

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

PRINTED: 12/27/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>12/12/2013</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217</b>
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F 000	INITIAL COMMENTS	F 000		
F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated</p>	F 225		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *X. M. Maureen Caustrey* TITLE: *X. Administrator* (X6) DATE: *1/30/13*

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



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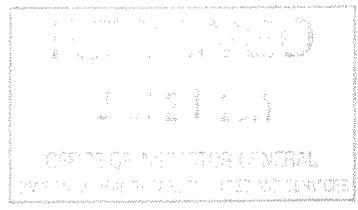
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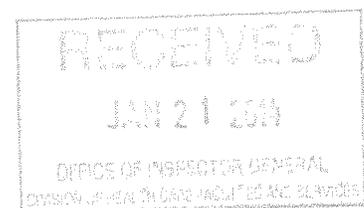
F 225	<p>Continued From page 2</p> <p>provided to the State Survey Agency, Adult protective Services, and as appropriate, law enforcement officers. The report shall be provided within five (5) working days of the incident.....5. A copy of the investigation report shall be provided to the QA Committee.....</p> <p>Under the Misappropriation of Resident Property section of the "Abuse Policy"....6. As soon as possible, but within no more than 2 hours of the suspected abuse, neglect or mistreatment, the Administrator shall notify the State Agency, local agencies (public health and local law enforcement (of the suspect abuse, neglect or mistreatment.</p> <p>1. During the review of the 5G Protocol regarding Abuse investigations, completed by the facility, it was determined Resident #4 had reported \$200.00 missing the week of 11/18/13. This had been reported to the Accounts Manager, on 11/25/13. Review of the "Report of Missing Property", completed by the facility, revealed the resident reported a family member had given him/her cash for his/her birthday, and had put the money inside a pocket of a sweater inside the room closet. The report revealed the resident was unsure if the closet had been locked or not, and expressed he/she was not so concerned, but wanted the facility aware.</p> <p>Review of Resident #4's clinical record revealed the resident had been admitted, on 12/07/10, with diagnoses of Osteoarthritis, Hypertension, and Peripheral Vascular Disease. The resident was alert and oriented with no behavior concerns, according to the 11/08/13 Annual Comprehensive Assessment.</p>	F 225	<p>speak with the residents as a whole on the topic of ways to safeguard self and belongings, in order to assure them that we are putting proper emphasis on their concerns.</p> <p>In order to ensure that all reports or complaints of alleged loss if property are addressed, the following steps will be taken:</p> <p>When the Administrator is made aware of any monetary loss, three individuals will help with the report of the alleged loss. These persons will be a Sister Supervisor, Residents Account Manager and staff member with knowledge of the complaint. The Social Services Director will record all of the findings on the designated form from the State. This will also be recorded on the "Missing Property Report" form in the social services office.</p> <p>The information is transmitted via fax to the appropriate State Agency. All records are kept confidential. When the investigation is completed by a representative from the State or any other agency, it will be noted in the Resident's personal chart. All information is to be kept confidential.</p>	
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F 225	<p>Continued From page 3</p> <p>Interview with Resident #4, on 12/12/13 at 4:10 PM, revealed the resident's closet was locked and the key was kept on his/her person. The resident revealed he/she did not know how the key was used to unlock the closet, but stated it could be done. The resident stated there had been no follow-up regarding the incident, and the Social Services Director had spoke with him/her initially after the incident.</p> <p>Interview with the Director of Nursing (DON), on 12/12/13 at 3:55 PM, revealed she may have heard something in passing regarding the incident, but did not know the outcome. The DON stated the Social Services Director always handles any allegations of Misappropriation of Property, and forwards the "Report of Missing Property" to the Administrator for reporting.</p> <p>Interview with the Social Services Director, on 12/12/13 at 3:30 PM, revealed all residents are given locked closets upon admission. The Director stated she was responsible for completing the initial report, which is given to the Administrator for reporting. The Social Service Director stated there were few reports of abuse or misappropriation in the facility; however, stated residents are encouraged to report any grievances upon admission. The Director stated she interviewed Resident #4 after the incident was reported to her, and the resident was not concerned about the money at the time.</p> <p>Interview with the Administrator, on 12/12/13 at 3:50 PM, revealed Resident #4 had not told the administrator of the incident; however, revealed the incident was reported to the Account Manager, who reported to Social Services Director. The Administrator stated that Social</p>	F 225	<p>Going forward, all pertinent staff has reviewed LSP policy on 1/13/2014 and is aware of their responsibilities. Furthermore, Little Sisters has a Theft and Loss Prevention Program in place that includes newly hired employees being trained regarding Resident Abuse/Neglect Policy; a written inventory of resident's personal property; a Missing Property Report completed, as well as notifications to appropriate State agencies, as required.</p> <p>Little Sisters will enhance current mandatory staff in-service of Resident Abuse and Neglect by reviewing at such time, staff responsibilities when Resident misappropriation of property is alleged.</p> <p>This policy will be discussed at the next Quality Assurance Meeting (QA) on January 15th.</p> <p>At the QA suggestions for improvement will be examined and recorded in the minutes.</p>	1/16/2014	





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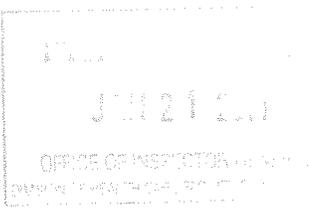
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<p>F 225</p> <p>F 226 SS=D</p>	<p>Continued From page 5</p> <p>previous employee here. The HR director stated the Nurse Aide Registry Check should have been completed prior to starting work.</p> <p>483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES</p> <p>The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility "Abuse Policy", it was determined the facility failed to follow their policy for screening, reporting and investigating allegations of Misappropriation of Property regarding one (1) of ten (10) sampled residents (Resident #4).</p> <p>The findings include:</p> <p>Review of the facility policy "Resident Abuse/Neglect" revised 03/09/09, revealed under "Investigation"...1. The Administrator shall conduct an investigation and report the results as noted: a. observation and interview of the resident. b. Review of the resident's clinical record...c. staff, resident, family and /or visitor interviews including, in the case of suspected resident abuse, all staff assigned to the resident during the previous 48 hours..d. review of incident reports involving the resident.. e. review of employee schedules and personnel records and f. review of Quality Assurance records.....2. The</p>	<p>F 225</p> <p>F 226</p>	<p><b>POC Violation 226</b></p> <p><b>Investigate/Report Allegations/ Individuals</b></p> <p><b>A complete internal investigation of the loss was done. This loss was reported to the Office of the Inspector General on January 8, 2014. In order to prevent further losses of this nature the Policy in our Social Service Office was reviewed by the Administrator and Sister Supervisors. The policy was reviewed on 1/13/2014 with the Social Services Director to ensure understanding and compliance expectation. To ensure conformity to policy on Stolen or Lost Items, we have installed a detailed check list, which will be reviewed by administrator and placed in Resident's File.</b></p> <p><b>The Facility will monitor and create an awareness of this incident and any others by posting such occurrences in a secure place for employee notification, in so maintaining the confidentiality of the Residents. In regards to Resident #4 and the incident concerning missing property, our facility will address this Resident to inform/educate him/her on ways to help safeguard self and belongings We will contact our Ombudsman and local law enforcement to have them</b></p>	
			<p>speak with the residents as a whole on the topic of ways to safeguard self and belongings, in order to assure them that we are putting proper emphasis on their concerns.</p>	



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F 226	<p>Continued From page 6</p> <p>Administrator or Director of Nursing shall notify the resident, physician, family, or responsible party....4. The results of the investigation shall be described in a written report which shall be provided to the State Survey Agency, Adult protective Services, and as appropriate, law enforcement officers. The report shall be provided within five (5) working days of the incident.....5. A copy of the investigation report shall be provided to the QA Committee.....</p> <p>Review of the Policy "Misappropriation of Resident Property" which was a section of the "Abuse Policy" revealed....6. As soon as possible, but within no more than 2 hours of the suspected abuse, neglect or mistreatment, the Administrator shall notify the State Agency, local agencies (public health and local law enforcement (of the suspect abuse, neglect or mistreatment.</p> <p>1. Review of Resident #4's report of Misappropriation of Property, on 12/12/13 revealed the resident had reported \$200.00 missing the week of 11/18/13. Resident #4 had reported this to the Accounts Manager, on 11/25/13. Review of the "Report of Missing Property", completed by the facility, determined the resident reported a family member had given him/her cash for his/her birthday, and had put the money inside a pocket of a sweater inside the room closet. The report revealed the resident was unsure if the closet had been locked or not, and expressed he/she was not so concerned, but wanted the facility aware.</p> <p>Interview with the Director of Nursing (DON), on 12/12/13 at 3:55 PM, revealed she was not aware of the details of the incident, and did not know the</p>	F 226	<p>In order to ensure that all reports or complaints of alleged loss if property are addressed, the following steps will be taken: 1.)When the Administrator is made aware of any monetary loss, three individuals will help with the report of the alleged loss. These persons will be a Sister Supervisor, Residents Account Manager and staff member with knowledge of the complaint.</p> <p>2.)The Social Services Director will record all of the findings on the designated form from the State. This will also be recorded on the "Missing Property Report" form in the social services office. The information is transmitted via fax to the appropriate State Agency. All records are kept confidential. When the investigation is completed by a representative from the State or any other agency, it will be noted in the Resident's personal chart. All information is to be kept confidential.</p> <p>Going forward, all pertinent staff has reviewed LSP policy on 1/13/2014 and is aware of their responsibilities.</p>	
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JAN 21 2014  
DIVISION OF HEALTH CARE SERVICES

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F 226	<p>Continued From page 7</p> <p>outcome. The DON stated the Social Services Director always handles any allegations of Misappropriation of Property, and forwards the "Report of Missing Property" to the Administrator for reporting.</p> <p>Interview with the Social Services Director, on 12/12/13 at 3:30 PM, revealed she was responsible for completing the initial report of missing property, which is given to the Administrator for reporting to any state agencies. The Social Service Director stated the facility received very few reports of abuse or misappropriation, and had received no reports of abuse since the last survey, on 02/15/13.</p> <p>Interview with the Administrator, on 12/12/13 at 3:50 PM, revealed Resident #4 did not report the incident to her; however, did report to the Account Manager, who then reported to the Social Services Director. The Administrator stated that Social Services handles all the interviews with residents, and completes the initial Report of Missing Property, which is then given to her. The Administrator stated the resident was not concerned about the missing \$200.00, so she did not report the allegation to the State Agencies, complete a thorough investigation, or complete and send the required 5 day follow-up to the State Agency. The Administrator stated they did not always report misappropriation allegations, unless they substantiate the allegation first themselves.</p> <p>B. Review of the facility policy regarding "Abuse Misappropriation of Resident Property" related to Screening revealed....it is the policy of the Little Sisters of the Poor to conduct personal reference checks and criminal investigation checks on all personnel. In addition, potential employees are</p>	F 226	<p>Furthermore, Little Sisters has a Theft and Loss Prevention Program in place that includes newly hired employees being trained regarding Resident Abuse/Neglect Policy; a written inventory of resident's personal property; a Missing Property Report completed, as well as notifications to appropriate State agencies, as required.</p> <p>Little Sisters will enhance current mandatory staff in-service of Resident Abuse and Neglect by reviewing at such time, staff responsibilities when Resident misappropriation of property is alleged.</p> <p>This policy will be discussed at the next Quality Assurance Meeting (QA) on January 15th.</p> <p>At the QA suggestions for improvement will be examined and recorded in the minutes.</p>	1/16/2014
		F226B	<p><b>Personnel Records</b></p> <p>The human resources manager presented the records of five newly hired employees. In order</p>	



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F 226	Continued From page 8 screened for a history of abuse, neglect, or mistreating residents by verifying that a potential employee's name is not listed on the State Nurse's Aide Registry and by checking with the appropriate licensing boards and registries. The policy did not list the checks should be on or before hire of the employee.  Review of the employee file, on 12/12/13, revealed employee #1 had a hire date of 12/06/13; however, the nurse aide abuse registry check was not completed until 12/09/13, or three (3) days after hire.  Interview with the Human Resources Director, on 12/12/13 at 11:30 AM, revealed Nurse Aide Abuse Registry Checks should be completed on or before hire for all new employees. The HR Director stated Employee #1's registry check was completed after hire, because she had been a previous employee here. The HR director stated the Nurse Aide Registry Check should have been completed prior to starting work.  Further interview with the Administrator, on 12/12/13, also revealed they have had no reports of suspected abuse since the last survey on 02/15/13, and have only had a couple of reports of Misappropriation of Property. In addition, interview with the Administrator revealed she had been out on medical leave, and relied on other departments to complete her duties.	F 226	to assure that no abuse occurs, a Nurse Aide Registry check is run prior to interviewing each candidate and again the first day of work in the facility. This was overlooked before one new employee reported for week end training. Her records were checked immediately at the beginning of the new work week. The employee whose record was not in order was a former part time employee whose records had been verified at her original hire date. All records will be cleared through the Nurse Aide Registry prior to hire. In order to assure that no repeated noncompliance occurs, no employee will be allowed to work until all record are cleared for hire. This record was immediately corrected and Supervisors have been made aware that new employees will not be scheduled to start until HR has completed all required checks and verifications.	12/30/2013	
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	F 282			

*Little Sisters of the Poor*

**THEFT AND LOSS PREVENTION CHECK LIST**

- Missing Property Report has been completed and given to administrator.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Report has been filed with Office of the Inspector General.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Internal investigation completed

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Report has been filed with proper State or Local Law Officials if required.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Staff and pertinent individuals have been notified of incident.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Incident resolution.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

- Report has been reviewed by Quality Assurance Committee.

Initials \_\_\_\_ Date \_\_\_\_

Comments: \_\_\_\_\_

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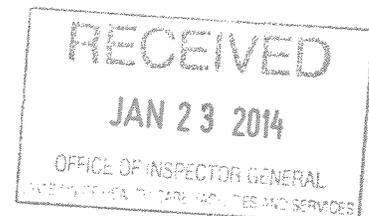
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F 282	<p>Continued From page 9 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of clinical record, it was determined the facility failed to provide care according to the care plan for one (1) of ten (10) sampled residents (#6). Resident #6 was care planned to have a floor mat beside the bed to prevent injury if a fall occurred. Observation revealed the fall mat was not provided.</p> <p>The findings include:</p> <p>Review of facility policy titled Care Plan, dated May 2006, revealed the purpose of the policy was to develop quantifiable objectives for the highest level of functioning the resident may be able to attain. The policy indicated staff uses these objectives to follow residents' progress.</p> <p>Review of the comprehensive care plan for Resident #6, dated 08/15/13, revealed fall mats are to be placed on either side of the bed to prevent injury if a fall should occur. Review of the most current physician orders for Resident #6, dated 12/11/13, revealed a mat is to be on the floor next to the bed for safety and a personal alarm was ordered. Refer to F-309.</p> <p>Observation of Resident #6, on 12/10/13 at 10:55 AM, 12:55 PM, 2:23 PM, 3:25 PM and 4:30 PM, revealed the resident lying in bed. There was no fall mat beside the bed. On 12/11/13, observation at 7:30 am, 8:20 AM, and 9:02 AM revealed no fall mat beside the bed.</p>	F 282	<p>F282 Services by Qualified Person Per Care Plan. Resident #6. Telephone order received from Dr. Robert Hammer to discontinue order for fall pads and personal alarm on 12/12/13 because resident no longer attempts to get out of bed, and this was removed from care plan. The MDS nurse has reviewed all ancillary orders to ensure they are current and consistent with care plan and Kardex. This was completed on 1/3/14. There were two residents that had skin treatments that had been ordered until healed, and these were discontinued and removed from care plan because the areas were healed. 1/9/14.</p> <p>To ensure that this will not happen again the MDS Coordinator will review with all CNA's where the Kardex and actual plan of care is to know how to care for the residents. To report any changes or refusal by the residents. This will be completed by 1/20/14. Also to ensure that this does not happen again, there will be one specific nurse assigned to complete the monthly rewrites to monitor for any new orders or changed orders. This same nurse will review ancillary orders with M.D. visits and notify DON and ADON of any discrepancies. Changes will be made by the MDS Coordinator to the Kiosk and the care plan. The care plan will be reviewed the Monday before care conference by the Inter Disciplinary Team according to the care plan list. 1/6/14. The Inter Disciplinary Team will also review the Kardex according to the Care Conference list and those residents will be spot checked according to their Kardex by the Director of Nursing, the Assistant Director of Nursing or the MDS Coordinator. The CNA caring for the resident and the Unit Sister Supervisor will be part of the QA/spot check. This will begin on 1/21/14.</p>	1/21/2014
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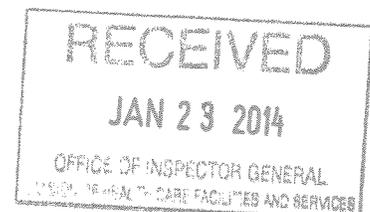
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NAME OF PROVIDER OR SUPPLIER  LITTLE SISTERS OF THE POOR			STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217		
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F 282	Continued From page 10  Interview with CNA #5, on 12/11/13 at 9:05 AM, revealed the resident had experienced a decline since a fall in April 2013. She stated the resident no longer attempted to get out of bed so the staff quit using the fall mat and personal alarm. She thought the floor mat and alarm had been discontinued.  Interview with the DON, on 12/12/13 at 9:55 AM, revealed she had reviewed the most current physician orders and made rounds with the resident's physician yesterday. She stated the resident had not used the floor mat and personal alarm for some time. The resident was now comfort care only and did not attempt to get out of bed unassisted. She stated she should have gotten an order to discontinue the floor mat and personal alarm. She failed to mention it to the physician the prior day.	F 282			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309			
	This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide care and services according to physician				



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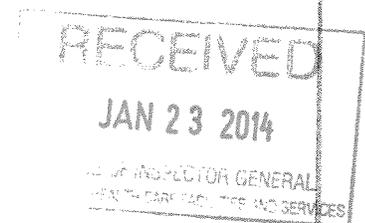
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F 309	<p>Continued From page 11</p> <p>orders for two (2) of ten (10) sampled residents. (Residents #5 and #6) The facility failed to provide a fall mat beside Resident #6's bed for safety as ordered by the physician. The resident has a history of falling with injury. The facility failed to provide support stocking for Resident #5 until after surveyor intervention.</p> <p>The findings include:</p> <p>Review of facility policy titled Physician orders, dated July 2005, revealed the purpose of the policy was to ensure residents received appropriate treatment and medication. Prior to the physician's visit, residents' orders are checked by a licensed nurse for errors and omissions. The nurse reviewing the most current orders will sign name, title, date and verify she read and understood the orders. Physician telephone orders are completed exactly as given.</p> <p>1. Review of Resident #5's clinical record revealed the resident has resided at the nursing facility since 11/23/11. The resident's current diagnoses included: Diabetes, Hypertension, Osteoarthritis, Spinal Stenosis, and Cervical Spondylosis, Fall with fractured Humerus (8/30/13) and Thoracic aneurysm. Review of the most recent physician orders, dated 11/13/13, revealed the physician continued the order for Jobst support knee high stocking to the left lower leg, to be applied in the morning and removed at bedtime. The original order for the support stocking was 08/17/12.</p> <p>Observations of Resident #5, on 12/10/13 at 10:00 AM, 12:58 PM, 2:20 PM, 3:30 PM, and 4:30 PM revealed the resident either sitting in wheelchair/recliner or in bed. The resident wore</p>	F 309	<p>F309 Provide Care / Services for Highest Well-Being.</p> <p>Resident #5. Telephone order received from Dr. Robert Hammer on 12/18/13 after review to discontinue Jobst stocking to left lower extremity for c/o claudication. To ensure that this does not happen again the MDS nurse has reviewed all ancillary orders to ensure they are current and consistent with care plan and Kardex. This was completed on 1/3/14.</p> <p>To ensure that this will not happen again the MDS Coordinator will review individually with all CNA's how to locate the Kardex information and care plans for resident care. To report any changes or refusal by the residents. This will be completed by 1/20/14. Also to ensure that this does not happen again, there will be one specific nurse assigned to review and complete the monthly rewrites to monitor for any new orders or changed orders. This same nurse will review ancillary orders with M.D. visits and notify DON and ADON of any discrepancies. Changes will be made by the MDS Coordinator to the Kardex and the care plan. The care plan will be reviewed the Monday before care conference by the Inter Disciplinary Team according to the care conference list. 1/6/14. The Inter Disciplinary Team will also review the Kardex according to Care Conference list and those residents will be spot checked according to their Kardex by the Director of Nursing, the Assistant Director of Nursing or the MDS Coordinator. The CNA caring for the resident and the Unit Sister Supervisor will be part of the QA/spot check. This will begin on 1/21/14.</p>		



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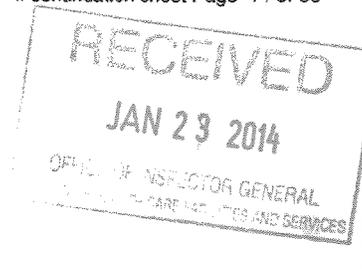
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F 309	<p>Continued From page 12</p> <p>white crew socks, not the support stocking. Interview with the resident at 3:30 PM revealed he/she did not have any stockings. Continued observation, on 12/11/13 at 7:32 AM, 8:15 am, 9:10 AM and 12:00 noon revealed the resident sitting up in wheelchair without the support stocking applied. On 12/12/13 at 9:45 AM observation revealed the resident sitting in recliner with regular white crew socks on.</p> <p>Interview with Certified Nursing Assistant (CNA #4), on 12/12/13 at 9:50 AM, revealed she did not know where the resident's support stocking was located. The surveyor, CNA #4, and the Director of Nursing (DON) went to Resident #5's room and the CNA searched the resident's closet, chest, and night stand. No support stockings were found. The resident voiced he/she had not worn the stocking for awhile because they couldn't find them. The DON stated she did not think the resident had worn the support stocking for awhile but there was still an order for the stocking to be applied daily. She stated there must not have been any oversight to ensure the support stocking was applied.</p> <p>Observation, on 12/12/13 at 11:25 AM, revealed the resident sitting in wheelchair in the hallway. A pair of white support stockings had been placed on the resident's legs. However, the stockings had holes and runs the entire length of the stockings.</p> <p>Interview with CNA #7, on 12/12/13 at 11:30 AM revealed she was responsible for Resident #7 that day. She stated she had assisted the resident with dressing this morning and she had put white crew socks on the resident because she could not find the support stocking. She revealed</p>	F 309	<p>The nurse who will review and complete the monthly rewrites to monitor for new or changed orders will report finding monthly to the DON. The DON will report these findings at the QA meeting quarterly beginning in April 2014 (the next QA meeting) until the QA committee determines that the QA reports can be less frequent.</p>		



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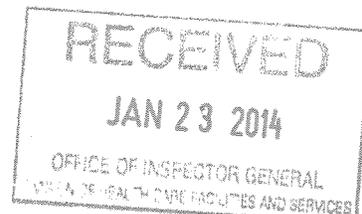
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F 309	<p>Continued From page 13</p> <p>the resident wore the support stocking in the past and was support to wear them every day. She stated she reported the missing stockings to CNA #4 (lead nurse aide) and she was suppose to look in the laundry for them. She stated CNA #4 had just brought her a pair of stockings she had found in the laundry and told her to put them on the resident. She acknowledged the stockings had holes and runs. When asked what instructions were given to the nurse aides on how to care for each resident, she replied she would look at the Kardex in the Kiris (computer system).</p> <p>CNA #4 was re-interviewed on 12/12/13 at 11:45 AM. She revealed CNA #7 had reported the missing stocking earlier that morning. She had planned to search for the stocking in the laundry but had gotten busy and forgot. She stated she went to the laundry and found a pair of white support stockings that the resident has on now. She knew they did not belong to the resident. She continued to say the resident did not have the stocking on yesterday. She stated that information should be on the Kardex.</p> <p>Review of the Kardex in the Kiris computer system revealed no instructions to put on the support stocking on the left lower leg. Review of the comprehensive care plan revealed no interventions of applying the knee high support stocking to the left lower leg.</p> <p>Interview with the Minimum Data Set (MDS) coordinator, on 12/12/13 at 2:05 PM, revealed she thought the support stocking had been discontinued. She had not care planned to apply the support stocking and therefore had not forward that information to the Kardex for the nurse aides to follow. She did not know how long</p>	F 309			



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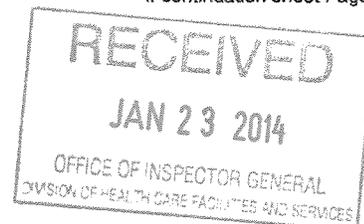
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F 309	Continued From page 14 the resident had been without the stocking.  2. Record review for Resident #6 revealed the resident has resided at the nursing facility since 02/12/10. Review of the most current physician orders for Resident #6, dated 12/11/13, revealed a mat is to be on the floor next to the bed for safety and a personal alarm was ordered. Further review of the clinical record revealed the resident sustained an injurious fall on 04/18/13 that resulted in a cervical fracture. The record revealed the resident sustained a non-injury fall on 07/16/13 and 08/01/13 when attempting to transfer without assist. These falls were identified on the Minimum Data Set (MDS) assessments and a care plan was developed to prevent additional falls. Review of the comprehensive care plan, dated 08/15/13, revealed fall mats to be on either side of the bed to prevent injury if fall should occur. The care plan stated the resident had history of attempting to get out of bed without assistance.  Observation of Resident #6, on 12/10/13 at 10:55 AM, 12:55 PM, 2:23 PM, 3:25 PM and 4:30 PM, revealed the resident lying in bed. There was no fall mat beside the bed. On 12/11/13, observation at 7:30 am, 8:20 AM, and 9:02 AM revealed no fall mat beside the bed.  Interview with CNA #5, on 12/11/13 at 9:05 AM, revealed the resident had experienced a decline since the fall in April 2013. She stated the resident does not attempt to get out of bed unassisted now. The staff quit using the fall mat and personal alarm. She thought the floor mat and alarm had been discontinued. The staff used a mechanical lift to transfer the resident and the resident only got up for lunch now.	F 309	F309 Provide Care / Services for Highest Well-Being. Resident #6. Telephone order received from Dr. Hammer to discontinue fall mats and personal alarm on 12/12/13 r/t no longer attempting to get out of bed w/o assistance. This was removed from the Kardex and care plan. To ensure that this does not happen again, the MDS nurse has reviewed all ancillary orders to ensure they are current and consistent with care plan and Kardex. This was completed on 1/3/14. To ensure that this will not happen again the MDS Coordinator will review individually with the CNA's how to locate the Kardex information and care plans for resident care. To report any changes or refusal by the residents. This will be completed by 1/20/14. Also to ensure that this does not happen again, there will be one specific nurse assigned to review and complete the monthly rewrites to monitor for any new orders or changed orders. This same nurse will review ancillary orders with M.D. visits and notify DON and ADON of any discrepancies. Changes will be made by the MDS Coordinator to the Kardex and the care plan. The care plan will be reviewed the Monday before care conference by the Inter Disciplinary Team according to the care conference. 1/6/14. The Inter Disciplinary Team will also review the Kardex according to Care Conference list and those residents will be spot checked according to their Kardex by the Director of Nursing, the Assistant Director of Nursing or the MDS Coordinator. The CNA caring for the resident and the Unit Sister Supervisor will be part of the QA/spot check. This will begin on 1/21/14.		



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F 309	Continued From page 15  Observation revealed the resident's physician went into the resident's room while the surveyor was interviewing CNA #5. The Director of Nursing (DON) was with the physician. When they came out of room, the surveyor went into room with CNA #5. Observation revealed there was no floor mat in the resident's room. No personal alarm in place.  Interview with the DON, on 12/12/13 at 9:55 AM, revealed she had reviewed the most current physician orders and made rounds with the resident's physician yesterday. She stated the resident had not used the floor mat and personal alarm for some time. The resident was now comfort care only and did not attempt to get out of bed unassisted. She stated she should have gotten an order to discontinue the floor mat and personal alarm. She failed to mention it to the physician the prior day.	F 309	The nurse who will review and complete the monthly rewrites to monitor for new or changed orders will report finding monthly to the DON. The DON will report these findings at the QA meeting quarterly beginning in April 2014 (the next QA meeting) until the QA committee determines that the QA reports can be less frequent.	1/21/2014
F 329 SS=D	483.25(I) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS  Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above.  Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		



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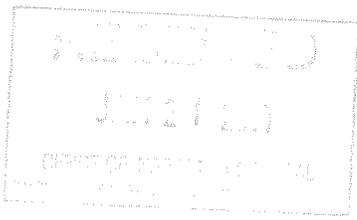
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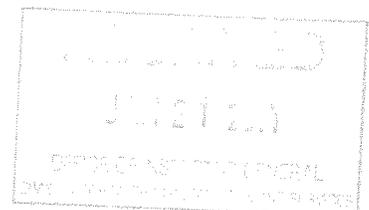
F 329	<p>Continued From page 16</p> <p>therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, review of the clinical record, facility policy, and pharmacy recommendations, it was determined the facility failed to ensure all residents were free from unnecessary drugs in regards to contraindicated drug combination for one of ten (10) sampled residents (#7). Resident #7 was on two (2) anti-depressant medications with classifications of serotonin reuptake inhibitors and monoamine oxidase (MAO). Upon review of the resident's admission medications, the pharmacist alerted the nursing facility that the combination of these drugs were contraindicated and generally should not be dispensed or administered to the same patient. The Pharmacy recommended the physician review the resident's medications and consider switching medications. However, the nursing facility failed to notify the resident's attending physician of the pharmacy's recommendation and the resident continued on the combination of these drugs for over a month. In addition, there was no evidence the nursing facility educated the nurses who would administer the medications and did not monitoring the resident during this period.</p>	F 329	<p>Rd. #7 was admitted 11/5/2013 on 2 antidepressant medications classified as a serotonin reuptake inhibitor and a monoamine oxidase inhibitor. The admitting pharmacy (PCA) did notify the facility that there was the potential for a drug interaction between these classes of drugs when used in combination. This notification was sent in standard format, via regular medication delivery, in a nondescript brown envelope, on the PCA NEW MEDICATION REGIMEN REVIEW FORM. (see attached) PCA pharmacy always will make a phone call to us regarding medications that are contraindicated and these medications will not be dispensed. Rd. #7 PCP did review the medications on 11/5/2013 in his office on the date of admission. However the PCP is not the ordering physician for these medications. The orders plainly state that Parkinson's Medications are through the U of L Movement Disorders Division. Rd. #7 is seen by U of L Neurology. Rd. #7 was seen on July 24, 2013 by Neurology and ALL meds were reviewed including the medications in review samples by the survey team. Rd. #7 was due and seen on Dec. 4, 2013 by Neurology with medications reviewed. At this appointment Azilect was stopped in hope of lessening dyskinesias. Rd. #7 is well known to this group and had been taking the SSRI and MAO for months (years) before the admission here. Blood Pressures have been</p>	
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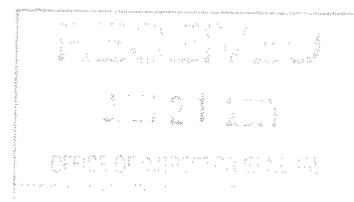
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F 329	Continued From page 17  The findings include:  Review of facility policy titled Psychoactive Drugs, dated July 2005, revealed the purpose of the policy was to ensure each resident received appropriate medications with monitoring and to protect residents from receiving unnecessary drugs. The Director of Nursing (DON) and Interdisciplinary Care Plan team is to monitor residents for unnecessary drugs. When a drug is found to be given in excessive doses, for excessive periods of time, without adequate monitoring, or has undue adverse consequences, the drug is brought to the attention of the attending physician to ensure that those drugs are discontinued. Each resident's drug regimen is free of unnecessary drugs and drugs are only administered to treat a specific documented condition.  Review of Resident #7's clinical record revealed the facility admitted the resident on 11/05/13 with the following diagnoses: Hypertension, Anxiety Disorder, Depressive Disorder, A-fib, Parkinson's Disease, and Adult Failure to Thrive. Review of the resident's admission medication included: Azilect 1 mg (1) daily (to treat Parkinson's Disease symptoms), Prozac 40 mg (1) daily (depression), Cymbalta 60 mg (1) daily (major depression), Clonazepam 1 mg at bedtime (insomnia, and is a long-acting benzodiazepine), Ativan 0.5 mg (1) five times a day and PRN (as needed for anxiety), and Trazodone 100 mg (1) at bedtime (depression). Further review of the record revealed the pharmacy sent recommendations regarding potential interaction between the drugs Azilect, Prozac, Tradozone, and Cymbalta with delivery of the admission	F 329	documented once daily on the MAR since admission on 11/5/2013. Blood pressure and Pulse are now added to the MAR to be documented twice daily, morning and evening since January 12, 2014. Information regarding Serotonin Syndrome, Medications associated with it, Signs and Symptoms are placed in the front of each Medication Pass Book for easy referral by staff. When a resident is identified as having a classification of medications that are contraindicated, a call will be made to the PCP or Prescriber for notification of the contraindication and orders by the nurse receiving the written or telephone notification. Rd. #7 MAR was marked to reflect to monitor for serotonin syndrome in the box with the SSRI. A flow sheet has been added to reflect the specific signs and symptoms of serotonin syndrome.  Education Material from PCA pharmacy was placed at the station and in the front of Rd. #7 chart. 5 Informational Articles on Serotonin Syndrome are now on a clipboard at the station for a read, sign and initial and the article that was read in-service for CMT's and Nurses. All nurses and CMT's have completed and signed by 1/15/2014. There was a verbal review with question and answer session about Serotonin Syndrome with Nurses given by the DON and the MDS. The meeting was held on 1/15/2014 at 2:00pm. 1 CMT and 2 nurses were not in attendance and will be in-serviced individually.		



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F 329	<p>Continued From page 18</p> <p>medications on 11/05/13. The pharmacy also included material on the potential drug interaction stating these drugs were contraindicated drug combination and generally should not be dispensed or administered to the same patient.</p> <p>Review of the potential drug interaction material provided by the pharmacy revealed Serotonin reuptake inhibitors (Prozac and Cymbalta) and MAOIs (Azilect) may act synergistically to increase blood pressure and evoke behavioral excitation. The pharmacy also sent literature regarding the potential drug interaction with Azilect and Trazodone. The material stated Trazodone should not be used within fourteen (14) days of a MAOI (Azilect). All materials regarding Prozac, Cymbalta, and Trazodone stated a serious condition called serotonin syndrome could result and if Azilect was used, the patient should not receive no more than 0.5 mg daily. Resident #7 was prescribed and administered Azilect 1 mg daily.</p> <p>Continued review of the record revealed Resident #7 received these combination of drugs from 11/05/13 to 12/04/13 until the resident's appointment with the Neurologist. The Neurologist discontinued the Azilect on 12/04/13 but continued the other medications.</p> <p>Interview with the Minimum Data Set (MDS) coordinator, on 12/12/13 at 2:05 PM, revealed she did not know about the drug interactions. She did record these medications onto the MDS assessment but she did not review psychoactive medications, that would be the responsibility of the DON.</p>	F 329	<p>PCA Pharmacy would not have dispensed ANY of the medications or not dispensed at least ONE of the medications (Azilect) AND PCA PHARMACY would have made a phone call if the probability of an interaction was likely. The call would have gone to the responsible person such as the DON or ADON, the reason the medications were not coming and the possibility of the interaction. If neither of them were available then the nurse on duty would take the call. All Nurses in attendance at the Nurses Meeting on 1/15/2014 were instructed on procedure of the PCA Policy of sending the Review Recommendation Form for new Admissions'. The envelope was displayed (with the stamp noted) and the form was displayed. Directions were given that the nurse signing for the envelope is responsible for opening and addressing the information inside IF there is an indication to do so, either with the PCP or the Prescriber. The Pharmacy may also be notified to discuss the concerns listed on the form for clarification as necessary. The form will then be placed in the resident chart in the orders section and will remain there, and not to be thinned from the chart. There was a question and answer session. 1 CMT and 2 Nurses were not in attendance. 1 on 1 In-servicing will be conducted and completed before 1/25/2014. 5 Articles were pulled from the internet for review. 1. Medline Plus 2. Mayo Clinic 3. American Physician 4. AAFP 5. WebMD. 7 staff read the Medline Plus Article, 5 staff read the Mayo Clinic Article and 2 staff read the American Family Physician Article. Some staff read more than 1 article. No one read the AAFP or the WebMD</p>		



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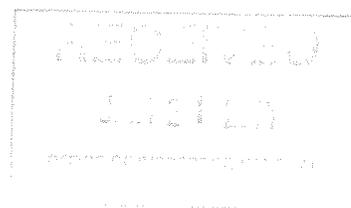
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F 329	<p>Continued From page 19</p> <p>Interview with RN #1, on 12/12/13 at 2:50 PM, revealed the Pharmacy recommendations goes to the DON and staff nurses do not address those concerns. She was unaware of drug interactions between Azilect, Prozac, Trazodone, and Cymbalta. She stated the Azilect was discontinued at the Neurologist visit on 12/04/13.</p> <p>Interview with the DON, and ADON present, on 12/12/13 at 3:44 PM, revealed they knew the resident was on multiple drugs upon admission. The resident's daughter during the admission process stated the resident had been on these medications (Prozac, Cymbalta, and Azilect) for a long time and was on them at the other nursing facility that the resident transferred from. The daughter told them the Neurologist had ordered the medications and she voiced concern about the nursing facility discontinuing the medications. The DON told the daughter the medications would have to be reviewed and may need to be reduced. The daughter told them she knew the residents was on a lot of medications, she is small with little weight, but the daughter said she was in tune with the resident's medications and knew the Neurologist appointment was coming up on 12/04/13. The DON stated she had not reviewed the residents' medication for possible reduction.</p> <p>Continued interview with the DON revealed she found the envelope containing the literature from the pharmacy regarding the potential drug interaction between the drugs Azilect and Prozac and Cymbalta lying on the counter in the medication room. This was several days after the resident's admission but she could not recall the exact date. She stated the envelop from the</p>	F 329	<p>articles.</p> <p>Rd. #7 is not SSRI or MAO naïve. Rd. #7 is long established on these medications. Rd. #7 has been prescribed Azilect since at least 2/29/2012. Azilect has less potential for drug interaction that other MAO's (See attached study article) provided by PCA Pharmacist Rachel Chauncey RPH. The Consultant Pharmacist Forum SELEGILINE and RASAGILINE: Twins or Distant Cousins? by Dawn S. Knudsen Gerber Rd. #7 medications were reviewed at length during interview with Social Services, DON and ADON, Rd. #7 and Rd. #7 daughter on 10/29/2013. This interview lasted approx. 40 minutes and Rd. #7 and daughter stayed for lunch. At the time of interview the medical records from 2 other LTC facilities were reviewed. This included medications. It was noted at the time that most of the medications were for Parkinson's and are prescribed through U of L. Azilect 2/29/12, Ativan 9/22/11, Clonazepam 8/23/11, Prozac 1/27/12, Trazodone 8/23/11 &amp; Cymbalta added 4/9/2013. Azilect was discontinued on 12/4/2013 when Rd. #7 went to neurology appointment. Azilect was stopped in hope of decreasing some dyskinesia, not because of drug interactions.</p>	
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F 329	<p>Continued From page 20</p> <p>pharmacy had not been opened. When she opened the envelop, she found the pharmacy's recommendation and literature regarding the potential drug interactions. She read the information regarding manufacturers statements about potential drug interaction and the contraindication drug combination. The DON stated she posted that information for all nurses to read. However, she had not ensured all nurses had read the information and did not know if they had read the material. The DON had not called the pharmacy for more information and did not notify the resident's attending physician. She stated since the resident was seeing the Neurologist on 12/04/13, she felt the potential drug interaction would be addressed then. Neither the ADON or DON called the Neurologist to inform them of the pharmacy recommendation prior to the 12/04/13 appointment. The DON revealed the contract pharmacist had conducted a drug regime review on 11/11/13 for Resident #7; however, she did not recommend anything.</p> <p>Additional interview with the DON, on 12/12/13 at 4:13 PM, revealed there had been no monitoring of the drugs for potential interactions and she had not ensured the nurses had read the literature provided by the pharmacy and understood what to monitor. She stated the resident's primary physician should have been called and informed of the risk. The DON stated she was responsible for reviewing psychotropic medications for proper use but since the resident was scheduled for a visit with the Neurologist, she thought it would be okay to wait until then to address the potential drug interactions between those drugs.</p> <p>A telephone interview with the contract pharmacist, on 12/12/13 at 5:10 PM, revealed</p>	F 329	<p>Psychoactive medications are reviewed by the MDS coordinator for side effects and drug interactions and will continue to be reviewed for drug interactions and side effects according to the MDS/CAA's quarterly and as needed.</p> <p>A Mandatory Nurses Meeting with all shifts was held on January 15th, 2014 to address correspondence from the PCA Pharmacy and the nurses roll with the different types of correspondence including the PCA NEW MEDICATION REGIMEN REVIEW FORM. Minutes of the meeting were kept and a sign in sheet kept. Nurses/CMT's not in attendance will have a 1 on 1 in-service following the minutes of the meeting to ensure they receive the same information as those in attendance. To maintain continued compliance a check by the DON/ADON will be done at the station when a new admission arrives and the chart will be checked for placement of Review Form in the chart and that proper procedure has been followed. Lisa Cooke RPH for our facility will print and review with the DON and ADON; the Psychoactive and Hypnotic/Sedative Utilization Review Report when she reviews our charts, in house each month. The compliance log will then be initialed for each resident reviewed and in each month reviewed. Issues will be discussed as needed during the Quarterly QA Committee Meetings with the first meeting occurring 1/15/2014 at 8:00AM. The IDT will</p>		



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F 329	<p>Continued From page 21</p> <p>she knew about the pharmacy recommendation and material provided by the pharmacy regarding potential drug interaction upon Resident #7's admission. She state Azilect was well known to have drug interactions with other drugs. She stated the resident had been on the Azilect before admission and she assumed the resident's physician was aware of the drug interactions and possible adverse reactions. In theory, she stated Azilect interacts with many drugs. When asked why she did not recommend the physician review the combination of these drugs upon her drug regime review on Nov 11th, she responded the nursing facility had been given information regarding the potential drug inactions and she assumed they were monitoring the resident. She stated a resident's blood pressure and heart rate should be monitored and any change in condition. If the resident experienced a sudden onset that could not be explained, the normal things you would recognize as different for the resident. "I would assume the NF would have follow-up with the primary physician or neurologist."</p> <p>When asked if she would have made the same recommendations, she would not answer. She stated again, I would think they would have spoken with the primary physician or neurologist regarding the recommendation. When she conducted the second drug regime review on 12/09/13, the drug Azilect had been discontinued.</p> <p>Search of the Internet site, Pharmacy Wikipedia, revealed Clonazepam is a long acting benzodiazepine and a resident can become dependent after long term use. The side effects included cognitive impairment, drowsy, sluggish, and irritable after awaking. The medication can</p>	F 329	<p>continue to review the psychoactive drugs on a monthly basis well.</p> <p>During the pre-admission interview on 10/29/2013, Social Services, DON, ADON, now Rd. #7 and Rd. #7 daughter reviewed her medications at length. We discussed the possibility that some of the medications would very possibly be decreased.</p> <p>The NEW MEDICATION DRUG REGIMEN FORM is filled out by a PCA Pharmacist when they get admission orders and put the admission date on it. It then goes to triage to be stamped and put into an envelope and into a tote for delivery. There could be a lag of time of several days for delivery of a REVIEW FORM for CONSIDERATIONS. If there is a TRUE INTERACTION the Medications will NOT be sent and a CALL will be made to the Facility.</p> <p>Rd. #7 Rd#7 has orders for blood pressure and pulse weekly and full vital signs monthly. Vital signs are also at the nurse's discretion.</p> <p>#4</p> <p>Consultant Pharmacist will do an onsite QA psychotropic drug review with DON monthly. Lisa Cooke RPH for our facility will print and review with the DON and ADON; the Psychoactive and Hypnotic/Sedative Utilization Review Report when she reviews our charts, in house each month. The compliance log will then be initialed for each resident reviewed and in each month reviewed. Issues will be</p>	

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F 329	<p>Continued From page 22</p> <p>cause or worsen depression. Special precautions indicated elderly metabolize this drug slowly and are more sensitive to the effects. Clonazepam is not generally recommended for use in the elderly people for insomnia. However, previous interview with the DON revealed she had not reviewed the residents' medications.</p> <p>Observation of Resident #7, on 12/11/13 at 4:00 PM, revealed the resident sitting on a small sofa in the room, legs crossed, swinging right foot outward. The resident was in continuous movement. Observation and interview with the resident, on 12/12/13 at 1:30 PM, revealed the resident dressed and sitting on the sofa. The resident was observed again to be swinging legs or shuffling feet against the floor in front of the couch. Interview with the resident revealed these movements were from the Parkinson's Disease and she/he had experienced those prior to admission to this nursing facility. The resident stated the mornings are hard on her/him because they feel sluggish.</p>	F 329	<p>discussed as needed during the Quarterly QA Committee Meetings with the first meeting occurring 1/15/2014 at 8:00AM. The IDT will continue to review the psychoactive drugs on a monthly basis well.</p> <p>#5</p> <p>The Group Education for Communication of Procedure for Medication Review Form from PCA Pharmacy and our expectations for Nurses/CMT's on Review form has been completed as of 1/15/2014 with the exception of 3 staff members. The education will be completed no later than 1/25/2014.</p> <p>The Group Education for Serotonin Syndrome has been completed by 1/15/2014 for the question and answer session with the exception of 3 staff members. The education will be completed no later than 1/25/2014</p>	1/25/2014
F 371 SS=F	<p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>The facility must -</p> <p>(1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and</p> <p>(2) Store, prepare, distribute and serve food under sanitary conditions .</p> <p>This REQUIREMENT is not met as evidenced</p>	F 371	<p><b>Each item for correction is described separately.</b></p> <p><b>Towel Drying of Dishes</b></p> <p>Criterion 1: What corrective action will be accomplished for those residents affected by the violations: No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. The issues stated on the POC were addressed on Monday, December 30, 2013. Towels are no longer permitted in the dish drying area, as dishes are to air dry.</p>	

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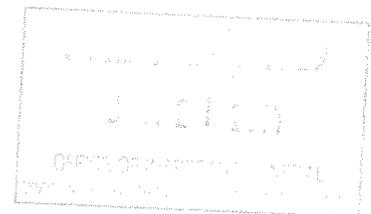
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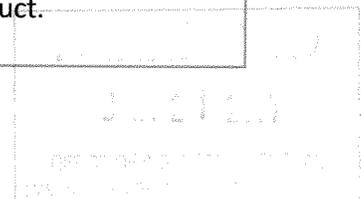
F 371	<p>Continued From page 23</p> <p>by:</p> <p>Based on observation, interview and review of the Dietary Policies and Procedures, it was determined the facility failed to ensure food was stored, prepared and served under sanitary conditions. Food items were retained past expiration dates, held too long in storage and some without labels. Equipment (meat slicer) was stored with dried food particles. There was no evidence of a system to rotate stock. Staff failed to utilize the appropriate size scoop when serving a starch (mashed potatoes). In addition, the facility failed to clean and sanitize dishes to ensure safe use.</p> <p>The findings include:</p> <p>Review of the facility's Dietary policies revealed Safe Operation of the Hobart Dishwasher (not dated or revised) directed staff to wash hands thoroughly before picking up clean dishes from the dishwasher and to let them air dry for several seconds after leaving the machine. Staff were to handle clean dishes by the edges, and to keep their fingers from the mouth of cups and glasses.</p> <p>Review of the Dietary policy Storage of Food Items, dated 07/19/10, revealed rotation of stock using the first in, first out was essential. They were to place newly received products behind old stock. A labeling gun was to be used to stamp the items indicating the date they were received prior to placing the items on the shelf. Dented cans and damaged articles were to be placed in a designated area to be returned to the vendor.</p> <p>Review of the Donated Food Items Policy, dated 02/28/01, revealed all donated foods would be carefully inspected for expiration dates and sell by</p>	F 371	<p>Criterion 2: How the facility will identify other residents affected by the same violations.</p> <p>All residents had the potential to be affected by this violation.</p> <p>Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. The dishes will be air dried exclusively. The dish towels that were provided for drying the dishes will be removed from the dish room. The dietary staff involved in the dish room activities will be in-serviced on appropriate procedure and rationale for these procedures. The in-service will also include a review of the policies and procedures in place related to dish room operation. On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.</p> <p>Criterion 4: How the facility will monitor its corrective actions to ensure that the violation is being corrected and will not recur.</p>	
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F 371	<p>Continued From page 24</p> <p>dates and discarded as necessary. All highly perishable donated foods that could not be frozen would be used within one day of delivery. Foods would be dated and labeled accordingly.</p> <p>Review of the Food Storage policy revealed all foods should be properly stored according to temperatures. Dietary Policy for Cleaning Meat Slicer (not dated), revealed the machine must be cleaned immediately after each use.</p> <p>Review of the Dietary Policy for Health, Grooming and Conduct of Personnel, Infection Control (not dated), revealed staff were to keep hair covered with a hair net or cap and dietary staff were to avoid touching mouth, face, nose, hair or arms while handling food. If parts of the body were touched they were to wash hands before proceeding.</p> <p>No policy was provided regarding appropriate scoop sizes utilized to portion foods. Review of the Daily Menu revealed for lunch the meat/protein portion was 3 ounces, starch serving was 1/2 cup, and vegetable serving was a 1/2 cup.</p> <p>Observation, on 12/10/13 at 7:30 AM, of the kitchen revealed the refrigerator had an extra large stainless steel bowl with a label dated 11/21/13, overfilled with grapefruits cut in half. In the walk-in refrigerator, a large plastic container held a white liquid substance covered with loose plastic wrap, dated December 2005 and another large stainless pot with a white liquid substance covered with loose plastic wrap dated December 2009 (staff identified the white liquid as milk). Four (4) large boxes labeled cheese cake, were opened, filled with pumpkin cheese cakes and</p>	F 371	<p>The dietary manager or shift cook will monitor dish room operation and check the status of clean dishes at least once a week, then record findings in the dish room binder. These findings will be presented at Quality Assurance meetings (next on 1/15/2014), and reviewed for compliance and further training needs. The Registered Dietitian will review dish room operation and check the status of clean dishes at least once a month.</p> <p><b>Personal Hygiene of Employees</b></p> <p>Criterion 1: What corrective action will be accomplished for those residents affected by the violations; No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. The issues stated on the POC were addressed on Monday, December 30, 2013, all staff serving or preparing food were instructed on the proper manner for putting on hair nets, gloves and hand washing.</p> <p>Criterion 2: How the facility will identify other residents affected by the same violations. All resident had the potential to be affected by this violation.</p> <p>Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. All dietary employees will be in-serviced on the Policy for Health, Grooming and conduct.</p>	



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217</b>		
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F 371	<p>Continued From page 25</p> <p>plain cheesecakes wrapped in sealed plastic wrap. The containers were not dated. Seven (7) pecan pies dated December 2004 and eight (8) caramel pumpkin pecan pies dated 12/01/13 were labeled as sale by dates. A ten (10) inch pumpkin pie was not dated. A large box of individual sliced pies and cakes were piled together with no identifying information or dates labeled on them and were stacked on top of two (2) large boxes of produce. The refrigerator near the stoves had four (4) divided plates with prepared pureed food and not labeled to identify the food or dated.</p> <p>Interview, on 12/10/13 at 10:45 AM, with the Dietary Manager (DM) revealed everything was to be labeled and dated when opened. She stated they did not keep food over three (3) days. She stated the staff was going to use the milk in the recipes. She stated they would not know the use by or expiration date of the milk when it was removed from the original container. She stated the cheesecakes and pies were all donated to the facility for the festival. She stated they had several festivals since Thanksgiving, but was not sure of the dates. She stated she knew they were to have dates on them to ensure they were safe to serve to the residents. She stated they were going to throw them out today. She indicated she or two of her staff were to examine all donated foods for expiration dates and sell by dates to ensure they were safe. She stated she had inspected them but could not recall when they were delivered to the facility. The cheesecakes had been previously frozen and they could not re-freeze them again. She stated they should have been disposed. She should not have kept the individual slices of pies and cakes without having labels on them.</p>	F 371	<p>A particular emphasis on appropriate washing of the hands will be provided. The in-service will include a review of the policies and procedures in place related to personal hygiene. This in-service with the emphasis on hand washing and personal hygiene will be added to the new employee orientation training.</p> <p>On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.</p> <p>Criterion 4: How the facility will monitor its corrective actions to ensure that the violation is being corrected and will not recur. The dietary manager or shift cook will monitor dish room operations and document observations related to hygiene providing corrective feedback to employees as needed. The observations will be recorded in the Dish Room binder at least once a week. These findings will be presented at Quality Assurance meetings (next on 1/15/2014), and reviewed for compliance and further training needs. The Registered Dietitian will observe the dish room operation and document observations related to hygiene at least once a month.</p>	

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F 371	<p>Continued From page 26</p> <p>Interview with Dietary Staff #1, on 12/12/13 at 11:20 AM, revealed a lot of the food, cheesecakes, pies, cupcakes, and breads had been donated for the festival held after Thanksgiving. Dietary Staff #1 stated she had asked if they should be used since there were no labels or dates on them. She indicated she had asked the DM if they were to keep them and was told they were to use them. She stated they did not inventory or keep records of the donated food items. She stated they used to date the foods upon arrival; however, the stamp was not working and they just quit labeling and dating when they received the food items. She stated the undated and labeled items should have been discarded. She stated everything placed in the refrigerator should be dated and discarded after three (3) to four (4) days.</p> <p>Observation, on 12/10/13 at 10:45 AM, of the dry storage area revealed two (2) eleven (11) pound boxes of Natural Dates were on the shelf. The label on the box stated to keep in cold storage, recommended temperature of 35 degree Fahrenheit. Numerous six (6) pound (plus) cans of Tomatoes, Puree, Refried Beans, Lima Beans, Butter Beans, Kale, Asparagus, Chili Beans, Kidney Beans, Wax Beans, Pears, Pineapple, and Applesauce had no dates to identify expiration or when it was placed on the shelves for use. Ten (10) six (6) pound cans of water chestnuts were on the shelf for use and stamped, best if used by Jan. 13, 2013. There was no evidence of a system to determine if the stock was rotated to ensure the oldest was used first. One six (6) pound and twelve (12) ounce can of Butter Beans and one six (6) pound can of Zucchini Tomatoes were dented and on the</p>	F 371	<p><b>Storage: Dry storage, stock rotation, and dented can disposal.</b></p> <p>Criterion 1: What corrective action will be accomplished for those residents affected by the violations; No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. Kitchen staff, Paul and Wanda, on December 30, 2013 started the process of going through the storage room removing dented cans, and rotating stock.</p> <p>Criterion 2: How the facility will identify other residents affected by the same violations.</p> <p>All residents had the potential to be affected by this violation. Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. The Dietary policy Storage of Food Items will be followed.</p> <p>Specifically:</p> <p>A. All food items stored will be labeled with a date upon receipt. Permanent markers will be provided for this purpose.</p> <p>B. Food will be stored with the most recently received items in the back to facilitate the First in First out inventory rotation practice.</p> <p>C. All food items will be covered, sealed and labeled as to contents if the original package is opened.</p> <p>D. All food items will be stored at the recommended temperature for that food item.</p>	
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OFFICE OF SURVEYOR GENERAL  
DIVISION OF HEALTH CARE SERVICES

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

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F 371	<p>Continued From page 27</p> <p>storage shelf for use. Additional observation, revealed two (2), one gallon containers of Italian Fat Free Dressing had a clear tape wrapped around the lid and the top of the container. There was no date identifying when or if the containers had been opened.</p> <p>Interview, on 12/12/13 at 9:30 AM, with the Dietary Manager (DM) revealed the Dates were brought in for the Sisters. She stated she did not know when they were delivered or how long they had been on the shelf. She stated the directions recommended for the Dates to be refrigerated. She stated dented cans were not to be kept. She stated she could not identify when the can goods had been rotated or if they were within their expiration date since there was no identifying information on the cans. She stated they used to mark the cans, but had stopped. She stated they received many donated food items, that she and two other staff would inspect them. She stated she would make the call to keep or dispose of the food items. She stated staff were supposed to rotate the food supplies; however, she was not able to identify if the can goods and dry goods had been rotated. She stated the Italian Dressing was given to them by a cooking school and she did not know if they had been opened or not. She stated the school may have used the dressing for a test recipe and sent the rest to the facility. She stated it should have been refrigerated and dated after opening, not left in the dry storage room. She stated it was important to ensure the foods were safe for the residents.</p> <p>Continued interview with Dietary Staff #1, on 12/12/13 at 11:20 AM, revealed they rotated the can goods when they received the new ones. She stated they used to stamp a date received on</p>	F 371	<p>E. Any dented cans will be removed from the general stock location, placed in a designated area and not used by the facility.</p> <p>All dietary employees that are relevant to stock management will be in-serviced on the facility policy related to the storage of food items and the rationale and principles related to safe food storage. On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.</p> <p>Criterion 4: How the facility will monitor its corrective actions to ensure that the violation is being corrected and will not recur. The dietary manager or shift cook will monitor for stock dating, rotation and dented can removal weekly and record findings in Stock Room binder. These findings will be presented at the next Quality Assurance meeting (next on 1/15/2014), and reviewed for compliance and further training needs. The Registered Dietitian will review the stock room for appropriate dating, rotation and dented can removal at least once a month.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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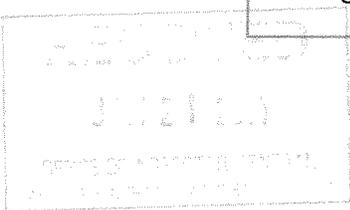
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F 371	<p>Continued From page 28</p> <p>the cans; however, the stamp broke and they stopped marking the can goods. They were not supposed to keep dented cans and they should be discarded. She stated she could not tell when the can goods were delivered or if they were rotated or not. She stated they did not have a system in place to ensure rotation of the food supplies were done. She stated the Dates should have been refrigerated and not placed in the dry storage room.</p> <p>Observation, on 12/11/13 at 8:20 AM, in the small dining room, revealed CNA's #2 and #3 were serving food from the steam table. CNA #2 and #3 had their bangs and sides of their hair hanging loosely outside of the hair covering.</p> <p>Observation, on 12/11/13 at 12:00 PM, revealed CNA #4 was filling plates with food for the residents in the small dining room. Her hair was hanging outside of the head covering. As she prepared an alternate choice for Resident #7, she was observed to use a half cup scoop to dip green beans out of the steam table, she did not fill the scoop to capacity and did not empty all the contents of the scoop onto the resident's plate. CNA #4 used a 1/4 cup scoop to serve mashed potatoes for the resident. She picked up a sliver of turkey approximately 2"x 3" to place on the plate. When asked what the scoop sizes were, she stated she did not know.</p> <p>Review of the lunch menu for 12/11/13, revealed the alternate food was 1/2 cup mashed potatoes and 1/2 cup of green beans. Meat or protein identified 3 ounces as a serving size. No alternate meat or protein was identified on the menu.</p>	F 371	<p><b>Equipment: Meat Slicer Cleaning</b></p> <p>Criterion 1: What corrective action will be accomplished for those residents affected by the violations; No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. On 12/11/2013, shift cook cleaned the meat slicer and the cleaning schedule was posted.</p> <p>Criterion 2: How the facility will identify other residents affected by the same violations.</p> <p>All residents had the potential to be affected by this violation.</p> <p>Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. The cleaning schedule will be posted by the dietary manager or shift cook prior to the next month.</p> <p>Food preparation equipment in the dietary department is to be cleaned after each use or as needed per the dietary cleaning schedule.</p> <p>Dietary employees will clean equipment as directed, and record the cleaning or check of the equipment as required by the cleaning schedule.</p> <p>Cook supervisor will review cleaning schedule prior to the end of the shift, providing increased supervision related to cleaning as needed. All relevant dietary staff will attend in-service about proper cleaning and monitor of cleaning per cleaning schedule.</p>	
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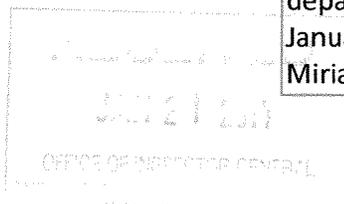
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F 371	<p>Continued From page 29</p> <p>Interview with Dietary Cook #2, on 12/11/13 at 11:45 AM, revealed she did not know the scoop sizes in the mashed potatoes or in the green beans. She thought it was maybe a size 16, but did not know the portion size. Additional interview at 12:00 PM with Dietary Cook #2 revealed she went to find out the size of the scoop in the mashed potatoes and said it was 1/4 cup and it should have been a 1/2 cup. She stated it was important to know the portion sizes to ensure the residents received the appropriate caloric intake to meet their needs.</p> <p>Interview, on 12/11/13 at 12:05 PM, with CNA #4 revealed she was a CNA and had not been trained in dietary services. She stated she did not know the differences in the size of servings for the scoops. She stated the resident preferred small portions and the dietary card would be circled for small portions. She reviewed the dietary list and stated she did not know what 3 ounces of meat was and did not know the differences of the scoop portions. Observation of the dietary card for Resident #7 revealed no small portion selection had been identified.</p> <p>Observations, on 12/12/13 at 8:29 AM, revealed CNA #3 was in the small dining room kitchen preparing breakfast drinks for residents with her bangs and sides of temple hair unsecured by the head covering.</p> <p>Interview with CNA #3, on 12/12/13 at 8:29 AM, revealed she did not know she had to keep all of her hair covered. She stated she had not been trained to serve food.</p> <p>Interview, on 12/12/13 at 8:45 AM, with Dietary Aide #4, revealed staff were supposed to cover</p>	F 371	<p>Rational and principles of cleaning equipment will be provided by Dietary Manager or shift cook. On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.</p> <p>Criterion 4: How the facility will monitor its corrective actions to ensure that the violation is corrected and will not recur. The dietary manager or shift cook will monitor cleaning schedule at least weekly and save completed cleaning schedules for review at the Quality Assurance meeting. (next meeting 1/15/2014)</p> <p>These completed schedules will be reviewed for compliance and further training needs.</p> <p>The Registered Dietitian will review the cleaning schedules at least monthly.</p> <p><b>Refrigerated storage: Labeling, Dating and Disposal</b></p> <p>Criterion 1: What corrective action will be accomplished for those residents affected by the violations; No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. Kitchen staff, Paul and Wanda on</p>		

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F 371	<p>Continued From page 30</p> <p>all their hair; however, the covering provided by the facility would slide off. She stated she had not been trained to identify the appropriate scoop and serving sizes. She stated they usually used the scoops put into the food. She stated when giving portions to the resident she would "eye ball it".</p> <p>Interview with the Dietary Manager, on 12/12/13 at 9:30 AM, revealed she did not train the CNA's on the dietary process. She stated she had not directed the staff to train the CNA's. She stated her staff would tell the CNA's about the process of serving foods; however, she could not ensure the CNA's were knowledgeable regarding the dietary process. She stated, she guessed she should do an orientation for the CNA's regarding food service. She stated the CNA's did not have to wear hair covering when delivering the resident's food; however, anyone preparing and serving resident's food from the steam table should have their hair secured by the head covering.</p> <p>Observation, on 12/10/13 at 11:37 AM, during the initial tour of the kitchen revealed the meat slicer had a plastic cover over it and was ready for use. A dried yellowish, crusted substance was observed on the back of the blade and on the base of the machine.</p> <p>Review of the Dietary Equipment Cleaning Schedule revealed no December schedule was available for staff to document cleaning done.</p> <p>Interview with Dietary Cook #1, on 12/11/13 at 11:37 AM, revealed she had used the meat slicer the previous day to slice turkey. She stated it should have been cleaned after each use and it</p>	F 371	<p>December 30, 2013 started the process of going through the refrigerated storage: checking for proper labeling and dates, disposing of items not labeled.</p> <p>Criterion 2: How the facility will identify other residents affected by the same violations.</p> <p>All residents had the potential to be affected by this violation.</p> <p>Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. All dietary employees will be in-serviced on the Donated Food Items Policy and Storage of Food Items Policy. All food items will be stored at the appropriate temperature, labeled and dated. All food items will be disposed of per facility policy. (Seven days old, three days old if containing mayonnaise) A comprehensive sweep of all refrigeration units in the dietary department will be conducted every three days by the cook supervisor on alternating shifts. Food items found to be undated, unlabeled or older than seven days will be discarded. All relevant dietary staff will attend in-service about proper cleaning and monitor of cleaning per cleaning schedule. Rational and principles of cleaning equipment will be provided by Dietary Manager or shift cook. The Registered Dietitian will inspect the refrigerated storage of the dietary department monthly. On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge,</p>	



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was not done. She stated she would document on the cleaning schedule when she used and washed the meat slicer; however, there was no schedule out for December.

Observations, on 12/12/13 at 8:58 AM, during the dietary sanitation tour revealed Dietary Staff #3 had loaded a rack of bowls to be cleaned. After they came through the dishwasher and rinse cycle, she began to remove the bowls and stack them while they had water droplets running into the bowls and on the outside of the bowls. When questioned about stacking the bowls while wet, Dietary Staff #3 reached for one (1) of two (2) dish towels that was on the shelf over the dishwasher system. A large open Rubbermaid container sitting on the floor was half full with white cotton dish towels with a blue stripe were piled in the container. She started to dry the bowls with the dishcloth and stated if they were not dry they had to dry them with the dishcloths provided by the facility. She stated "I know they are supposed to air dry because the cloth towels can flake off onto the dishes", as she continued to stack the bowls. Dietary Staff #3 was observed to have a clear nasal drainage to run down from the nares. Dietary Staff #3 reached for a paper towel and wiped her nose. As she held the soiled paper towel in her right hand she folded the towel and placed it on the "clean" cart then tossed the soiled paper towel in the trash can. She then began to remove the other bowls from the rack holding the bowls in her bare hands placing her thumb inside of the bowl as she observed them. She continued to stack the bowls together with her soiled hands. Surveyor intervened and she stopped, stating she should have washed her hands before touching anything.

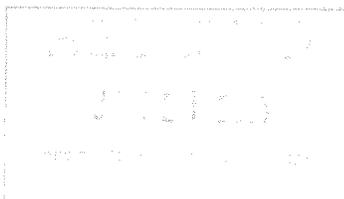
F 371

, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.

Criterion 4: How the facility will monitor its corrective actions to ensure that the violation is corrected and will not recur. The dietary manager or shift cook will monitor cleaning schedule at least weekly and save completed cleaning schedules for review at the Quality Assurance meeting, (next meeting 1/15/2014). These completed schedules will be reviewed for compliance and further training needs. The Registered Dietitian will review the schedules at least monthly.

**Serving sizes / Scoop Usage / Hair Restraint use**

Criterion 1: What corrective action will be accomplished for those residents affected by the violations; No residents were noted to be directly affected by the violations, but all residents will continue to be monitored for overall health indicators. The issues stated on the POC were addressed on Monday, December 30, 2013, as follows: new scoops and portion size charts have been ordered.



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185260</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>12/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>LITTLE SISTERS OF THE POOR</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 371	Continued From page 32 Interview with Dietary Staff #3, on 12/12/13 at 9:10 AM, revealed she was supposed to wash her hands when going from dirty to clean and did not think. She stated she should have disposed of the paper towel and washed her hands prior to stacking any other dishes.  Interview with the Dietary Manager, on 12/12/13 at 9:30 AM, revealed a previous Sister had directed the dietary staff to use the dish cloths to dry dishes. She stated they were supposed to air dried when they came out of the dishwasher and should be allowed to dry while on the table. She stated the towels were originally to be used on the pots and pans. She stated bacteria grows in water and staff should not stack the wet dishes. In addition, she stated the staff were to clean the equipment after each use. She stated they had a dietary equipment cleaning schedule for staff to sign off when they completed the job. She stated she had not printed a schedule for December as of 12/12/13.	F 371	Size charts will be laminated and placed in areas of service. Kitchen staff and anyone one who is serving has been trained in how to properly put on hair nets and gloves. Criterion 2: How the facility will identify other residents affected by the same violations. All residents had the potential to be affected by this violation. Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur. All employees in nursing and dietary that may serve meals will be in-service on scoop size, appropriate portion size per the menu, facility policy on small portion definitions and proper use of hair covering per facility protocol. On Friday, January 10, 2014, Registered Dietitian, Miriam Wooldridge, conducted two (2) in-service trainings on: Portion Control, Personal Hygiene, Food Labeling and Dating, Proper Storage of Leftovers - Perishable and Non-Perishable, and Cleaning and Sanitizing Dishes, Utensils, Pots and Pans. The in-service was recorded for future use.		
F 520 SS=D	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS  A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff.  The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of	F 520			

insert page 33A



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NAME OF PROVIDER OR SUPPLIER  LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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		F371	<p>A tool will be developed and distributed to food service areas that will identify scoop size by handle color. This will be provided with the appropriately sized scoops for the meal to be served. Spoodles will be treated in a similar manner.</p> <p>This in-service will be provided in the orientation package to all new employees who will be serving meals. Proper service requirements, portion sizes, scoop/spoodle sizes and hair restraints will be addressed at orientation and periodically as needed. The dietary manager or shift cook will provide information verbally as well.</p> <p>Criterion 4: How the facility will monitor its correct actions to ensure that the violation is being corrected and will not recur. The dietary manager or shift cook will observe one a meal a week in each dining room and document findings in Meal Service Binder. Corrective feedback will be provided as needed. These findings will be presented to Quality Assurance quarterly meetings and reviewed for compliance and further training needs.</p> <p>The Registered Dietitian will observe one meal service a month and document observations.</p>	1/16/2014
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OFFICE OF ADMINISTRATIVE CENTRAL SERVICES

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F 520	<p>Continued From page 33 action to correct identified quality deficiencies.</p> <p>A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.</p> <p>Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the plan of correction for the February 2013 survey, it was determined the facility failed to have an effective Quality Assurance (QA) committee to identify, develop, and implement appropriate plans of actions to maintain ongoing compliance with quality deficiencies. The facility had been cited for dietary sanitation on the last four standard surveys (including this survey). The facility's QA committee failed to continue corrective measures to ensure ongoing compliance and failed to identify the non-compliance until surveyor intervention. Refer to F-371.</p> <p>The findings include:</p> <p>Review of the signature sheet for the facility's QA meetings revealed the QA committee met on 01/16/13, 04/10/13, 07/17/13, and 10/16/13. The signature sheet revealed the Medical Director was present at those QA meetings. In addition, the Dietary Manager was present except for the 07/17/13 meeting.</p>	F 520	<p><b>Quality Assurance Committee-Meeting/Quarterly/Plans.</b></p> <p><b>Criterion 1: What corrective action will be accomplished for those residents affected by the violations. The Administrator, Sister Maureen Courtney identified the problems in this survey and reviewed past surveys with the Medical Director, the Registered Dietitian and Director of Nursing. The issues including causal factors will be discussed at the Quality Assurance Meeting on January 15, 2014. Prior to that meeting the Medical Director will review the Plan of Correction for this year and previous deficiencies to ensure all areas are addressed. In order to ensure that quality of care be given to all Residents, checks will be made by the Dietary Supervisor, Sister Charles, to be certain that all practices will be completed.</b></p> <p>Criterion 2: How the facility will identify other residents affected by the same violations. All residents, and in addition, any visitors of the Residents or members of the apartments a had the potential to be affected by this violation. The Administrator, DON, and Medical Director reviewed past POC's and policies to guide the QA Committee in identifying other possible sources of deficient practices regarding quality of care. This process will be continued and refined based on recent discoveries.</p> <p>Criterion 3: The measures that will be put into place or systemic changes made to ensure the violations will not recur.</p>	
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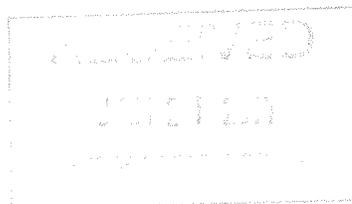
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F 520	Continued From page 34  Interview with the Administrator, on 12/12/13 at 4:40 PM, revealed the Dietary Manager had been present at most QA meetings. She stated the Registered Dietician (RD) was not attending the QA meeting and really had no part in the kitchen's sanitation. She stated that would change and the RD would assist the Dietary Manager and help identify problems in the kitchen and bring forward those issues to the QA meetings. She stated she had conducted random audits of the kitchen and found some problems; however, she had not documented anything and did not forward those concerns to the QA committee. She acknowledged the kitchen has been a problem and she identified the need to conduct unannounced checks. She stated little oversight had been provided in this area. She stated the Medical Director had not been involved in the problems with the kitchen; therefore, he could not have assisted the facility in development of a plan of action to maintain compliance.  Review of the plan of correction for the 02/15/13 standard survey revealed F-371 citation would be discussed at the QA meetings to monitor and ensure continued compliance. When asked who was responsible for ensuring the corrective actions were implemented, the Administrator stated she was. However, she revealed the monitoring and audits only included what was specifically cited during that survey (cold food temps. ice scoop, ice on freezer floor, and plate covers) and did not include any new problems identified in the kitchen. The problems found in the kitchen on this survey had not been identified by the QA committee and no corrective plans had been developed.	F 520	The Dietary Manager is no longer employed by the facility. The Registered Dietitian, Miriam Wooldridge will be responsible for the in-service and training of all employees. This includes knowledge of the policies and procedures and the enforcement of said policies. The Quality Assurance Committee and the Administrator will ensure the monitoring of the situation which caused this deficiency. The new Dietary Manager will receive advice from and will report to the Quality Assurance Committee and the Administrator to ensure that policy is being followed. The QA Committee will ensure the new Dietary Manager receives proper and complete training. Due to multiple system failures in the sanitation / food procurement / food storage and preparation area, the Dietary Manager or Registered Dietitian will complete monthly sanitation inspections of the dietary department and document the findings. All dietary employees will be in-serviced on Food Service Sanitation by Miriam Wooldridge, Registered Dietitian by 1/15/2014. This in-service will be repeated annually and as needed. Criterion 4: How the facility will	
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monitor its correct actions to ensure that the violation is being corrected and will not recur.  
The Sanitation inspection findings will be presented at Quality Assurance meetings and reviewed for further action and training requirements.

Insert  
Page 35 A

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NAME OF PROVIDER OR SUPPLIER  LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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		F520	<p>The QA Committee will direct the Registered Dietitian and the new Dietary Manager in the development and implementation of the changes called for in the POC. The QA Committee will determine the effectiveness of changes by reviewing training and cleaning records and by inspections completed by the Registered Dietitian. The Medical Director will assist as needed with the development and implementation of the POC and will be available to the Administrator, DON and Registered Dietitian upon their request. Sister Administrator holds an Administrative License in Kentucky as well as in several other states. Sister Administrator is current in all continuing education courses to maintain said license and has been an active participant in Quality Assurance meetings since moving to St. Joseph's Home in 2011.</p> <p>The Administrator will monitor and be aware of the day-to-day activity in the dietary dept. and will point out any situation that does not follow procedure or the POC. The governing body will review the minutes of the QA Committee meetings to monitor the committee's actions.</p>	1/16/14
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NAME OF PROVIDER OR SUPPLIER  LITTLE SISTERS OF THE POOR	STREET ADDRESS, CITY, STATE, ZIP CODE 15 AUDUBON PLAZA DRIVE LOUISVILLE, KY 40217
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1990</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: one (1) story, Type II (222)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 12/10/13. Little Sisters of the Poor was found not in compliance with the Requirements for Participation in Medicare and Medicaid in accordance with Title 42, Code of Federal Regulations, 483.70 (a) et seq. (Life Safety from Fire). The facility is certified for thirty five (35) beds with a census of thirty three (33) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal</p>	K 000		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

*X Courtney Mausser* *X Administrator* *X 1/20/13*

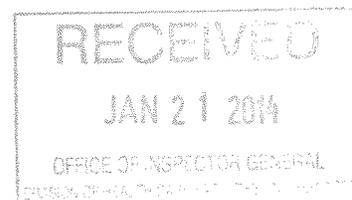
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

JAN 21  
OFFICE OF THE  
DIRECTOR OF HEALTH CARE

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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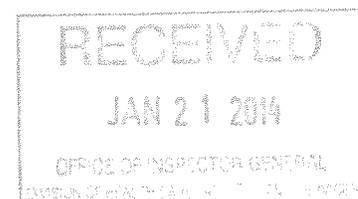
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K 000	Continued From page 1 Regulations, 483.70(a) et seq. (Life Safety from Fire).	K 000		
K 076 SS=D	Deficiencies were cited with the highest deficiency identified at "D" level. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities.  (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation.  (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure oxygen storage areas were protected in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is certified for thirty five (35) beds with a census of thirty three (33) on the day of the survey.  The findings include:	K 076	<b>K076</b> Life Safety Exit Date: 12/10/13 Violation: The oxygen storage room had a light switch and receptacle installed below five feet from the floor. #1 Corrective action accomplished for affected residents: The light switch and the receptacle were both removed from the oxygen room and relocated to the hallway outside the oxygen room. This work was completed by Assistant Maintenance Engineer Bobby Brady. Signage was placed on the outside of the door to the oxygen room stating: <b>OXYGEN STORAGE AUTHORIZED PERSONS ONLY PLEASE KEEP DOOR CLOSED AT ALL TIMES; and another stating: WARNING: OXYGEN IN USE NO SMOKING, NO OPEN FLAMES, NO MATCHES, NO CANDLES.</b> #2 How the facility will identify other residents potentially affected by the same violation: All residents had the potential to be affected by this violation.	



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K 076	<p>Continued From page 2</p> <p>Observation, on 12/10/13 at 2:16 PM, with the Maintenance Director revealed thirty nine (39) E type oxygen tanks stored in the Oxygen Storage Room located in the Holy Family Hall. The room had a light switch and a receptacle installed below five (5) feet from the floor. Oxygen storage greater than 300 cubic feet cannot have an ignition source installed below five (5) feet from the floor.</p> <p>Interview, on 12/10/13 at 2:16 PM, with the Maintenance Director revealed he was not aware of the requirements for oxygen storage.</p> <p>Reference: NFPA 99 (1999 edition) 8-3.1.11.2 Storage for nonflammable gases greater than 8.5 m3 (300 ft3) but less than 85 m3 (3000 ft3) (a) Storage locations shall be outdoors in an enclosure or within an enclosed interior space of noncombustible or limited-combustible construction, with doors (or gates outdoors) that can be secured against unauthorized entry. (b) Oxidizing gases, such as oxygen and nitrous oxide, shall not be stored with any flammable gas, liquid, or vapor. (c) Oxidizing gases such as oxygen and nitrous oxide shall be separated from combustibles or materials by one of the following: (1) A minimum distance of 6.1 m (20 ft) (2) A minimum distance of 1.5 m (5 ft) if the entire storage location is protected by an automatic sprinkler system designed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems (3) An enclosed cabinet of noncombustible construction having a minimum fire protection rating of ½ hour. An approved flammable liquid storage cabinet shall be permitted to be used for</p>	#3 K 076  #4	<p>Measures to ensure that the deficient practice will not recur: The physical location of the light switch and receptacle were permanently changed.</p> <p>How the facility will monitor to ensure that solutions are sustained: Daily checks of the area will be completed by the Maintenance Engineer or one of the two Maintenance Assistants to ensure that the oxygen room is in proper order and the signage is in place. The Quality Assurance Committee under the chairmanship of Dr. Robert Hammer, will meet on January 15, 2014 to discuss this deficient practice. Kathy Abell in Medical Records checks the oxygen room daily and will report on these checks at QA Meetings.</p>	1/16/2014



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K 076	<p>Continued From page 3 cylinder storage. (d) Liquefied gas container storage shall comply with 4-3.1.1.2(b)4. (e) Cylinder and container storage locations shall meet 4-3.1.1.2(a)11e with respect to temperature limitations. (f) Electrical fixtures in storage locations shall meet 4-3.1.1.2(a)11d. (g) Cylinder protection from mechanical shock shall meet 4-3.5.2.1(b)13. (h) Cylinder or container restraint shall meet 4-3.5.2.1(b)27. (i) Smoking, open flames, electric heating elements, and other sources of ignition shall be prohibited within storage locations and within 20 ft (6.1 m) of outside storage locations. (j) Cylinder valve protection caps shall meet 4-3.5.2.1(b)14.</p> <p>8-3.1.11.3 Signs. A precautionary sign, readable from a distance of 5 ft (1.5 m), shall be conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: <b>CAUTION OXIDIZING GAS(ES) STORED WITHIN NO SMOKING</b></p>	K 076		

