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OFFICE OF INSPECTOR GENERAL
DIVISION OF SURVEY & CERTIFICATION SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING _____ B. WING _____	09/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 A standard health survey was conducted on 09/05/12 through 09/07/12 and a Life Safety Code Survey was conducted on 09/05/12 through 09/06/12, deficiencies were cited with the highest scope and severity of an "F". The facility had the opportunity to correct the deficiencies before imposition of remedies would be recommended.	F 000	**This plan of correction constitutes a written allegation of compliance for deficiency cited on September 7, 2012. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by federal and state law.**	
F 156 SS=C	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES 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. 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.	F 156	**F156** **1):** **The resident's noted to have been affected including #22, #23, and #24 no longer reside in the facility.** **2):** **The appropriate Notice of Medicare Non-Coverage letter that includes the appeal process will be utilized for current Medicare recipients upon their discharge from Medicare.** **3):** **The appropriate Notice of Medicare Non-Coverage letter will be utilized going forth that includes the appeal process.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

X _____ — X Exe Dir — X 10-10-12

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 156	Continued From page 1 The facility must inform each resident before, or at the time of admission, and periodically during 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	F 156	**Social Services staff and Admissions staff have been educated by The Administrator on 10/12/12 on the use of the appropriate Medicare Non-Coverage letter that includes instructions for the appeal process.** **4):** **A monthly audit of all issued Notice of Medicare non-coverage letters will be conducted by the Executive Director monthly for three months and then quarterly to ensure that the appropriate Medicare non-coverage letter has been utilized.** **Results of this audit will be reviewed and discussed in the monthly RM/QI Committee meeting.**	**10/19/12**

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F 156	Continued From page 2 specified in subpart I of part 489 of this chapter related to maintaining written policies and 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. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to provide the Medicare residents a Notice of Medicare Non-Coverage letter that included the appeal process upon termination of all Medicare services for three (3) of the three (3) closed records (#22, #23, and #24). It was determined the facility's notice of non-coverage letter did not include the appeal information for the beneficiary to request an appeal.	F 156		

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F 156	Continued From page 3 The findings include: Review of the facility's Resident Admission and Information Packet included information on how the resident can apply for benefits under Medicare and Medicaid. A copy of a blank Notice of Medicare Non-Coverage letter is included in the admission packet and provided to the resident or responsible party during the admission process. 1. A closed record review of Resident #22's clinical record revealed the facility admitted the resident on 02/29/12 for skilled services. The record revealed, on 03/05/12, the facility issued a notice of exclusions from Medicare benefits that did not include the appeal information. The resident was discharged with remaining skilled days left. 2. A closed record review of Resident #23's clinical record revealed the facility admitted the resident on 05/15/12 for skilled services. The record revealed, on 06/05/12, the facility issued a notice of exclusions from Medicare benefits that did not include the appeal information. The resident was discharged on 08/03/12 with remaining skilled days left. 3. A closed record review of Resident #24's clinical record revealed the facility admitted the resident on 05/29/12 for skilled services. The record revealed the facility issued a notice of exclusions from Medicare benefits that was not dated and did not include the appeal information. The resident was discharged on 08/06/12 with remaining skilled days left.	F 156		

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F 156	Continued From page 4 Interview with the Social Service Director, on 09/07/12 at 1:05 PM, revealed she did not realize she was using the wrong notification letter. The Social Service Director acknowledged the letter she was using did not have the appeal information. The Social Service Director revealed she did not receive training on which letter to use for the Notice of Medicare Non-Coverage letters. Interview with the Administrator, 09/07/12 at 1:30 PM, revealed he was unaware the notice letter that was being sent did not include the name or number for resident's to contact if they wanted to appeal the decision of non-coverage. The Administrator confirmed the Social Service Director did not receive formal training regarding Medicare non-coverage letters.	F 156	**F272** **1):** **Resident #5 was reassessed by the IDT to accurately reflect bowel and bladder functional status.** **The care plan for resident #5 was reviewed and revised as indicated to reflect functional status.** **2):** **An assessment will be completed by nursing management team consisting of Director of clinical services, Asst DCS, and Unit Managers to determine accurate bowel and bladder functional status.** **Care plans will be reviewed by the interdisciplinary team consisting of Nursing, Activities, Social Services and Dietary and revised as indicated.** **3):** **Licensed staff will be re-educated on the importance of accurate evaluation upon admission by the Director of Clinical of services and/or the Assistant Director of Clinical Services by 10/18/12.**	
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems;	F 272		

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F 272	Continued From page 5 Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to complete an accurate assessment that reflected the functional abilities of one (1) of twenty-four (24) sampled residents (Resident #5). The facility assessed Resident #5 as continent of bowel and bladder, even though documentation confirmed the resident was incontinent of bowel and bladder with the use of a brief. The findings include: The facility follows the Centers for Medicare and Medicaid Services (CMS) RAI process for assessment of residents upon admission. No formal policy was provided.	F 272	**Non-licensed nursing staff will be re-educated by the DCS and/or ADCS on the importance of turning and repositioning, incontinence care and appropriate utilization of briefs by 10/18/12.** **QI monitoring rounds will be conducted 2 times each shift by a licensed nurse to ensure residents are turned, repositioned, provided incontinence care and to confirm that briefs are appropriately utilized. Any variances will be addressed immediately.** **4):** **The Unit managers will conduct QI monitoring rounds 100, 200, Sub acute 1 and 2 Units. Daily for 5 days for one week, then Weekly for four weeks then monthly.** **Findings will be reviewed in the monthly RM/QI meeting for review and development if indicated of action plans to ensure bowel and bladder function is accurately assessed.**	10/19/12

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Review of the medical record for Resident #5 revealed the facility admitted the resident on 08/30/12 at 1:30 PM with diagnoses of Urinary Tract Infection, Hematuria with indwelling catheter removal, and a Stage II Pressure Wound (a shallow open ulcer with a red pink wound bed) to the buttock area. The residents Brief Interview for Mental Status (BIMS) was assessed as moderately impaired at a nine (9). The facility completed an Admission Data Collection and Initial Plan of Care form to obtain Resident #5's health information. The resident was assessed to be continent of his bowels and bladder. The facility developed Resident #5's care needs as continent of bowel and bladder from the admission data collected. Documentation of bowel and bladder activity revealed Resident #5 was incontinent of urine within 24 hours of admission. Further documentation of the facility's bowel and bladder detail report documented by the CNA revealed incontinence and a brief was used on 09/01/12.

Observation, on 09/06/12 at 1:30 PM, revealed during Resident #5's skin assessment and wound care the resident was wearing an adult brief. The brief was urine soaked that extended up the back side of the brief and stained dark yellow with a strong smell of urine.

Interview, on 09/06/12 at 2:00 PM, in the residents room revealed he had not had a brief change since this morning. The resident stated night shift changed his brief before leaving that morning.

Interview with Resident #5's family member, on

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09/07/12 at 9:15 AM, revealed since May 2012 the resident had some episodes of incontinence. However, he/she was not present for the resident's admission but spoke with the facility staff by phone and encouraged the facility staff to call if they had any questions or concerns.

Interview, on 09/06/12 at 2:55 PM, with CNA #2 revealed that Resident #5 was continent according to the information in the CareTracker Message Center. The CNA further stated she did not know the resident was wearing a brief and she did not get a shift change report from the third shift CNA leaving for the day.

Interview, on 09/07/12 at 4:30 PM, with CNA #1 revealed she was not that familiar with Resident #5, and was not aware of the residents wound. She thought the resident was continent and was able to make his needs known.

Interview, on 09/06/12 at 2:50 PM, with Rehabilitation Manager Licenses Practical Nurse (LPN) revealed Resident #5's brief had a large amount of urine. She further stated the resident was at risk for further breakdown when a brief is not checked and changed. On 09/07/12 at 11:35 AM, she revealed the facility policy was for the nursing staff to provide a report to the oncoming nursing staff and was concerned shift change reporting was not happening and Resident #5's needs for a brief were not known. She further stated Resident #5's bowel and bladder needs should have been initiated on the comprehensive care plan.

Interview, on 09/07/12 at 2:00 PM, with the Assistant Director of Nursing (ADON) revealed

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F 272	Continued From page 8 the unit manager updates the CNA profiles for residents care. He further stated if Resident #5 had a change in his bowel or bladder function that information should have been passed on to the nurse and then the unit manager should have updated the resident's profile to meet his need for briefs. He acknowledged the resident was at risk for further breakdown because of his urinary incontinence. Interview, on 09/07/12 at 1:25 PM, with the Director of Nursing revealed the facility expectation was for nursing staff to provide report after their shift to the on coming staff.	F 272		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	**F279** **1):** **The comprehensive care plan for Resident #4 was reviewed and revised to include a plan for the management of an indwelling catheter.** **2):** **Residents with foley catheters will be reviewed by the IDT by 10/18/12 to ensure the comprehensive care plan includes a plan for the management of indwelling catheters.**	

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F 279	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to develop a comprehensive care plan based on the triggered area of Incontinence and Indwelling Catheter within the Minimum Data Set (MDS) assessment for one (1) of twenty-four (24) sampled residents, Resident #4. The findings include: Record Review of the facility's care plan policy dated 03/2012, revealed the facility must develop a comprehensive care plan for each resident which included measureable objectives and timetables to meet the resident's medical, nursing and mental, and psychosocial needs identified in the comprehensive assessment. Record review revealed the facility admitted Resident #4 on 07/27/12 with diagnoses of a Urinary Tract Infection and a Stage Three (3) Pressure Ulcer. In addition, Resident #4 was admitted utilizing an indwelling urinary catheter. Record review of the Care Area Assessment Summary (CAAS) of the admission MDS dated 08/03/12, revealed Resident #4 triggered for Problem Area 6, Urinary Incontinence and Indwelling Catheter. In addition, the document indicated a care plan would be developed for this care area. Record Review of the comprehensive care plan for Resident #4, dated 08/09/12, did not reveal a care plan for the management of the resident's	F 279	**3):** **MDS Coordinators will be re-educated by 10/18//12 by the regional case mix consultant on the development of a comprehensive care plan based on triggered areas.** **Licensed staff will be re-educated by the DCS and/or the ADCS by 10/18/12 on the responsibilities to add or update the care plan as necessitated.** **4):** **The DCS and ADCS will QI monitor the comprehensive care plans of residents with indwelling catheters monthly times three months then quarterly times two. Finding will be reviewed and discussed monthly in the RM/QI meeting times three then quarterly times two for review and development of action plans to ensure the comprehensive care plans address triggered areas.**	10/19/12

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F 279	Continued From page 10 indwelling urinary catheter. Observation, on 09/05/12 at 11:20AM, revealed Resident #4 had an indwelling urinary catheter to bed side drainage with clear/yellow urine within the catheter tubing. Interview, on 09/07/12 at 11:00 AM, with the Rehab Sub-Acute 2 Unit Manager, revealed the comprehensive care plan should have included a plan for the management of Resident #4's indwelling catheter. The purpose of the care plan would be to identify goals, interventions, timelines, and indicators of infection associated with Resident #4's indwelling catheter, and to assure continuity of care was maintained by all direct care givers assigned to Resident #4. Interview, on 09/07/12 at 11:40AM, with the MDS coordinator revealed comprehensive care plans were developed based on the problem areas identified during the MDS assessment process, and she stated a care plan for Resident #4's indwelling catheter should have been developed. The MDS nurse stated she typically initiated the care plans based on the problem areas identified, and other staff nurses were also responsible for adding to or updating care plans as additional needs were identified. The MDS coordinator stated this component of Resident #4's comprehensive care plan was apparently missed. Interview, on 09/07/12 at 4:05 PM, with the Director of Nurses (DON) revealed a care plan should have been developed for the management of Resident #4's indwelling catheter. The care plan should include a schedule for catheter care, how often the catheter should be changed,	F 279		

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F 279	Continued From page 11 interventions for preventing contamination, and monitoring for signs and symptoms of a urinary tract infection (UTI).	F 279		
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 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to follow physician orders related to heel boots for one (1) of twenty-four (24) sampled residents, Resident #3. The facility failed to ensure Resident #3 wore heel boots as ordered by the physician while in bed to prevent pressure. The findings include: The facility did not provide a policy for following physician orders. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 05/30/12 with diagnoses of Failure to Thrive, Peripheral Vascular Disease, and Dementia. Physician orders for September 2012 included heel lift boots to both feet while in bed. The resident's comprehensive care plan for	F 309	**F309** **1):** **Resident #3 had heel boots placed on per physician order on 9/7/12. Heel boots will be used for Resident #3 as per physician order.** **2):** **Residents with heel boots were assessed by the IDT by 10/18/12 to ensure that the boots are still appropriate to be used by the residents assessed to require heel boots.** **Licensed staff will assure heel boots are applied as per physician order. By visual observation two times each shift.** **Care plans for residents with orders for heel boots will be reviewed and revised by the IDT by 10/18/12.**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING _____ B. WING _____	09/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 309	Continued From page 12 prevention of pressure ulcers revealed the use of heel lift boots. Observation, on 09/4/12 at 8:40 AM, 11:25 AM, 12:10 PM, and 2:20 PM, revealed Resident #3 lying in bed with heel boots in the wheelchair. Interview, on 09/07/12 at 12:40 PM, with Licensed Practical Nurse (LPN) #3 revealed the Certified Nursing Assistants (CNAs) were responsible to ensure Resident #3 had the heel boots on his/her feet when he/she was lying in bed. The LPN stated the nurses should put the boots on if they noticed the boots were off the resident's feet. She stated Resident #3 had the heel boots for extra protection of pressure areas as the resident stays in bed a lot. The LPN stated the resident had a wound on the left heel that was not related to pressure; however, the resident moved his/her legs frequently and without the boots the resident could have friction which could lead to pressure wounds. On 09/07/12 at 1:10 PM, interview with the Unit Manager (UM) revealed the CNAs and nurses were both responsible to ensure residents had on the heel lift boots while in bed. She stated the CNAs would know which residents had heel boots as listed in the computer. The UM stated she checks resident rooms every morning to monitor the use of the heel boots, but was unable to provide evidence of the monitoring. She stated if staff had a problem, then she referred them to the Staff Development Coordinator. She stated Resident #3 needed the heel boots to avoid skin breakdown, even with using a low air loss mattress, and turning. The UM stated if the resident did not have the heel boots on while in	F 309	**3):** **Licensed staff were re-educated by the DCS and/or ADCS on following physician orders to include heel boots by 10/18/12.** **Non-licensed nursing staff will be re-educated by the DCS and/or ADCS on the importance of following instructions to apply heel boots and the checking of the placement of heel boots.** **QI monitoring rounds will be conducted 2 times each shift by licensed staff to ensure residents requiring heel boots have them in place.** **4):** **Unit Managers will QI monitor through visual observation on nursing rounds 2 times weekly on-going, current resident population requiring heel boot placement on 100, 200, sub acute 1 and 2 units, to ensure heel boots are in place. Findings will be brought to the RM/QI meeting monthly for review and development of action plan if indicated to ensure physician orders are followed.**	10/19/12

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F 309	Continued From page 13	F 309		

the bed, the resident could have further breakdown, infection, sepsis, or lose his/her legs.

Interview, on 09/07/12 at 1:30 PM, with CNA #5 revealed the aides were responsible to ensure residents had the heel boots in place. The CNA stated she was unaware Resident #3 had heel boots for use when in the bed. She stated the computer informs the aides if a resident has a protective device but the computer does not specify what type. The CNA stated she had not had any training by the facility regarding the use of heel boots for residents. She stated the nurses will ask if residents have heel boots on; however, she had not been asked on this day. The CNA stated if the resident did not have on the heel boots when in the bed, the resident could have skin breakdown on the heels.

Interview with the Director of Nursing (DON), on 09/07/12 at 3:15 PM, revealed the DON was new and had been working at the facility two (2) weeks. She stated she was not yet familiar with Resident #3 or why the resident had an order for heel boots; however, the use of heel boots was to prevent skin breakdown. The DON stated the UM was responsible to monitor the units and use of heel boots for residents. She stated she was unsure about training for aides and nurses for the use of resident heel boots. The DON stated she expected CNAs and nurses to follow physician orders and plans of care. She stated Resident #3 could have skin breakdown without the heel boots in place.

On 07/15/12 at 4:00 PM, interview with the Staff Development Coordinator revealed new CNAs and nurses received training during orientation

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F 309	Continued From page 14 regarding heel boots and skin prevention. He stated the UM was responsible to monitor resident heel boots.	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy, it was determined the facility failed to provide pressure relief through turning and repositioning resident with pressure ulcers and failed to ensure incontinent care was provided for one (1) resident of twenty-four (24) sampled residents, Resident #5. The findings include: Review of the facility's policy titled Wound Care Prevention and Treatment Objectives, dated 03/13, revealed the facilities objective was to prevent the development of pressure sore, ulcers by performing routine skin and risk assessments. Accurately identify existing pressure ulcers and appropriate stages to optimize healing by utilizing consistent, standardized treat, maintain and	F 314	**F314** **1):** **Resident #5 was reassessed to determine the status of bowel and bladder function and the need for a positioning program by the IDT by 10/18/12.** **The care plan for Resident #5 was reviewed and revised by the IDT by 10/18/12.** **2):** **Residents with pressure ulcers have been reassessed by 10/18/12 by the IDT, consisting of nursing, activities, social service, and dietary, to determine the need for a turning and repositioning program and for their bowel and bladder functional status. Care plans have been reviewed and revised by the interdisciplinary team consisting of nursing, activities, social service, and dietary; include turning and repositioning and continence care.**	

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F 314	Continued From page 15 improve tissue tolerance, protect against adverse effects of external forces, and provide proactive intervention and education. Review of the clinical record for Resident #5 revealed the facility admitted the resident on, 08/30/12 at 1:30 PM, with diagnoses of Urinary Tract Infection, Pain, Ascites, and Hematuria with indwelling catheter removal, Malnutrition, Upper Gastrointestinal Bleed which required a blood transfusion and a Stage II pressure wound (a shallow open ulcer with a red pink wound bed) to the buttock area. The facility completed an Admission Data Collection and Initial Plan of Care form on 08/30/12 to obtain Resident #5's health information. The resident was assessed to be continent of his bowels and bladder. The facility developed Resident #5's care needs as continent of bowel and bladder from the admission data collected: however, the resident was incontinent of urine and stool. Documentation for the Activities of Daily Living (ADL) for the Minimum Data Set (MDS) look back period from 08/31/12 to 09/06/12 revealed the resident was assessed to need extensive assist of one person for toileting. The resident was assessed on 08/30/12 to be at high risk for pressure wounds and had identified six (6) wound areas with orders for daily medications and treatments. The residents Brief Interview for Mental Status (BIMS) was assessed as moderately impaired at a nine (9). An initial nutrition assessment completed on 09/05/12 by the facility's Registered Dietitian (RD) revealed Resident #5 was at nutritional risk related to his health status. Interview, 09/07/12 at 9:55 AM, with the RD revealed from her initial assessment Resident #5	F 314	**3):** **Licensed staff have been re-educated by 10/18/12 by the DCS and/or ADCS on pressure ulcer management, accurate assessment, bowel and bladder function, and incontinence care.** **Non-licensed nursing staff have been re-educated by 10/18/12 on the importance of turning and repositioning and the care of residents with incontinence.** **QI monitoring rounds will be conducted 2 times each shift by a licensed nurse to ensure residents are turned and repositioned, provided with incontinence care and that briefs are appropriately utilized. Any variances identified will be addressed immediately.**	

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F 314	Continued From page 16 was at risk for further breakdown due to his history of malnutrition, current wounds, low blood counts, and periods of incontinence. She further stated the resident should not lay or sit on his bottom for extended periods of time. Record review of the facility's training and education records revealed Licenses Practical Nurse #2 (LPN) was provided education and in-serviced on wound care on 03/14/12, and new pressure risk on 04/10/12. Observation, on 09/05/12 at 8:00 AM, revealed Resident #5 was laying on his/her back in the bed, at 11:35 AM, 12:05 PM, 2:20 PM, 3:40 PM the resident was observed dressed and laying in his bed on his back with the head of the bed up 20 degrees. The resident was observed using the side rails to shift his/her body position. Observation, on 09/06/12 at 7:55 AM, 8:50 AM, 10:40 AM, 11:30 AM, 1:00 PM, revealed Resident #5 was laying in the bed on his/her back and observed slightly shifting his/her weight while in the bed. Observation, on 09/06/12 at 1:30 PM, during a skin assessment and wound care for Resident #5 revealed Resident #5 had a urine soaked brief, stained dark yellow, with a strong odor that was removed by License Practical Nurse #2 (LPN). A new pressure wound was discovered and identified by LPN #2 as a stage II pressure located above the anus and measured at 0.75 millimeters (mm) x 0.5 mm x 0 mm, and a small to scant amount of bright red blood was present. Interview, on 09/07/12 at 8:45 AM, with Resident	F 314	**4):** **The DCS and/or ADCS will conduct QI monitoring rounds daily 5 times for 1 week then monthly for 3 months visually observe residents are turned and repositioned and provided with incontinence care and that briefs are utilized. Rounds will be conducted on 100, 200, sub acute 1 and 2 units.** **Findings will be reviewed in the monthly RM/QI meeting with development of action plans as needed to ensure that the facility provides treatment and services to prevent and heal pressure sores.**	**10/19/12**

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F 314	Continued From page 17 #5 revealed the CNA's come in to tell him/her to turn, but he/she cannot see the television that way. Resident #5 denied having any pain today and he/she could not remember how many time staff changed his/her brief or provided incontinence care. Interview, on 09/06/12 at 2:55 PM, with Certified Nursing Assistant #2 revealed the resident refused to turn twice and bathe today. She further stated she informed the resident's nurse, LPN #2 and the Rehabilitation Unit Manager LPN. Interview, on 09/06/12 at 2:50 PM, with Rehabilitation Manager Licenses Practical Nurse (LPN) revealed Resident #2 was on an every two hour turn schedule; however, the resident refused to turn or if he/she turned for staff he/she would just turn back to his/her back. Review of the medical record for Resident #5 revealed the facility received orders for a wound care specialist consultation and treatment. The consultation and treatment began on 09/06/12 Observation, on 09/07/12 at 9:00 AM, during a second wound observation for Resident #5 revealed the residents bilateral buttocks was less red, no bleeding was noted, and LPN #2 re-measured the new stage II pressure wound at 1.3 mm x 0.5 mm x 0 mm. Interview, on 09/07/12 at 11:00 AM, with LPN #2 revealed Resident #5 should be turned every two hours avoiding his back because of his/her wound status and malnutrition. The nurse further stated he tried to educate the resident to turn because his/her wound could get worse.	F 314		

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F 314	Continued From page 18 Interview, on 09/07/12 at 11:35 AM, with Rehabilitation Manager LPN revealed Resident #5 prior stage II pressure and malnutrition did affect his need for turning every two hours. Interview, on 09/07/12 at 2:00 PM, with Assistant Director of Nursing (ADON) revealed all facility mattresses are pressure reducing and Resident #5 was on an every two hour turn. The ADON was aware of the resident's urine soaked brief. He stated it was possible the urine soaked brief could have contributed to the resident developing new pressure wounds. The ADON revealed the CNA care tracker indicated Resident #5 was continent of his/her bladder and bowels when the resident had incontinence at time. He stated the communication for the CNA's should have been updated to reflect the resident's current bladder and bowel status.	F 314		
F 315 SS=E	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 observation, interview, and record	F 315	**F315** **1):** **Resident #6 was re-assessed to determine the need for continued utilization of the foley catheter. Based upon this assessment, the catheter has been discontinued.** **Residents #4, #18, and #19 were re-assessed and determined to require catheter based on medical condition. Resident #17 no longer resides in the facility.**	

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F 315	Continued From page 19 review, it was determined the facility failed to ensure residents admitted without indwelling catheters were not catheterized without medical justification and residents were assessed utilizing the facility's catheter assessment (per policy) for thirteen (12) of fourteen (14) residents who had indwelling catheters, out of a total sample of twenty-four (24) residents. Residents # 2, 4, 6, 7, 17, 18, 19, unsampled B, C, D, E, and F. The findings include: Review of the facility's policy for catheter assessment (effective March 2012) revealed assessment of an indwelling catheter would be conducted to determine the need for continued use. The assessment must be completed upon admission, quarterly, significant changes, time of a new order for a catheter, and when a resident's medical condition changes in relation to the need for a catheter. The catheter assessment questions prompted the staff to determine what medical condition and diagnoses that would require a catheter. If no clinical or medical condition was noted, the physician must be contacted and the catheter should be discontinued and alternatives (bowel and bladder training, external catheter, and prompted toileting schedules) must be care planned and monitored. 1. Observation during a tour of the facility, on 09/05/12 at 8:45 AM, revealed Resident #6 sitting up in bed eating breakfast. A catheter drainage bag with yellow urine was observed anchored to the bed frame. Review of the clinical record revealed the resident has resided at the nursing facility since May 2010.	F 315	**Unsampled residents B, C, D, E, and F were re-assessed. The catheter for resident B was discontinued. Residents C, D, E, and F were determined to require a catheter based upon medical condition. Resident #2 no longer resides in the facility. The care plan for resident #5 was reviewed and revised as indicated.** **2):** **A catheter assessment has been completed by unit manages on current residents with who have foley catheters to determine utilization based on medical condition and/or diagnosis.** **The Care plans were reviewed and revised by IDT consisting of consisting of nursing, activities, social service, and dietary.** **3):** **Licensed staff have been re-educated by 10/18/12 by the DCS and/or ADCS on the policy and procedure for utilization and management of foley catheters.**	

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F 315	Continued From page 20 Review of the most current diagnoses included Diabetes, Hypertension, Muscle Weakness, Cellulitis, Congestive Heart Failure, Peripheral Vascular Disease, and Depression. Review of the annual Minimum Data Set (MDS) assessment, completed on 02/13/12, and Quarterly MDS assessment completed on 07/02/12, revealed the facility identified the resident to be incontinent of bladder and had no indwelling catheter. The resident has a colostomy. The MDS assessments revealed the facility assessed the resident to have no cognition impairment. Review of the comprehensive care plan revealed a care plan was developed on 08/08/12 to address an UTI; however, the care plan stated without a catheter. Continued review of the clinical record revealed the resident was in the hospital from 08/26/12 to 08/30/12 for an urinary tract infection with blood cultures that grew Staph hominis bacteremia. The hospital discharge summary, dated 08/30/12, revealed the resident presented to the hospital with an altered mental status that had cleared during the hospital stay. The resident was re-admitted to the nursing facility with a PICC (peripheral inserted central catheter) with intravenous (IV) antibiotic medications to be given through the PICC line. On 08/31/12, the resident was seen by the nurse practitioner (NP) that noted the antibiotic medication (Vancomycin) would need to be continued until 09/15/12. The record revealed the resident had a hospitalization from 01/29/12 to 02/06/12 for an UTI with a positive urinalysis for Escherichia Coli. Interview with LPN #11, on 09/06/12 at 1:35 PM, revealed the indwelling catheter was placed in the hospital during the recent August 26 th	F 315	**New admissions with foley catheters will be QI monitored by the Unit Managers the next business day following admission to ensure that the foley catheter is utilized based on medical condition and/or diagnosis. Any variance will be addressed immediately.** **4):** **The DCS and/or ADCs will QI monitor foley catheter utilization monthly times 3 months the quarterly times 2 for medical condition and/or diagnosis.** **Findings will be brought to the monthly RM/QI meeting for review and action plans will be developed as necessary to ensure foley catheters are utilized based on medical condition and or diagnosis.**	**10/19/12**

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F 315	Continued From page 21	F 315		

hospitalization. She revealed the resident did not have a catheter prior to the hospital stay but was incontinent of bladder and required assistance to the bathroom. She stated the catheter was not discontinued because of a Staph infection (methicillin resistant staph aureus, MRSA) in the urine that required the urine to be contained. She stated she had not documented that information in the clinical record.

Interview with Resident #6, on 09/07/12 at 2: 05 PM, revealed the resident had questioned the staff why he/she still had the indwelling catheter and was told he/she must keep the catheter for fifteen (15) days. The resident indicated he/she did not know why and would prefer to have the catheter removed.

Interview with the 100 Unit Manager, on 09/07/12 at 2:15 PM, revealed the resident was readmitted with the indwelling catheter. She stated the catheter was to be continued until completion of the IV antibiotic medication. She indicated there was no supporting diagnosis. She said the NP visited on 08/31/12 and thought there was MRSA in the urine and she did not want to discontinue the catheter until after completion of the IV antibiotic. However, review of the urinalysis results from the hospital revealed no bacteria was found in the urine. The labwork findings revealed a blood culture was positive for Staphylococcus hominis with the bacteria susceptible to Vancomycin,which was ordered until 09/15/12.

Interview (via telephone), on 09/07/12 at 2:20 PM, with lab staff at the local hospital, where the test was obtained, revealed the urine culture obtained at the hospital was negative with no growth found.

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F 315	Continued From page 22	F 315		

However, the blood culture was positive for Staphylococcus hominis that was susceptible to Vancomycin.

The Unit Manager was re-interviewed, on 09/07/12 at 2:30 PM, after the above telephone interview, that revealed the labwork findings must have been interpreted wrong. She stated she could not find supporting documentation to continue the use of the indwelling catheter. She indicated the catheter assessment had not been completed per policy because she did not know it was suppose to be completed.

Record review for Residents #4, #17, #18, #19, and unsampled residents B, C, D, E, and F revealed the catheter assessment were not completed according to facility policy to determine if the catheter the residents' utilized was appropriate to treat a medical condition, had a supporting diagnosis, and was discontinued with alternatives measures attempted.

Interview with the Director of Nursing (DON), on 09/07/12 at 3:40 PM, revealed she was unaware of the new catheter assessment. She had only been at the facility for two weeks and did not know of the policy. She did not know when the policy should have been implemented.

Interview with the Regional Director of Clinical Services, on 09/07/12 at 3:45 PM, revealed the new policy for catheter assessments should have been implemented by April 2012. She stated the prior DON was responsible for the implementation and it appeared that was not done.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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Interview with the Staff Development nurse, on 09/07/12 at 4:00 PM, revealed he had no knowledge of the catheter assessment and had not inserviced any nurses on the new catheter assessment that was suppose to be effective March 2012.

2. Review of Resident #2's clinical record revealed the facility admitted the resident on 12/17/12. The resident was sent to the hospital, on 05/14/12, and diagnosed with a urinary tract infection, low blood sugar and mental status changes. The resident was discharged from the hospital and readmitted to the facility on 05/16/12 with an indwelling urinary catheter. The resident was again sent to the hospital with the indwelling urinary catheter in place, on 05/29/12, with a diagnoses of urinary tract infection with sepsis. The resident was readmitted to the facility on 6/3/12 with an indwelling urinary catheter in place. Review of Resident #2' s lab work revealed a urine culture, dated 07/13/12, positive for two (2) different types of bacteria.

Observations of Resident #2, on 09/05/12 at 11:30 PM, 12:00 PM, 2:20 PM, 3:30 PM, and on 09/06/12 at 7:40 AM, 8:45 AM, and 1:57 PM revealed an indwelling urinary catheter to bedside drainage bag with dark, cloudy, yellow urine.

Further review of Resident #2's clinical record revealed there was neither a nursing assessment for the catheter's necessity after either readmission from the hospital, nor was there a physician's order for the indwelling urinary catheter.

Interview with Licensed Practical Nurse (LPN) #1,

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 315	Continued From page 24 on 09/07/12 at 10:10 AM, revealed the LPN thought the indwelling urinary catheter was in place because of the urinary tract infection. The LPN revealed urinary catheters are appropriate to use if a resident has urinary retention or wounds. The LPN revealed she did not know why the resident had the indwelling urinary catheter in place. Interview with the Sub Acute 1 Unit Manager (UM), on 09/07/12 at 10:25 AM, revealed medical necessity for an indwelling urinary catheter would include urinary retention, but not for a urinary tract infection. The UM revealed the catheter should have been discussed with the physician for necessity. The UM revealed she expected the nurses to either obtain an order to keep the catheter or to discontinue the use of the catheter. The UM revealed she monitors by chart audit. However, the UM revealed the chart audits are completed by the night shift nurses. The UM stated Resident #2's catheter was not assessed for medical necessity. Interview with the Assistant Director of Nursing (ADON), on 09/07/12 at 2:35 PM, revealed he was also responsible for staff education. The ADON revealed there had not been training on evaluation for appropriateness and medical necessity of a urinary catheter. The ADON revealed he had never seen the policy for the catheter assessment form. The ADON revealed he was never notified that a new policy and procedure was to be implemented.	F 315		

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3. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 03/19/12, with the most recent re-admission on 07/25/12, with diagnoses of Dementia and Chronic Open Wound of the Buttock. The initial Minimum Data Set (MDS), dated 03/29/12, and the quarterly MDS, dated 07/10/12, revealed the resident had a Brief Interview Mental Status (BIMS) of fifteen (15) and had an indwelling urinary catheter.

Review of the physician orders, dated 07/03/12, revealed Resident #7's catheter should be changed every month and cleaned each shift. Review of the Medication Administration Record (MAR) revealed Resident #7's catheter was changed on 07/16/12. The August 2012 and September 2012 physician orders and Medication Administration Record revealed Resident #7's physician orders for changing and cleaning the catheter were not transcribed and there was no discontinue order. Review of the resident's care plan, dated 03/30/12, for an indwelling catheter revealed the catheter should be cleaned and changed per physician orders.

Observation, on 09/05/12 at 2:25 PM, on 09/06/12 at 1:45 PM, and on 09/07/12 at 11:00 AM, revealed Resident #7 had a urinary catheter in place.

Interview with Resident #7, on 09/05/12 at 2:25 PM, revealed the indwelling catheter had been changed only once since he had been at the facility and had not been changed since re-admission. The resident stated he was admitted to the facility with an infection from the catheter.

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Interview, on 09/07/12 at 11:00 AM, with Licensed Practical Nurse (LPN) #3 revealed the Certified Nursing Assistant (CNA) are responsible for cleaning residents' catheters; however, nurses could as well. The LPN stated Resident #7 had received catheter care but was unsure if the catheter had been changed. She stated she had not changed the resident's catheter since re-admission on 07/25/12. The LPN stated without the documentation on the Medication Administration Record, she was unable to determine if or when the catheter had been changed in August 2012. She stated if the catheter was not changed and catheter care not provided each shift per physician orders, then it could lead to infection.

On 09/07/12 at 1:10 PM, interview with the Unit Manager (UM) revealed the catheter change and care orders were not included on the August 2012 physician orders or placed on the August 2012 MAR for Resident #7. The UM stated without the MAR documentation, there was no way to know if catheter care was provided each shift, or if the catheter had been changed in August 2012. She stated the last time the catheter was changed was 07/16/12 based upon review of the MAR for July 2012. The UM stated nurses were to sign the MAR when the catheter was changed and catheter care provided. The UM stated if the resident's catheter was not changed every month or cleaned each shift the resident could have a urinary tract infection, or the skin around the catheter tubing could grow to the tubing.

Interview, on 09/07/12 at 3:15 PM, with the Director of Nursing (DON) revealed she was new

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F 315	Continued From page 27 and had been at the facility two (2) weeks. She stated she had met Resident #7 and the resident had not voiced complaints regarding the catheter.	F 315		
F 431 SS=F	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. 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. 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. 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.	F 431	**F431** **1):** **The two open containers of normal saline identified were removed and discarded from the treatment cart on the Subacute II unit.** **The one open container of normal saline identified on the treatment cart on Subacute I was removed and discarded.** **The two open containers of normal saline identified on the treatment cart for unit 100 were removed and discarded.** **The two open containers of acidic acid irrigation solution were removed and discarded from treatment card A on the 200 unit.** **The two open containers of acidic acid irrigation solution were removed and discarded from treatment card B on the 200 unit.**	

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F 431	Continued From page 28	F 431	**The treatment cart on the Subacute 1 Unit identified to have been unlocked was immediately locked.** **2):** **Medication rooms have been assessed by the Unit Managers for the labeling and storage of medications and biologicals to include wound cleaning solutions and irrigation solutions. Any opened, unlabeled medications and biologicals identified were removed, discarded and replaced.** **Medication and treatment carts were inspected by licensed staff to ensure they were secured.** **3):** **Licensed staff have been re-educated by 10/18/12 by the DCS and/or the ADCS on the policy and procedure regarding the labeling and storage of medications and biologicals and the importance of medication carts and treatments carts being secure at all times.**	

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, record review, and review of the facility's Pharmacy Services and Procedures manual, it was determined the facility failed to store medications and biologicals in a safe and sanitary manner. Wound cleansing solutions and irrigation solutions were found, not labeled with open dates, on four (4) of the four (4) unit treatment carts. A treatment cart was left unattended, opened and unlocked on one (1) of the four (4) units.

The findings include:

Review of the facility's Pharmacy Services and Procedures Manual revealed irrigation solutions such as sterile acetic acid and sterile sodium chloride should be labeled with date and time when opened and discarded twenty-four (24) hours after opening. The facility should ensure that all drugs and biologicals, including treatment items, are securely stored in a locked cabinet/cart or locked medication room, inaccessible by resident and visitors.

1. Observation, on 09/06/12 at 11:00 AM, of the Treatment Cart on the Sub Acute 2 Unit revealed two (2) opened containers of Normal Saline (Sodium Chloride solution) not dated when opened.

Observation, on 09/06/12 at 11:20 AM, of the Treatment Cart on the Sub Acute 1 Unit revealed one (1) opened container of Normal Saline not dated when opened.

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F 431	Continued From page 29 Observation, on 09/06/12 at 11:40 AM, of the Treatment Cart on the 100 Wing Unit revealed two (2) opened containers of Normal Saline not dated when opened. Observation, on 09/06/12 at 1:30 PM, of the treatment carts on the 200 Wing Unit revealed Treatment Cart A-2 had two (2) opened containers of Acetic Acid Irrigation Solution not labeled when opened. Observation of the B-1 Treatment Cart on the Unit revealed two (2) opened containers of Acetic Acid Irrigation Solution not dated when opened. Interview, on 09/06/12 at 11:20 AM, with Licensed Practical Nurse (LPN) #2 revealed irrigation solutions and wound cleansing solutions are to be labeled with dated upon opening and are to be discarded twenty-four (24) hours after opening. LPN #2 stated keeping opened solutions longer than twenty-four (24) hours could cause bacteria to grow in the solution and cause contamination to occur. Interview, on 09/06/12 at 11:00 AM, with LPN #5 revealed she was trained to label irrigation solutions and Normal Saline with dates when opening and to discard solutions twenty-four (24) hours after opening. LPN #5 commented using solutions beyond the discard date could cause an infection in a resident's wound. Interview, on 09/06/12 at 11:45 AM, with LPN #12 the Manager for the 100 Wing Unit and the Sub Acute 1 Unit, revealed Normal Saline and Acetic Acid solution should be labeled with the opening date and discarded after twenty-four (24) hours.	F 431	**Unit Managers will QI monitor medication rooms and medication carts and treatment carts weekly times four then monthly for 2 months to identify problems with labeling and storage of medications and biologicals and issues with security of mediation and treatment carts. Any variances will be immediately addressed.** **4):** **The DCS and/or ADCS will QI monitor medication rooms, medications carts and treatment carts monthly for 3 months, then quarterly to ensure medications and biologicals are labeled and stored properly and that carts are secure. Findings will be brought monthly for 3 months, then quarterly to the RM/QI with action plans developed as indicated to ensure medications and biologicals are labeled and stored in a safe and sanitary manner.**	**10/19/12**

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F 431	Continued From page 30 LPN #12 was unsure where the Pharmacy policies were stored within the facility and commented that keeping solutions too long could cause contamination and infection. Interview with LPN #3, on 09/06/12 at 2:00 PM, revealed she was unaware how long to keep acetic acid irrigation solutions and thought she could continue to use the acetic acid because it had a delivery date of 07/22/12. LPN #3 stated the solution could lose its strength but would not grow bacteria because it was an acid. 2. Observation, 09/06/12 at 2:45 PM, revealed a treatment cart on the Subacute 1 Unit (located behind the nursing station in an unlocked area) with both doors open and the cart unlocked. Interview, 09/16/12 at 2:50 PM, with Licensed Practical Nurse (LPN) #2 revealed he had the treatment cart keys and had the keys in his possession all that day and confirmed the treatment cart doors were open and unlocked. The nurse stated treatment carts should be locked when not in use so residents would not have access to the medication on the cart. The nurse further stated it was facility policy to keep all treatment medications locked. Interview, 09/07/12 at 2:00 PM, with the Assistant Director of Nursing (ADON) revealed the treatment cart should have been closed and	F 431		

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F 431	Continued From page 31 locked. He further stated the risk of having an opened and unlocked treatment cart was a resident could have ingested medications or the resident could have put medications in their eyes causing injury or potential harm.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions 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.	F 441	**F441** **1):** **Resident #5 is receiving medication that is appropriately labeled and stored in the treatment cart.** **2):** **Residents with identified pressure ulcers have been reviewed by the IDT, consisting of consisting of nursing, activities, social service, and dietary, to ensure physician orders for treatment are being followed and that medication is available for their personal use.** **Medication rooms and treatment carts were reviewed by 10/18/12 by Unit Managers to ensure that discontinued medications and treatments had been removed and discarded.**	

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F 441	Continued From page 32 (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policies, it was determined the facility failed to ensure staff used only those medications and treatments with a dispensing label for the correct resident and failed to ensure medications and treatments without labels, were not accessible to staff, not administered to residents or utilized on residents for one (1) of twenty-four (24) sampled residents. The findings include: Record review of the facility's policy titled Transdermal Medications-Application, dated 03/12, stated to obtain a physician's order for prescribed medications and identify the resident. The facility policy titled Standards of Practice, dated 03/12, stated residents admitted to the facility can expect nursing care which: Makes provisions for a clean, safe, healthful environment practicing proper infection control procedures in accordance with infection control standards. Review of the medical record for Resident #5 revealed the facility admitted the resident, on 08/30/12 at 1:30 PM, with diagnoses of Urinary Tract Infection, Pain, Ascites, Hematuria, Pneumonia, Anemia, Malnutrition, and a Stage II Pressure Wound (a shallow open ulcer with a red	F 441	**3):** **Licensed staff have been re-educated by 10/18/12 by the DCS and/or ADCS on the importance of only using medication and treatments for a resident that have been dispensed and labeled for that specific resident. Licensed staff have also been re-educated by 10/18/12 on the removal of medications and treatments when orders are discontinued or when the resident no longer resides in the facility. All medications and treatments without labels have discarded. The education included that if a medication or treatment is not labeled it is not to be used on any resident and is to be appropriately discarded.** **Unit Managers will QI monitor medication rooms and treatment carts weekly times 4 weeks, then monthly to ensure discontinued medications and treatments have appropriately been removed and discarded.**	

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F 441	Continued From page 33 pink wound bed) to the buttock area. The resident also required oral prophylactic antibiotic therapy related to pressure wound risk factors. A new verbal order was written 09/06/12 for Resident #5 by the Nurse Practitioner to apply Vasolex to coccyx area of excoriation. Record review of the facility's training and education records revealed Licensed Practical Nurse #2 (LPN) was provided The Six Rights of Medication Administration, dated 11/10/11, the Medication Administration Guidelines, undated and the Medication Administration Guidelines by D&R Pharmacare undated, revealed all facility medications should be checked for client, medication, route, dosage, time, and documentation. The guidelines revealed to prevent errors, facility staff were to double check the medication label with the Medication Administration Record (MAR), making sure the label matched the MAR. The guidelines further stated if a medication was NOT available, contact the pharmacy as soon as possible to obtain the medication. The guidelines presented by Pharmacare stated facility staff were not to borrow medications, if a medication was not available notify the pharmacy immediately. Observation, on 09/06/12 at 1:30 PM, revealed during a skin assessment and wound care a newly identified wound was discovered for Resident #5 and new orders were written for a prescription medication ointment treatment, (Vasolex) for the new area on 09/06/12. LPN #2 left the residents room and returned with a previously opened and half used tube of the prescribed medication ordered by the Nurse	F 441	**4):** **The DCS and/or ADCS will QI monitor medication room, treatment and medication carts monthly times 3 months, the quarterly to assure discontinued medication has been appropriately removed and discarded. Findings will be reviewed monthly at the RM/QI meeting with development of action plans to ensure medication and treatments are utilized appropriately.**	**10/19/12**

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Practitioner just minutes prior to application to the residents new wound. The medication tube had no label with Resident #5's information, the medication was not in a box, and the medication tube had no written open date. LPN #2 continued to withdraw the medication from the opened and used tube and then applied the medication to Resident #5's bilateral buttocks.

Interview, on 09/06/12 at 4:45 PM, with LPN #2 revealed the used and opened tube of prescription medication Vasolex had no label with a name listed. The nurse stated he did not have a new tube to use for Resident #5. The nurse further stated it was not the facility policy to use prescribed multiple dose medications on multiple residents. LPN #2 could not verify who the opened and used tube of medication had been used on or who the medication was prescribed for.

Interview, on 09/06/12 at 2:50 PM, with Rehabilitation Manager Licenses Practical Nurse (LPN) revealed during Resident #5's skin assessment and wound care the prescribed medication Vasolex had been opened and used without a label. She further stated this was not the normal process for getting medication for resident from the pharmacy. She acknowledged Vasolex was not a medication the facility kept in stock and the medication must come from the pharmacy supplier. The nurse revealed the use of an opened and used medication put Resident #5 at greater risk for infection from contamination secondary to diagnoses.

Interview, 09/07/12 at 10:45 AM, with LPN #2 revealed the potential problem with the use of an

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 441	Continued From page 35 opened, used and undated medication without a label was infection control and cross contamination from resident to resident. He further stated he had a lapse of nursing judgment and this should never have happened. Interview, on 09/07/12 at 11:35 AM, with Rehabilitation Manager Licenses Practical Nurse (LPN) revealed she was not able to identify the source of the tube of Vasolex medication or how long the medication had been opened. Interview, on 09/07/12 at 2:00 PM, with Assistant Director of Nursing (ADON) revealed the facility policy was staff cannot borrow medications from other residents; all medications were provided by the pharmacy and labeled for individual resident use only. He further stated his concern was infection control and cross contamination from resident to resident. The ADON revealed he provided staff orientation and education to the facility staff and LPN #2 had received training and education related to infection control and pharmacy services for the residents. The ADON also stated he did not monitor or surveillance the facility staff to ensure facility policies and procedures were followed. Interview with the Director of Nursing, on 09/07/12 at 1:25 PM, revealed the facility nursing staff should provide and use only prescribed, labeled and individualized medications for every resident in the facility.	F 441		
F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each	F 514		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING _____ B. WING _____	09/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 514	Continued From page 36 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; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to document the resident's pain before and after the administration of pain medication for five (5) of twenty-four (24) residents, Residents #1, #7, #8, #19 and #21. The facility failed to have an effective system to evaluate and document residents' pain and the effectiveness of pain interventions. The findings include: Review of the facility's policy regarding Pain Assessment, effective 03/12, revealed a Pain Flow Record will be maintained with the resident's Medication Administration Record (MAR). 1. Record review revealed the facility admitted Resident #1 on 11/09/09 with diagnoses of Coronary Artery Disease, Coronary Bypass Graph, Cerebral Vascular Accident and Hypertension. Resident #1 was to receive	F 514	**F514** **1):** **Residents #1, #7, #8, #19, and #21 have been reassessed by the IDT.** **Care plans have been reviewed and revised as indicated by the IDT.** **2):** **Clinical records of residents receiving pain medications were reviewed by the IDT, consisting of consisting of nursing, activities, social service, and dietary, for documentation of resident's pain before and after the administration of pain medication. The attending physician was notified as indicated.** **Care plans have been reviewed and revised as indicated, by the IDT consisting of consisting of nursing, activities, social service, and dietary.**	

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	185289	A. BUILDING _____ B. WING _____	09/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 514	Continued From page 37 palliative care as of April 2012. Review of Physician's Orders dated 08/29/12 revealed an order for Lortab 5/500 mg twice a day. No reason for the medication was noted on the order. Review of the September 2012 MAR for Resident #1 revealed the resident received Lortab twice a day for pain. There was no documented assessment of pain prior to administration of the pain medication or any documentation that the pain medication was effective. Review of the Nurses Notes in the multi-shift daily Care Track (computer program) revealed only eleven (11) daily charting records were part of the resident's record since 07/28/12, and only one (1) had documentation regarding Resident #1's pain for all three (3) shifts. 2. Record review revealed the facility admitted Resident #8 on 04/26/09 with diagnoses of Alzheimer's Disease, Parkinson's Disease, Paralysis Agitans, Coronary Artery Disease and Atrial Fibulation. Review of the Physician's Orders dated 07/13/12 revealed the resident was to receive Hydrocodone-APAP 5/325 mg four (4) times a day for pain. The previous order was for the medication to be given three (3) times a day. It was documented by Occupational Therapy that Resident #8 was experiencing pain during therapy and the medication was increased. Occupational Therapy was discontinued 07/25/12; however, the resident's pain was not reassessed to determine if the resident was still experiencing pain. The September 2012 MAR for Resident #8 revealed Hydrocodone-APAP 5/325 mg was administered four (4) times a day for pain as ordered during therapy sessions. In addition, there was no documented evidence on the MAR that the resident's pain was assessed prior to	F 514	**3):** **Licensed staff have been re-educated by the ADCS regarding the policy and procedures pertaining to pain management documentation.** **Unit managers will QI monitor pain assessments/pain monitoring records 5 times weekly for 4 weeks then weekly, to ensure the resident's pain before and after pain medication administration is documented as well as the evaluation effectiveness of the pain interventions. The attending physician will be notified when change is needed as determined by resident.** **4):** **The DCS and/or ADCS will QI monitor 25% of the resident population receiving pain medications for documentation prior to and after administration of pain medication for effectiveness. Findings will be reviewed in the monthly RM/QI for review and development of action plans to ensure pain medication is appropriately documented.**	10/19/12

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DIVISION OF HEALTH CARE FACILITIES SURVEYS

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING _____ B. WING _____	09/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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administration of pain medication or any record to note if pain relief was attained.

3. Record review revealed the facility admitted Resident #19 on 07/25/07 with diagnoses of Peripheral Vascular Disease, End Stage Renal Disease, Sepsis and Diabetes. Review of the Physician's Orders dated 08/06/12 revealed the resident was to receive Percocet 5/325 four (4) times a day. The reason for the medication was not noted on the order. The September MAR for Resident #19 revealed the resident received Percocet 5/325 mg four (4) times. There was no documentation on the MAR to reveal an assessment of pain occurred prior to administration of pain medication or any record to note if pain relief was attained. Review of the Nurses Notes in the multi-shift daily Care Track revealed only eight (8) daily charting records were part of the residents chart since 08/22/12, and of those present, only third shift had made a check mark by the Comfort Level box. No charting was present for first or second shift.

Interview, on 09/06/12 at 8:00 AM, with Licensed Practical Nurse (LPN) #7 revealed there should have been documentation related to the effect and results of pain medication given to Residents #1 and #8. She reviewed the MAR and Nurses notes during the interview and found no documented evidence Resident #1 or #8;'s pain had been assessed. She did not know who was responsible to monitor the residents' pain.

Interview, on 09/06/12 at 10:08 AM, with LPN #3 revealed she was responsible for monitoring the effectiveness of pain medication administered to the residents. She revealed she did not know

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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F 514	Continued From page 39	F 514		

why Resident #1 was on narcotics. She stated pain was monitored by staff by just knowing when a resident was in pain. She revealed pain relief would be determined by looking at the charting; however, there was no documented evidence the reason Resident #1 was on narcotic pain medication or if the resident received pain relief. Resident #1 was on palliative care. LPN #3 stated the Palliative Care nurse should be monitoring the pain of Resident #1 and it's effectiveness. She stated she monitored her residents for pain by looking at their actions to see how they (the residents) were.

Interview, on 09/07/12 at 8:20 AM, with LPN #5 revealed residents were asked how they rate their pain on a pain scale and then it was charted on the back of the MAR or in the nurses notes. In addition, she revealed this would be the case for all residents receiving pain medication, not just as needed (PRN) medications. However, for Residents #1, #8 and #19 there was no documentation.

Interview, on 09/07/12 at 8:30 AM, with Resident #1's physician revealed he reviewed the resident's medications on visits and if no note was entered by facility staff, he would not know of a change in the resident's condition. He stated the facility was lacking a process to follow the pain of the residents. He revealed Resident #1 was placed on pain medication because he sits in the wheelchair for many hours and his backside would become painful.

Interview, on 09/07/12 at 11:30 AM, with the 200 Wing Second Shift Supervisor revealed pain was monitored on a pain monitoring sheet on the

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MAR. She stated the nurse should document what pain medications were given, their effectiveness, and how well the medication was tolerated. She stated this was for the well being of the resident. No documentation was found for Residents #1, #8 and #19. She revealed the Unit Manager are suppose to monitor the records monthly. In addition, she revealed there was no effective system in place to monitor pain medications. She revealed poor charting and poor documentation contributed to effective monitoring of residents' pain.

Interview, on 09/07/12 at 2:30 PM, with the Assistant Director of Nursing/Educator revealed documentation for medication should be found on the MAR or in the Nurses Notes. He revealed all narcotics, both routine and as needed, would be charted there. He revealed the Unit Managers or the MDS personnel monitored medications and documentation. He stated if the nursing staff failed to document a resident's response to pain medication, either as positive or negative, the physician would not be made aware of any concerns when reviewing the resident's chart. The physician may not change the resident's medications, even if a change was warranted. He revealed there was a problem with communication causing a system problem related to pain medication.

Interview, on 09/07/12 at 3:20 PM, with the Director of Nursing revealed she was not familiar with the pain medication policy. She had been at the facility less than one month.

4. Record review revealed the facility admitted

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F 514	Continued From page 41 Resident #7 on 03/19/12 and re-admitted on 07/25/12 with diagnoses of Dementia, Paraplegia, and Chronic Open Wound of the Buttock. The admission Minimum Data Set (MDS), dated 03/29/12, and the quarterly MDS, dated 07/10/12, both revealed the resident had a Brief Interview Mental Status (BIMS) of fifteen (15) as well as frequent, severe pain. Review of Resident #7's physician orders, dated 09/01/12 thru 09/30/12, revealed Percocet 10-325 mg was ordered routinely and scheduled every eight (8) hours. OxyContin 15 mg was ordered routinely and scheduled to be given every eight (8) hours. Review of the care plan for Resident #7 under Pain Management, dated 03/30/12, revealed the facility would administer pain medications per physician order and would evaluate the resident's pain intensity with a zero (0) to ten (10) scale. The goal for the resident was to achieve a comfort level of one (1) to two (2) on the pain intensity scale. Interview with Resident #7, on 09/05/12 at 2:25 PM, revealed the resident had consistent pain and needed his scheduled pain medicine on time. The resident stated he frequently received his pain medicine late which increased his pain. However, this was not reflected on the MAR. 5. Record review revealed the facility admitted Resident #21 on 08/01/11 and re-admitted on 08/15/11 with diagnoses of Dementia and Difficulty Walking. The admission MDS, dated 08/22/11, and the quarterly MDS, dated 06/19/12, both revealed the resident BIMS score was a	F 514		

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F 514	Continued From page 42	F 514		

three (3).

Review of physician orders, dated 09/01/12 thru 09/30/12, for Resident #21 revealed Percocet 5-325 mg was ordered routinely and scheduled twice a day and every six (6) hours as needed (PRN).

Review of Resident #21's care plan for Pain Management, dated 06/25/12, revealed the facility would evaluate the resident's pain intensity prior to providing interventions and thirty (30) to sixty (60) minutes after providing interventions. The care plan revealed pain intensity would be evaluated with a zero (0) to ten (10) scale and clinical or behavioral characteristics. The goal for the resident was to achieve a comfort level of zero (0) to one (1) on the pain intensity scale.

Interview, on 09/07/12 at 1:40 PM, with Licensed Practical Nurse (LPN) #4 revealed the facility did not use a pain scale and evaluated resident pain by asking if the resident was hurting. The LPN stated there was not a pain intervention sheet for Resident #21. She stated communication between the facility and the physician, regarding the resident's pain, occurred by a verbal report from the nurses to the physician. However, there was no evidence of the pain medications effectiveness in the clinical record.

On 09/07/12 at 2:00 PM, interview with the Sub Acute II Unit Manager (UM) revealed Resident #21's pain was monitored by the resident's mood, and by an increase in tearfulness or anxiousness. The UM stated there was no pain scale or pictures of faces for the resident to communicate her pain level to the facility staff. The UM stated if

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F 514	Continued From page 43 the resident's pain was not controlled she would have breakthrough pain and would require the use of the PRN medication.	F 514		

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DIVISION OF HEALTH CARE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1991, original building and 1995, sub-acute addition. SURVEY UNDER: 2000 Existing FACILITY TYPE: S/NF DP TYPE OF STRUCTURE: One (1) story, Type III Unprotected. SMOKE COMPARTMENTS: Five (5) smoke compartments. FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1995. SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system, hydraulically designed. GENERATOR: Type II, 100 KW, fuel source is diesel. A standard Life Safety Code survey was initiated on 09/05/12 and concluded on 09/06/12. Hurstbourne Care Center at Stony Brook was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from	K 000	**This plan of correction constitutes a written allegation of compliance for deficiency cited on July 12, 2012. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by federal and state law.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 9/28/12

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.

JR

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 000	Continued From page 1 Fire) Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)	K 000		
K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure there were no impediments to the closing of corridor doors to resist the passage of smoke, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke	K 018	**K018** **1):** **On 9/5/12 maintenance personnel immediately removed the door knob on the door identified and installed a new door latch and striker plate.** **2):** **Maintenance personnel inspected doors on 9/5/12 to identify similar issues and none were identified.** **3):** **Life Safety rounds are being conducted weekly in accordance with the maintenance Tels program including the inspection of doors for proper latching. Deficient practice identified on these rounds is corrected and recorded and presented to the Safety Committee monthly for additional training as necessitated.**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2012

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K 018	Continued From page 2 compartments, approximately thirty-five (35) residents, staff, and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: Observation, on 09/05/12 at 10:30 AM, with the Maintenance Director and the Safety and Maintenance Person revealed the door to resident room 19 did not latch when tested. A piece of plastic had been jammed into the strike plate in the lockset which would not allow the door to latch. Interview, on 09/05/12 at 10:30 AM, with the Maintenance Director and the Safety and Maintenance Person revealed the door would not latch and resist the passage of smoke in the event of an emergency. The Maintenance Director indicated that a staff person could have hit the lockset with a cart while moving in and out of the resident room. Reference: NFPA 101 (2000 edition) 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80,	K 018	**On 9/5/12 maintenance personnel immediately removed the door knob on the door identified and installed a new door latch and striker plate.** **4):** **Life Safety rounds are being conducted weekly in accordance with the maintenance Tels program including the inspection of doors for proper latching. Deficient practice identified on these rounds is corrected and recorded and presented to the Safety Committee. Additional staff training will be conducted as directed by the Safety Committee.**	10/19/12

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HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

(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 018	Continued From page 3 Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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K 018	Continued From page 4 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.	K 018		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701. Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13 Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3) , 10.3.4. 19.7.5.3 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the installation of shower curtains were in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds	K 074	**K074** **1):** **The Housekeeping Supervisor immediately removed the deficient curtains and replaced them with a vinyl curtain with a 12 inch mesh that provides proper coverage of the sprinkler system in the event of a fire. The curtains were removed and replaced on 9/5/2012.** **2):** **Housekeeping Supervisor inspected other shower curtains to identify similar issues and none were identified.**	

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	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HURSTBOURNE CARE CENTRE AT STONY BROOK	2200 STONY BROOK DR LOUISVILLE, KY 40220

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K 074	Continued From page 5 and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: Observation, on 09/05/12 at 9:38 AM, with the Maintenance Director and the Safety and Maintenance Person revealed the privacy curtains hung in the Shower Room located in the 100 Unit, were of a solid fabric hung directly below the ceiling. The solid fabric would obstruct the spray pattern of the automatic sprinklers in the event of a fire. Interview, on 09/05/12 at 9:38 AM, with the Maintenance Director and the Safety and Maintenance Person revealed they were not aware of the requirements for proper coverage of the sprinkler system and acknowledged that a solid fabric curtain could obstruct the spray pattern in the event of a fire. NFPA 13 Cubicle curtains; Reference to: NFPA 13 Standard for the Installation of Sprinkler Systems 1998 Edition 19.3.5.5 For the proper operation of sprinkler systems, cubicle curtains and sprinkler locations need to be coordinated. Improperly designed systems might obstruct the sprinkler spray from reaching the fire or might shield the heat from the sprinkler. Many options are available to the designer including, but not limited to, hanging the cubicle curtains 18 in. (46 cm) below the sprinkler	K 074	**3):** **The Housekeeping Supervisor will conduct weekly rounds of all shower rooms in the facility to identify curtains that do not meet the criteria required. The result of these rounds will be recorded and reviewed monthly in the Safety Committee meeting. Any identified curtains that do not meet the criteria required will be removed and replaced with curtains that have the 12 inch mesh providing for ample sprinkler coverage.** **Housekeeping staff have been re-educated on how to identify shower curtains that do not meet the required criteria.** **4):** **The Housekeeping Supervisor will conduct weekly rounds of all shower rooms in the facility to identify curtains that do not meet the criteria required. The result of these rounds will be recorded and reviewed monthly in the Safety Committee meeting. Any**	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 074	Continued From page 6 deflector; using a ½-in. (1.3-cm) diagonal mesh or a 70 percent open weave top panel that extends 18 in. (46 cm) below the sprinkler deflector; or designing the system to have a horizontal and minimum vertical distance that meets the requirements of NFPA 13, Standard for the Installation of Sprinkler Systems. The test data that forms the basis of the requirements of NFPA 13 is from fire tests with sprinkler discharge that penetrated a single privacy curtain.	K 074	**identified curtains that do not meet the criteria required will be removed and replaced with curtains that have the 12 inch mesh providing for ample sprinkler coverage.**	10/19/12
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the emergency generator was installed and maintained in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, all residents, staff, and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include:	K 144	**K144** **1):** **Maintenance personnel have contacted Wagner Electric Company to install an annunciator at the Nurses Station where it will be heard 24 hours per day. The annunciator was installed on 9/25/2012** **2):** **No other annunciator issues were identified.** **3):** **Maintenance personnel have been re-educated on NAPF 70, National Electrical Code 700-12.**	

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	185289	A. BUILDING 01 - MAIN BUILDING 01 B. WING	09/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 144	Continued From page 7 Observation, on 09/05/12 at 3:00 PM, with the Maintenance Director revealed the annunciator panel for the emergency generator, located in the Electrical Room across the corridor from the Laundry Room, was not located in an area that was continuously monitored by Staff, to ensure the generator was functioning properly. Interview, on 09/05/12 at 3:00 PM, with the Maintenance Director, revealed the audible signal on the annunciator panel had been previously monitored when the Laundry Room was in operation during all three (3) working shifts. The facility had recently discontinued the third shift working between 11:00 PM and 7:00 AM. When tested, the audible signal was heard in the Laundry Room. Further testing revealed it could not be heard in the nearest Nurses' Station located in the 200 Unit, occupied during all three (3) working shifts. Reference: NFPA 99 (1999 Edition). 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: a. Individual visual signals shall indicate the	K 144	**4):** **Weekly generator inspection rounds will be conducted including the inspection of the annunciator panel. Any problems identified will be immediately resolved.** **Results of weekly audits will be discussed in the monthly Safety Committee for three months. Additional education will take place as warranted by issues identified during weekly rounds.**	**10/19/12**

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K 144	Continued From page 8 following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning b. Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144		
K 147 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments,	K 147	**K147** **1):** **Maintenance personnel immediately removed unauthorized equipment on 9/5/2012 from power strips. Staff was re-educated on 9/5/2012 on the misuse of power strips.**	

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K 147	Continued From page 9 approximately fifty (50) residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and seventeen (117) on the day of the survey. The findings include: Observations, on 09/05/12 between 1:30 PM and 2:45 PM, with the Maintenance Director and the Safety and Maintenance Person revealed: 1) In resident room 38, medical equipment (an oxygen concentrator) was plugged into a power strip. 2) In resident room 39, a refrigerator was plugged into a power strip. 3) In resident room 204, medical equipment (a nebulizer) was plugged into a power strip. 4) In resident room 219, a refrigerator was plugged into a power strip. 5) In resident room 224, medical equipment (motorized bed) and a refrigerator were plugged into a power strip. Interviews, on 09/05/12 between 1:30 PM and 2:45 PM, with the Maintenance Director and the Safety and Maintenance Person revealed they were not aware of the misuse of power strips in resident's rooms. They periodically monitored the misusage of power strips and indicated that the resident's families could have installed them, not realizing the potential for an accident to occur.	K 147	**2):** **Resident rooms were inspected by maintenance personnel on 9/5/2012 to identify electrical items plugged improperly. No additional issues were identified at that time.** **3):** **The unauthorized use of power strips will be monitor through weekly rounds by the maintenance personnel. Issues identified will be immediately corrected.** **4):** **Results of weekly rounds will be discussed in the monthly Safety meeting for 3 months. Additional education will be provided as needed for issues identified.**	**10/19/12**

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 147	Continued From page 10 Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		

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