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DEC 17 2010

OFFICE OF INSPECTOR GENERAL PRINTED: 12/06/2010
DIVISION OF HEALTH CARE FACILITIES AND SERVICES FORM APPROVED
OMB NO. 0938-0391

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE 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
F 000	INITIAL COMMENTS	F 000		
F 156 SS=D	<p>A standard health survey was conducted on 11/16/10 through 11/18/10 and a Life Safety Code survey was conducted on 11/17/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.</p> <p>483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES</p> <p>The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing.</p> <p>The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section.</p> <p>The facility must inform each resident before, or at the time of admission, and periodically during</p>	F 156	F156 <ul style="list-style-type: none"> 1. A licensed nurse clarified Resident #19's Code status with the MD and Responsible Party. On 11/17/2010 an order was written to clarify Full Code status. 2. 100% review of all resident's advanced directives will be completed by Social Services and Health Information Management. Any residents identified with inconsistencies in the code status forms and physician orders will be clarified. The audit consisted of checking and comparing the written Advanced Directives, with the physician orders, and the care plan, for inconsistencies. 3. The DNR policy was reviewed by Administrator, Director of Nurses, (for future purposes DON means Director of Nurses), Social Service Director and Health Information Manager and revised. The revision included on going Advanced Directive validation by Social Services through the MDS process. On December 9, 2010 education was initiated to the licensed nursing staff that included the policy and the process utilized in changing an advanced directive. This education was initiated by DON/ Social Services Director, Assistant Director of Nurses/ Staff Development Director/ Weekend Supervisor. 	

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

Karol Hamilton

TITLE

Administrator

(X6) DATE

12-15-10

deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 156	Continued From page 1 the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and	F 156	F-156 continued 4. An audit will be completed by the Social Service Director for the next 30 days. This audit will correspond with resident's MDS assessment dates and will include a review of physician orders, care plans and advance directive forms. Following the initial audit the Social Service Director will be responsible for auditing 10 residents per month for 4 months. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment team which consists of at least the DON, Medical Director and one or more of the following (<i>Administrator, Unit Managers, Therapy, Activities, Certified Nursing Assistant, Assistant Director of Nursing, Dietary Manager, MDS Coordinator.</i>) The Quality Assurance and Assessment committee will determine if additional auditing or education is required. 5. Director of Social Services and Director of Nursing Services are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.	

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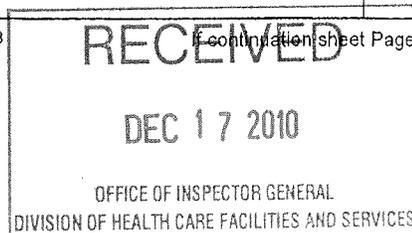
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F 156	<p>Continued From page 2</p> <p>procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to ensure one (1) of twenty-five (25) sampled residents the choice to have a full code was honored. Resident #19's code status was changed from a DNR to a Full Code by Resident #19's Power of Attorney on 08/06/10. No physician order was obtained to honor Resident #19's wish for a Full Code.</p> <p>The findings include:</p> <p>The facility policy related to code status stated that the purpose of this process is to communicate to caregivers a resident's code</p>	F 156		
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F 156	Continued From page 3 status in order to facilitate emergency care in a manner that respects and honors a resident's, or their responsible parties, end of life care direction. Review of the record revealed Resident #19 was admitted to the facility on 09/12/08 with diagnoses of metabolic encephalopathy, acute renal failure, chronic kidney disease, mental retardation, hypertension and diabetes. Review of the physician orders effective date 06/24/09 which was renewed on 11/01/10 revealed that Resident #19's code status was a "Do Not Resuscitate" (DNR). Review of the social service progress notes dated 08/12/10 revealed that the family had changed the code status from DNR to full code on 08/06/10. Further review of the record revealed the Director of Social Service did not obtain the physician order until 11/18/10. Interview with Licensed Practical Nurse (LPN) #1 on 11/18/10 at 1:00pm revealed it is the nurse's responsibility to obtain the order for a change in code status. She further revealed the full code status would not be valid without a physician's order. Interview with the Director of Social Services on 11/18/10 at 2:00pm revealed that once a change in code status is requested, the physician or the nurse writes the order. She further revealed that the code status is only valid once the order is obtained from physician.	F 156		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

If continuation sheet Page 4 of 22

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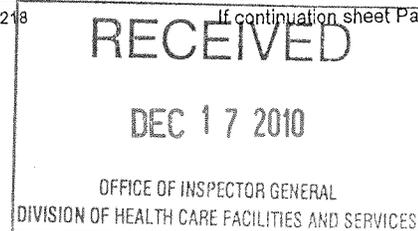
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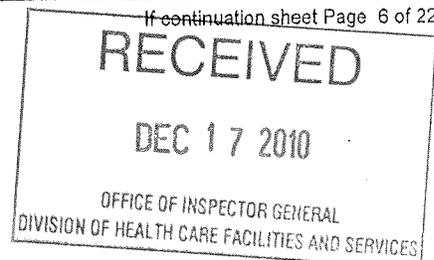
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F 309	<p>Continued From page 4</p> <p>or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based upon record review, observation, and interview, the facility failed to provide necessary care and services to maintain the highest physical well-being for two (2) of twenty-five (25) sampled residents. Resident #10 had continuous oxygen delivered at an incorrect liter flow, and no order was obtained from the attending physician to cancel the Do Not Resuscitate (DNR) order for Resident #19, after the family decided to revoke the DNR order.</p> <p>The findings include:</p> <p>Record review of physician orders for Resident #10 revealed an order dated 11/01/10 for oxygen at three (3) liters per minute by nasal cannula continuously.</p> <p>Observations on 11/16/10 at 11:30am and on 11/16/10 at 3:05pm found Resident #10 lying in bed receiving oxygen at two (2) liters per minute by nasal cannula.</p> <p>Observations on 11/17/10 at 9:15am and 10:10am found Resident #10 lying in bed receiving oxygen at two (2) liters per minute by nasal cannula.</p> <p>Interview on 11/17/10 at 10:15am with LPN #9 revealed that Resident #10 had an order for</p>	F 309	<p>F309</p> <ol style="list-style-type: none"> The oxygen flow rate was adjusted for Resident #10 by a licensed nurse on 11/17/10 and a clarification order was written for oxygen titration. <p>The DNR order for Resident #19 and clarified with the MD on 11/17/2010 to reflect a full code status. Advanced Directive, MD orders and care plan were updated by a licensed nurse.</p> <ol style="list-style-type: none"> All residents with oxygen orders were identified. Their orders were reviewed, and settings validated by a licensed nurse. <p>100% review of all resident's advanced directives will be completed by Social Services and Health Information Management. Any residents identified with inconsistencies in the code status forms and physician orders will be clarified. The audit consisted of checking and comparing the written Advanced Directives, with the physician orders, and the care plan, for inconsistencies.</p> <ol style="list-style-type: none"> The policy and procedure for oxygen administration was reviewed by the Director of Nursing, (DON) and no revisions were necessary. The DON/ Assistant Director of Nursing (ADON), Staff Developer (SDC), Shift Supervisors began inservicing to the licensed nursing staff on 12/9/10. This education included accuracy of oxygen liter flow rates. 		



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F 309	<p>Continued From page 5</p> <p>oxygen at three (3) liters per minute. She stated she assessed Resident #10 earlier in the morning and did not notice the oxygen setting was two (2) liters per minute. She said sometimes the staff will bump the setting while in the room without noticing. LPN #9 was aware that Resident #10 had multiple hospital admissions for treatment of Congestive Heart Failure and stated she understood the negative effects associated with an incorrect oxygen setting for Resident #10.</p> <p>The facility policy related to code status stated that the purpose of this process is to communicate to care givers a resident's code status in order to facilitate emergency care in a manner that respects and honors a resident's, or their responsible parties, end of life care direction.</p> <p>Review of the record revealed Resident #19 was admitted to the facility on 09/12/08 with diagnoses of metabolic encephalopathy, acute renal failure, chronic kidney disease, mental retardation, hypertension and diabetes. Review of the physician orders effective date 06/24/09 which was renewed on 11/01/10 revealed that Resident #19's code status as "Do Not Resuscitate (DNR).</p> <p>Review of the social service progress notes dated 08/12/10 revealed that the family had changed the code status from DNR to full code on 08/06/10. Further review of the record revealed the Director of Social Services did not obtain the physician order until 11/18/10.</p> <p>Interview with Licensed Practical Nurse (LPN) #1 on 11/18/10 at 1:00pm revealed that it is the nurse's responsibility to obtain the order for a change in code status. She further revealed that the full code status would not be valid without a</p>	F 309	<p>The DNR policy was reviewed by Administrator, Director of Nurses, (for future purposes DON means Director of Nurses), Social Service Director and Health Information Manager and revised. The revision included on going Advanced Directive validation by Social Services through the MDS process. On December 9, 2010 education was initiated to the licensed nursing staff that included the policy and the process utilized in changing an advanced directive. This education was initiated by DON/ Social Services Director, Assistant Director of Nurses/ Staff Development Director/ Weekend Supervisor.</p> <p>4. Auditing will be completed by the Administrative nursing staff regarding oxygen flow rate (for future reference administrative nursing staff includes the Director of Nurses, ADON, SDC, Unit Managers, Shift Supervisors). The initial audit will include monitoring daily oxygen flow settings for 30 days. The audit will include checking the oxygen flow rate setting at the time of the audit with the Physician order. Following the initial audit, the audit will continue 20 oxygen flow rate validations per month for 3 months.</p>	



F309 – continued

An audit will be completed by the Social Service Director for the next 30 days. This audit will correspond with resident's MDS assessment dates and will include a review of physician orders, care plans and advance directive forms. Following the initial audit the Social Service Director will be responsible for auditing 10 residents per month for 4 months. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment team which consists of at least the DON, Medical Director and one or more of the following (*Administrator, Unit Managers, Therapy, Activities, Certified Nursing Assistant, Assistant Director of Nursing, Dietary Manager, MDS Coordinator.*) The Quality Assurance and Assessment committee will determine if additional auditing or education is required.

5. Director of Social Services and Director of Nursing Services are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.

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F 309	Continued From page 6 physician's order.	F 309		
F 371 SS=F	<p>Interview with the Director of Social Services on 11/18/10 at 2:00pm revealed that once a change in code status is requested the physician or the nurse writes the order. She further revealed that the code status is only valid once the order is obtained from physician.</p> <p>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>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</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to serve, prepare, and distribute food under sanitary conditions. Multiple frozen food items were not resealed after having been opened, the reach-in refrigerator did not contain a thermometer, employee lunch was stored in the walk-in refrigerator, the fan and ceiling in the walk-in refrigerator was not clean, clean dishes were improperly stored, a fan in the dishwashing room blowing across dishes was not clean, and cleaning products and supplies were not properly stored. Also, the automatic dishwasher was not cleaning adequately, and there was improper use of the three compartment sink, while meal service</p>	F 371	<p>F-371:</p> <ol style="list-style-type: none"> Director of Dietary Services resealed each of the 6 boxes of frozen foods; placed a thermometer in the reach-in refrigerator; the employee lunch was removed on 11/16/10 from walk-in refrigerator; the fan and ceiling in the walk-in refrigerator were cleaned on 11/18/10; dishes were removed from improper storage; fan in dishwashing room was removed on 11/21/10; the mop head and broom was removed. The Director of Dietary Services removed all items (buckets containing re-usable latex gloves, cleaning brushes, and bottle of floor cleaner), from the 3-compartment sink and all items stored under 3-compartment sink were removed on 11/18/10; wet dishes were removed; top and underside of steamer were cleaned; dietary staff members were verbally educated on the proper use of hair and beard restraints, and scraping of dishes prior to placing in automatic dishwasher. As noted by Director of Dietary Services, a sign that was posted for non-entry into dietary dept. was not intended to restrict entrance; but rather intended to limit entrance to the vestibule area. The sign was removed. A sanitation audit was completed by the Director of Nursing on 12/11/10. Additional areas in need of dietary sanitation were identified. These areas were corrected by dietary staff on 12/11/10. (floor needed sweeping and hairnets were out of box making it difficult to determine if they were used or clean.) 	

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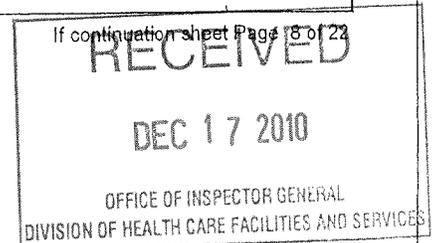
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F 371	<p>Continued From page 7</p> <p>was provided on wet dishware, and surfaces including the top of the steamer and underside of the tray line were observed to be unclean. In addition, two (2) dietary staff persons did not wear appropriate hair restraints, and multiple non-dietary staff entered the kitchen area without required hair covering and handwashing.</p> <p>The findings include:</p> <p>Review of the policy for use of the three compartment sink for dishwashing revealed the water temperature should be at least 110 degrees; dishes should be washed and rinsed under warm running water in the rinse sink to remove soap, then placed in sanitizer sink for at least one minute, followed by air drying of all dishes before storage. Review of the policy for storage of frozen foods revealed all partial cases of frozen food must be completely wrapped in a secure bag or other container allowing no air to reach them. Review of the policy for storage of chemicals, mops, and brooms revealed that all chemicals should be stored in the chemical room, and mops and brooms not in use must be stored in the chemical or dish room, and not within a minimum of 8 feet from food or dishes. Review of the policy for storage of employee lunches revealed that employees may place the item in the kitchen refrigerator but required the items to be packaged separately and properly labeled with employee name and date. Review of the protocol for handwashing in the kitchen revealed that hands must be washed upon entering the kitchen or before beginning a new task. Review of the policy for hairnets and beard nets revealed that employees are required to wear a hairnet when entering the kitchen and are to remove the hairnet upon exiting the kitchen. The hairnet should</p>	F 371	<p>3. Dietary policies and Procedures were located and reviewed and updated by Director of Dietary and Administrator. The revisions included storage of frozen food items; reach-in refrigerator thermometer; proper storage of cleaning supplies; use of fans; storage of employee lunches; recording of automatic dishwasher temps; 3-compartment sink washing and recording of the temperatures and sanitizer levels; cleanliness and dryness of all dishes and wares; hair and beard restraints; steamer surface cleaning; walk-in refrigerator fan and ceiling cleaning schedule.</p> <p>The Director of Dietary Services implemented a protocol for cleaning and drying dishes before use, and daily sanitation audits. The Director of Dietary Services initiated inservicing to dietary staff regarding policy and procedure revisions, dietary sanitation, and daily cleaning schedules</p> <p>4. Director of Dietary Services or Cook will audit the dietary department 7 times per week for 2 months. This audit will include storage of frozen food items; reach-in refrigerator thermometer; no cleaning items or supplies within 8 feet of clean wares; no fans in the dishwashing room; no cleaning items stored under the 3-compartment sink; no storage of employee lunches in the dietary refrigerator; recording of automatic dishwasher temps; 3-compartment sink washing and recording of the temperatures and sanitizer levels; cleanliness and dryness of all dishes and wares; hair and beard restraints; steamer surface cleaning; walk-in refrigerator fan and ceiling cleaning schedule.</p>	



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F 371	<p>Continued From page 8</p> <p>cover all hair on the head. Beard nets are to be worn to cover beards one-fourth an inch or longer.</p> <p>Record review on 11/16/10 at 8:05am revealed the automatic dishwasher temperature/chemical record lacked documentation of required temperature/chemical checks on 11/12/10, 11/13/10, 11/14/10, and 11/15/10.</p> <p>Observation on 11/16/10 at 8:05am, during the initial tour, revealed six (6) boxes of frozen foods in the freezer which had been previously opened and were not resealed and left open to air. These items included: one (1) box Salisbury steaks, one (1) box pancakes, one (1) box frozen cookie dough, two (2) boxes of corndogs, and one (1) box chicken nuggets. Other observations during the initial tour revealed no thermometer inside the reach-in refrigerator, clean bowls stored on a low-wheeled cart in a utility area of the kitchen next to a dark colored mop head and broom lying flat on the floor, a large fan in the dishwashing room blowing across clean dishes with dark fuzzy material attached to the cage of the fan, and two buckets containing yellow reusable latex gloves and cleaning brushes and a bottle of floor cleaner stored on the floor under the three part sink. These items were also observed in the same location under the three compartment sink on 11/18/10 at 1:00pm. Observation during the initial tour also revealed a plastic grocery bag stored in the walk-in refrigerator dated 11/15/10 which was described by the Director of Dietary Services to be an employee lunch left from the day before. An observation during the initial tour revealed the automatic dishwasher temperature/chemical record lacked documentation of required temperature/chemical checks on 11/12/10,</p>	F 371	<p>Following the initial audit, random audits will be completed 5 times per week for 2 months by the Director of Dietary Services and Registered Dietitian. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment Committee. The Quality Assurance and Assessment committee will determine if additional auditing or education is required.</p> <p>5. The Director of Dietary Services and the Administrator are responsible for the completion of this Tag - facility alleges compliance as of January 2, 2011.</p>	
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
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F 371	<p>Continued From page 9</p> <p>11/13/10, 11/14/10, and 11/15/10. Observations on 11/16/10 at 12:00pm revealed nursing staff entered the door to kitchen from Holly Hall Dining Room where a sign was posted to restrict entrance to kitchen and allowed access to kitchen/dietary staff only. Observations on 11/16/10 during the lunch service found multiple nursing staff passed the sign and entered the kitchen area without hair covering or required handwashing. Observations on 11/17/10 at 11:15am revealed multiple nursing staff entered the kitchen area without hairnets or required handwashing.</p> <p>Observation on 11/17/10 at 11:15am during the tray line service found the Cook using the three compartment sink to wash remaining dishes and food trays from breakfast. A large tray coated with cooked eggs was found soaking in the rinse sink and the Cook poured the soaking water from the tray with bits of egg down the rinse drain. The sink was not sanitized and he continued to wash dishes and then placed utensils in the bottom of the rinse sink. The rinsed dishes were quickly dipped in the sanitizer solution then placed on the shelf to dry. Continued observation during the tray line service revealed the following; a dietary worker removed twelve trays and several plates from the tray serving line explaining the dishes were "dirty." Wet plates, plate holders, plate covers, and patient trays were utilized for food service on the tray line for the afternoon meal. The cook/dietary worker #1 served the food on the tray line with a beard uncovered, and dietary worker #2 worked the tray line without full coverage of their hair.</p> <p>Observation on 11/18/10 at 1:00pm revealed the wash cycle of the high temperature automatic</p>	F 371			

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F 371	<p>Continued From page 10</p> <p>dishwashing machine was ineffective to remove food particles from dishes, as food particles were observed on multiple items which had been processed through the machine.</p> <p>Observation on 11/18/10 at 1:00pm revealed sticky dark material all along the underside of the tray line just above the steam table, a dark sticky substance was found on top of the steamer where pot holders were laying, and dark fuzzy material was found on the fan and ceiling of the walk-in refrigerator.</p> <p>Interview on 11/16/10 at 8:05am with the Director of Dietary Services regarding use of the three compartment sink revealed the preferred temperature of the sink water was 115-120 degrees, and that sanitizer is added to water, then strip test for desired 200 ppm. He stated no log was maintained to verify sanitizer level, and that sanitizer is added to water and strip tested until appropriate level is achieved. He reported that no immersion time is observed for use in the sanitizer sink.</p> <p>Interview on 11/16/10 at 8:05am with the Directory of Dietary Services regarding the clean bowls stored low to the floor near a mop head and broom lying on the floor revealed, the floor had just been cleaned after breakfast and the mop head and broom should have been returned to the environmental storage area. The Director of Dietary Services stated employees have been allowed to store their lunches in the walk-in refrigerator and identified a plastic grocery bag as an employee lunch which was left from the day before and asked, "Is that OK?" He stated that the temperature and chemical checks on the automatic dishwasher process was required with</p>	F 371		
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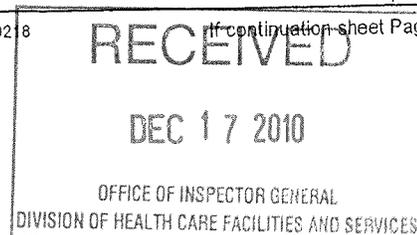
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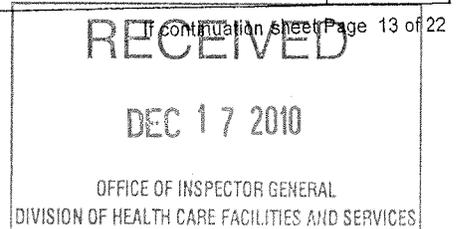
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F 371	Continued From page 11 each meal and must be documented on the log. Interview on 11/17/10 at 11:15am with the Director of Dietary Services regarding hair restraint policy revealed that he was uncertain if the Cook needed a beard net because the beard was short. He stated he always has to remind Dietary Aide #2 to keep her hair tucked inside the bouffant cap. He did not request either staff member to comply with hair restraint during the tray service. Interview on 11/17/10 at 11:15am with Cook/Dietary Aide #1 regarding the tray left to soak in the rinse sink found the tray was placed in the rinse sink because he did not have room to sit the soaking tray anywhere else. The Director of Dietary Services said the tray should not have been emptied into the rinse sink and said the dietary workers need to be in-serviced on the proper use of the three compartment sink. Interview on 11/17/10 at 12:40pm with the Director of Dietary Services regarding the nursing staff entering the kitchen revealed this had been an accepted practice at the facility. He explained the sign was intended to restrict entrance to the kitchen, but the staff who enter the kitchen must remain behind a red line and were not required to wear hair restraint or wash hands as the kitchen staff do, but that hand sanitizer was available for use in that area of the kitchen. Interview on 11/18/10 at 1:00pm with the Director of Dietary Services revealed the frozen items which were open and exposed were removed and discarded. Regarding the fan in the dishwasher room, he said it helps to cool the room as well as improve dry times and it was due to be cleaned.	F 371		



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F 371	Continued From page 12 He said he intended to increase dry times to avoid serving meals on wet dishware. The Director of Dietary Services said he was aware the automatic dishwasher was not working well as many dishes had been handwashed because the dishes had not been clean coming from the automatic dishwasher. He said the buckets, floor cleaner; gloves and brushes are stored under the three compartment sink so the items are readily available to clean the floor as necessary. He said the underside of the tray line is cleaned monthly, and the top of the steamer is cleaned daily and upon inspection of both areas, he agreed these need to be cleaned more frequently. He also stated the fan and ceiling of the walk-in refrigerator would be cleaned immediately to remove the dark residue. Interview on 11/18/10 at 2:15pm with the Director of Dietary Services regarding the origin of the policies which were provided to explain kitchen procedures revealed the facility had no policies regarding kitchen procedures. The documents provided had no implementation date or revision date, and he explained since the facility has no policies, he wrote "protocols" on word documents this week to address the concerns which were communicated during the current survey process.	F 371		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.	F 431	F431 1. Expired medications were removed from the medication cart by a licensed nurse. The 1C and the 2C medication carts were cleaned by unit managers. 2. All medication storage areas were identified. All of the medications stored in these areas were checked for expiration dates, none were found outside of expiration dates. All medication carts and bottles were checked, if soiled they were cleaned.	



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F 431	<p>Continued From page 13</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and 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 record review it was determined the facility failed to store all drugs and biological in accordance with currently accepted professional principles. Two (2) nasal sprays with expired dates were available for residents use. One (1) medication cart was not maintained in a clean and sanitary condition.</p> <p>The findings include: Review of the facility medication policy on</p>	F 431	<p>3. The policy and procedure for storage of medications was reviewed by the DON and no revisions were necessary. The protocol for the cleaning of medication carts was reviewed by the DON and no revisions were necessary. The administrative nursing staff provided education to the licensed nursing staff. The education included checking medications prior to administering for expiration dates, and removing medications from the medication carts prior to their expiration. Education also included the importance of infection control and of following the cleaning schedule for the medication carts.</p> <p>4. Administrative Nursing (which consist of Director of Nursing, Assistant Director of Nursing, Unit Managers, and Staff Development) will monitor medication carts 5 times a week times 4 weeks to determine that medications are stored appropriately. This audit will include a review of medications to validate they are not outside of there expiration dates. At that time the audit will move to 10 audits a month x 2 months.</p> <p>Administrative Nursing will monitor medication carts 5 times a week times 4 weeks to determine that carts are clean. The audits will include review of the carts for clean surfaces. At that time the audit will move to 10 audits a month x 2 months. The results of this audit will be presented to the QA&A team which consist of at least the Administrator, DON, and one or more of the following (<i>Unit Managers, Therapy, Activities, DON, ADON, Dietary Manage, RAI Coordinator</i>) Any further reviews will be determined through this process.</p>	

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If continuation sheet Page 14 of 22

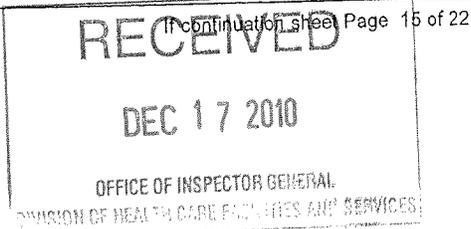
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F 431	<p>Continued From page 14</p> <p>11/18/10 at 5:00pm revealed that nasal spray should be discarded after 30 days of opening.</p> <p>Observation of the 1C medication cart, on 11/16/10 at 4:30pm revealed expired calcitonin-salmon nasal spray was available for use to an unsampled resident. Further observation revealed calcitonin-salmon nasal spray label had an open date of 10/05/10 and discard date 11/05/10. The label also revealed the medication should be discarded after 30 days.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 11/16/10 at 4:30pm in the medication room on 1C, revealed that calcitonin-salmon nasal spray was available for use to an unsampled resident. She stated that expiration dates should be checked on all medication prior to administration. She further revealed that the unsampled resident had received the nasal spray past the expiration date.</p> <p>Record review of the unsampled resident revealed that expired calcitonin-salmon nasal spray had been given daily as ordered.</p> <p>Observation of 2C 's medication cart, on 11/16/10 at 4:45pm revealed a pinkish, brownish, sticky substance in the bottom of the multiple use medication drawer.</p> <p>Interview with LPN #3, on 11/16/10 at 4:45pm in the medication room on 2C, revealed that calcitonin-salmon nasal spray was available for use to an unsampled resident. She stated that the calcitonin-salmon nasal spray should have been discarded on or before the expired date. She further stated that the unsampled resident had received the nasal spray past the expired</p>	F 431	<p>5. Director of Social Services and Director of Nursing Services are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.</p>	



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F 441	<p>Continued From page 16</p> <p>from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to establish and maintain an Infection Control Program to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease. Staff removed a meal tray from a resident's overbed table and placed the tray into the meal cart with meals not yet served to residents. Staff touched residents' food without using gloves. Staff contaminated the snack bin by carrying it from room to room and placing the bin on each resident's overbed table. Staff returned the ice scoop into the ice bin each time they used the scoop.</p> <p>The findings include:</p> <p>Observation of the main dining room on 11/16/10 at 12:00pm revealed staff using an ice scoop to fill glasses with ice then placing the ice scoop back in the ice bin until needed again.</p>	F 441	<p>4. The DON / ADON / Unit Managers / 3-11 supervisor and Weekend RN Supervisor will monitor the above practices daily, times 30 days. The audit will include monitoring appropriate ice scoop storage, snack distribution, clean tray delivery and soiled tray retrieval, and that appropriate barriers are in place for staff assisted dining. At that time the audit will move to 10 audits a month x 3 months. The results of this audit will be presented to the Quality Assurance & Assessment committee which consist of at least the Administrator, DON, and one or more of the following (<i>Unit Managers, Therapy, Activities, DON, ADON, Dietary Manage, MDS Coordinator.</i>) Any further reviews will be determined through this process.</p> <p>5. Director of Nursing Services is responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.</p>	

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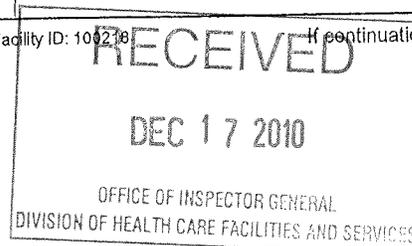
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F 441	Continued From page 17 Observation on 11/16/20 at 12:18pm revealed Certified Nurse Aide (CNA) #7 assisted Resident #21 with lunch by removing a ham sandwich from a wrapper and fed the resident with bare hands. Observation on 11/16/10 at 8:30am on initial tour revealed the ice scoop handle lying in an ice chest on 2C hallway. Observation on 11/17/10 at 12:22pm revealed CNA #2 placed a meal tray on a resident's tray table, told the resident what was for lunch, then picked up the meal tray after the resident refused the meal and placed the meal tray back in the cart with meals which were ready to serve to other residents. Interview on 11/17/10 at 12:25pm with CNA #2 revealed there should be either all clean trays on the meal cart or all dirty, otherwise there was a risk of cross contamination. Interview on 11/17/10 at 12:29pm with LPN #5 revealed there was a cross contamination risk when putting dirty trays into a meal cart with unserved meals still on it. Observation on 11/18/10 at 2:05pm revealed CNA #1 carried the snack bin into residents' rooms and placed the bin on the resident's overbed tray table while offering the resident a snack then walked into another resident's room with the snack bin and placed the snack bin on the resident's tray table. Interview on 11/18/10 at 2:30pm with CNA #1 revealed he was taught to pass the snacks by taking them room to room and he was not trained to put the snacks on the tray table. Also, he stated that putting the snack bin on a resident's tray table and then going into another room was an infection control risk.	F 441		

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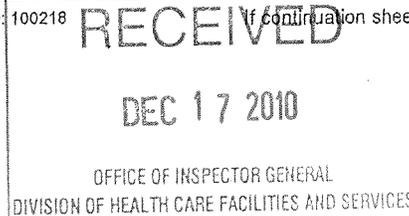
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F 441	Continued From page 18 Interview on 11/17/10 at 2:08pm with Registered Nurse (RN) #1 revealed there was a risk for spreading bacteria from room to room when the container is placed on resident tray tables, then carried to another resident's tray table.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observations and interviews, it was determined the facility failed to provide a safe, functional and comfortable environment for residents in the following areas: a window in the second floor dining room leaked and allowed rain to enter the room, Room 208 had broken floor tiles, holes were in the doors of the second floor dirty utility room and Room 212, Room 234 had a whole in the wall behind the bed, eleven (11) wardrobes on the second floor had worn finish, splinters and scrapes, an outlet cover was missing in the 2C dining room, a hole was in the ceiling over the tub on 1B, caulking was missing around the window in Room 102, the water fountain on the 1C hallway was not working and the call light in Room 107 had a brown substance on the cord. The findings include: During the initial Environmental tour of the facility on 11/17/10 at 8:00am, the following items were in need of repair:	F 465	F-465 1. Maintenance repaired the leak in the window in C dining room at the time of the survey, and repaired the window caulking in room 102; the broken floor tiles in room 208; holes in the door of the dirty utility room and room 212; hole in wall behind the bed in room 234 on 11/19/10. Maintenance completed the repair of all the wardrobes and dressing cabinets in rooms 235, 237, 239, 243, 247, 248, and 249 on 12/1/10. Maintenance replaced the outlet cover in the C dining room on 11/17/10. Maintenance repaired the ceiling over tub on 1B, replaced the ceiling tile on 2B across from elevators and in resident room 239, and removed the non-functional water fountain on 12/09/10. Maintenance also repaired the missing Formica in rooms 234, 244 and 247 on 12/8/10. Housekeeping Supervisor cleaned the call cord for room 107 and removed the sheet from under the radiator for 234 on 11/17/10. Housekeeping and Maintenance completed their cleaning and painting of all radiator vents for rooms 234, 236, 243, and 244 on 12/1/10.	



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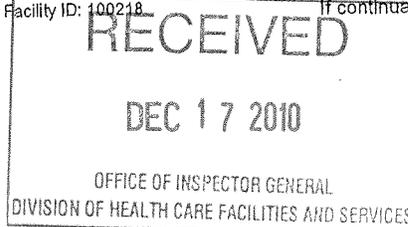
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 11/18/2010
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE 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
F 465	Continued From page 19 Armoire dressing cabinets in rooms 235, 237, 239, 243, 247, 248 and 249 had scrapes, scuffs, missing finish, splintered around the edges of the sliding doors and frame. Missing Formica around the edges of desktops in room 234, 244, and 247. Broken floor tile in room 208. A hole penetrating the surface of the door in the soiled utility room on 2C. Radiator vents in room 234, 236, 243, and 244, had gray and fuzzy dust particles accumulated. In room 212, the inside of the bathroom door had a hole partially through the door approximately one (1) inch in diameter. Ceiling tile across from the elevators on 2B was stained yellow. Room 234 had a hole in the wall behind the bed. The ceiling tile located against the wall adjacent from the first bed in room 229 was stained yellow. Room 234 had a white sheet stuffed in the radiator which had yellow stains and black stains along with large black particles on the sheet. Interview on 11/17/10 at 11:16am with the Housekeeping District Manager revealed residents have the potential to get skin tears on splintered desk areas. Areas are difficult to clean because the furniture is old.	F 465	2. A facility tour was completed by Director of Maintenance on 12/8 and the following items were identified: all windows in facility for open spaces in caulked areas and repaired any/all open areas to assure no further leaks; all resident rooms for broken floors tiles and repaired any/all broken tiles; all resident rooms for broken floor tiles and repaired any/all broken tiles; all doors (including resident room doors) for holes and repaired an/all holes in doors; audited all resident room wardrobes and dressing cabinets and repaired any/all that were showing wear; all other Formica surfaces in resident rooms and repaired any/all other surfaces showing wear. Housekeeping and Maintenance completed cleaning and painting of all remaining radiator vents on 1B and 2B units as of 12/1/10. Maintenance audited all outlets in facility and found no other outlets without covers; all other ceiling areas for holes in ceiling and found no other holes in ceilings. Housekeeping audited all call cords in facility on 11/18/10 and found no other call cords to be dirty. 3. The monthly preventative maintenance protocol was reviewed and revised by the Administrator. The revision included new audit tools. The Housekeeping Supervisor inserviced housekeeping staff regarding daily call light cleaning and has added this to their daily cleaning schedule. 4. Maintenance will continue to audit on a monthly basis to assure the following are in good repair: leaks from windows, broken floor tiles, holes in doors and behind walls, outlet covers, resident wardrobes and dressing cabinets, ceiling holes,	



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F 465	Continued From page 20 Interview on 11/17/10 at 11:28am with the Housekeeping District Manager revealed the issue with having a sheet under the heater was an infection control issue and stated "it looked like someone put the sheet under there to stop a leak". He also revealed that maintenance was responsible for cleaning the inside of the radiator vents while housekeeping was responsible for cleaning the outside of the radiator vents. Interview on 11/17/10 at 11:30am with the Maintenance Assistant revealed he takes the heaters apart then wipes down the inside. Further interview with maintenance on 11/17/10 revealed they were not aware of a missing outlet cover in the 1C dining room, the hole in the ceiling in the 1C shower room, stains in the ceiling, or that the water fountain on the 1C hallway did not work. Interview on 11/18/10 at 3:44pm with the Director of Maintenance revealed he has a schedule of the rooms for weekly inspection. He stated they had recently begun making room rounds. He stated that he had the second floor room rounds but he could not produce the paperwork where he had made room rounds on the second floor at the time of the interview. Record review of the HVAC (RTU) cleaning and air filter changing schedule revealed that once a year the furnace and heat exchanger were to be vacuumed.	F 465	and Formica are repaired as needed. Maintenance will audit on a monthly basis all water fountains to assure they are in working condition. Maintenance and Housekeeping Supervisor will also audit all 1B and 2B radiator vents on a monthly basis to assure they are adequately cleaned. Housekeeping Supervisor will audit weekly all call cords to assure that they remain clean. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 6 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. 5. Director of Maintenance, Director of Housekeeping Services and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.	
F 468 SS=F	483.70(h)(3) CORRIDORS HAVE FIRMLY SECURED HANDRAILS The facility must equip corridors with firmly secured handrails on each side.	F 468	F-468. 1. Maintenance repaired the handrails immediately prior to survey exit. 2. A facility tour was completed on 11/21/10 by Maintenance and no other handrails were found to be unsecure.	



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F 468	Continued From page 21 This REQUIREMENT is not met as evidenced by: Based on observations and interviews it was determined the facility failed to ensure the facility had firmly secured handrails in hallways used by residents of the facility. Hand rails on the right side of the hallway on the first floor were loose. On the second floor the railing on the right side of the hallway was loose. These hand rails are used by residents that are ambulatory, or utilize a walker or wheelchair. The findings include: Observations on 11/16/10 at 8:30am revealed a loose hand rail on the right side of the hallway as you enter the 1C unit. Observations on 11/17/10 at 11:10am revealed a loose hand rail on the right side of the hallway as you exit the 2nd floor dining room. An interview with maintenance on 11/17/10 at 11:35am revealed there were no work orders and maintenance was unaware of the loose railings.	F 468	3. The monthly preventative maintenance protocol was reviewed and revised by the Administrator. The revision included new weekly audit tool validating that handrails are secure. 4. Maintenance will continue to audit all handrails on a weekly basis to assure that all handrails remain secure. The results of these audits will be reviewed by the Administrator and will be presented to the Quality Assurance & Assessment committee for no less than 6 months. The Quality Assurance and Assessment committee will determine if additional auditing or education is required. 5. Director of Maintenance and the Administrator are responsible for the completion of this Tag - Facility alleges compliance as of January 2, 2011.	

