

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

PRINTED: 04/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/20/2011
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that any deficiencies are accurate. The Plan of Correction is submitted as a written allegation of compliance.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to follow the care plan for one (1) of three (3) sampled residents. Resident #3 was not wearing the heel protectors as ordered by the physician and indicated per plan of care. The findings include: Record review (RR) of the clinical record for Resident #3 revealed an admission on 05/13/10 with the diagnosis of Osteomyelitis, Diabetes Mellitus, Hypertension, Renal Insufficiency, Colitis and Hypoxemia. RR of the physician orders dated 01/13/11 revealed an order for Heel Lift Boots (HLB) at all times, may remove for bathing and Activities of Daily Living Care (ADL). RR of the Treatment Administration Record (TAR) dated 04/11 revealed the treatment for heel lift boots at all times (may remove for bathing and ADL) and was initialed and circled for the 7-3 shift on six (6) of the last eight (8) day shift (04/12, 13, 15, 16, 17	F 282	It is the facilities policy to be in compliance with this regulation. 1. Resident #3 was reassessed by Physician and new orders were received to discontinue the heel lift boots. 2. (3) other residents in the facility were identified as having orders for heel lift boots; heel lift boots were found in place on all (3) residents as ordered. 3. Nursing staff were re-educated on following the resident Care Plan and following orders with regards to adaptive equipment. The DON/ADON will QI monitor heel protectors to assure they are in place as ordered 5x/ weeks x4 weeks, then monthly x3 months, then quarterly. 4. The findings will be reviewed in the RM/QI meeting monthly x3 months then quarterly to ensure the facility is following the residents Care Plan.	4/29/11

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

TITLE

(X6) DATE

[Signature] *[Signature]* X 5-6-2011

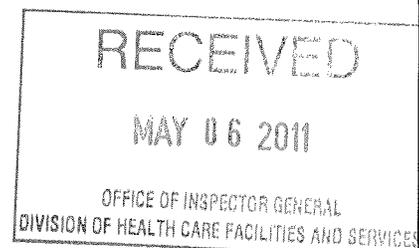
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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.

RECEIVED
If continuation sheet Page 1 of 3
MAY 06 2011
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 04/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/20/2011
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 1 and 19/11). RR of the care plan dated 01/13/11 revealed the resident is care planned for heel lift boots as ordered.</p> <p>The facility failed to provide a policy related to care planning on 04/20/11.</p> <p>Observation of Resident # 3 on 04/20/11 at 8:35am and at 9:43am revealed the resident was not wearing the HLB while lying in bed.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 04/20/11 at 11:20am revealed the facility did not have heel lift boots in the room available for Resident #3. LPN #1 reported she/he had initialed the TAR and circled his/her initials to indicate the HLB were not used on the day shift of 04/12, 04/13, 04/15, 04/16, 04/17 and 04/19/11 when he/she was caring for this resident. LPN #1 reported the HLB were not in the room and no attempt to locate them was made. LPN #1 reported Resident #3 had the HLB in the past, but did not have any in the room. LPN #1 reported he/she is a float nurse, works on the various units, and doesn't know everything about the residents because she/he floats. LPN #1 reported the care plan is to be followed and the care plan should be followed. It was his/her responsibility to follow the care plan when providing care.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 04/20/11 at 3:25pm revealed there is no one particular assigned person to track the interventions and care to be provided on the care plan. She reported she relies on the charge nurses to complete the tasks assigned and care as ordered by the physicians' as noted on the</p>	F 282		



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

PRINTED: 04/29/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 04/20/2011
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 2 care plan. Interview with the Director of Nursing (DON) on 04/20/11 at 3:40pm revealed there was not a tracking system in place to ensure the interventions were completed by the staff. She reported she relies on the charge nurses to complete the tasks assigned in accordance to the physician orders and care plans.	F 282		

