

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

PRINTED: 11/09/2012  
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  10/25/2012
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 000	INITIAL COMMENTS  A standard health survey was conducted on 10/23-25/12. Deficient practice was identified with the highest scope and severity at "E" level.	F 000	Without admitting or denying the validity or existence of the alleged deficiencies, Highlandspring Health Care and Rehab ("Highlandspring") provides the following plan of correction. However, the law requires us to prepare a plan of correction for the citation regardless of whether we agree with it. 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.	
F 164 SS=C	483.10(e), 483.75(1)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS  The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.  Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.  Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.  The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.  The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident.  This REQUIREMENT is not met as evidenced by:	F 164	THIS PLAN OF CORRECTION SERVES AS HIGHLANDSPRING'S CREDIBLE ALLEGATION OF SUBSTANTIAL COMPLIANCE AS OF December 6, 2012.  <u>F164</u>  Highlandspring has developed and implemented written policies and procedures that ensure residents rights to personal privacy and confidentiality of his or her personal and clinical records.  Random periodic monitoring will occur through informal nursing rounds by nursing management to observe  ongoing practices related to confidentiality of resident information including MAR and TAR confidentiality. If concerns are noted during the informal rounds, actions will be taken at that time that may include additional one-on-one education.	

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

*Molly Burtz*

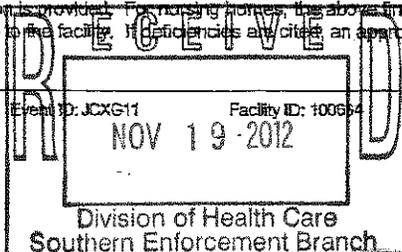
TITLE

*Administrator*

(X6) DATE

*11-19-12*

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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F 164	<p>Continued From page 1</p> <p>Based on observation, interview, and review of facility policy, the facility failed to ensure resident health information was maintained in a private and confidential manner during medication administration and when medication carts were not in use and unsupervised for two sampled residents (Residents #18 and #3) and five unsampled residents (Residents B, C, D, F, and G.) Observation of medication pass on 10/23/12 and 10/24/12 revealed the Medication Administration Record (MAR) that contained resident health information was left open on top of the medication cart in the hallway and as a result, residents' personal information was exposed to the public and other residents.</p> <p>The findings include:</p> <p>A review of the facility's policy titled Safeguards for Protected Health Information (dated March 2003), revealed facility staff was responsible to maintain the confidentiality of the residents' personal and clinical records. However, the policy did not include specific directions for staff during medication administration to protect residents' medical information.</p> <p>1. Observation during medication pass on 10/23/12 at 5:00 PM, revealed Licensed Practical Nurse (LPN) #1 entered Resident B's room to administer five oral medications and a subcutaneous insulin injection to the resident. Further observation revealed the MAR, located on top of the medication cart in the hallway, was not covered and residents' personal and confidential information was exposed to anyone in the area of the hallway where the cart was located. The MAR contained a list of Resident</p>	F 164	<p>LPN #1, #2 and RN #1 and #3 were in-serviced on the importance of safe guarding the confidentiality of all resident personal and clinical information but not limited to the Medication Administration Record and the Treatment Administration Record on 10-25-12 by DON.</p> <p>The Safeguards of Protected Health Information policy was revised by the Regional Medical Records Director on October 25, 2012, to specifically include confidentiality of the MAR/TAR. A copy of the policy is attached as EXHIBIT A.</p> <p>Licensed nursing staff will be in-serviced by the DON on of confidentiality of personal and clinical records including but not limited to the Medication Administration Record and the Treatment Administration Record on 11-15-12, 11-19-12 and 11-21-12.</p> <p>Each MAR and TAR will be supplied with a laminated cover sheet to ensure confidentiality of residents personal and clinical records are maintained during medication administration and treatment implementation.</p>		

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F 164	<p>Continued From page 2</p> <p>#B's medications, dosage and time scheduled to be administered, diagnoses, diet order, allergies, admission date, resident's name and room number, date of birth, sex, and the name of the resident's physician,</p> <p>2. Observation on 10/24/12 at 9:20 AM, revealed a medication cart was positioned in the hallway outside resident room 2308. Further observation revealed the medication cart was unattended and the MAR had been left open on top of the medication cart. LPN #1 was observed to return to the medication cart and stated she had administered medications to Resident F. LPN #1 had left the MAR exposed to anyone that passed by the medication cart positioned in the hallway.</p> <p>Interview conducted on 10/24/12 at 12:40 PM, with LPN #1 revealed she was knowledgeable of the requirement to keep residents' personal information private. LPN #1 stated she should have covered the MAR or closed the book that contained the MARs when leaving the medication cart unattended. LPN #1 stated she had rushed to complete the medication pass and failed to ensure residents' personal information remained private.</p> <p>3. Further observation on 10/24/12 at 10:45 AM, revealed a medication cart located against a wall near the entrance of the activity room was not in use and was unattended. The medication cart was unattended by the medication nurse and the MAR was open and exposed Resident #3's personal and private information to anyone that passed by the medication cart. Several staff members and visitors were observed to walk past the medication cart while the MAR was left</p>	F 164	<p>A PI worksheet will be utilized to monitor compliance to ensure resident confidentiality during medication administration. A copy of the worksheet is attached as EXHIBIT B. This PI worksheet is completed by the Unit Manager weekly x 4 then monthly. If issues are noted the Unit Manager will take appropriate action at the time the concern is noted. Results of the PI worksheet will be reported to the PI committee for a determination of the need for further ongoing formal monitoring.</p> <p>The Director of Nurses to monitor for compliance.</p>	12/6/2012
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F 164	<p>Continued From page 3</p> <p>exposed. Staff failed to maintain the confidentiality of the residents' personal and clinical records as mandated by facility policy.</p> <p>Interview conducted on 10/24/12 at 10:55 AM, revealed LPN #2 was responsible for medication administration from the medication cart positioned in the hallway near the activity room. LPN #2 stated she had been trained to maintain confidentiality of residents' medical information. The LPN stated the residents' personal information should be kept private in accordance with facility policy and acknowledged the MAR should not be visible to the public.</p> <p>4. Continued observation on 10/24/12 at 6:15 PM, revealed a medication cart was positioned outside the closed door of resident room 2102. Further observation revealed the medication cart was unattended and the MAR that included residents' personal and private information had been left open on top of the medication cart. RN #3 was observed to exit Resident G's room and proceed to conduct a medication pass. RN #3 failed to follow facility policy and failed to ensure the residents' private and personal information contained on the MAR was kept private and confidential.</p> <p>Interview conducted on 10/24/12 at 6:15 PM, revealed RN #3 was knowledgeable of the requirement to keep residents' personal information private. RN #3 stated she should have closed the MAR prior to entering the resident's room for the medication administration.</p> <p>Interview with the Second Floor Unit Manager on 10/25/12 at 2:45 PM, revealed staff should</p>	F 164			

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F 164	Continued From page 4 protect residents' private information during medication pass and confirmed the information on the MAR should be covered during medication administration and when not in use and unattended in the hallway.  5. Observation during a medication pass conducted on 10/24/12 at 4:35 PM, revealed Registered Nurse (RN) #1 walked away from the medication cart to administer medications to Residents C, D, and #3. Further observation revealed the MAR which contained residents' confidential information was left uncovered on top of the medication cart sitting in the hallway. Several staff members and residents were observed to pass by the medication cart.  Interview conducted with RN #1 on 10/24/12 at 5:15 PM, revealed the RN had been trained to cover the MAR during medication administration. The RN stated she forgot to cover the MAR.  Interview conducted with the Director of Nurses (DON) on 10/25/12 at 2:00 PM, revealed residents' personal and confidential information identified on the MAR should be protected when staff administered medications to the residents. The DON stated the MAR should be covered or closed to protect resident information.	F 164			
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  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 endangered.	F 246	F246  The facility ensures that the 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 endangered.		

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F 246	<p>Continued From page 5</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure individual needs were accommodated for two of twenty-four sampled residents (Residents #9 and #20). Observation during the evening meal on 10/23/12 revealed Resident #9 was served a meal tray in the room; however, there was no overbed table to place the meal tray on. In addition, Resident #20 had no overbed table in the room, the resident's water pitcher was located across the room on a nightstand, and the resident was unable to reach the water pitcher.</p> <p>The findings include: A review of the facility's Resident Rights (revision date 10/31/04) revealed each resident would be treated with consideration, respect, and full recognition of his/her dignity and individuality, including privacy in treatment and in care for his/her personal needs.</p> <p>Observation of the evening meal on 10/23/12 at 7:00 PM, revealed Resident #9 received a meal tray in the room. The resident required assistance from the staff. There was no overbed table in the resident's room, and the staff had to set the meal tray on the windowsill while holding onto the tray so the tray would not spill. The staff member set the tray in the staff member's lap to finish feeding the resident.</p>	F 246	<p>Resident #9 will be provided an over bed table when he chooses to eat in his room.</p> <p>Resident #20 was provided an over bed table for her water pitcher</p> <p>and other personal items for easy access on 10-29-12. Residents were assessed based upon their current conditions and overbed tables were provided as indicated by the assessment on 11-16-12. In addition residents will continue to be assessed on a quarterly basis.</p> <p>Each nursing staff member was in-serviced by the DON or designee on the resident's right to receive services in the facility with reasonable accommodation of individual needs and preferences including but not limited to over bed tables on 11-15-12, 11-19-12 and 11-21-12. STNA #3,4,5 and 12 including LPN #3 were in attendance.</p> <p>A PI worksheet will be completed for accommodation of needs and preferences. Results will be reported to the Performance Improvement Committee for additional comments/interventions and for determination of the need of continued formal ongoing monitoring. A copy of worksheet is attached as EXHIBIT C. This PI worksheet is completed by the Unit Manager weekly x 4 then monthly.</p> <p>The Director of Nurses to monitor for compliance.</p>	12/6/2012

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F 246	<p>Continued From page 6</p> <p>Observation of Resident #20's room revealed there was no overbed table in the room. The resident's water pitcher was observed to be located across the room on a nightstand and the resident was unable to reach the water pitcher.</p> <p>Interview with Resident #20's family revealed the family member visited the resident on a daily basis and had never observed an overbed table in the resident's room. The family member voiced concerns about the lack of an overbed table and that the resident could not reach the water pitcher unassisted. In addition, the family member stated due to the resident's unsteady gait it would not be safe for the resident to get out of bed unassisted to obtain the water pitcher located across the room.</p> <p>Interview with Certified Nurse Aide (CNA) #12 on 10/23/12 at 7:00 PM, revealed there were not enough overbed tables to accommodate all the residents.</p> <p>Interviews with CNAs #3, #4, and #5, and Licensed Practical Nurse (LPN) #3 on 10/24/12 at 2:30-2:45 PM, revealed the facility did not have enough overbed tables for all residents. The staff stated the facility encouraged residents to eat in the dining room; however, if a resident received meals in their room, staff would need to locate an overbed table if a table wasn't in the room.</p> <p>Interview with the Administrator on 10/25/12 at 2:25 PM, revealed each resident had a nightstand and overbed tables were provided based on the resident's needs and physical abilities. The Administrator stated staff assisted residents with</p>	F 246			

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F 246	Continued From page 7 hydration and feeding and acknowledged if there was not a table in the resident's room staff would need to find a table for that resident to utilize for the meal tray or utilize the nightstand.	F 246		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER  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 observations, interview, and facility policy, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for one resident (Residents #10) in the selected sample of twenty-four residents. Observations during the provision of indwelling catheter care for Resident #10 revealed Certified Nurse Aide (CNA) #1 failed to provide catheter care in a proper manner and cleansed the indwelling catheter tubing toward the insertion site of the resident's indwelling urinary catheter.  The findings include:  A review of the facility's policy titled Urinary Catheter Care (revised January 2008) revealed	F 315	<u>F315</u>  The facility ensures 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.  C.N.A. #10 was provided one on one additional education with the DON on 11-1-12 on how to properly provide catheter care in compliance with the facility's policies and procedures.  Resident #10 was assessed for signs and symptoms of potential urinary tract infection on 10-25-12 by the nurse. Resident #10 has had no symptoms of UTI.  Each resident with a catheter was assessed on by RN staff for signs and symptoms of UTI. There were no residents with catheters that showed signs or symptoms of UTI.  Each C.N.A. will be reeducated on the importance of following the policy titled Urinary Catheter Care and skills check off utilizing proper technique will be completed on 11-15-12, 11-19-12 and 11-21-12.	

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F 315	<p>Continued From page 8</p> <p>catheter care would promote good hygiene as well as reduce risk of infection. The policy directed staff to provide catheter care in the AM and PM and as needed. The policy directed staff to cleanse the catheter tubing last while securely holding the tubing at the point of insertion, using friction and twisting motion while proceeding down the tubing.</p> <p>Observation on 10/24/12 at 10:15 AM, revealed CNA #1 used a wet washcloth and Remedy foaming cleanser to provide catheter care for Resident #10. CNA #1 cleansed Resident #10's perineal area using downward strokes; however, the CNA wiped the catheter tubing toward the catheter insertion site when she cleansed the catheter tubing. CNA #1 failed to follow facility policy and accepted professional standards by failing to cleanse the catheter tubing in a downward motion from the catheter insertion site.</p> <p>An interview on 10/24/12 at 3:00 PM, with CNA #1 revealed she was knowledgeable of cleansing the catheter tubing away from the indwelling catheter insertion site to decrease bacteria and infection. CNA #1 stated she was nervous and made a mistake by not cleansing Resident #10's catheter tubing away from the insertion site.</p> <p>interview on 10/25/12 at 2:45 PM, with the Second Floor Unit Manager revealed staff should always cleanse the catheter tubing by cleansing the tubing away from the resident.</p>	F 315	<p>The facility monitors facility infections, including urinary tract infections through the PI process of the infection Control Committee and reports such information to the PI Committee on at least a quarterly basis.</p> <p>Unit Managers will assess catheter care to ensure compliance.</p> <p>A Catheter Care PI is being completed by the Unit Manager on residents who receive catheter care, weekly x 4 then monthly. Results will be reported to the Performance Improvement Committee for additional comments/interventions and for determination of the need of continued formal ongoing monitoring. A copy of worksheet is attached as EXHIBIT D.</p> <p>The Director of Nurses to monitor for compliance.</p>	12/6/2012
F 323 SS=E	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards</p>	F 323	<p><u>F323</u></p> <p>The facility ensures that the resident environment remains as free of accident hazards as possible.</p>	

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F 323	<p>Continued From page 9 as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of Census and Condition and Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure residents' environment remained as free from accident hazards as possible. Observation during the environmental tour on 10/24/12 and 10/25/12 revealed the facility failed to ensure batteries, shaving cream, disposable razors, denture cleanser tablets, nail clippers, and sharp manicure sticks were secured/locked and not accessible to residents.</p> <p>The findings include: According to the Assistant Director of Nursing (ADON), the facility did not have a policy regarding safeguarding potentially hazardous items and maintaining resident safety related to personal hygiene items. Review of the facility's Census and Condition Record dated 10/24/12, revealed 69 residents had a diagnosis of Dementia. The facility provided a list that revealed four residents were assessed to exhibit wandering behaviors and resided on the second floor. Six residents that resided on the first floor had been assessed to exhibit wandering behaviors.</p>	F 323	<p>Supply closet doors on the 1100 and 2100 hallways were locked immediately and new door handles with automatic locks were installed on 11-6-12. Each C.N.A. received a key to gain access to the closet. Areas with supplies are now secured without resident access.</p> <p>Facility wide assessment will be completed by the Maintenance Director before December 6<sup>th</sup> to ensure there are no other areas with potential unsecured items.</p> <p>Nursing staff will be in-serviced on the importance of keeping hazardous materials locked. In-services will be completed by the DON and/or Administrator on 11-15-12, 11-19-12, 11-21-12 and 11-29-12.</p> <p>The policy for safeguarding hazardous materials was updated on 11-16-12, a copy of the policy is attached as Exhibit E.</p> <p>An Evaluating Environmental Safety PI is being completed by the Unit Manager weekly x 4 then monthly. Results will be reported to the Performance Improvement Committee for additional comments/interventions and for determination of the need of continued formal ongoing monitoring. A copy of worksheet is attached as EXHIBIT F.</p> <p>Director of Nurses to monitor for compliance.</p>	12/6/2012	

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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	
(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 323	<p>Continued From page 10</p> <p>Observation on 10/24/12 at 10:50 AM, and on 10/25/12 at 9:50 AM, 1:00 PM, and 4:45 PM, revealed a Supply Closet located on the second floor 2100 Hall was unsecured/unlocked. The Supply Closet contained the following: 8 disposable razors, 6 9-volt batteries, 36 Efferdent denture cleanser tablets, and 11 nail care kits that contained nail clippers and sharp manicure sticks.</p> <p>Observation of the first floor 1100 Hall on initial tour on 10/23/12 at 11:00 AM, and on 10/25/12 at 10:00 AM, 11:00 AM, and 4:20 PM, revealed the Supply Closet was unsecured/unlocked. The Supply Closet contained 12 disposable razors, 7 manicure kits that contained nail clippers and sharp manicure sticks, 20 Efferdent denture cleanser tablets, and 6 cans of shaving cream and were easily accessible to residents.</p> <p>Continued observation of the 1100 Hall on 10/25/12 at 4:25 PM, revealed a resident in a wheelchair had wandered into resident room 1306 and attempted to obtain an item (candy) from a resident's bedside table. Staff was observed to redirect the resident and stated the wandering resident resided in room 1314.</p> <p>Review of the MSDS for Efferdent Denture Cleaner revealed misuse of the denture cleanser could cause eye, skin, respiratory tract, and gastrointestinal burns. The MSDS directed staff to contact the Poison Control Center and seek medical attention immediately if the denture cleanser tablets were ingested or inhaled.</p> <p>Interview on 10/24/12 at 10:45 AM, with CNA #2</p>	F 323		

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F 323	Continued From page 11 assigned to the second floor, revealed the Supply Closet was never locked. CNA #2 stated he had never seen any resident attempt to obtain items stored in the Supply Closet, and acknowledged items stored in the Supply Closet could harm residents if the items were swallowed.  Interview on 10/25/12 at 4:20 PM, with CNA #11, assigned to the first floor, revealed resident personal hygiene items should be locked and not accessible to residents. CNA #11 stated residents could cut themselves or others if they had access to disposable razors or clippers and stated the denture tablets could cause an upset stomach if swallowed. CNA #11 stated residents should not have access to the items stored in the closet.  Interview on 10/25/12 at 6:15 PM, with the ADON revealed resident personal care items used by the CNAs had been moved to the hall supply rooms a few months earlier for easier access by the CNAs that provided personal care to the residents. The ADON stated it was an oversight to not ensure residents did not have access to the harmful items. The ADON acknowledged the items in the Supply Closet should not be accessible to residents and the door should be locked at all times.	F 323		
F 371 SS=D	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	F 371	<u>F371</u>  The facility stores, prepares, distributes and serves food under sanitary conditions.  The gas range top and grease trap were cleaned immediately.	

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F 371	Continued From page 12  This REQUIREMENT is not met as evidenced by: The facility failed to store and prepare food under sanitary conditions. The grease tray underneath the gas range top had a heavy buildup of a black substance (burned food) and food debris. In addition, two of four ingredient storage bins lids were broken.  The findings include:  Review of the policy/procedure (dated April 2003) for cleaning the gas range revealed the range tops were to be removed and cleaned with an all-purpose solution with a wire brush if needed.  1. During the initial tour of the kitchen conducted at 12:55 PM on 10/23/12, the grease tray underneath the gas range top was observed to be heavily soiled. The grease trap had a heavy buildup of a black substance (burned foods and grease) and food debris. In addition, two ingredient storage bin lids were observed to be broken.  Review of the weekly cleaning schedule for the gas range revealed the gas range was scheduled to be cleaned on Fridays.  Interview with the Dietary Supervisor at 2:10 PM on 10/25/12, revealed the gas range was cleaned once each month, and the range was due at the end of the month.	F 371	Replacement bin lids were ordered on 10-23-12 and lid was labeled. Replacement lids installed and labeled on 11-12-12.  Dietary staff were in-serviced on cleaning log, cleaning schedule, storage of food including but not limited to storage bins, range top and grease trap by Dietary Manager on 11/13/12, 11/14/12 and 11/15/12.  Kitchen Equipment Cleaning Schedule Exhibit G and Kitchen Daily Check Log Exhibit H were updated by the Dietary Manager on 11-13-12.  Dietary Supervisor will audit kitchen to include but not limited to clean equipment and proper food storage containers weekly x 4 then monthly. Monthly the Facility Dietician will audit to ensure food is prepared and stored under sanitary conditions. Results will be reported to the Performance Improvement Committee for additional comments/interventions and for determination of the need of continued formal ongoing monitoring. A copy of worksheet is attached as EXHIBIT I.  Dietary Manager to monitor for compliance	12/6/2012	



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F 431	<p>Continued From page 14</p> <p>Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility policies/procedures, it was determined the facility failed to ensure expired medications were not available for resident use. Observation of the second floor medication room revealed Promethegan (Phenergan) Rectal Suppositories had an expiration date of September 2012 and remained available for resident use.</p> <p>The findings include:</p> <p>Review of the facility policy titled Drug Storage (updated October 2010) revealed discontinued and expired medications should be removed from medication carts, refrigerators, and cupboards promptly. The policy directed staff to return or destroy the drugs according to pharmacy and facility policies.</p> <p>Observation of the medication room refrigerator located on the second floor on 10/25/12 at 4:50 PM, revealed an opened box of Promethegan (Phenergan) Rectal Suppositories (used to relieve nausea and vomiting). The manufacturer's expiration date on the box of Promethegan (Phenergan) Rectal Suppositories was September 2012. Review of the pharmacy label revealed the last time the medication had</p>	F 431	<p>Performance Improvement Committee for additional comments/intervention and for determination of continued formal ongoing monitoring. A copy of worksheet is attached as EXHIBIT J.</p> <p>The Director of Nurses to monitor for compliance.</p>	12/6/2012	

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F 431	Continued From page 15 been dispensed was for unsampled Resident E on 03/28/10.  Interview on 10/25/12 at 5:00 PM, with Licensed Practical Nurse (LPN) #11, assigned to administer medications, revealed staff did not have a schedule to monitor expired medications. LPN #11 stated someone from the pharmacy came once a month and checked the medication rooms but was not sure if the refrigerators were checked.  Interview with the Director of Nursing (DON) on 10/25/12 at 5:35 PM, acknowledged the facility did not have a system/schedule in place to ensure expired medications were not available for resident use. The DON stated nurses should check the medication expiration dates prior to giving medications. The DON also stated she thought the pharmacy conducted drug storage audits every six months, and was unaware expired medications were available for resident use.	F 431		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE  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.  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;	F 514	514  The facility maintains clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.  Resident #13's clinical record was corrected immediately on October 25 <sup>th</sup> , 2012. Physician was notified and medication was stopped.	

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F 514	<p>Continued From page 16 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 ensure accurate clinical records were maintained for one of twenty-four sampled residents (Resident #13). Although staff had identified and documented in Resident #13's medical record the resident had an allergy to ACE (angiotensin-converting enzyme, used for the treatment of high blood pressure) inhibitors, Resident #13's physician prescribed and facility staff administered Lisinopril (an ACE inhibitor) to Resident #13 on a daily basis from 10/13/11 through 10/25/12.</p> <p>The findings include:</p> <p>A review of the policy for Allergies (dated April 2004) revealed allergies were to be listed on an allergy sticker in the resident's medical record and any new allergies were to be added to the sticker. The physician and pharmacy were to be notified of any allergy changes.</p> <p>A review of a discharge summary from a hospital (dictated 10/13/11) revealed Resident #13 developed an angioedema reaction to the medication Lisinopril which resolved when the ACE inhibitor (Lisinopril) was withheld. A review of the medical record for Resident #13 revealed an allergy sticker located on the front cover of the medical record that identified Resident #13 as having an "Allergy to ACE inhibitors." However, even though the hospital discharge summary dated 10/13/11 and the allergy sticker on the front</p>	F 514	<p>Highlandspring completed audit of resident medical records to ensure accuracy for identification and compliance with resident allergies on October 29<sup>th</sup>, 2012.</p> <p>New Admission/Readmission medical records will be audited weekly for accuracy related to resident allergies.</p> <p>A Medical Record PI is being completed by the Unit Manager weekly x4 and then monthly. Results will be reported to the Performance Improvement Committee for additional comments/interventions and for determination of the need of continued formal ongoing monitoring. A copy of the worksheet is attached as EXHIBIT K.</p> <p>The Director of Nurses to monitor for compliance.</p>	12/6/2012	

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F 514	<p>Continued From page 17</p> <p>of the resident's medical record indicated the resident had a reaction/allergy to ACE inhibitors, a review of the Medication Administration Record (MAR) and the physician's orders for October 2012 revealed Resident #13 had no known allergies. In addition, a review of the MAR and physician's orders revealed Lisinopril (an ACE inhibitor) had been initially prescribed for Resident #13 on 10/13/11 and the prescription had been reordered on a monthly basis through October 2012. A review of the October 2012 MAR revealed Resident #13 had received 40 milligrams (mg) of Lisinopril every morning from October 2012 through the day of the review (10/25/12).</p> <p>An interview with the Charge Nurse (CN) on 10/25/12 at 9:25 AM, revealed the facility was unaware of the allergy sticker on the cover of Resident #13's medical record that indicated Resident #13 had an allergy to ACE inhibitors. The CN acknowledged the MARs and the physician's orders for Resident #13 did not identify the resident had any drug allergies. The CN stated although documentation in the medical record revealed Resident #13 had received the medication, there was no documentation Resident #13 had experienced any signs and symptoms of distress at the facility and facility staff had documented the resident's vital signs were within normal limits for the resident.</p> <p>An interview with the consultant pharmacist on 10/25/12 at 9:25 AM, revealed the pharmacist conducted a drug review of medications prescribed for Resident #13 every month and was unaware of an allergy sticker on the cover of the resident's medical record that indicated the</p>	F 514			

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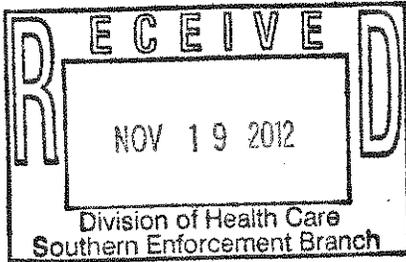
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F 514	<p>Continued From page 18</p> <p>resident had drug allergies. The pharmacist stated that based on documentation in Resident #13's medical record the resident had received the medication and there was no indication the resident had experienced any signs or symptoms of distress.</p> <p>An interview with Resident #13's primary care physician on 10/25/12 at 1:15 PM, revealed the resident had not experienced any side effects from the administration of Lisinopril. The physician stated the allergy sticker, the MARs, and the physician's orders needed to be updated on Resident #13's medical record.</p> <p>Interview with the Director of Nursing (DON) on 10/25/12 at 1:30 PM, stated when a resident returns to the facility following hospitalization the nurse admitting the resident back to the facility should update the resident's medical record, including the MARs and physician's orders, with any new information; e.g., medications, diagnoses, allergies. In addition, according to the DON, facility staff should contact the resident's physician and the pharmacy to inform them of any changes in the resident's condition/medications, including allergies. The DON acknowledged staff had failed to update all of Resident #13's medical record, including the physician's orders and MARs to reflect the resident's allergy to Lisinopril.</p>	F 514		

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K 000	INITIAL COMMENTS  CFR: 42 CFR 483.70(a) Building: 01 Plan Approval: 1992, 2006 Survey under: 2000 existing Facility type: S/NF Type of structure: Two (2) stories Type II (222) with partial basement. Smoke Compartment: Fifteen (15) smoke compartments 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. Sprinkler System: Complete automatic (dry and wet) sprinkler system. Generator: Type II diesel installed 1992  A standard Life Safety Code survey was conducted on 11/07/2012. 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 twenty-six (126). The facility is licensed for one hundred forty (140).  The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire). The highest s/s was at "D" level.	K 000		
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	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1	



LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Molly B. Bickel* TITLE: *Administrator* (X6) DATE: *11-19-12*

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 038	Continued From page 1  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the exits were maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of fifteen (15) smoke compartments, twenty-seven (27) residents, staff, and visitors. The facility is licensed for one hundred forty (140) certified beds with a census of one hundred twenty-six (126) on the day of the survey.  The findings include:  Observation, on 11/07/12 between 9:30 AM and 1:30 PM, with the Maintenance Director and Administrator revealed walkways leading away from the 1100 Hall Exit Door and Stairway Exit Door were graveled and did not have a durable surface to the public way.  Interview, on 11/07/12 at 11:55 AM, with the Maintenance Director and Administrator revealed the walkway has always been gravel for years and thought this was acceptable.  Reference: NFPA 101 (2000 edition)  7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in	K 038	The exit from the 1100 corridor to the concrete patio will have a path constructed of asphalt using 448 Type 1 asphalt, having an average 2.0" average compacted thickness to provide an exit to a public way that will be usable under all conditions to be conducive to evacuating residents. The Construction will be completed by 11/19/2012.  Maintenance Director to monitor for compliance.	12/5/2012	

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185383</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>11/07/2012</b>
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>		
(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	<p>Continued From page 2</p> <p>the case of fire or other emergency.</p> <p>7.5.1.1 Exits shall be located and exit access shall be arranged so that exits are readily accessible at all times.</p> <p>7.7.1* Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way.</p> <p>Exception No. 1: This requirement shall not apply to interior exit discharge as otherwise provided in 7.7.2.</p> <p>Exception No. 2: This requirement shall not apply to rooftop exit discharge as otherwise provided in 7.7.6.</p> <p>Exception No. 3: Means of egress shall be permitted to terminate in an exterior area of refuge as provided in Chapters 22 and 23.</p> <p>Reference: CMS S&amp;C letter 5-38</p> <p>Q2: Are exit discharges required to have a hard surface pathway to the public way? This is in reference to tag K-38 and previous guidance.</p> <p>A2: Previous interpretive guidance on this subject dated 07/07/93 (under tag K-32) is still acceptable. In that guidance we stated that our response to the question was " Yes, if there is much rain or snow and if patients are expected to exit or be evacuated in wheelchairs or beds. " This would include residents using walkers. Grass or soil may be acceptable if weather conditions permit. This determination is left up to the judgment of the surveyor as to the local weather conditions and the difficulty that a</p>	K 038			

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

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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		
(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 3 resident or patient may encounter while traversing between the building and the public way. Section 7.7.1 NFPA 101 of the LSC (2000 edition) requires that " Exits shall terminate directly at a public way or at an exterior exit discharge. Yards, courts, open spaces, or other portions of the exit discharge shall be of required width and size to provide all occupants with a safe access to a public way. " An appendix note to 7.7.1 states that the exit discharge is not required to be paved but that it must give safe access to a public way and references section 7.1.10. Section 7.1.10 of NFPA 101 of the LSC (2000 edition) requires that the means of egress be continuously maintained free of all obstructions or impediments to full and instant use in the case of fire or emergency. An appendix note to 7.1.10 specifically points out that accumulations of snow and ice are an impediment to free movement in the means of egress. CMS believes that a usable exit discharge is a fundamental and important life safety feature and contributes to the safety of staff and residents in an emergency. The use of the Fire Safety Evaluation System (FSES) is inappropriate as there is no equivalent to being able to exit the building at all times in an emergency.	K 038			