

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

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PRINTED: 08/11/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	DATE SURVEY COMPLETED  07/28/2011
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NAME OF PROVIDER OR SUPPLIER  TWINBROOK NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205
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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
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F 000	INITIAL COMMENTS  A standard health survey was conducted on 07/26/11 through 07/28/11 and a Life Safety Code survey was conducted on 07/26/11. 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.	F 000	F366 The dietary preferences of residents 21, 22 and 23 will be reviewed with the residents to ensure that the meal cards are accurate.	8/27/11
F 366 SS=D	483.35(d)(4) SUBSTITUTES OF SIMILAR NUTRITIVE VALUE  Each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served.  This REQUIREMENT is not met as evidenced by: Based on observation, review of facility policy, review of resident meal cards, review of staff inservices, and interview, it was determined the facility failed to assure food served to three (3) of twenty-three (23) sampled residents (#21, #22, #23) was specific to their preferences and dietary requirements. This is a repeat deficiency cited during the standard survey 07/09/2010.  The findings include:  Review of the facility's policy for Meal Service dated 2006 revealed the identification system was used to ensure residents received the diet ordered while accommodating their meal preferences.  Review of staff inservices from 07/09/10 to current date revealed the last inservice for tray card review was August 2010.	F 366	The dietary preferences of all other residents will be confirmed by the dietary manager by the completion date and on a quarterly basis at each care conference thereafter.  Twinbrook will implement a new color coded meal card system created by our consulting dietician which displays dislikes and allergies in red to call attention to these preferences and allergies. Staff will be inserviced on the new meal cards as well as the process of verifying that the food being served is consistent with the preferences on the meal card.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE  
*X Bradford A. McCoy, Admin.*

TITLE  
*X Admin.*

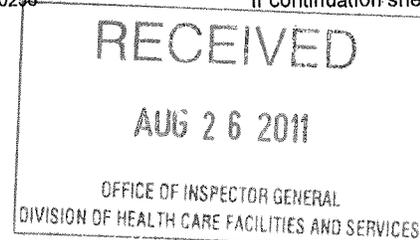
(X6) DATE  
*X 8/25/2011*

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.

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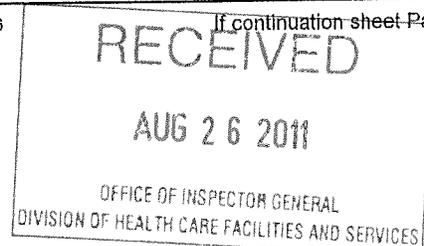
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F 366	<p>Continued From page 1</p> <p>Observation, on 07/26/11 at 12:45 PM, revealed Certified Nursing Assistant (CNA) #6 fed Resident #22 mechanical soft roast beef.</p> <p>Review of the tray card for Resident #22 revealed roast beef was listed as a dislike for this resident.</p> <p>Observation, on 07/27/11 at 12:00 PM, revealed Resident #23 was provided tomato soup. The resident was also served a pimento cheese sandwich with tomatoes on the side.</p> <p>Review of the tray card for Resident #23 revealed a dislike for tomatoes.</p> <p>Observation of Resident #21's lunch plate, on 07/27/11 at 12:49 PM, revealed mashed potatoes, peas, chicken livers and tea. Resident #21's meal ticket revealed his/her dislikes were chicken noodle soup, cottage cheese, greens, no sandwiches, peas, and tuna.</p> <p>Interview with a family member, on 07/27/11 at 12:49 PM, revealed Resident #21 did not like peas.</p> <p>Interview with Certified Nursing Assistant (CNA) #3, on 07/27/11 at 12:55 PM, revealed he was taught to look at the meal ticket for resident likes and dislikes and did not understand how he could miss the peas on Resident #21's plate.</p> <p>Interview with CNA #1, on 07/28/11 at 1:20 PM, revealed it was the CNA's responsibility to ensure the residents are being served foods they like. CNA #1 stated if the tray card listed a dislike, and</p>	F 366	<p>Meal cards will be reviewed by the cook when placing food on the plate, the dietary aide preparing the tray on the tray line and then again by the dietary aide or C.N.A. who places the tray before the resident. The results will be reported to the Q. A. Committee quarterly.</p>	8/27/11



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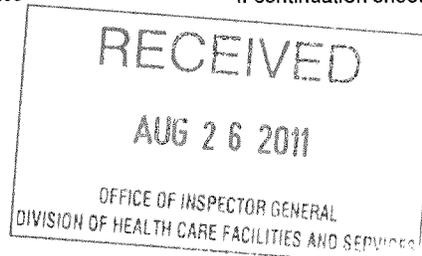
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F 366	<p>Continued From page 2</p> <p>it was on the tray, he would call back to the kitchen and get something else. He stated it seemed like at the end of the month the tray cards get a little crazy. CNA #1 stated, if residents were served foods they don't like, they won't enjoy what they are having.</p> <p>Interview with CNA #5, on 07/28/11 at 1:25 PM, revealed staff were to look at the meal ticket and make sure the food was accurate on the trays. CNA #5 stated staff should check for allergies and the correct diet.</p> <p>Interview with the 2nd Shift Cook, on 07/28/11 at 1:35 PM, revealed the facility's system was for staff to send a written order down to the kitchen and the Dietary Manager was to make the changes in the computer. An example of an order change would be a like or dislike change and a diet that was changed from regular to no concentrated sweets. The 2nd Shift Cook stated when looking at meal tickets, the server had to look at what diet the resident was currently on, and their likes and dislikes. The 2nd Shift Cook further stated there were two people who review the trays as they go out and ultimately it is the dietary staffs' responsibility to make sure trays were accurate.</p> <p>Interview with the Dietary Manager, on 07/28/11 at 2:25 PM, revealed the cook was responsible for the accuracy of the food items served. She further stated, sometimes the nursing staff write down on a ticket what they want changed for the resident. If the food change was something simple, the aids can just tell her, but if the change was a dietary change there must be an order. The Dietary Manager further stated the Cook was</p>	F 366		8/27/11



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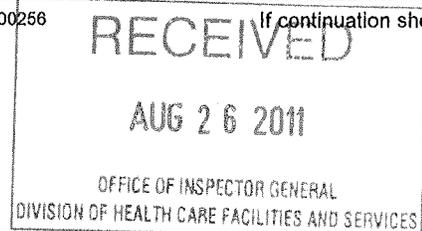
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F 366	Continued From page 3 responsible to look at the ticket for accuracy, then the two dietary assistants were to check the ticket after the cook. Once the trays were set out, it was the CNA's responsibility to check the meal ticket. There should be four (4) people checking the ticket for accuracy. She further stated she was the Dietary Manager last year and she implemented ticket checks once a week for accuracy. The Dietary Manager could not understand how the food items were missed.	F 366		8/27/11
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility policy on Food and Non-Food Storage, the facility failed to store food under sanitary	F 371		



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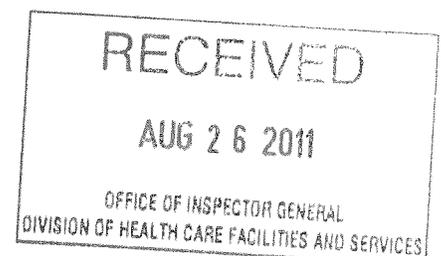
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F 371	<p>Continued From page 4</p> <p>conditions. Items were stored in the refrigerator unlabeled and undated after being opened. Also observed were five (5) spices opened and undated.</p> <p>The findings include:</p> <p>Review of the facility policy on Food and Non-Food Storage, Policy 7.1, under the subject Dry Food Storage revealed all dry food in storage is to be clearly labeled and dated.</p> <p>Review of the facility policy on Food and Non-Food Storage, Policy 7.2, under the subject Refrigerated and Frozen Storage revealed foods that have been removed from their original containers are to be clearly marked with contents and dated.</p> <p>Observation, on 07/16/11 at 8:10 AM, during the initial tour revealed refrigerators in the kitchen contained prepared salad not labeled or dated, cottage cheese in a covered cup container not labeled or dated, wrapped cut onion and tomato not dated, three (3) open bottles of syrup not dated, two (2) open bottles of steak sauce not dated, two (2) open baggies of pudding/pie filling not dated, five (5) partially filled drink pitchers not dated or labeled, cooked meat wrapped in cellophane not labeled or dated and three (3) covered rectangular containers with liquids in them, one (1) labeled soup, not dated and two (2) not labeled or dated. In addition, dry food storage of open containers of lemon pepper, white pepper, onion powder, seasoned salt and garlic powder were observed undated.</p> <p>Interview, on 07/26/11 at 11:55 AM, with the</p>	F 371	<p>F371</p> <p>No residents were cited as having been affected by this deficient practice.</p> <p>All residents have the potential to be affected by this deficient practice.</p> <p>All dietary employees will be in-serviced on the requirement that all opened items must be dated and labeled after opening. Signs will be placed on refrigerator doors instructing staff to label and date all open items prior to placing them in the refrigerator. Staff will also be instructed to label and date all dry food such as spices and powders as soon as opened and prior to storage.</p>	8/27/11



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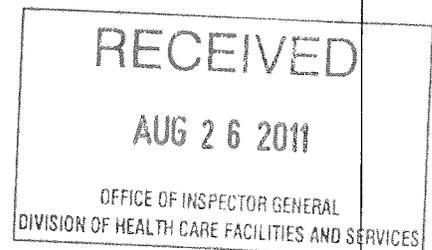
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F 371	Continued From page 5 Dietary Director revealed foods stored after opening are to be dated, as are drinks in pitchers. In addition, all spices are to be dated when opened.  Interview, on 07/26/11 at 12:35 PM, with Dietary Personnel #2 revealed she thought only items stored greater than twenty-four (24) hours needed to be dated. She was not aware items needed to be dated when opened or stored.  Interview, on 07/27/11 at 9:05 AM, with Dietary Personnel #1 revealed she was unaware that the opened stored items she was going to use needed to be labeled and dated.	F 371	At the end of each day one member of the dietary staff will inspect the refrigerators, freezers and dry food storage areas to ensure that all open containers are labeled and dated and shall record her/his findings on a "Stored Food Inspection Log". Any food not properly labeled shall be discarded. These inspection logs shall be presented to the Quality Assurance Committee each quarter to demonstrate compliance.	8/27/11	



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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: 1960, 1970, 1991, 1998</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Type II</p> <p>A standard Life Safety Code survey was conducted on 07/26/2011. Twinbrook Nursing Home was found not to be in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and seven (107) beds and the census was ninety-seven (97) on the day of the survey.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		8/27/11



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

*X Bradford A. McLaughlin, Admin.*

TITLE

*X Admin.*

(X6) DATE

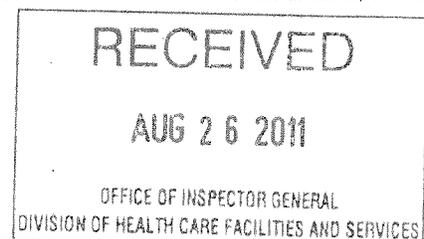
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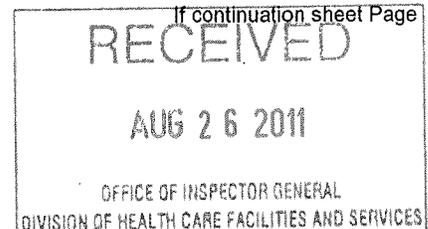
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K 000	Continued From page 1 Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors, according to NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke departments, approximately twenty (20) residents, staff and visitors. The facility is licensed for one-hundred and seven (107) beds	K 018	K018 Hold open devices that release when the door is pushed or pulled shall be installed on the doors to resident rooms G3 and G5.  All other resident room doors will be inspected to determine if additional doors need a hold open device.  Hold open devices will be installed on any additional resident room doors which require them.	8/27/11



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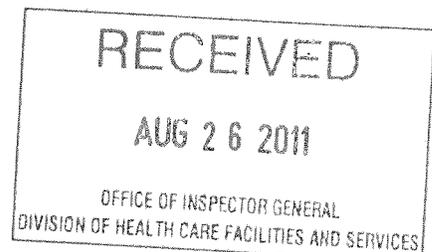
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K 018	Continued From page 2 and the census was ninety-seven (97) on the day of the survey.  The findings include:  Observations, on 07/26/2011 at 8:30 AM, with Maintenance revealed trash cans holding resident room doors G3 and G5 open.  Interview, on 07/26/2011 at 8:30 AM, with Maintenance revealed he was unaware that the trash cans were being used to hold open the resident's room doors.  Reference: NFPA 101 (2000 Edition)  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A.19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches.	K 018	Resident Room doors will be inspected for obstructions weekly by the Maintenance Department and the results recorded on the Weekly Safety Checks form. The results of these reports are presented to the Quality Assurance Committee on a quarterly basis.	8/27/11
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		



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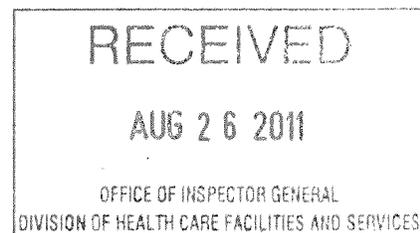
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K 038	Continued From page 3  This STANDARD is not met as evidenced by: Observation and interview revealed the facility failed to ensure the emergency egress doors worked properly for exiting the building in the event of an emergency, per NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke departments, approximately thirty (30) residents, staff and visitors. The facility is licensed for one-hundred and seven (107) beds and the census was ninety-seven (97) on the day of the survey.  The findings include:  Observation, on 07/26/11 at 9:00 AM, with Maintenance revealed the G Wing Addition exit door did not open when testing the 15 second delayed egress lock. When pressure was applied to the push bar, the door did not alarm or open after 15 seconds. The magnetic catch in the delayed egress hardware did not deactivate and release the door to open.  Interview, on 07/26/11 at 9:00 AM, with Maintenance revealed he was unaware the door was not working properly and the cause was probably due to lightning striking the side of the building two (2) days prior to the Survey. The next closest exit door in the G Wing was enabled to open when pushing the panic bar.  NFPA: 80, 1999  15-1.3 Replacement.	K 038	K038 The 15 second delay feature of the magnetic lock which was damaged by a lightning strike two days earlier was repaired as soon as it was discovered inoperable.  Only residents within the same smoke compartment had the potential to be affected.  All fire and exit doors are checked for proper operation weekly. We will also begin checking operation of doors after a lightning strike and recording their operational status on the door inspection log.  Results of door inspections will be presented to the Q.A. Committee on a quarterly basis.	8/27/11



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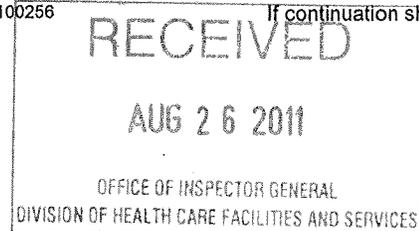
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185456	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - TWINBROOK NURSING H B. WING _____	(X3) DATE SURVEY COMPLETED  07/26/2011
NAME OF PROVIDER OR SUPPLIER  TWINBROOK NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 3526 DUTCHMANS LANE LOUISVILLE, KY 40205	
(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 038	Continued From page 4 Where it is necessary to replace fire doors, shutters, windows or their frames, hardware, and closing mechanisms, replacements shall meet the requirements for fire protection and shall be installed as required by this standard for new installations. 15-1.4 Repairs. Repairs shall be made and defects that could interfere with operation shall be corrected immediately. 15-2 Specific Requirements. 15-2.1* Inspections. 15-2.1.1* Hardware shall be examined frequently and any parts found to be inoperative shall be replaced immediately. 15-2.1.2 Tin clad and Kalamein doors shall be inspected regularly for dry rot.	K 038		
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system according to NFPA standards. The deficiency had the potential to affect three (3) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and seven (107) beds and the census was ninety-seven (97) on the day of the	K 062	K062 No residents were identified as having been affected.  All residents had the potential to be affected.  All items within 18 inches of a sprinkler head were removed immediately. The shelf which extended to within 18 inches of the sprinkler head has been lowered to less than 18 inches and staff have been instructed not to store items in those closets within 18 inches of the ceiling. A line has been placed on the wall 18 inches below the sprinkler head to indicate the highest possible storage levels in the affected areas. The rooms will be inspected weekly.	8/27/11



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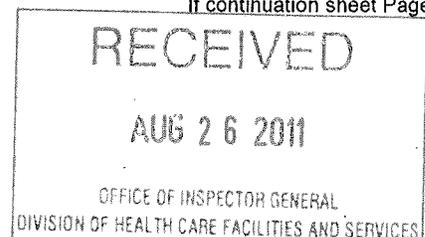
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K 062	Continued From page 5 survey.  The Findings Include:  Observation, on 07/26/11 between 12:15 PM and 12:45 PM, with Maintenance revealed items stored within 18" of a sprinkler head in two (2) different locations. The locations were within the sprinkler riser room located near the activities office and in the closet located within the transfer switch room.  Interview, on 07/26/11 at 12:15 PM, with Maintenance revealed he confirmed the initial observation and stated items cannot be stored within 18" of a sprinkler head.  Reference: NFPA 13 (1999 Edition)  5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing shall comply With 5-5.5.2.	K 062	The results shall be documented and reported to the Quality Assurance Committee on a quarterly basis.	8/27/11
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		



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K 147	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical panels were maintained according to NFPA standards. The deficiency had the potential to affect all smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and seven (107) beds and the census was ninety-seven (97) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 07/26/11 between 8:50 AM and 11:30 AM, with Maintenance revealed all electrical panels located in the resident corridors were unlocked.</p> <p>Interview, on 07/26/11 at 8:50 AM, with Maintenance revealed he was unaware the electrical panels located in resident corridors were required to be locked to prohibit unauthorized access .</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical</p>	K 147	<p>K147 No residents were identified as having been affected.</p> <p>All residents had the potential to be affected.</p> <p>Locks will be installed on electrical panel covers to enable them to be locked.</p> <p>Maintenance personnel will check to see that all electrical panel covers are locked on a weekly basis and report results of their inspections to the Q.A. Committee quarterly.</p>	8/27/11



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K 147	Continued From page 7 apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147		8/27/11	

