



**F246**

**483.15 Reasonable Accommodations of Needs/Preferences**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.**

The Forum at Brookside ensures that reasonable accommodations of the individual needs/preferences will be provided to the Residents, except when the health or safety of the individual or other Residents would be endangered.

With respect to the specific resident cited, The Forum at Brookside ensures that Resident #5 received a dual call light system on 10/14/10 to ensure the residents call light was attached to her bed and her chair at all times. The resident moved to our Personal Care Unit on 10/15/10.

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, The Director of Nursing completed a room audit on 10/15/10 of all residents to ensure that call light length was adequate and the proper numbers of call lights are present. On 11/4/10 an audit was conducted by the Director of Nursing and the Admission Director of 100% of the residents in the Nursing Facility to ensure adequate environmental accommodations in the rooms and a verbal interview was also conducted with these residents to ensure the resident's needs were being met by the facility.

With respect to what systematic measures have been put into place to address that stated concern, The Forum at Brookside's Licensed Nurses are completing room rounds every two (2) hours on a daily basis and signing off on their assignment sheet after completion of their shift which began on 10/15/10 and will be an ongoing check. Room rounds are also being conducted twice a week at random times and dates by Administrative staff with findings reported to the Director of Nursing or designee on a weekly basis; meeting generally occurs Wednesday at 10:30am unless schedule does not permit and alternate time is scheduled; these room rounds will include an interview with the resident to ensure all reasonable accommodations of the resident's environment are being met. A healthcare staff meeting will be conducted beginning 10/16/10 through and completed on 11/7/10; inservicing the staff on policy and procedure of answering call lights and reasonable accommodations of individual needs and preferences.

With respect to how the plan of corrective measures will be monitored, the Director of Nursing or designee will track and trend all discrepancies and schedule further education of staff as needed and will report all environmental needs immediately to the proper department for repairs or ordering of equipment. The Director of Nursing or designee will report all findings and solutions to the Quality Assurance Committee on a quarterly basis per performance improvement reporting calendar.

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

PRINTED: 10/12/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/28/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>THE FORUM AT BROOKSIDE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 BROOKSIDE DRIVE LOUISVILLE, KY 40243</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)	(X6) COMPLETION DATE
F 246	Continued From page 1 she moved the call bell to the chair after she took the resident to the bathroom. Continued interview revealed she was aware the call bell was to be within the resident's reach.  Interview on 09/28/10 at 9:20 AM with the Director of Nursing revealed the call light should have been placed within the resident's reach after the resident was transferred to the chair and before the Certified Nursing Assistant exited the room, as the facility's policy stated.  Review of the facility's Answering Call Lights Policy, dated 01/01/01 revealed call lights were to be placed within the resident's reach before staff exited the resident's room.	F 246		
F 281 SS=G	<b>483.20(k)(3)(I) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  The services provided or arranged by the facility must meet professional standards of quality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to meet professional standards of quality for four (4) of ten (10) sampled residents (Resident #3, #4, #7, and #10). The facility assessed Resident #10 on admission to require a bed in a low position; developed an Initial Plan of Care with an approach to adjust the resident's bed height; and, identified Resident #10 was a fall risk and required a low bed with positioners on the Certified Nursing Assistant (CNA) Assignment/Care Plan. However, the facility failed to ensure the bed was maintained in that position and the resident sustained an injury to	F 281		11-8-10

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F 281	<p>Continued From page 2 the perineum.</p> <p>Resident #7's Initial Plan of Care indicated the resident's bed was to be in the lowest position; however, the resident's CNA Assignment/Care Plan did not indicate to maintain the resident's bed in the lowest position.</p> <p>Resident #4's Physician's order for tracheostomy care had not been followed and Resident #3's right arm sling was not in place, nor was the proper padding for the sling provided per Physician's orders.</p> <p>The findings include:</p> <ol style="list-style-type: none"> <li>1. Closed record review revealed Resident #10 was admitted to the facility on 05/17/10 with diagnoses which included Dementia, Behavioral Disturbance, Alzheimer's Disease and Depression. Review of the admission Data Collection Tool dated 05/17/10, revealed the facility assessed Resident #10 to have short term memory deficit, to be continent of bowel and bladder, and to require one (1) person physical assist with transfer and ambulation.</li> </ol> <p>Review of the Bed-Safety Device Risk Review Tool dated 05/17/10, revealed the facility assessed Resident #10 as requiring ½ bed-safety rail as an enabler to promote independence and safety, and a low bed with positioners for safety and independence.</p> <p>Review of the Initial Plan of Care dated 05/18/10, revealed Resident #10 had an alteration in memory which required verbal and visual cues. Resident #10 had altered mood and behavior and was taking psychotropic medications. The resident also had impaired physical functioning</p>	F 281		
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F 281	<p>Continued From page 3</p> <p>and required assistance with transfers and ambulation and had altered Activities of Daily Living (ADL's) which required assistance with bed mobility and toilet use. Resident #10 had an initial care plan for falls with an approach to adjust the resident's bed height so the resident's feet would be planted firmly on the floor during transfers.</p> <p>Review of Resident #10's CNA Assignment/Care Plan revealed the resident required a one person assist with transfers utilizing a gait belt. The CNA Assignment/Care Plan identified the resident as a fall risk and indicated the resident's bed to be a low bed with positioners.</p> <p>Review of the Care Plan Conference Summary dated 05/27/10, two (2) days prior to the injury, revealed Resident #10 was receiving Rehabilitation Therapy for assistance in using a slide board. The Summary indicated Nursing Services was to provide ADL assistance, safety precautions, and medication administration.</p> <p>Review of the Hospital's Admission Summary dated 05/29/10, revealed Resident #10 was admitted to the hospital with diagnoses which included rectal bleeding secondary to a rectal tear of three (3) to four (4) centimeters (cm) in length, hypoxemia and fever of 103 degrees Fahrenheit. Further review of the Summary revealed Resident #10 had Dementia, was quite agitated and was trying to get out of bed.</p> <p>Interview with Certified Nursing Assistant (CNA) #1 on 09/27/10 at 2:50 PM revealed Resident #10 had self transferred and was found by CNA #1, sitting on the toilet. Interview with CNA #1 revealed he noted there was blood in the toilet.</p>	F 281		
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F 281	<p>Continued From page 4</p> <p>CNA #1 stated, Resident #10's roommate told him that Resident #10 had sat on the brake extension of the wheelchair. Upon interview with CNA #1, the CNA stated, the CNA Assignment/Care Plan should have been reviewed prior to caring for Resident #10. CNA #1 stated, he didn't know the resident that well and was unaware the bed was to be in the lowest position.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 11:38 AM, revealed the facility's investigation of the injury determined CNA #1 did not place the bed in the lowest position. Review of the facility's investigation dated 06/04/10 revealed Resident #10's "personal wheelchair was found with a right brake extension that was bent. It is presumed that Resident #10 injured him/herself while transferring from the bed into the wheelchair and sat down on the brake extender". Interview with the DON on 09/27/10 at 12:00 PM, revealed CNA #1 failed to follow the CNA Assignment/Care Plan by not placing the bed in low position. Further interview with the DON on 09/27/10 at 3:30 PM, revealed CNA #1 was unaware the bed went to a lower position and CNA #1 has since been re-educated. Per interview with the DON on 09/28/10 at 11:15 AM, the injury would not have occurred if the bed had been in the lowest position.</p> <p>2. Resident #7 was admitted to the facility on 09/22/10 with diagnoses which included Hemiplegia, Intracranial Hemorrhage and Dysphagia with Gastrostomy Tube Placement. Based on the Admission Data Collection Tool dated 09/22/10 at 8:00 PM, the facility assessed Resident #7 to be severely impaired with decision making, non-weight bearing and required total</p>	F 281			

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F 281	<p>Continued From page 5</p> <p>assist for transfers. The Admission Data Collection Tool revealed, the facility had assessed the resident to be totally dependent with all Activities of Daily Living (ADL's).</p> <p>Review of the Nurses' Notes dated 09/22/10 at 6:00 PM, revealed Resident #7 was alert, had right side weakness and the left side was flaccid and required the use of a lift for transfers. Review of the Nurses' Notes dated 09/27/10, revealed Resident #7 required total assist with ADL's.</p> <p>Review of the Initial Plan of Care for Resident #7 dated 09/22/10, revealed the resident had an alteration in ADL ability related to a Cerebrovascular Accident (CVA) and required assistance with toilet use and bed mobility. The resident was also assessed to require assistance with transfers using a mechanical lift. Under the fall section of the Initial Plan of Care, Resident #7 was assessed to be a moderate risk for falls related to the CVA and required referrals to Physical Therapy and Occupational Therapy and the bed was to be in the lowest position.</p> <p>Review of the Certified Nursing Assistant (CNA) Assignment/Care Plan dated 09/28/10, revealed Resident #7 was a fall risk, was unable to use his/her left side of body, and had right side weakness. However, the CNA Assignment/Care Plan did not reveal that the resident's bed should be in the lowest position.</p> <p>Interview with the Assistant Director of Nursing (ADON) on 09/28/10 at 2:10 PM, revealed the admission Nurse created the CNA Assignment/Care Plan and the ADON updated the CNA Assignment/Care plan with any new</p>	F 281		

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F 281	<p>Continued From page 6 orders.</p> <p>Interview with the Director of Nursing (DON) on 09/28/10 at 3:11 PM, revealed he/she was the one who completed the CNA Assignment/Care Plan for Resident #7 and didn't realize the low bed was not on the CNA Assignment/Care Plan.</p> <p>Interview with CNA #6 on 09/28/10 at 3:07 PM, revealed the CNA was the one who cared for Resident #7 on 09/28/10. Per interview, the CNA was not aware the resident's bed was suppose to be in the lowest position based on the CNA Assignment/Care Plan.</p> <p>3. Resident #4 was admitted to the facility on 07/28/10 with diagnoses which included Brain Injury, Respiratory Failure, Spinal Cord Injury and Tracheostomy. Review of the Admission Minimum Data Set (MDS) dated 08/09/10, revealed Resident #4 was totally dependent with all ADL's and had a diagnosis which included attention to tracheostomy.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 08/09/10, revealed Resident #4 was in a motor vehicle accident and sustained a traumatic brain injury. All of Resident #4's needs were anticipated by staff. The RAPS also revealed Resident #4 had a tracheostomy with humidification that required cleaning at least two (2) times per shift.</p> <p>Review of the Physician's Telephone Orders dated 08/02/10, revealed Resident #4 had an order to have a tracheostomy dressing change two (2) times per shift.</p> <p>Review of the Short Term Problem List included in</p>	F 281			

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F 281	<p>Continued From page 7</p> <p>the Comprehensive Plan of Care dated 08/09/10, revealed Resident #4 required tracheostomy care two (2) times per shift.</p> <p>Review of the Treatment Record (TAR) for August and September 2010 revealed Resident #4's tracheostomy was changed only one (1) time per shift even though a new order had been received on 08/02/10 for two (2) time per shift.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 3:00 PM, revealed the order for tracheostomy care should have been placed on the TAR by the Nurse who completed the order.</p> <p>4. Record review revealed Resident #3 was admitted on 08/10/10 with a Fractured Right Humerus which resulted from a fall at home on 08/06/10.</p> <p>Review of the Physician's orders dated 08/24/10, revealed an order which stated the resident's arm sling may be removed for thirty (30) minute periods, wear sling most of the time. Further review of the Physician's orders revealed an order dated 09/13/10, which stated "sheepskin or other form of padding to elbow in sling for comfort and protection- therapy will provide".</p> <p>Observation on 09/26/10 at 12:00 PM, revealed the sling was not in use and there was no evidence that padding was provided. The Occupational Therapist (OT) came into the resident's room, applied the sling and the resident complained that the mesh hurt his/her elbow. The OT put a folded pillowcase in the sling.</p> <p>Observations on 09/27/10 at 10:30 AM and 11:00 AM, revealed the sling was not in use.</p>	F 281			

**F281**

**483.20 Services Provided Meet Professional Standards**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.**

The Forum at Brookside will ensure services provided to the Residents will meet professional standards.

With respect to the specific residents cited, The Forum at Brookside ensures that although Resident #10 did not return to the facility after hospitalization; the CNA received 1:1 training regarding following the CNA careplan and positioning beds in the lowest position on 6/4/10. Resident #7, although the resident's bed was kept in the lowest position; the CNA careplan was adjusted to reflect "bed in lowest position" on 10/5/10. With respect to Resident #4, a new order was received that changed the tracheostomy treatment to once per shift and as needed, the order was also transcribed to the treatment administration record on 9/27/10. With respect to Resident #3, the right arm sling is being checked every 2 hours during room rounds; resident remains non-compliant. A non-compliant careplan was initiated on 10/15/10, as well as documentation in the nurses' notes.

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator completed an audit of 100% of the Nursing Facility resident's careplans, CNA careplans on 11/4/10 to ensure accuracy. A 100% audit of all Nursing Facility Residents Treatment administration records and Medication administration records was completed by the Director of Nursing on 11/3/10 to ensure all orders and treatments were implemented. Any discrepancies to be found were corrected immediately. An audit of 100% of the Nursing Facility Resident's fall assessments was completed on 11/7/10 by the Director of Nursing, with updated and corrected Safety Status Sheets for the resident's rooms.

With respect to what systematic measures have been put into place to address that stated concern, The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator completed educational inservicing to all healthcare staff on CNA careplans, policy and procedure on physician orders, and nursing careplans beginning on 10/16/10 and were completed on 11/7/10. On 10/14/10 the third (3<sup>rd</sup>) shift nurses began checking all new orders to ensure placement in the accuflo system or on the treatment administration record daily for implementation as part of the 3<sup>rd</sup> shift nursing duty checklist. The Director of Nursing or designee will complete a monthly audit of all medication and treatment orders and administration records to ensure accuracy. The Assistant Director of Nursing receives a copy of all new physician orders on a daily basis to continuously update changes to the CNA careplans as needed.

With respect to how the plan of corrective measures will be monitored, the Director of Nursing or designee will complete a monthly audit of all current resident's nursing careplan, CNA careplan and treatment records to present to the Quality Assurance Committee on a monthly basis for 6 months per performance improvement calendar; then on a quarterly basis thereafter.

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F 281	Continued From page 8 Observation at 12:00 PM, revealed the sling was in use; however, no padding was noted in the sling.  Interview on 09/27/10 at 11:40 AM with the Rehabilitation (Rehab) Director, revealed that she was unaware the resident required a sling and was unsure why the sheepskin or padding was not provided. Further interview revealed the Nurses and Certified Nursing Assistants (CNA) were responsible for ensuring the sling was on the resident and OT was responsible for training the nursing staff how to apply the sling.  The Rehab Director was unable to provide documented evidence the nursing staff were trained in the proper application of the sling and padding.  Interview on 09/27/10 at 3:15 PM, with the Director of Nursing (DON) revealed it was Nursing and Therapy's responsibility to ensure the sling was worn most of the time. The DON stated the resident was non-compliant and removed the sling at times. However, there was no documented evidence of non-compliance.	F 281		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced	F 323		11-8-10

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F 323	<p>Continued From page 9</p> <p>by: Based on interview and record review It was determined the facility failed to provide an environment free from accidents and hazards for one (1) of ten (10) sampled residents (Resident #10). The facility assessed Resident #10 as requiring the bed to be in the lowest position. However, Resident #10's bed was left in an elevated position and the resident sustained an injury when an unassisted transfer from the bed was attempted. Resident #10 sustained a penetrating wound to the perineum, which required surgical intervention.</p> <p>The findings include:</p> <p>Closed record review revealed Resident #10 was admitted to the facility on 05/17/10 with diagnoses which included Dementia, Behavioral Disturbance, Alzheimer's Disease and Depression. Review of the Data Collection Tool dated 05/17/10, revealed the facility assessed Resident #10 to have short term memory deficit, to be continent of bowel and bladder and required one (1) person physical assist with transfers and ambulation.</p> <p>Review of the Bed-Safety Device Risk Review Tool dated 05/17/10, revealed Resident #10 was assessed to require ½ bed-safety rails, which were to be used as an enabler to promote the resident's independence and safety, and a low bed with positioners for safety and independence.</p> <p>Review of the Initial Plan of Care dated 05/18/10, revealed Resident #10 had an alteration in memory which required verbal and visual cues. The resident had altered mood and behavior and was taking psychotropic medications. Resident</p>	F 323		
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F 323	<p>Continued From page 10</p> <p>#10 also had impaired physical functioning and required assistance with transfers and ambulation. The resident's Activities of Daily Living (ADL's) were altered, which required assistance with bed mobility and toilet use.</p> <p>Review of the CNA Assignment/Care Plan revealed the resident was identified to be a fall risk and the resident was to be in a low bed.</p> <p>Review of the Care Plan Conference Summary dated 05/27/10, two (2) days prior to the incident, revealed Resident #10 was receiving Rehabilitation for assistance in using a slide board. The Summary also indicated Nursing was to provide ADL assistance, safety precautions and administer medications.</p> <p>Review of the Hospital's Admission Summary dated 05/29/10, revealed Resident #10 was admitted to the hospital with diagnoses which included rectal bleeding secondary to a rectal tear of three (3) to four (4) centimeters (cm) in length, hypoxemia and fever of 103 degrees Fahrenheit. Further review of the Summary revealed Resident #10 had Dementia, was quite agitated and was trying to get out of bed.</p> <p>Review of the Hospital's Discharge Summary dated 06/10/10 at 9:26 AM, revealed Resident #10 was admitted to the hospital from the facility for an injury the resident sustained when he/she jumped or fell off the bed onto a wheel chair extended brake handle, which caused a penetrating wound. Resident #10's discharge diagnoses included a penetrating wound to the perineum, Anemia with probable acute blood loss component, Toxic Metabolic Encephalopathy and Non-ST elevated Myocardial Infarction. The</p>	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185194</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>09/28/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>THE FORUM AT BROOKSIDE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>200 BROOKSIDE DRIVE LOUISVILLE, KY 40243</b>
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F 323	<p>Continued From page 9</p> <p>by: Based on interview and record review it was determined the facility failed to provide an environment free from accidents and hazards for one (1) of ten (10) sampled residents (Resident #10). The facility assessed Resident #10 as requiring the bed to be in the lowest position. However, Resident #10's bed was left in an elevated position and the resident sustained an injury when an unassisted transfer from the bed was attempted. Resident #10 sustained a penetrating wound to the perineum, which required surgical intervention.</p> <p>The findings include:</p> <p>Closed record review revealed Resident #10 was admitted to the facility on 05/17/10 with diagnoses which included Dementia, Behavioral Disturbance, Alzheimer's Disease and Depression. Review of the Data Collection Tool dated 05/17/10, revealed the facility assessed Resident #10 to have short term memory deficit, to be continent of bowel and bladder and required one (1) person physical assist with transfers and ambulation.</p> <p>Review of the Bed-Safety Device Risk Review Tool dated 05/17/10, revealed Resident #10 was assessed to require ½ bed-safety rails, which were to be used as an enabler to promote the resident's independence and safety, and a low bed with positioners for safety and independence.</p> <p>Review of the Initial Plan of Care dated 05/18/10, revealed Resident #10 had an alteration in memory which required verbal and visual cues. The resident had altered mood and behavior and was taking psychotropic medications. Resident</p>	F 323		
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F 323	<p>Continued From page 10</p> <p>#10 also had impaired physical functioning and required assistance with transfers and ambulation. The resident's Activities of Daily Living (ADL's) were altered, which required assistance with bed mobility and toilet use.</p> <p>Review of the CNA Assignment/Care Plan revealed the resident was identified to be a fall risk and the resident was to be in a low bed.</p> <p>Review of the Care Plan Conference Summary dated 05/27/10, two (2) days prior to the incident, revealed Resident #10 was receiving Rehabilitation for assistance in using a slide board. The Summary also indicated Nursing was to provide ADL assistance, safety precautions and administer medications.</p> <p>Review of the Hospital's Admission Summary dated 05/29/10, revealed Resident #10 was admitted to the hospital with diagnoses which included rectal bleeding secondary to a rectal tear of three (3) to four (4) centimeters (cm) in length, hypoxemia and fever of 103 degrees Fahrenheit. Further review of the Summary revealed Resident #10 had Dementia, was quite agitated and was trying to get out of bed.</p> <p>Review of the Hospital's Discharge Summary dated 06/10/10 at 9:26 AM, revealed Resident #10 was admitted to the hospital from the facility for an injury the resident sustained when he/she jumped or fell off the bed onto a wheel chair extended brake handle, which caused a penetrating wound. Resident #10's discharge diagnoses included a penetrating wound to the perineum, Anemia with probable acute blood loss component, Toxic Metabolic Encephalopathy and Non-ST elevated Myocardial Infarction. The</p>	F 323			

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F 323	<p>Continued From page 11</p> <p>Discharge Summary also revealed Resident #10 required surgery, which was performed by a Colorectal Surgeon, to repair the penetrating wound to the perineum. After surgery, a drain had to be left in place to the wound. Further review of the Hospital's Discharge Summary revealed, Resident #10 received a ten (10) day course of Intravenous (IV) Zosyn for presumed wound infection.</p> <p>Interview, on 09/27/10 at 2:50 PM, with Certified Nursing Assistant (CNA) #1, who cared for the resident revealed he found Resident #10 sitting on the toilet. The CNA noted there was blood in the toilet, and reported this to the Nurse. Further interview with CNA #1 revealed Resident #10's roommate told him the resident had gotten caught on the extended brake handle on the wheel chair. Interview with CNA #1 revealed the resident's bed was not in a low position. The CNA stated he didn't know the resident that well and should have looked at the CNA care plan.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 11:38 AM, revealed the outcome of the facility's investigation of the incident revealed CNA #1 did not place Resident #10's bed in the lowest position. Review of the facility's investigation dated 06/04/10 revealed Resident #10's "personal wheelchair was found with a right brake extension that was bent. It is presumed that Resident #10 injured him/herself while transferring from the bed into the wheelchair and sat down on the brake extender".</p> <p>Further interview with the DON on 09/27/10 at 12:00 PM, revealed CNA #1 failed to implement the resident's CNA Assignment/Care Plan. The DON stated during the interview on 09/28/10 at</p>	F 323		
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**F323**

**483.25 Free of Accident Hazards/Supervision/Devices**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.**

The Forum at Brookside will ensure that the resident's environment will be free from accident hazards as is possible.

With respect to the specific residents cited, The Forum at Brookside ensures that although Resident #10 did not return to the facility after hospitalization; the CNA received 1:1 training regarding following the CNA careplan and positioning beds in the lowest position on 6/4/10. Resident #7, although the resident's bed was kept in the lowest position; the CNA careplan was adjusted to reflect "bed in lowest position" on 10/5/10.

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, on 11/4/10 a 100% audit of Nursing Facility resident's rooms and common areas was completed by the Director of Nursing and Admissions Director to ensure the environment was free of potential accident hazards as is possible, and that all accommodations for supervision and assistance devices were in place.

With respect to what systematic measures have been put into place to address that stated concern, The Staff Development Coordinator, Assistant Director of Nursing and Director of Nursing inserviced all healthcare staff on prevention of accidents and hazards and supervision, following CNA careplans, Fall Safety Program and Safety Status Sheets beginning 10/16/10 and completed on 11/7/10. The Forum at Brookside's nursing staff are completing room rounds every two (2) hours on a daily basis and signing off on their assignment sheet after completion of their shift which began on 10/18/10 and will be an ongoing check. All incidents/accidents will be reviewed in a daily meeting; Monday through Friday to evaluate cause and implement and evaluate interventions. Daily meeting will include: Nursing, Rehab, Admissions and Administration. Room rounds are also being conducted twice a week at random times and dates by Administrative staff with any potential hazards to be reported immediately to the Director of Nursing or designee.

With respect to how the plan of corrective measures will be monitored, the Director of Nursing or designee will complete a monthly audit of all current resident's nursing careplan and CNA careplan to present to the Quality Assurance Committee on a monthly basis for 6 months per performance improvement calendar; then on a quarterly basis thereafter. The Director of Nursing or designee will submit a report monthly to the Safety Committee and a Quarterly Report to the QA Committee in regards to corrective

measures that were implemented to ensure the resident's environment remains as free of accident hazards as is possible.



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F 514	<p>Continued From page 13</p> <p>Spinal Cord Injury and Tracheostomy. Review of the Admission Minimum Data Set (MDS) dated 08/09/10, revealed Resident #4 was totally dependent with all Activities of Daily Living.</p> <p>Review of the Resident Assessment Protocol Summary (RAPS) dated 08/09/10, revealed Resident #4 was in a motor vehicle accident and sustained a traumatic brain injury. All of Resident #4's needs were anticipated by staff. Review of the RAPS revealed Resident #4 had a tracheostomy with humidification that required cleaning at least two (2) times per shift.</p> <p>Review of the Physician's Telephone Orders, dated 08/02/10, revealed Resident #4 was ordered to have a tracheostomy dressing change two (2) times per shift.</p> <p>Review of the Short Term Problem List, dated 08/09/10 that was included in the Comprehensive Plan of Care, dated 08/09/10, revealed Resident #4 required tracheostomy care two (2) times per shift.</p> <p>Review of the Treatment Administration Record (TAR) for August and September, 2010 revealed Resident #4's tracheostomy care was performed only one (1) time per shift even though a new order had been received on 08/02/10 for two (2) time per shift.</p> <p>Interview with the Director of Nursing (DON) on 09/27/10 at 3:00 PM revealed the order for tracheostomy care should have been placed on the TAR by the nurse who completed the order.</p>	F 514		

**F514**

**483.75 Resident Records-Complete/Accurate/Accessible**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of Correction is prepared solely as a matter of compliance with federal and state law.**

With respect to the specific resident cited, The Forum at Brookside ensures that a new order was obtained on 9/27/10 for Resident #4 changing the tracheostomy treatment to every shift and as needed. The treatment administration record was also updated with the new order on 9/27/10. A complete audit of Resident #4's medical record was completed by the Director of Nursing on 9/29/10 to ensure records were complete, accurately documented, readily accessible; and systematically organized.

With respect to how the facility will identify residents with the potential for the identified concern and take corrective action, The Director of Nursing completed an audit of 100% of the Nursing Facility Resident's medical records to ensure records were complete, accurate, readily accessible, and systematically organized. The audit was initiated on 9/29/10 and completed on 10/1/10. Any discrepancies found were corrected immediately on the date of review.

With respect to what systematic measures have been put into place to address that stated concern, inservices for all nursing staff were conducted by the Staff Development Coordinator, Director of Nursing and Assistant Director of Nursing beginning on 9/16/10 and completed on 11/7/10 regarding policy and procedure for completing and maintaining accurate medical records including physician orders, and treatment/medication records. On 10/14/10 the third (3<sup>rd</sup>) shift nurses began checking all new orders to ensure placement in the accuflo system or on the treatment administration record daily as part of the 3<sup>rd</sup> shift nursing duty checklist, this checklist is turned in to the Director of Nursing daily for review. Copies of all new orders are given to the Director of Nursing, Assistant Director of Nursing or designee for review of completeness, accuracy and implementation.

With respect to how the plan of corrective measures will be monitored, the Director of Nursing or designee will complete a monthly audit of all current residents medical records to ensure records are complete, accurate, readily accessible and systematically organized and present a report to the Quality Assurance Committee on a quarterly basis per performance improvement calendar.

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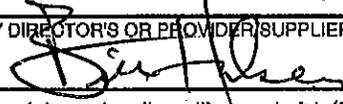
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185194	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  09/28/2010
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NAME OF PROVIDER OR SUPPLIER  THE FORUM AT BROOKSIDE	STREET ADDRESS, CITY, STATE, ZIP CODE 200 BROOKSIDE DRIVE LOUISVILLE, KY 40243
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K 000	INITIAL COMMENTS	K 000		
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure there were no impediment to the closing of the corridor fire doors.</p>	K 018		

**RECEIVED**  
OCT 21 2010  
BY: \_\_\_\_\_

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE Rex Director	(X8) DATE 10/19/10
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

**K018**  
**NFPA 101 LIFE SAFETY CODE STANDARD**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.**

**1. Corrective Action for the Residents cited by Deficient Practice**

With respect to the specific residents cited, there were no specific residents cited.

**2. Identification of Other Facility Residents that may be affected**

With respect to how the facility will identify residents and staff with the potential for the identified concern and take corrective action, The Forum at Brookside will ensure that all staff are inserviced regarding items that may impede the closing of the corridor fire doors by 11-3-10.

**3. Implementation of Systemic Measure**

With respect to what systematic measures have been put in place to address the stated concern, The Director of Plant Operations or his designee will monitor that the corridor fire doors are not impeding in closing during monthly fire drills. Employees will be inserviced upon hire and ongoing as needed based upon the findings of these fire drills.

**4. Monitoring of Corrective Action**

With respect to how the plan of corrective measures will be monitored, the Director of Plant Operations or designee will perform monthly fire drills to monitor that the corridor fire doors are not impeded in closing. The results of the audits will be monitored and evaluated monthly at the Quality Assurance Committee for six months, then quarterly.

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K 018	Continued From page 1 The findings include:  Observation during the fire alarm test, on 09/28/10 at 1:45 PM, with the Maintenance Director revealed one of the double doors to the C-hall corridor was being blocked from closing by the ice cart.  Interview with the Maintenance Director, on 09/28/2010 at 1:45 PM, indicated he had informed staff at the nursing station to make sure there was no impediment to the closing of the doors during the fire alarm test.	K 018		
K 073 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  No furnishings or decorations of highly flammable character are used. 19.7.5.2, 19.7.5.3, 19.7.5.4  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to ensure that no combustibile decorations were used in the facility, according to NFPA standards.  The findings include:  Observation during the tour of the building, on 09/28/10 at 10:30 AM, with the Maintenance Director, revealed thirteen (13) resident rooms with hanging decorations on the doors. The resident rooms were numbered 5, 6, 10, 11, 13, 23, 24, 27, 29, 33, 34, 35, and 38.  Interview with the Maintenance Director, on 09/28/2010 at 10:30 AM, revealed being unaware of the requirement related to the need of these decorations being flame retardant.	K 073		11-3-10

**K073**

**NFPA 101 LIFE SAFETY CODE STANDARD**

**Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the Statement of Deficiencies. The Plan of correction is prepared solely as a matter of compliance with federal and state law.**

**1. Corrective Action for the Residents cited by Deficient Practice**

With respect to the specific residents cited, there were no specific residents cited. Specific doors were cited in which doors of resident rooms 5, 6, 10, 11, 13, 23, 24, 27, 29, 33, 34, 35, and 38 had hanging decorations that were not flame retardant, the Forum at Brookside treated these decorations on 9/28/10 with flame retardant spray.

**2. Identification of Other Facility Residents that may be affected**

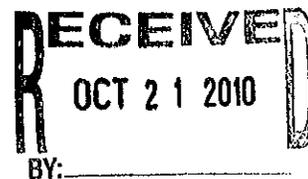
With respect to how the facility will identify other residents that may be affected, The Forum at Brookside treated all hanging decorations on all doors with flame retardant spray on 9/28/10.

**3. Implementation of Systemic Measure**

With respect to what systematic measures have been put in place to address the stated concern, The Forum at Brookside will send a letter to all resident's and/or responsible parties notifying them that all decorations brought into the facility must be brought to attention of staff in order for them to be treated with flame retardant spray. This information will also be given to all new residents and/or their responsible party on admission. The facility will put an identifying marker on the decoration once it has been treated with flame retardant spray in order to identify those decorations treated verses those that need to be treated.

**4. Monitoring of Corrective Action**

With respect to how the plan of corrective measures will be monitored, the Director of Plant Operations or designee will perform monthly audits of all door decorations for six months, then quarterly audits after that to ensure that all door decorations have been treated with flame retardant spray. The audits will be reviewed by the quality assurance committee monthly for six months then quarterly thereafter..



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K 073	Continued From page 2  NFPA Standard NFPA 101.2000 Edition 19. 7. 5. 4 Combustible decorations shall be prohibited in any health care occupancy unless they are flame-retardant.	K 073		11-3-10