nurse on 03/07/14. Interview with Registered Nurse (RN) #1, on 03/25/14 at 2:35 PM, revealed she was the nurse who did a head-to-toe assessment on Resident #17 on 03/07/14.	{F 441}	7. LPN#1 was re-educated on the hand washing policy and procedure and the changing of gloves policy and procedure on 3/4/2014 by the DON. LPN #1 on 3/4/14 completed a skin assessment competency with the DON without concerns. 8. CNA #6 was re-educated on the hand washing policy and procedure and the changing of gloves policy and procedure on 3/6/2014 by the DON.  b.)How other residents having the potential to be affected by the same deficient practice will be identified and what corrective actions(s) will be taken;  All residents have the potential to be affected by this practice. Every staff member employed by the facility was re-educated on the facilities Infection Control Policy and Procedures including hand washing, changing of gloves, handling linen, cleaning equipment, isolation precautions and the use of PPE. Each licensed nurse was re-educated on the clean dressing change		

