

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

PRINTED: 09/26/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
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NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 860 HIGHLAND AVENUE FORT THOMAS, KY 41075
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>AMENDED SOD 09/28/11</p> <p>A standard health survey was conducted 09/06/11 - 09/09/11. A Life Safety Code survey was conducted on 09/08/11. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>This was a nursing home initiative survey initiated on 09/06/11 at 6:10 PM.</p> <p>An abbreviated survey was conducted from 09/06-09/09/2011 to investigate KY16168, KY15965, KY15667, KY17003 and KY15957. The Division of Health Care unsubstantiated the allegations due to lack of sufficient evidence for KY16168, KY15965, KY15667, KY17003, KY15957 however, unrelated deficiencies were cited.</p>	F 000	<p>HIGHLANDSPRING OF FT. THOMAS CARE CENTER SURVEY ENDED September 9, 2011</p> <p>Without admitting or denying the validity or existence of the alleged deficiencies, including but not limited to any determinations of scope or severity made by the Kentucky Cabinet for Health and Family Services. Highlandspring of Ft. Thomas Health Care Center ("Highlandspring") provides the following plan of correction. This plan of correction is submitted as required by the state and federal guidelines and is not an admission or agreement with any of the cited information.</p> <p>This plan of correction is not meant to establish any standard of care, contract, obligation or position and Highlandspring reserves all rights to raise all possible contentions and defenses in any civil or criminal claim action or proceeding.</p> <p>THIS PLAN OF CORRECTION SERVES AS HIGHLANDSPRING'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF October 9, 2011.</p>	
F 167 SS=C	<p>483.10(g)(1) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>A resident has the right to examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility.</p> <p>The facility must make the results available for examination and must post in a place readily accessible to residents and must post a notice of their availability.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 167	<p>F167</p> <p>Highlandspring will make the results of the most recent survey available for examination in a location readily accessible to residents and post a notice of their availability.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X UNIT	(X6) DATE RECEIVED X 10/18/11
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any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that their safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 167	<p>Continued From page 1</p> <p>by:</p> <p>Based on observation, interview and review of the facility's policy, it was determined the facility failed to ensure the results of the most recent survey was in a place readily accessible to the residents. In addition, the posting of the notice of the availability of the survey results was posted at the main door entrance, outside of the locked nursing units.</p> <p>The findings include:</p> <p>Review of the facility policy Resident Bill of Rights and Responsibility revised 09/08/11 section I Examination of Survey Results revealed, A resident has the right to examine the results of the most recent survey.....in a place readily accessible to residents.</p> <p>Observation, on 09/06/11 at 6:15 PM, revealed a sign stating "survey results available upon request" posted on the wall beside the receptionist desk. This sign was not posted any other place within the nursing units.</p> <p>Observation, on 09/06/11 at 6:15 PM, revealed a code had to be entered to open the door to enter or exit both the first and second floor nursing units.</p> <p>A group interview was conducted, on 09/07/11 at 11:00 AM, with eight (8) residents in attendance. When the residents were asked about Resident Right the residents voiced no one had talked to them about items including how to contact the Ombudsman, what an Ombudsman was, the survey inspection book, Care Plan meetings or how to contact an advocacy groups.</p>	F 167	<p>The IPS Director added a full screen page with a 30 second pause on the screen and in a 32 point font to the facility in-house channel, as well as a sign in each living room, on September 9, 2011, informing residents of where the annual survey results were located. The living room handbook, in which the survey results were located, was re-labeled and placed at a height accessible to residents on September 29, 2011 by the Administrative Assistant.</p> <p>In addition to giving each resident/responsible party a list of advocacy groups upon admission, the IPS Director also notified residents of advocacy groups during resident council on September 28, 2011. A flyer was distributed to all residents, including those not in attendance, with contact information for advocacy groups.</p> <p>The IPS Director or IPS Designee will notify the residents quarterly at resident council meetings of their rights, as well as the availability of advocacy groups, including but not limited to, contact information for the Ombudsman.</p> <p>The IPS Director or IPS Designee will conduct a formalized P.I. audit related to living room handbooks and the availability of advocacy information, weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the residents are aware of who their Ombudsman is, how to contact the advocacy groups, where the recent survey inspections were located and that the information is accessible to residents.. If issues are noted, the IPS Director will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as <b>Exhibit A</b>.</p> <p>The IPS Director will monitor.</p> <p>Date of Completion:</p>	October 9, 2011

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F 167	Continued From page 2  Observation, on 09/08/11 at 4:10 PM, of the living room on the 1300 hall revealed a binder on the top shelf of a book/magazine/newspaper rack. The description of what was in the binder was not visible. The survey binder had to be pointed out by the Administrative Assistant.  Interview with the Administrative Assistant, on 09/08/11 at 4:10 PM, revealed the binder could be lowered to the second or third shelf to be more accessible to the residents and that the binder could be identified a little better so residents would know what was in the binder.	F 167		
F 168 SS=F	483.10(g)(2) RIGHT TO INFO FROM/CONTACT ADVOCATE AGENCIES  A resident has the right to receive information from agencies acting as client advocates, and be afforded the opportunity to contact these agencies.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy, it was determined the facility failed to post information regarding contact information for Advocacy groups including, the Ombudsman, and the Office of Inspector General, and be readily accessible to residents, for two (2) of two (2) nursing units.  The finding include:  Review of the facility's policy Residents' Bill of Rights and Responsibility revealed a resident had the right to receive information from agencies	F 168	F168  Highlandspring provides the residents with information from agencies acting as client advocates, and affords residents the opportunity to contact these agencies.	

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F 168

Continued From page 3  
acting as client advocates and be afforded the opportunity to contact these agencies. In addition, the Residents' Bill of Rights and Responsibility Procedure six (6) revealed the Social Worker shall provide ongoing explanation of rights and responsibilities during monthly resident council meetings.

Interview, on 09/07/11 at 11:00 AM, during the Resident Council Meeting revealed Resident #15 and four (4) unsampled Resident Council Members did not know an Ombudsman was assigned to the nursing facility and did not know how to contact the Ombudsman. Resident #15 said the facility had an Ombudsman in the past, but she had retired and no Ombudsman was currently assigned to their facility. None of the eight (8) Resident Council members were aware of where the Ombudsman contact information was posted in the facility. The facility Ombudsman was in attendance at the Resident Council Meeting and was introduced to the group.

Interview, on 09/07/11 at 12:00 PM, with the Facility Ombudsman revealed the Ombudsman contact information posters were provided to the nursing facility but were not posted. The Ombudsman did not receive an explanation of why the Ombudsman information was not posted; however, was told the contact information was available on television screens within the facility.

Observation, on 09/07/11 at 12:00 PM, revealed a posting: to file a complaint..... with the Office of Inspector General that included the phone numbers, posted beside the elevators, outside of the locked nursing units.

F 168

The IPS Director updated the in-house channel on September 9, 2011 with a 30 second pause on the full screen page, in a 32 point font, to show the contact information for the Ombudsman and the Office of the Inspector General in a larger font and for an extended period of time.

The IPS Director also notified residents of advocacy groups during resident council on September 28, 2011. A flyer was distributed to all residents, including those not in attendance, with contact information for advocacy groups.

The IPS Director or IPS Designee will notify the residents quarterly at resident council meetings of their rights, as well as the availability of advocacy groups, including but not limited to, contact information for the Ombudsman.

The IPS Director has scheduled the Ombudsman to meet with the residents on October 11, 2011. The Ombudsman will continue to meet with the residents on a routine basis, scheduled by the IPS Director to answer questions and educate the in-house residents. The Director requested the Ombudsman bring additional posters to the facility to hang, which will be delivered after the state prints additional copies. An interim poster was placed on September 28, 2011, in the Activity Room until the poster arrives.

The IPS Director or IPS Designee will conduct a formalized P.I. audit related to the availability of advocacy information, weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the residents are aware of how to who their Ombudsman is, and how to contact the advocacy groups. If issues are noted, the IPS Director will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit A.

The IPS Director will monitor.

Date of Completion:

October 9, 2011

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*Handwritten signature*

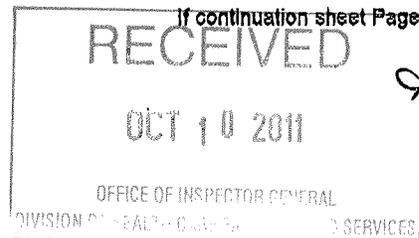
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F 168	<p>Continued From page 4</p> <p>Observation, on 09/07/11 at 12:30 PM, revealed a television screen was displayed about one third of the way down from the ceiling, on the wall, in the sitting area of both nursing units. Various information was streaming across the screen including menu's for the day, and activities for the day. There was a runner about two inches from the top and a runner two inches on the bottom, both going in opposite directions. In addition, various items would pop up in the middle of the screen. Continued observation revealed the information regarding contact information for the Ombudsman and the Office of the Inspector General popped up approximately every five (5) minutes and lasted fifteen (15) seconds. The font size was small and the person listed as the Ombudsman was incorrect.</p> <p>Interview, on 09/08/11 at 5:10 PM, with the Social Worker revealed she was not aware the Resident Council Members did not know an Ombudsman was assigned to the facility. The Social Worker said the ombudsman contact information was available in the resident handbook, and the contact information was provided on an information channel on the resident's televisions, and the televisions in the common areas of the facility. The informational posters were not displayed because the posters were not a suitable fit with the decor of the facility.</p>	F 168		
F 246 SS=E	<p>483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES</p> <p>A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be</p>	F 246	<p>F246</p> <p>Highlandspring will ensure the residents receive services with reasonable accommodation of individual needs and preferences. The facility will ensure lab services are provided so as not to disturb resident sleeping patterns.</p>	



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F 246	<p>Continued From page 5 endangered.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the Nursing Facility Laboratory Agreement, It was determined the facility failed to ensure the residents received services with reasonable accommodation of individual needs and preferences. The facility failed to ensure Lab services were provided during reasonable hours, so as to not disturb the residents' sleeping patterns for one (1) resident (#15) of the seventeen (17) residents who received Lab draws prior to 4:00 AM. During the period between 09/02/11 and 09/09/11, Resident #15 had lab collection of blood specimens performed prior to 4:00 AM.</p> <p>The findings include:</p> <p>Review of the nursing Facility Laboratory Agreement with an effective date of 9/08/10, revealed the nursing facility and the lab agreed that the lab would provide lab draw times that were convenient to the residents.</p> <p>Interview, on 09/07/11 at 11:00 AM, with the Resident Council revealed Resident #15 complained that on the morning of 09/07/11 at 3:45 AM, the lab representative turned on all the lights in the room, and awakened Resident #15 and the roommate to obtain a blood specimen. Resident #15 complained that it was difficult to get back to sleep, and after an hour, decided to get up for the day. Resident #15 did not</p>	F 246	<p>The DON contacted the Medlab account representative to receive a verbal agreement, stating the lab would not obtain routine specimens until 5am. The licensed nursing staff was in-serviced by the DON on September 21, 2011 on the importance of acceptable hours of routine lab draws, and the importance of the accommodation of individual needs and preferences.</p> <p>Resident #15 was followed up by DON that routine lab services would not be provided before 5am unless ordered by the physician.</p> <p>The IPS Director or IPS Designee will notify each resident that lab services will done after 5 am and will monitor the resident's preferences in regards to lab services during monthly resident council meetings. Findings will be reported to the DON after each meeting.</p> <p>The D.O.N or Unit Manager will conduct a formalized P.I. audit related to routine lab collection weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the resident's individual needs and preferences are met related to lab collection times. If issues are noted, the D.O.N will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit B.</p> <p>The D.O.N will monitor.</p> <p>Date of Completion:</p>	October 9, 2011

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F 246	<p>Continued From page 6</p> <p>understand why it was necessary for the Lab to come so early, and thought the facility residents needed to get their rest.</p> <p>Record review of the Lab Requisition Reports, timed and dated when the lab specimen was obtained, and provided to the nursing facility during the period of 09/02/11 through 09/09/11, revealed seventeen (17) residents had blood specimens obtained between the hours of 2:15 AM and 4:00 AM.</p> <p>Record review of the Lab Requisition Report dated 09/07/11, revealed a CBC (blood count) lab was drawn for Resident #15 on 09/07/11 at 3:41 AM.</p> <p>Interview, on 09/09/11 at 11:30 AM, with Resident #15 revealed they never complained about the early morning collection of lab specimens because that was the way it was always done since Resident #15 was admitted twelve (12) years ago. Resident #15 stated the lab representative was too loud and turned on every light in the room on the most recent visit, which was the reason Resident #15 complained about the timing of lab collections on this date.</p> <p>Interview, on 09/09/11 at 2:05 PM, with the contracted lab Account Representative revealed the lab obtained specimens as early as the nursing facility would allow, but did not know what hours the nursing facility had agreed upon for collection of lab specimens. The Account Representative stated he was not aware that collection of lab specimens were being done as early as 2:15 AM.</p>	F 246		

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F 246	<p>Continued From page 7</p> <p>Interview, on 09/09/11 at 2:20 PM, with the contracted laboratory Phlebotomy Manager revealed that in most facilities, the Lab begins morning lab collections between 3:00 and 4:00 AM. The Phlebotomy Manager said after review of the agreement terms with the nursing facility, morning lab collections should begin at 4:00 AM. The Phlebotomy Manager was not aware that collection of lab specimens were being done as early as 2:15 AM, and said she would need to investigate and stated this should not be happening.</p> <p>Interview, on 09/09/11 at 4:10 PM, with the Assistant Director of Nursing (ADON) revealed all lab specimens should be drawn prior to breakfast; however, it would not be acceptable to obtain lab specimens prior to 5:00 AM. The ADON said she did not know lab specimens were being collected prior to 5:00 AM, and thought the facility should be able to provide a more acceptable time for morning lab collections.</p> <p>Interview, on 09/09/11 at 6:50 PM, with the Director of Nursing (DON) revealed she had not received any resident complaints about the timing of morning lab collections. The DON could not remember what the agreement was with the Lab regarding collection times of lab specimens.</p>	F 246		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p>	F 282	<p>F282</p> <p>Highlandspring provides care and services that meet the professional standards of care including through the employment of licensed nurses with the skill and expertise to provide care for the residents. Quality care is rendered by the nursing assistants under the supervision of the licensed nurses. Outside resources are utilized when appropriate in meeting the needs of the residents.</p>	

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F 282	<p>Continued From page 8</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to develop a Care Plan for one (1) of twenty-four (24) sampled residents. Resident #9 had an indwelling catheter since admission to the facility that was not included in the care plan.</p> <p>The findings include:</p> <p>Review of the facility's policy for Care Plans revised 01/21/09 revealed a nursing initial note will be completed within twenty-four (24) hours of admission including a preliminary, short term care plan.</p> <p>Review of the medical record for Resident #9 revealed the facility admitted the resident on 08/24/11 with a re-admission date of 09/03/11 and diagnoses including, Wound Infection Left Femur, Diabetes Mellitus Type Two (2), Respiratory Failure, and Congestive Heart Failure.</p> <p>Review of the Short Term Care Plan for Resident #9 revealed the facility failed to develop a plan of care for the indwelling catheter for Resident #9 or indicated on any part of the short term care plan the resident had an indwelling catheter.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 09/08/11 at 7:30 PM, revealed she was the admission nurse and was responsible for developing short term care plans for new admissions. She stated there was a care plan for indwelling catheters that should have been added</p>	F 282	<p>Residents are having their individual care plans consistently implemented to meet the care needs including the interventions related to catheters.</p> <p>The Unit Managers/Supervisors and nursing management personnel perform routine informal nursing rounds to observe the care that is being rendered to the residents, including observations of devices and appliances included in individual resident plans of care. If issues are noted by the nursing management personnel, interventions will be taken at that time that may include additional one-on-one education with staff members. A check list to show these routine rounds have been completed is included as Exhibit H.</p> <p>Resident #9's short and long term care plans were updated to include an indwelling foley catheter on September 8, 2011.</p> <p>Each resident's care plans will be reviewed by October 9, 2011 by RN staff to assure appropriate short term care plans are in place. Nursing staff will monitor to assure that nursing care, including but not limited to updated short term care plans is being provided in the facility.</p> <p>Licensed nursing staff was in-serviced by the DON on September 21, 2011 to reinforce the importance of accurate short term care plans, including but not limited to indwelling foley catheter's per facility policy.</p> <p>The D.O.N or Unit Manager will conduct a formalized P.I. audit related to monitoring short term care plan implementation weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the short term care plans are developed and in place for indwelling foley catheters to provide the necessary care and services. If issues are noted, the D.O.N will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/ interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit C.</p> <p>The D.O.N will monitor.</p> <p>Date of Completion:</p>	October 9, 2011

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If continuation sheet Page 9 of 23  
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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>185383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/09/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>HIGHLANDSPRING OF FT THOMAS</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>960 HIGHLAND AVENUE FORT THOMAS, KY 41075</b>
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F 282	Continued From page 9 for Resident #9. LPN #5 stated the Charge Nurse was responsible to do an audit seventy-two (72) hours after the admission to ensure medications and treatments ae correct, and short term care plans are put in the charting book as a guide for charting by the nurses. LPN #5 stated the chart for Resident #9 did not get audited.	F 282		
F 309 SS=D	<p><b>483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</b></p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide 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 for one (1) of twenty-four (24) sampled residents. The facility failed to perform wound care for Resident #4 as stated in the physician's order.</p> <p>The findings include: Record review of the clinical Record for Resident #4 revealed documentation of a pressure ulcer on the left heel which was acquired prior to admission to the facility. Review of the Wound Progress note dated 09/07/11 revealed the facility</p>	F 309	<p><b>F309</b></p> <p>Highlandspring will provide 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 for all residents.</p> <p>The facility nursing staff follows physician orders and documents healing progress of wounds. Physicians are notified of any concerns or lack of healing for further interventions.</p> <p>The nursing supervisors and nursing management team perform periodic informal rounds, as a component of their daily duties, observing the direct care staff in rendering care for the residents including wound progress. If concerns are noted, the nursing supervisor or manager takes appropriate interventions at that time, including additional one-on-one reeducation of the employee. A check list to show these routine rounds have been completed is included as <b>Exhibit H</b>.</p> <p>The LPN immediately on September 9, 2011 completed wound care for Resident #4 as per physician order. Counseling for LPN #4 was conducted on September 14, 2011 on the importance of following physician orders for providing resident care.</p> <p>An audit was completed by the ADON on all residents receiving wound care on September 9, 2011 to ensure that the treatment performed was accurate according to physician orders.</p>	

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NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 880 HIGHLAND AVENUE FORT THOMAS, KY 41075
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F 309

Continued From page 10  
assessed the left heel as a Stage III with a red and yellow tissue base.

Record review of Physician Orders for Resident #4 revealed an order dated 09/07/11 to discontinue the use of Santyl and Bactroban on the left heel ulcer, and stated the heel was to be cleaned with saline, Puracol cut to fit the wound and applied to the wound base, then covered with four inch gauze and secured with rolled gauze to be performed daily and as needed when soiled.

Observation, on 09/09/11 at 2:00 PM, of the wound care for Resident #4 performed by LPN #4, revealed the wound was cleaned with saline, then Santyl and Bactroban was applied to the wound base and covered with a four inch gauze, and wrapped with rolled gauze.

Interview, on 09/09/11 at 2:32 PM, with LPN #4 revealed he performed the wound care for Resident #4 previously and was familiar with the treatment which was ordered by the physician. LPN #4 said he neglected to check the Treatment Administration Record (TAR) before he did the dressing change on 09/09/11 for any changes to the treatment.

Interview, on 09/09/11 at 2:40 PM, with the Assistant Director of Nursing (ADON) revealed the Wound Care Nurse from the Wound Clinic changed the wound care treatment for Resident #4 on 09/07/11. The ADON said the nurse was expected to take the TAR to the bedside when doing a treatment to ensure the resident received the care as directed by the physician order.

F 315  
SS=D 483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER

F 309

Licensed nursing staff were in-serviced by the DON on September 21, 2011 to reinforce the importance of following physician orders, specifically related to wound care.

The ADON or Unit Manager will conduct a formalized P.I. audit related wound care performance weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the physician orders are followed related to wound care. If issues are noted, the ADON will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/ interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit D.

The D.O.N will monitor.

Date of Completion:

October 9, 2011

F 315

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F 315

Continued From page 11

Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.

This REQUIREMENT is not met as evidenced by:  
Based on interview, record review and review of the facility's policy, it was determined the facility failed to have medical justification for an indwelling catheter for one (1) of twenty-four (24) sampled residents. The facility documented a diagnosis of wound healing for the use of an indwelling urinary catheter for Resident #6. The facility failed to discontinue the indwelling urinary catheter when the wound healed and failed to assess the resident for bladder control.

The findings include:

Review of the facility policy indwelling catheter insertion for females and males was to facilitate the flow of urine.....to monitor urinary output...maintain skin integrity.... The facility did not provide any other policies for medical justification for indwelling catheters.

Review of the medical record for Resident #6 revealed the facility admitted the resident on

F 315

F315

Highlandspring will ensure that appropriate medical justification for an indwelling catheter is documented within an individual resident's record.

The facility will ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. The facility will discontinue catheters on resident's who lack medical justification for indwelling catheter use. The facility will provide documentation of bladder training in trial removals of all indwelling catheters without medical justification.

Resident #6 has documentation of a bladder training program in place beginning October 1, 2011 with goal to remove catheter by October 4, 2011.

The DON completed a review on September 8, 2011 of each resident who currently has indwelling catheters to ensure appropriate medical justification was in place.

Licensed nursing staff were in-serviced by the DON on September 21, 2011 to reinforce the need for medical justification for catheterization based on the resident's clinical condition.

*unit manager 10-10-11 per Amy Thompson / PB*

The D.O.N or designee will conduct a formalized P.I. audit related to indwelling catheter's weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the medical justification for an indwelling catheter is documented within the resident record per facility policy. If issues are noted, the D.O.N or designee takes appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit C.

The D.O.N will monitor.

Date of Completion:

October 9, 2011

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F 315	<p>Continued From page 12</p> <p>02/13/09 with diagnosis including Benign Brain Tumor, Congestive Heart Failure, and Dementia.</p> <p>Review of the Physician's orders for Resident #6 revealed the facility received an order on 04/03/11 for "Foley" Catheter to aid in wound healing. On 05/10/11, the facility received an order to change the "Foley" Catheter use from wound healing to urinary retention.</p> <p>Interview with the Health Care Unit One (1) Nurse Manager, on 09/08/11 at 6:30 PM, revealed when residents are admitted to the facility with indwelling catheters the facility works to get them removed as soon as possible. She stated most of the residents with indwelling catheters currently have a diagnosis of urinary retention, Hospice care or skin integrity issues. The unit manager stated Resident #6 had "urinary retention, but I know it's not documented. If you get that information let me know".</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 09/09/11 at 3:30 PM, revealed she was the nurse responsible for both physician orders on 04/03/11 and 05/10/11. If she had done a trial of removing the indwelling catheter for Resident #6 she would have documented the information in the record. LPN #5 stated she believed Resident #6 had a history of urinary retention.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 09/09/11 at 4:10 PM, revealed she went through the medical record for Resident #6 and could not find any notation of a history of urinary retention, and no one had documented any trial removal of the indwelling catheter.</p>	F 315		

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F 315	Continued From page 13 Interview with the Director of Nursing (DON), on 09/09/11 at 6:30 PM, revealed she was aware residents in the facility with indwelling catheters should have an appropriate diagnosis for the use of an indwelling catheter. The DON stated she didn't know if it was presented to staff that residents had to have a medical justification for the use of an indwelling catheter. It was not the facility's practice to get a physician's order to change the diagnosis. The DON stated she was aware of the need to decrease indwelling catheter use because residents with indwelling catheters have an increased risk for infection.	F 315		
F 371 SS=F	483.35(l) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for Safe Food Handling and Storage, it was determined the facility failed to serve and store food under sanitary conditions. A previously frozen food which had thawed in a pool of raw meat juices was stored on the same tray with ready-to-eat food in the walk-in refrigerator.	F 371	F371  Highlandspring stores, prepares, distributes, and serves food under sanitary conditions.  During the survey, the storage of all meats was reviewed. The thawing meats, as well as the ready to eat meats, that were stored inappropriately were removed and discarded by the Dietician to avoid food contamination and food borne illness. There have been no cases of food borne illnesses in the facility.	

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F 371	<p>Continued From page 14 The findings include:</p> <p>Record review of the facility's policy for Safe Food Handling and Storage revealed proper storage and handling of all foods is essential in preventing contamination. All foods are defrosted in the refrigerator to ensure safety, and foods which need to thaw are moved from the freezer to the refrigerator and placed on a tray on the bottom shelf of the refrigerator. The policy stated raw meat and poultry should be wrapped securely to avoid leakage and contamination of other foods or surfaces. Plastic bags are used over commercial packaging and the product is placed on a tray to contain raw juices.</p> <p>Observation, on 09/06/11 at 6:20 PM, during an initial tour of the kitchen revealed a large roll of sausage was placed on a tray to thaw on the third shelf of the walk-in refrigerator with one (1) whole unopened deli-style, ready-to-eat roast beef, and one (1) previously opened piece of deli-style, ready-to-eat roast beef which was wrapped in saran. The roll of sausage had thawed and raw meat juices covered the surface of the tray and was within the plastic wrapped piece of deli-style, ready-to-eat roast beef.</p> <p>Interview, on 09/06/11 at 6:30 PM, with the Registered Dietician revealed the roll of sausage should not be thawed on a tray with ready-to-eat foods and stated that the foods would be removed immediately. The Registered Dietician said the ready-to-eat roast beef should be discarded in the trash.</p> <p>Interview, on 09/08/11 at 9:45 AM, with the Executive Chef revealed it was not safe to store</p>	F 371	<p>Dietary staff was in-serviced on September 27, 2011 by the Chef on the proper methods for protein storage and thawing methods. Daily compliance is being informally monitored by the Chef or Dietician on each shift in the dietary department to assure all items are properly wrapped, labeled and dated and stored in a safe and sanitary manner per facility policy (Exhibit I). Compliance is monitored by PI audits, completed by the Chef. Audits are being completed three times per week for one month. If findings are satisfactory, audits will be done weekly for one month. If findings continue to be satisfactory, audits will continue monthly thereafter (Exhibit E). If issues are noted, the Chef will take appropriate interventions at that time, including additional one-on-one reeducation/counseling of the employee.</p> <p>The Executive Chef will monitor.</p> <p>Date of Completion:</p>	October 9, 2011

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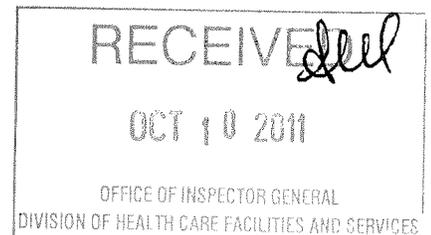
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F 371	Continued From page 15 thawing food on the same shelf/tray with ready-to-eat food based on the facility policy to avoid food contamination and foodborne illness.	F 371		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.  (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.  (c) Linens Personnel must handle, store, process and	F 441	F441  Highlandspring will establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infection.  As a component of their routine duties, Unit Managers/ Supervisors make direct observations of care provided by with the observation of the resident on a periodic basis. Additionally, the Director of Nursing and Administrator make informal rounds to assure the infection control procedures within the facility are being maintained. A check list to show these routine rounds have been completed is included as Exhibit H.  Resident #6 has a cloth drainage bag cover provided for storage of catheter bag and tubing to prevent tubing from lying or dragging on the floor; she has had no UTI in the past 30 days.  Resident #20 has a cloth drainage bag cover provided for storage of catheter bag and tubing to prevent tubing from lying or dragging on the floor; she has had no UTI in the past 30 days.	



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F 441	<p>Continued From page 16</p> <p>transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to maintain a sanitary environment for two (2) of twenty-four (24) sampled residents. Residents #6 and Resident #20 had indwelling catheters that were observed laying or dragging on the ground. The facility failed to store medications in a sanitary manner. Two (2) of four (4) medication carts were dirty. In addition, on 09/08/11, the ice scoop was stored in the ice chest while staff were passing ice to the residents.</p> <p>The findings include:</p> <p>Review of the facility policy for Infection Control revised 09/08, #2 revealed the facility had adopted standard precautions as its primary means of reducing risk exposures..... of infectious disease.</p> <p>Interview with the Director of Nursing (DON), on 09/09/11 at 6:30 PM, revealed that it was not acceptable for catheters or tubing to be touching or dragging the floor. She stated it was an infection control issue.</p> <p>1. Observation, on 09/08/11 at 9:50 AM, revealed staff pushing Resident #6 in a wheelchair down the hallway with the indwelling catheter tubing</p>	F 441	<p>Each resident with a foley catheter was reviewed for infection control practices and catheter bags were provided to reduce the occurrence of the tubing dragging on the floor.</p> <p>Medications will be stored in a sanitary manner. Medication carts will be monitored and cleaned daily by charge nurses.</p> <p>The 1200 and 1300 medication carts were cleaned on September 8, 2011 by the charge nurse.</p> <p>Each facility medication and treatment cart was cleaned on September 8, 2011 by the charge nurse.</p> <p>Ice scoop is stored in a closed container when not in use.</p> <p>Residents are assessed for signs and symptoms of infections by the licensed nurse.</p> <p>When an infection is identified, the licensed nurse documents the findings and recommendations in resident chart/record. The Infection Control Nurse monitors the physician orders and follows-up as required. The Infection Control Nurse initiates the tracking procedure for the infections and follows through the monthly Infection Control Report which is given to the DON, Administrator and QA Committee.</p> <p>Nursing staff, both licensed and STNA's, were in-serviced by the DON on September 21, 2011 to reinforce the importance of maintaining a sanitary environment. The information covered included but was not limited to the importance of indwelling catheter bags and tubing not lying or dragging on the ground, medication carts being clean and sanitary, and the ice scoop appropriately stored in a closed container outside of the ice chest.</p> <p>The ADON or Unit Manager will conduct a formalized P.I. audit related to infection control weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the nursing interventions, specific storage of</p>	

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FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185383	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  09/09/2011
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NAME OF PROVIDER OR SUPPLIER  HIGHLANDSPRING OF FT THOMAS	STREET ADDRESS, CITY, STATE, ZIP CODE 960 HIGHLAND AVENUE FORT THOMAS, KY 41075
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F 441	<p>Continued From page 17 dragging the floor.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 09/08/11 at 9:56 AM, revealed she had just given Resident #6 a shower. She stated the catheter and tubing should not be on the floor because they would become contaminated.</p> <p>Observation, on 09/09/11 at 10:30 AM, revealed Resident #6 sitting in a wheelchair out in the hallway. The indwelling catheter bag was laying on the floor.</p> <p>2. Observation, on 09/09/11 at 9:05 AM, 9:55 AM, and 10:25 AM revealed Resident #20 was sitting in a wheelchair at the bedside. The indwelling catheter tubing was found lying on the floor.</p> <p>Interview, on 09/09/11 at 10:30 AM, with CNA #5 revealed the indwelling catheter tubing should not be lying on the floor because the tubing could get tangled and cause the catheter to become dislodged which would result in pain and injury to the resident. CNA #5 voiced she was not aware of the risk of infection which could result from the tubing lying on the floor.</p> <p>Record review of the facility policy for Ice Pass, revealed the ice scoop should be stored in the holder on the ice cart.</p> <p>3. Observation, on 09/08/11 at 3:35 PM, revealed during a pass of ice and water on the 1300 Hall, an ice scoop was stored inside the portable ice chest with the handle of the scoop stored in the ice.</p>	F 441	<p>catheter tubing and drain bags, clean and sanitary medication carts, and appropriate storage of the ice scoop are carried out per facility policy. If issues are noted, the ADON takes appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit F.</p> <p>The D.O.N will monitor.</p> <p>Date of Completion:</p>	October 9, 2011

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F 441

Continued From page 18

Interview, on 09/08/11 at 3:40 PM, with CNA #6 revealed the ice scoop should be stored in the closed case provided on the cart. CNA #8 said during the ice water pass, she forgot and placed the ice scoop inside the chest, rather than inside the covered container.

Interview, on 09/08/11 at 7:00 PM, with the First Floor Unit Manager revealed during ice water pass, staff were trained to store the ice scoop in the container on the cart to prevent cross-contamination.

Interview, on 09/09/11 at 5:50 PM, with the Director of Nursing (DON) revealed staff were trained to store the ice scoop in the container provided on the ice cart to avoid cross-contamination.

The facility was unable to provide a policy or procedure on the cleaning of Medication Carts.

4. Observation, on 09/08/11 at 3:30 PM, of the two (2) Medication Carts on the first floor revealed the 1200 cart had a crusty white build up on the inside of the bottom drawer and brown drips down the side of the cart near the trash receptacle. The 1300 cart had a sticky substance on the inside of the bottom drawer and brown drips down the side of the cart near the trash receptacle.

Interview, on 09/08/11 at 7:28 PM, with Unit Manager (UM) #1 revealed the cleaning of Medication Carts was the responsibility of each nurse that used the cart. There was no set

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F 441	Continued From page 19 schedule for cleaning the Medication Carts. She revealed there was an expectation that nurses on the night shift clean the medication carts weekly and prn.  Interview, on 09/09/11 at 3:55 PM, with the Director of Nursing (DON), revealed each nurse was responsible to clean the Medication Carts after use.	F 441		
F 502 SS=F	483.75(j)(1) ADMINISTRATION  The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.  This REQUIREMENT is not met as evidenced by: Based on observation and Interview It was determined the facility failed to ensure the laboratory supplies were not expired in two (2) of two (2) medication rooms. Observation of the medication rooms revealed a total of fifty-six (56) expired laboratory vials and four (4) expired culture swabs.  The findings include:  Observation of the Second Floor Medication Room, on 09/08/11 at 1:30 PM, revealed nine (9) red top tubes expired 08/2011; eight (8) red and black top tubes expired 06/2011; twenty-three (23) yellow top tubes expired 07/2011; two (2) culture swabs expired 07/2011 and two (2) culture swabs expired 10/2010.  Observation of the First Floor Medication Room,	F 502	F502  Highlandspring obtains laboratory services to meet the needs of the residents in a timely manner. The facility will ensure lab supplies are available and not expired.  All lab supplies in the building were checked, and expired lab supplies from the facility were removed on September 9, 2011 by the ADON. New supplies were ordered to replace those discarded.  As a component of their routine duties, Unit Managers/ Supervisors make direct observation of the unit and supplies used for resident care. Additional, the Director of Nursing and Administrator make informal rounds to assure supplies are used on or before their expiration date, and discarded appropriately otherwise. A check list to show these routine rounds have been completed is included as Exhibit H.  Licensed nursing staff were in-serviced by the DON on September 21, 2011 to reinforce the importance of verifying expiration dates on supplies prior to use and discarding supplies on or before date of expiration per facility policy.	

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F 502	<p>Continued From page 20 on 09/08/11 at 2:00 PM, revealed sixteen (16) yellow top tubes expired 08/2011.</p> <p>Interview, on 09/09/11 at 9:15 AM, with Unit Manager #2 revealed it was the responsibility of each nurse to check for expiration dates prior to using any supplies. She stated she checked for inventory but did not check for expiration dates.</p> <p>Interview, on 09/09/11 at 3:55 PM, with the Director of Nursing revealed no one was designated to check expiration dates of supplies. All nurses should check prior to using any supplies. The DON stated expired laboratory supplies could cause incorrect lab values.</p>	F 502	<p>The D.O.N or ADON will conduct a formalized P.I. audit related to lab supplies weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the supplies used and maintained within the building are not expired. If issues are noted, the D.O.N takes appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit B.</p> <p>The D.O.N will monitor.</p> <p>Date of Completion:</p>	October 9, 2011
F 514 SS=D	<p>483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to maintain an accurate medical record for one (1) of twenty-four</p>	F 514	<p>F514</p> <p>Highlands maintains clinical records for each resident in accordance with accepted professional standards and practices that are complete, accurately documented, readily accessible and systematically organized.</p> <p>Residents, including current residents, have their records maintained in a complete, accurate and organized manner. The facility utilizes a computerized charting system for much of the medical record including nurse's notes. This computerized charting allows for accurate and organized documentation.</p> <p>Resident #9's medical record was immediately corrected by initiating an immediate need care plan with medical justification noted for the indwelling catheter use.</p>	

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F 514

Continued From page 21  
(24) sampled residents. The facility failed to accurately document the use of an indwelling urinary catheter and urinary retention for Resident #6.

The findings include:

Review of the medical record for Resident #9 revealed the facility admitted the resident on 08/24/11 and readmitted on 09/03/11 with diagnoses including Wound Infection Left Femur, Diabetes Mellitis Type Two (2), Respiratory Failure and Congestive Heart Failure. There was no documentation Resident #9 had a diagnosis of Urinary Retention.

Review of the nursing progress notes revealed on 09/03/11 the facility documented Resident #9 had an indwelling catheter related to immobility. On 09/06/11 the facility documented the resident had an indwelling catheter related to urinary retention.

Interview with Resident #9, on 09/08/11 at 12:10 PM, revealed the resident was alert and orientated to person, place and time. The resident could explain events leading up to being admitted to the facility. Resident #9 stated the indwelling catheter had been in for some time. The resident stated the catheter was placed when the resident was first admitted to the hospital with the fractured femur. Since that time the resident had sustained a second fracture of the left femur and then developed an Infection within the surgical wound. Resident #9 stated there had never been any bladder problems that the resident was aware of. The catheter was placed because the resident couldn't get around very well. Resident #9 stated the facility never discussed removing the

F 514

Licensed nursing staff were in-serviced on September 21, 2011 by the Director of Nursing to discuss the importance of accurate documentation of foley catheter use as well as completing and maintaining accurate clinical records.

The licensed nursing staff involved with the resident's daily care were verbally counseled by DON on September 3, 2011 and September 6, 2011 to reinforce the importance of following professional standards of care related to clinical record documentation accuracy.

An audit was completed by the D.O.N on October 1, 2011, to verify medical justification, specific to foley catheter use, is accurately documented within the resident record. All records related to medical justification of foley catheter are accurate.

The D.O.N or ADON will conduct a formalized P.I. audit related to resident treatment records weekly for the next four (4) weeks, twice monthly for a month, and then monthly to assure that the nursing interventions, specific to foley catheter use, is accurately carried out per physician orders, and documented within the resident record per facility policy. If issues are noted, the D.O.N takes appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/ interventions and for a determination of the need of continued formal ongoing monitoring. A copy of such worksheet is attached as Exhibit C.

The D.O.N will monitor.

Date of Completion:

October 9, 2011

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F 514	<p>Continued From page 22 indwelling catheter.</p> <p>Interview with the Director of Nursing (DON), on 09/09/11 at 6:30 PM, revealed it was not the facility's practice to document Urinary Retention if a resident had an indwelling catheter. The DON could not give an explanation for the inaccurate nursing progress note for Resident #9.</p>	F 514		

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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: 1992, 2006</p> <p>Survey under: 2000 existing</p> <p>Facility type: S/NF</p> <p>Type of structure: Two (2) story Type II222 with partial basement.</p> <p>Smoke Compartment: Fifteen (15) smoke compartments</p> <p>Fire Alarm: Manual initiating devices located at exits. Smoke detectors located in all corridors and resident rooms. Heat detectors located in boiler room, laundry/wash room, and kitchen.</p> <p>Sprinkler System: Complete automatic (dry and wet) sprinkler system.</p> <p>Generator: Type II diesel installed 1992</p> <p>A standard Life Safety Code survey was conducted on 09/08/2011. Highlandspring of Fort Thomas was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The census the day of the survey was one hundred thirty three (133). The facility is licensed for one hundred forty (140).</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from</p>	K 000	<p>K62</p> <p>Highlandspring will have an automatic sprinkler system that will be maintained in a reliable operating condition and inspected and tested periodically.</p> <p>The facility sprinkler system is inspected quarterly by an outside contractor. Facility valves meet exception number 1; valves are in supervised areas and are inspected monthly.</p> <p>The Maintenance Director was in-serviced by the Corporate Maintenance Director on September 22, 2011 regarding the necessary visual inspection of the sprinkler system valves to be done on a monthly basis.</p> <p>These inspections will be recorded on a hang tag at the location of the valve, and as well as recorded on an inspection sheet (Exhibit G) that was created to record the monthly inspections. This inspection sheet will be kept and monitored by the Maintenance Director.</p> <p>Each facility valve was visually inspected by the Maintenance Director on October 1, 2011.</p> <p>The Maintenance Director or Maintenance Assistant will do a monthly visual inspection of the fire system related control valves. This inspection will verify that the valves are in the following condition: a) in the normal open position, b) are properly sealed, locked or supervised, c) accessible, d) provided with appropriate wrenches, e) free from external leaks, f) provided with the appropriate signage identifying the portion of the system they control.</p> <p>The Maintenance Director will turn in the inspection sheet to the Administrator monthly as a formal PI audit. If issues are noted, the Administrator will take appropriate action at the time the concern is noted. The P.I. worksheet results will be reported to the Performance Improvement Committee for additional comments/interventions and for a determination of the need of continued formal ongoing monitoring.</p> <p>The Administrator will monitor</p> <p>Date of Completion: October 9, 2011</p>	October 9, 2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

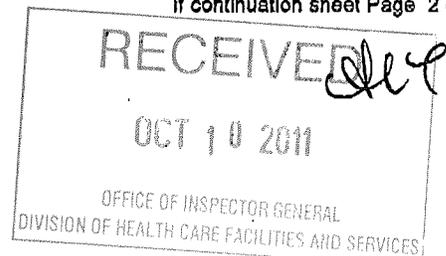
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K 000  K 062 SS=F	<p>Continued From page 1 Fire)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.5, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure sprinkler systems were inspected according to National Fire Protection Association (NFPA) standards. Sprinkler systems must be inspected to ensure their reliability in a fire. The deficiency had the potential to affect fifteen (15) of fifteen (15) smoke compartments, one hundred thirty three (133) residents, and staff.</p> <p>The findings include:</p> <p>Record review of sprinkler inspection documentation with the Maintenance Director reveled the facility had an outside contractor inspect control valves located in the sprinkler system quarterly.</p> <p>Interview, on 09/08/2011 at 12:20 PM, with the Maintenance Director revealed he was not aware valves located in the sprinkler system were to be inspected monthly.</p> <p>Reference: NFPA 25 (1998 edition)</p>	K 000  K 062		



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(X4) ID PREFIX -TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 062	<p>Continued From page 2</p> <p>9-3.3 Inspection.</p> <p>9-3.3.1 All valves shall be inspected weekly.</p> <p>Exception No. 1: Valves secured with locks or supervised in accordance with applicable NFPA standards shall be permitted to be inspected monthly.</p> <p>Exception No. 2: After any alterations or repairs, an inspection shall be made by the owner to ensure that the system is in service and all valves are in the normal position and properly sealed, locked, or electrically supervised.</p> <p>9-3.3.2* The valve inspection shall verify that the valves are in the following condition:</p> <ul style="list-style-type: none"> <li>(a) In the normal open or closed position</li> <li>(b) *Properly sealed, locked, or supervised</li> <li>(c) Accessible</li> <li>(d) Provided with appropriate wrenches</li> <li>(e) Free from external leaks</li> <li>(f) Provided with appropriate identification</li> </ul>	K 062		

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If continuation sheet Page 3 of 3

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## HIGHLANDS MONTHLY SPRINKLER AND GAUGE INSPECTION

Exhibit G

DATE	LOCATION	CHECKED BY	COMMENTS
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (VALVE)		
	BOILER ROOM (GAUGE)		
	1ST FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (VALVE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	2ND FL. SOILED UTILITY (GAUGE)		
	<b>*GAUGES REPLACED EVERY 5 YRS</b>		

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# Unit Manager Daily Check Off

Date: \_\_\_\_\_

Exhibit H

*Manager Initials*

Spot check treatments are completed per physician order

\_\_\_\_\_

Spot check lab supplies are not expired

\_\_\_\_\_

Ice scoop is stored in closed container when not in use

\_\_\_\_\_

Foley catheter tubing and bag are stored appropriately and not dragging on floor.

\_\_\_\_\_

Medication and treatment carts are clean

\_\_\_\_\_

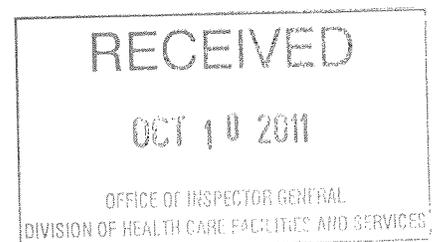
STCP for foley catheters are in place and updated

\_\_\_\_\_

Spot check to ensure appropriate medical justification is in place for all foley catheters

\_\_\_\_\_

DON Review Date \_\_\_\_\_  
\_\_\_\_\_



HIGHLANDSPRING OF FT THOMAS

Exhibit I

Lable, Dating & Thawing Log

DATE	Month:				Year:
	Cook's Fridge		Cooler		Exception/Comment
	A.M.	P.M.	A.M.	P.M.	
1					
2					
3					
4					
5					
6					
7					
8					
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