

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

PRINTED: 02/21/2012
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 195039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40206
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F 000	INITIAL COMMENTS A standard health survey was conducted 02/07/12 through 02/09/12. A Life Safety Code Survey was conducted on 02/07/12- 02/08/12. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct before remedies would be imposed.	F 000	Preparation and submission of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or the correctness of the conclusions set forth in the statement of deficiencies. The plan of correction is prepared and submitted solely because of requirements under state and federal law.	
F 156 SS=B	483.10(b)(6) - (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. "Notice of Medicare Non-coverage" letters were mailed to residents 22, 23, and 24 on 2/24/12. The social worker contacted the residents and or their responsible party to explain why the letters were being mailed and to validate that they understand their appeal rights. 2. The Business Office Manager reviewed all Medicare discharges from January 1, 2012 to February 6, 2012 to determine if any other resident	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Harold Hamilton* TITLE *Administrator* (X6) DATE *2-3-12-2012*

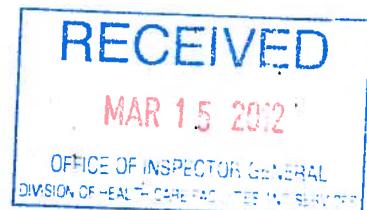
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 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	<p>Continued From page 1</p> <p>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.</p> <p>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;</p> <p>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.</p> <p>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.</p> <p>The facility must comply with the requirements</p>	F 156	<p>was discharged from Medicare services (with days remaining) and did not receive a letter of non-coverage. No other resident was identified.</p> <p>3. The policy and procedure for issuing Medicare Non-coverage letters was reviewed by the administrator and found to be acceptable. The administrator provided education to both social workers regarding the policy for issuing Medicare Non-coverage letters on 2/27/12. This education included sending Non-coverage letters to anyone that discharges from Medicare with Medicare days remaining, regardless of their discharge location.</p> <p>4. The social services directors will audit a 100% of all Medicare discharges for the next four months to validate that Medicare discharge notices are being sent timely to all residents that have not exhausted their days, regardless of their discharge location. The</p>		



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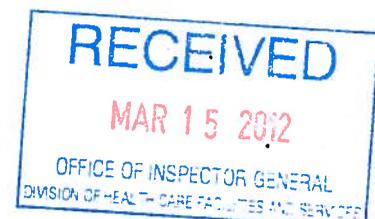
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F 156	<p>Continued From page 2</p> <p>specified in subpart l of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information 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.</p> <p>The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care.</p> <p>The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and interview it was determined the facility failed to ensure Medicare A residents were issued a "Notice of Medicare Provider Non-coverage" letter upon termination of all Medicare Part A services for three (3) of three (3) closed record review. The facility failed to issue a non-coverage letter, with information on beneficiary appeal rights for those residents that was discharged from the facility after Medicare Part A services were terminated. The facility only provided that information to those residents who</p>	F 156	<p>results of these audits will be reviewed by the administrator during QA & A monthly. (For future reference the QA&A Committee consists of the administrator, director of nursing, medical director and one or more of the following: unit manager(s), therapy, activities, certified nursing assistants, assistant director of nursing, dietary manager, housekeeping and RAI Coordinator). Following the initial four month audit, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by Social Services and submitted to the QAA committee. The QAA committee will determine if additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/9/12.</p>	



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F 156	<p>Continued From page 3</p> <p>continued to reside in the facility after Medicare Part A services was terminated.</p> <p>The findings include:</p> <p>Review of the facility's admission/financial agreement provides 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.</p> <p>1. A closed record review of Resident #22's clinical record revealed the facility admitted the resident on 12/27/11 for skilled services under Medicare Part A. The record revealed the resident was discharged to home on 01/22/12 with remaining skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights.</p> <p>2. A closed record review of Resident #23's clinical record revealed the facility admitted the resident on 03/11/11 for skilled services under Medicare Part A. The record revealed the resident was discharged from Medicare Part A skilled services on 04/01/11 with remaining skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights. The resident was discharged from the facility to an Assisted Living Home on 12/19/11.</p> <p>3. A closed record review of Resident #24's clinical record revealed the facility admitted the resident on 12/15/11 for skilled services under</p>	F 156			



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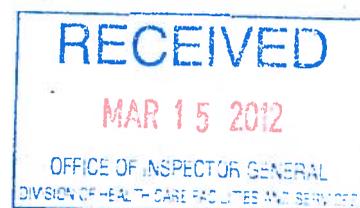
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F 158	Continued From page 4 Medicare Part A. The record revealed the resident was discharged to home on 01/31/12 with remaining skilled days left. However, the facility failed to issue a Notice of Medicare Non-coverage letter with appropriate beneficiary appeal rights. Interview with the Social Service Director, on 02/09/12 at 4:30 PM, revealed she was responsible for Liability Notices & Beneficiary Appeal letters after a resident's Medicare Part A skilled services are terminated. She stated she only issued those letters to residents who will remain in the facility under a different payor source. She said she had not provided the notice of non-coverage to residents who were discharged from the facility even though the residents had not exhausted all their skilled days. She indicated she did not know those residents were to receive a notice of Medicare non-coverage letter with appeal rights information included.	F 158		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's physical restraint policy, it was determined the facility failed to ensure residents were free from physical restraints for one (1) of twenty-five (25) sampled	F 221	1. The Restraint Committee re-assessed resident #13 for the lap cushion and tilt back reclining wheel chair on 2/16/12. The physician orders for resident #13's reclining wheel chair clarified on 2/9/12. 2. The restraint Committee met on 2/16/12 and 2/21/12 to review restraints and safety devices in the	



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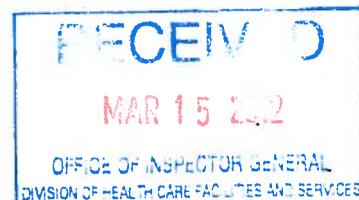
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F 221	<p>Continued From page 5</p> <p>residents. Resident #13 was placed in a tilt/reclining wheelchair with a lap cushion without an assessment or physician order prior to use.</p> <p>The findings include:</p> <p>Request for a physical restraint policy resulted in the facility providing a policy titled "Physical Restraint Alternatives" (no date). This policy revealed the purpose of the alternative program was to implement restraint alternative strategies for residents being assessed for or using a physical restraint. "An appropriate restraint may be used after assessment is completed and with a physician's order.</p> <p>Interview with the Assistant Director of Nursing, on 02/09/12 at 1:55 PM, revealed it was the facility's practice to assess any safety device prior to use. Therapy and the interdisciplinary team would review and sign off on the assessment to determine if the device was a restraint or position device. A physician order is required and the device is placed on the safety device monitoring sheet for the unit manager and nurses to monitor. The devices are to be evaluated quarterly and every thirty days restraints are reviewed in the restraint committee meetings to see if a reduction can be attempted. However, she could not provide any documented evidence the tilt/recliner wheelchair or the lap cushion had been reviewed.</p> <p>Review of the clinical record for Resident #13 revealed the facility admitted the resident on 08/09/11 with diagnoses of End Stage Dementia, Osteoporosis, Hypothyroidism, Glaucoma, Atrial Fibrillation, and Hypertension. Review of the admission MDS (minimum data set) assessment, dated</p>	F 221	<p>building. All residents with a restraint were identified and the committee validated that each resident had an appropriate assessment, physician order and clinical monitoring.</p> <p>3. The policy and procedure for restraints and restraint alternatives was reviewed by the director of nursing and found to be acceptable. The director of nursing and staff development coordinator initiated education regarding the federal guidelines for restraints on 2/24/12. This education included information regarding resident assessment, physician orders and clinical monitoring. The education will be provided to licensed nursing staffs and therapy team members.</p> <p>4. The director of nursing will audit 100% of all restraint committee meeting minutes for the next four months, to validate appropriate restraint assessments, physician orders and clinical monitoring. The results of these audits</p>		



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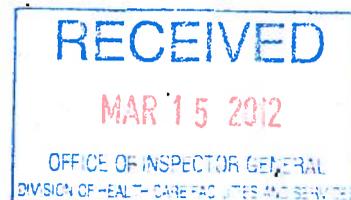
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F 221	<p>Continued From page 6</p> <p>08/16/11, revealed the facility assessed the resident with a cognitive impairment; required extensive assist with most Activities of Daily Living (ADL); and exhibited wandering behaviors. The facility identified the resident at risk for falling and at that time the resident was independent with ambulation.</p> <p>Continued review of the record revealed the facility assessed Resident #13 with a decline in functional mobility and review of the most current MDS assessment dated 01/03/12 revealed the resident was now total assist with most ADLs and could no longer walk. The resident had a hospital stay from January 7-10, 2012 for Respiratory Failure and Urosepsis. Review of the plan of care, revised on 01/16/12, revealed the resident utilized a tilt reclining wheelchair and lap buddy cushion as interventions to prevent falls.</p> <p>Observation of Resident #13, on 02/08/12 at 8:30 AM, revealed the resident sitting in a tilted/reclining wheelchair eating breakfast in the main dining room. A soft lap cushion was attached to the wheelchair and remained in place during the whole meal. At 10:00 AM, the resident was observed sitting in the reclined wheelchair, in the hallway, with the lap cushion attached. Observation during the lunch meal on 02/08/12 at 12:10 PM, the resident was again sitting in the tilt/reclining wheelchair with the lap cushion attached. On 02/09/12 at 7:50 AM, 8:30 AM, and 1:00 PM, observations revealed the resident sitting up in the tilt/reclining wheelchair with the lap cushion applied.</p> <p>Review of the clinical record revealed no physician order for the lap cushion and no</p>	F 221	<p>will be submitted to the QA & A Committee monthly.</p> <p>Following the initial four month audit, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per policy. The audit in August 2012 and October 2012 will be completed by Director of Nursing or Assistant Director of Nursing to determine if restraints assessments, Physician Orders and clinical monitoring are occurring per protocol.</p> <p>The results of this audit will submitted to the QAA committee. The QAA committee will determine if any additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/8/12 3-16-12 per adm. Review by PB 3-16-12</p>	



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F 221	<p>Continued From page 7</p> <p>documented evidence an assessment of the device had been completed to determine if the lap cushion was a physical restraint. Review of the safety device monitoring checklist for November and December 2011 revealed the lap buddy cushion was listed to be monitored. However, the facility could not provide evidence the device had been evaluated since that date. On 01/20/12, Occupational Therapy (OT) conducted an assessment and found the resident was leaning forward and sliding from a regular wheelchair. Recommendation was made for a tilt/reclining wheelchair to prevent the resident from sliding out of the wheelchair and leaning forward. However, there was no evidence a physician order was obtained prior to the use of the chair.</p> <p>On 02/09/12 at 9:30 AM, interview with OT, who had assessed the resident for the tilt/recliner wheelchair, revealed the lap buddy cushion was already in use when he assessed the resident for the tilt/recliner wheelchair on 01/20/12. He did not obtain a physician order for the tilt/recliner wheelchair.</p> <p>On 02/09/12 at 9:15 AM and 9:40 AM, interview with the unit manager for 1-B revealed there was no physician order for the tilt/reclining wheelchair or the lap cushion and there was no documented evidence an assessment had been conducted on the lap cushion prior to use. In addition, she revealed the staff did not document when the cushion was removed even though the care plan stated to remove every two (2) hours. The resident was receiving restorative therapy and could now walk with assistance.</p>	F 221			



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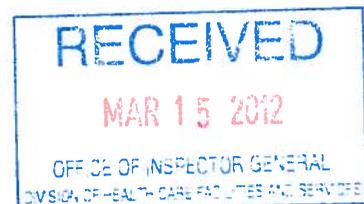
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F 221	Continued From page 8 Interview with Certified Nursing Assistant (CNA) #5, on 02/09/12 at 4:50 PM, revealed the lap cushion was used for safety and was not taken off except when the resident was in bed. CNA #5 stated the lap cushion was to keep the resident from falling from the wheelchair. Review of the clinical record revealed a physician order was obtained for the tilt/recliner wheelchair and cushion on 02/09/12 after surveyor intervention. The devices were placed on the MAR (medication administration record) to be monitored on the same date.	F 221			
F 258 SS=E	483.15(h)(7) MAINTENANCE OF COMFORTABLE SOUND LEVELS The facility must provide for the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on interviews during the group meeting and staff interviews it was determined the facility failed to ensure comfortable sound levels were maintained at bedtime for two (2) of four (4) units. Housekeeping ran floor buffers as late as 1:00 AM causing the residents' sleepless nights on units one (1) B and two (2) B. The findings include: Interview, on 02/08/12 at 3:05 PM, during the Group meeting revealed Resident's #17 and two (2) unsampled residents (Resident A and B) stated housekeeping staff used floor buffers as late as 1:00 AM in the hallway outside of their	F 258	F258 1. On 2/8/12, immediately following the notification of residents concerns with the sound level, the administrator notified the housekeeping staff that they could not complete floor buffing after 8:00pm. 2. No other issues were identified. 3. The administrator attended the resident counsel meeting on 2/28/12 and validated that residents are satisfied with the corrective action. The building will be transitioning to a new		



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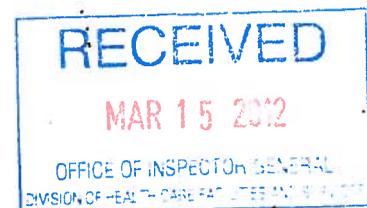
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F 258	Continued From page 9 bedrooms, waking them up. They stated sometimes they were not able to go back to sleep once awoken. The residents were distressed that they had to get up early in the morning to start their day. Resident #17 stated the noise level had increased due to the remodeling of the facility; however, the resident said he/she kept the TV on all night so the noise did not affect him/her. They stated they were going to address the noise level at the next resident council meeting. Interview, on 02/09/12 at 3:00 PM, with Housekeeper #1 and at 3:45 PM with Housekeeper #2, revealed the second shift housekeeping staff ran the buffers during the evening hours. The floors were not buffed during the days to their knowledge. Interviews, on 02/08/12 at 4:55 PM, with the Facility Administrator and Director of Nursing revealed they had not been made aware residents had been disturbed by the housekeeping staff running the floor buffers during the evening hours. They acknowledged housekeeping staff buffed the floors in the evening and said the housekeeping staff only buffed the floors in the common areas which included the hallways outside the residents' rooms. The Administrator stated the housekeeping followed a protocol but no specific policy for housekeeping. She stated the housekeeping service was a pilot program and they had previously operated in hotels and hospitals and were not familiar with long term care facilities.	F 258	environmental company during the next few weeks. The new housekeeping supervisor attended orientation on 2/22/12, at that time the administrator addressed the buffing and cleaning schedules after 8:00pm regarding sound levels. 4. The administrator will review all resident council meeting minutes for the next four months to determine if any additional concerns arise regarding the sound levels in the building. Any concerns identified will be corrected and reported to the QA&A Committee. Following the initial four month audit, this process will be reviewed again in August 2012 and October 2012 by the Administrator who will review Resident Council minutes to determine if there are any concerns with sound levels. The results of this audit will be submitted to the QAA committee; the committee will determine if any further interventions are required.	
F 272 SS=B	483.20(b)(1) COMPREHENSIVE ASSESSMENTS	F 272 (R)	5. The facility alleges compliance on 3/9/12.	



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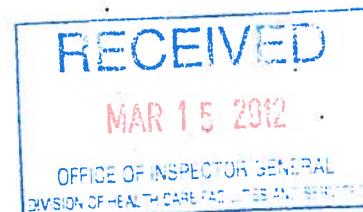
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40208	
(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 272	Continued From page 10 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; 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.	F 272	F 272 1. On 2/9/12, the RAI Coordinator #2 completed a modification for section G, functional limitation and range of motion, for resident #4's admission assessment dated 2/21/11. The RAI Coordinator #2 also completed a modification for section K, weight loss, on resident #7's quarterly assessment dated 11/28/11. 2. The RAI coordinators reviewed 100% of resident coding on the most recent MDS for sections G and K on 3/7/2012. During this review, no other coding issues were identified for any other sections of the residents most recent MDS. 3. RAI Coordinators have been given the option to work out of alternative offices to facilitate decreased environmental stimuli. The	



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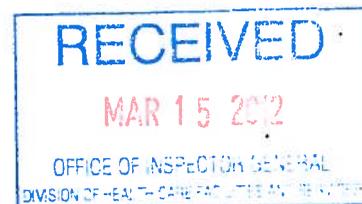
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 186039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X8) DATE SURVEY COMPLETED 02/09/2012
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F 272	<p>Continued From page 11</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, record review and review of the facility's policy, it was determined the facility failed to complete accurate assessments for two (2) of twenty-five (25) sampled residents. (#4 and #7) The facility did not capture contractures for Resident #4 on the admission assessment and the facility did not identify a twenty pound weight loss for Resident #7 on the quarterly assessment.</p> <p>The findings include:</p> <p>Interview, on 02/09/12 at 3:00 PM, with the Minimum Data Set (MDS) Coordinator revealed the facility used the Resident Assessment Instrument (RAI) manual as guidance to complete the MDS assessments.</p> <p>1. Observation of Resident #4, on 02/07/12 at 2:00 PM, revealed the resident was lying in bed on a specialized pressure reduction mattress. The resident's left arm and both legs appeared to be contracted.</p> <p>Observation of a skin assessment for Resident #4 completed, on 02/08/12 at 10:00 AM, with LPN #2 revealed contractures to both lower extremities and the left arm.</p> <p>Review of the clinical record for Resident #4 revealed the facility admitted the resident on 02/14/11 with diagnoses including: Cerebral Vascular Accident (CVA), Expressive Aphasia Disorder, and Prostate Cancer.</p> <p>Review of the admission MDS completed for</p>	F 272	<p>Registered dietitian will be responsible for section K completion. The Director of Nursing provided education to the Care Team members that participate in the MDS coding process on 2/28/2012. This education included a discussion regarding accuracy of MDS coding for all sections of the MDS. (The team members involved in coding the MDS are as follows RAI Coordinators, activity director, dietary and social services.)</p> <p>4. The Director of Nursing and/or the Assistant Director of Nursing will audit five records per week for four weeks, to validate accurate coding of all sections of the MDS. Following the initial four week audit, the Director of Nursing and/or Assistant Director of Nursing will continue the auditing</p>	



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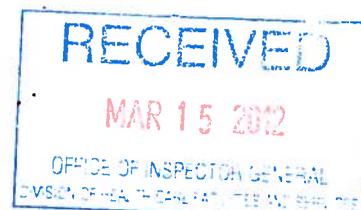
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F 272	<p>Continued From page 12</p> <p>Resident #4 on 02/25/11 revealed section G0400, Functional Limitation in Range of Motion, the facility assessed the resident as having no impairment to the upper and lower extremities.</p> <p>Review of the admission Physical Therapy (PT) assessment completed for Resident #4, on 02/15/11, revealed the lower extremity range of motion was assessed by PT with the right knee of -62 degree range and the left knee as -60 degree range of motion.</p> <p>Review of the Occupational Therapy Evaluation assessment completed on 02/15/11 revealed the therapist assessed the right upper extremity as within functional limit, and left upper extremity elbow within functional limit, and left shoulder active range of motion at 80 degree.</p> <p>Interview with the Vice President of Operations Rehab Division, who is an Occupational Therapist, on 02/09/12 at 9:45 AM, revealed he had reviewed the admission assessments completed for Resident #4 and had completed the Occupational Assessment. He stated the resident was admitted with some pretty severe contractures.</p> <p>Interview with the 2B Unit Manager, on 02/09/12 at 9:00 AM, revealed she was familiar with Resident #4 and stated the resident was admitted with contractures.</p> <p>Interview with LPN #4, on 02/09/12 at 2:45 PM, who had provided care for Resident #4 since the resident was admitted, revealed the resident had contractures of lower extremities, the left arm and right fingers upon admission.</p>	F 272	<p>process or an additional three months. Following the initial four month audit, this process will be reviewed again in August 2012 and October 2012 by the Director of Nursing who will review 10 MDS's each month for coding of all sections of the MDS. The results of this audit will submitted to the QAA committee. The QAA committee will determine if any additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/9/12.</p>	



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F 272	Continued From page 13 Interview with MDS coordinator #1, on 02/09/12 3:15 PM, revealed the person who completed the admission MDS for Resident #4 was no longer in the department. He stated he was not sure if it was an honest mistake or what happened. Interview with MDS coordinator #2, on 02/09/12 at 3:15 PM, revealed she had completed the conceptive MDS assessments for Resident #4 and had coded the contractures correctly. She stated she just didn't catch the mistake on the Admission MDS. 2. Observation, on 02/07/12 at 2:15 PM, revealed Resident #7 sitting up in a wheelchair propelling self in the hallway. The resident had left hemiplegia, and appeared well groomed. Review of the clinical record for Resident #7 revealed the facility admitted the resident on 08/15/11 with diagnoses including: CVA (stroke); Human Immunosuppressive Virus (HIV); and Diabetes Mellitus (DM). Review of the monthly weights for Resident #7 revealed weights as followed: 8/11=178; 9/11=164.4; 10/11=159.3; 11/11= 166; 01/12=144.2; and 02/12=140.0 representing a 10.3% (26 pound) wt loss in 120 days. Review of the Quarterly MDS Assessment for Resident #7, dated 11/28/11, revealed a weight of 178 pounds. This was also the weight on the admission assessment completed on August 2011. Interview with MDS Nurse #2, on 02/09/12 at 3:15 PM, revealed she had completed the	F 272		



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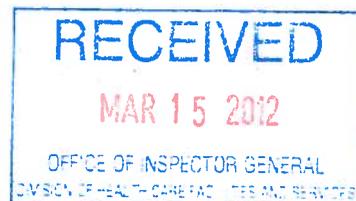
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F 272	Continued From page 14 Admission MDS and Quarterly MDS and the weight was a transcription error on her part. She stated It was important to monitor the weights for a change in condition.	F 272		
F 275 SS=D	483.20(b)(2)(III) COMPREHENSIVE ASSESS AT LEAST EVERY 12 MONTHS A facility must conduct a comprehensive assessment of a resident not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview and facility policy, it was determined the facility failed to complete a comprehensive assessment within the required timeframe for one resident (#11) in the selected sample of twenty-five(25). Finding Include: The facility utilized the RAI Version 3.0 Manual reference for the policy. The manual stated an comprehensive assessment must be done no less than every 12 months (366) calendar days. Record review revealed Resident #11 was admitted by the facility on 01/08/10 with diagnoses of Alzheimer, Diabetes Mellitus, and Hypertension. The Admission Minimum Data Set (MDS) Assessment was dated 01/14/10 and the next annual would be due 12 months from that date. However, four quarterlies dated: 04/24/11; 07/14/11; 10/14/11; and 01/14/12 had been completed. The annual assessment due in January 2012 was not completed.	F 275	F 275 1. No changes can be made regarding the comprehensive assessment reference date for resident #11. 2. A review of existing residents was completed by the RAI coordinators to validate that no other residents were outside of the 12 month RAI time frame for completion of a comprehensive assessment. 3. The director of nursing reviewed the RAI guidelines for scheduling assessments with both RAI Coordinators on 2/27/12. A systemic	



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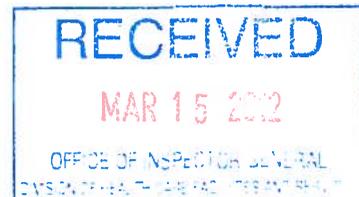
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F 275	Continued From page 15	F 275	change has been completed in the RAI ARD tracking, The facility now uses a computerized based system to set the ARD schedule.	
F 278 SS=D	<p>483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS</p> <p>A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to ensure a quarterly review assessment was completed within the required timeframe for one (1) of twenty-five (25) sampled residents. The facility did not complete Resident #10's Quarterly assessment, that was due on 02/03/12, until 02/08/12, which was 5 days late.</p> <p>The findings include:</p> <p>Review of the RAI Version 3.0 Manual (referenced for the policy utilized by the facility) revealed the quarterly (non comprehensive) must be completed within ninety-two (92) calendar days with fourteen days to complete.</p> <p>Record review for Resident #10 on 02/08/12 revealed the last quarterly review had been</p>	F 278 (P.N)	<p>4. The director of nursing/ or assistant director of nursing will audit 100% of all MDS assessments completed for four weeks to determine if accurate assessment reference dates are being utilized. Following the initial four week audit, the director of nursing or assistant director of nursing will audit a minimum of ten records per month for three months to determine if accurate assessment reference dates continue. Following the initial four month audit, This process will be reviewed again in August 2012 and October 2012 by the Director of Nursing who will review 100% of the MDS's scheduled for those months for timely completion of quarterly assessments. The results of this audit will submitted to the QAA committee. The QAA</p>	



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F 278	Continued From page 16 completed on 10/20/11. The next quarterly review was to be completed by 02/03/12. Review of the completed quarterly assessment on 02/08/12 revealed a completion date of 02/08/12, five (5) days late.	F 278	committee will determine if any additional education or auditing is required.		
F 280 SS=C	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced	F 280 (P.19)	5. The facility alleges compliance on 3/9/12. 1. No changes can be made regarding the quarterly assessment reference date for resident #10. 2. A review of existing residents was completed by the RAI coordinators to validate that no other residents were outside of the RAI guidelines for a quarterly assessment. 3. The director of nursing reviewed the RAI guidelines for scheduling assessments with both RAI Coordinators on 2/27/12. A systemic change has been completed in the RAI ARD tracking. The facility now uses a computerized based system to set the ARD schedule.		



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F 280	Continued From page 17 by: Based on interviews and review of the RAI (Resident Assessment Instrument) Version 3.0 Manual referenced by the facility for their policy the facility failed to ensure the residents were invited to the care plan conference for one (1) of twenty-five (25) sampled residents and two (2) of three (3) unsampled residents. (Resident #10 and unsampled residents A and C). The findings include: Review of the RAI Version 3.0 Manual (referenced by the facility as policy) revealed on page four (4) at point 5...Every effort should be made to include the input of the resident, family, or resident's representative in creating the individualized care plan. They should also be invited to participate in team discussions in an ongoing manner, and be encouraged to share their perspectives on the delivery of care. This can be accomplished by having individual team members discuss preliminary care plan ideas with the resident, family, or resident representative in order to get suggestions, confirm agreement, or clarify reasons for developing specific goals and approaches. Review of the Basic Interview for Mental Status (BIMS) scores which identified the resident's cognitive status as intact revealed Resident A had a score of 16 and Resident C had a score of 15. Resident #10 had a BIMS score of 14. These scores indicated the residents' cognition was intact with no impairment noted. Interview, on 02/08/12 at 11:00 AM, with Resident #10 revealed he/she had not been notified of the	F 280	4. The director of nursing/ or assistant director of nursing will audit 100% of all MDS assessments completed for four weeks to determine if accurate assessment reference dates are being utilized. Following the initial four week audit, the director of nursing or assistant director of nursing will audit a minimum of ten records per month for three months to determine if accurate assessment reference dates continue. Following the initial four month audit, This process will be reviewed again in August 2012 and October 2012 by the Director of Nursing who will review 100% of the MDS's scheduled for those months for timely completion of quarterly assessments. The results of this audit will submitted to the QAA committee. The QAA committee will determine if any additional education or auditing is required. 5. The facility alleges compliance on 3/9/12.	



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F 280	<p>Continued From page 18</p> <p>care plan meetings. Resident #10 did not know if the guardian had attended the meeting or not.</p> <p>Review of the Care Plan Summary, dated 06/10/11, revealed the care plan meeting was held, the resident's guardian had been invited but did not attend.</p> <p>Interviews, 02/08/12 at 3:05 PM, with unsampled Residents A & C during the group interview, revealed the residents had not been invited to their care plan meetings and had not had the opportunity to participate in the development of their care plans. They stated they would like to be notified and offered an opportunity to participate.</p> <p>Review of the Care Plan Summary for unsampled Resident C, dated 01/12/12, revealed the responsible party was invited but was not in attendance.</p> <p>Interview, on 02/09/12 at 1:10 PM, with MDS Coordinator #1 revealed he was not aware residents were not invited to the care plan meeting. He stated he scheduled the care plan meeting and as a courtesy the receptionist sent a letter to the responsible persons. He stated if the resident was not their responsible person they would not be given an invitation letter to notify them of the care plan meeting. He stated he did not personally notify residents of their scheduled care plan meeting.</p> <p>Interview, on 02/09/12 at 8:10 AM, with the Director of Social Services revealed she would sometimes notify residents (who were responsible for themselves) of the care plan</p>	F 280	<p>F 280</p> <ol style="list-style-type: none"> The MDS Coordination reviewed resident #10's plan of care with resident #10 on 2/27/12. Resident A was offered an individualized care plan meeting by the RAI coordinator on 3/7/12 but Resident A refused to attend. Resident C was also offered an individualized care plan meeting by the RAI coordinators and social services. Resident C declined the meeting stating "just follow the old one, nothing has changed". RAI coordinator reviewed all residents who have had Care Plan meetings scheduled between for January 1, 2012 to February 6, 2012, nineteen residents were identified as not receiving a care plan invitation. These residents were interviewed by the RAI coordinators on March 7, 2012 to determine if they would like a care plan 	



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F 280	Continued From page 19 meeting on the day the care plan meeting was to be held. She stated she was responsible for the residents on units 2B and 2C. She stated she did not notify any other residents of their scheduled care plan meeting. Interview, on 02/09/12 at 8:10 AM, with Social Services staff revealed letters were sent to the residents' responsible party notifying them of the scheduled care plan meeting. She stated she never invited any resident to participate in the care plan meeting. Interview, on 02/09/12 at 1:20 AM, with the Clinical Director for the corporation revealed they had a "faux pas" when they realized all residents had not been offered an opportunity to participate or attend their care plan meetings.	F 280	meeting. One resident requested a care plan meeting. This meeting occurred on March 7, 2012, with the RAI coordinators. 3. The RAI Coordinator provided education to the secretary on 2/8/2012 who is responsible for completing care plan invitations. All residents are expected to receive a care plan invitation. RAI coordinators are responsible for oversight to determine and maintain that care plan letters are distributed by the secretary.	
F 431 SS=D	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	F 431 (P.2)	4. The RAI Coordinators will review the care plan invitation book weekly for 16 weeks to validate that care plan invitations are being sent appropriately for care plan meetings (including to residents' that are their own responsible person). These audits will be submitted to the director of nursing and/or assistant director of nursing for	



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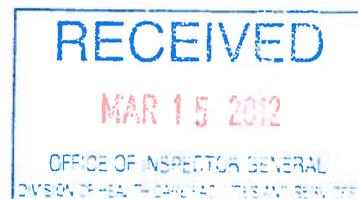
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/09/2012
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40206	
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F 431	<p>Continued From page 20</p> <p>facillty must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to date two open vaccine vials in one (1) of four (4) medication rooms. In addition, the vaccine serum was stored in the wrong box.</p> <p>The findings include:</p> <p>Review of the facility policy Recommended Minimum Medication Storage Parameters for Multi-Dose Vials for Injection (non-Insulin) revealed the staff were to date the vials when opened and discard any unused portion after 30 days.</p> <p>Observation, on 02/09/12 at 3:10 PM, revealed on the 2B unit medication refrigerator two vials, Flu vaccine and Pneumonia vaccine were opened and undated. In addition, the Flu vaccine was in</p>	F 431	<p>additional review. Following the initial four month audit, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by Director of Nursing or Assistant Director of Nursing and submitted to the QAA committee. The QAA committee will determine if any additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/9/12.</p> <p>F 431</p> <p>1. The vials of Flu and pneumovac were immediately dated. (New vials)</p> <p>2. All medication storage areas were reviewed by the Unit Managers on 2/6/2012, No expired biological were identified, and all other items were dated appropriately.</p> <p>3. The director of nursing reviewed the protocol for storage of medications and no revisions were required. Licences nursing staff were provided education</p>	



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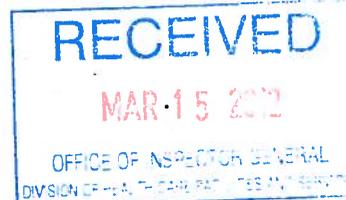
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F 431	Continued From page 21 the Pneumonia vaccine box and the Pneumonia vaccine was in the Flu vaccine box. This was verified by LPN #2. Interview with LPN #2, on 02/09/12 at 3:10 PM, revealed both vaccine vials should have been dated and were not. Interview with the 2B Unit Manager, on 02/09/12 at 3:10 PM, revealed the vials should have been dated when opened. In regards to the medications being in the wrong box, she stated the nurses should check the bottles when removing the medication from the boxes to ensure it was the correct medication. Interview with LPN #3, on 02/09/12 at 4:00 PM, revealed he was the one who failed to label the vials when opened and they should be labeled as they are only good for 30 days.	F 431	by the director of nursing and staff development coordinator regarding the storage of medication and dating items as indicated when opened. Licensed staff education was initiated on 2/28/2012 and complete on 3/1/2012. 4. The Administrative Nursing (which consist of Director of Nursing, Assistant Director of Nursing, Unit Managers, and Staff Development) will monitor medication carts 5 times a week times for 4 weeks to determine that medications are stored appropriately. This audit will include a review of medications to validate they are not outside of there expiration dates. At that time the audit will move to 10 audits a month x 2 months. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the Director of Nursing and/or Assistant Director of Nursing. The results of these audits will be submitted to the QAA	
F 514 SS-B	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.	F 514 (P-28)		



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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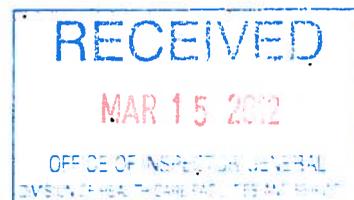
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F 514	<p>Continued From page 22</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to accurately document in the clinical record pertinent information regarding fluid intake to ensure adequate hydration for one (1) of twenty-five (25) sampled residents. Resident #3 received all nutrition and hydration through a gastrostomy tube (G-tube). The physician had ordered 300 ml every six (6) hours. However, the facility failed to document the amount of fluids administered through the G-tube.</p> <p>The findings include:</p> <p>The policy for enteral feeding provided by the facility, dated 2005, revealed the policy only addressed medication flushes and the facility did not provide a policy for specific documentation protocol in the clinical record.</p> <p>Review of the clinical record for Resident #3 revealed the facility admitted the resident on 11/17/09. The record revealed current diagnoses of Dementia, Dysphagia with Gastrostomy tube, Seizure Disorder, Urinary Retention, Hypertension, Depression, and Diabetes. The resident was recently hospitalized (December 16-19, 2011) for a perineal wound caused by long standing use of an indwelling catheter and a urinary tract infection. The indwelling catheter was removed and a suprapubic catheter was inserted. The facility readmitted the resident on December 19, 2011. The record revealed a physician's order for water flushes, 300 ml every 6 hours via the G-tube. Review of the December Enteral Flow record revealed the 300 ml water</p>	F 514	<p>committee. The QAA committee will determine if any additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/9/12.</p> <p>F 514</p> <p>1. The unit manager added water flushes to resident #3's MAR, during the annual survey.</p> <p>2. All residents who have gastric tubes were identified on 2/9/2012 by the administrative staff nurses (unit managers) and validated appropriate flush orders and flow sheets; and no other issues were identified.</p> <p>3. The protocol for recording water flushes was reviewed by the director of nurses and found to be acceptable. Education was provided to licensed nursing</p>	



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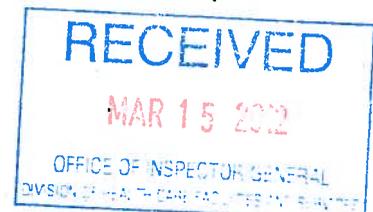
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F 514	<p>Continued From page 23 flushes had not been initiated until 12/27/11, nine (9) days after the resident was readmitted to the facility.</p> <p>Continued review of the clinical record revealed the February Enteral Flow record did not include the water flushes and there was no documented evidence in the clinical record any water flushes had been provided. Request for the January Enteral Flow record revealed the form had been removed from the clinical record and the facility could not find the form.</p> <p>Interview with License Practical Nurse (LPN) #8, on 02/09/12 at 10:00 AM, revealed the February Enteral record did not have the water flushes included. She stated she was looking for the January record but had not been successful. She said the nurses were providing water flushes as ordered but acknowledged they had not documented the amount and she could not be sure what amount was given. She indicated the February rewrite orders failed to include the water flushes.</p> <p>Interview, on 02/09/12 at approximately 4:00 PM, with The Director of Nursing, LPN#8, and the Nurse Consultant revealed the facility nurses had failed to document the amount of water flushes provided for Resident #3 for February 2012. In addition, they stated the January Enteral record had been removed from the clinical record and could not be found. The Director of Nursing stated the nurse who conducted the February rewrite orders failed to include the water flushes. In addition, no staff nurse had identified or documented in the clinical record how much water had been given. She stated interview with</p>	F 514	<p>staffs, by the director of nurses and staff development coordinator. The education included information regarding documentation of gastric flushes. Licensed staff education was initiated on 2/28/2012 and complete on 3/1/2012.</p> <p>4. The administrative nursing staffs (unit managers) will audit gastric tube flow sheets five times a week for four weeks to determine if gastric flushes are being recorded as ordered. Following the initial four week audit, this review will continue weekly for three months. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the Director of Nursing or Assistant Director of Nursing to validate that flush orders and flow sheets are accurate.</p>		



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
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F 514	<p>Continued From page 24</p> <p>the staff nurses working that day revealed they were providing 300 ml every six (6) hours as ordered by the physician in December 2011. The Director of Nursing stated a stat Basic metabolic panel (BMP) was obtained earlier and the results were normal findings. She stated she felt it was a documentation problem rather than the water flushes not being provided.</p> <p>Review of the BMP lab revealed the specimen was drawn, on 02/09/12 at 11:50 AM, with results reported at 3:40 PM. The resident's BUN and Creatinine (kidney function tests that would indicate dehydration) revealed normal ranges.</p> <p>Observation of Resident #3, on 02/09/12 at 10:00 AM, during a skin assessment with LPN-#8, revealed the resident's skin was moist without any skin breakdown. On 02/09/12 at 7:50 AM, the resident was observed lying in bed awake. Tube feeding of Glucerna was infusing at 60 cc/hr and the urine in the catheter tubing was yellow. The resident's mouth was moist.</p>	F 514	<p>The results of these audits will be submitted to the QAA committee. The QAA committee will determine if any additional education or auditing is required.</p> <p>5. The facility alleges compliance on 3/9/12.</p>	



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40206	
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1967, 1974, 2011 (New Ambulance Entrance and Stairwell addition under construction))</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Three (3) stories, Type II Unprotected.</p> <p>SMOKE COMPARTMENTS: Twelve (12) smoke compartments. Four (4) compartments per floor.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors. Upgraded in 2008</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. New service installed in 2011.</p> <p>GENERATOR: Type II generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was initiated on 02/07/12 and concluded on 02/08/12. Highlands Nursing & Rehabilitation Center was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for one-hundred and fifty-four (154) beds and the census was one-hundred and thirty-six (136) on the days of the survey.</p> <p>The findings that follow demonstrate</p>	K 000		

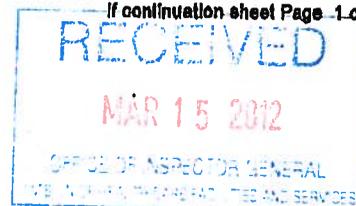
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Karee Hamilton Administrator x 3-14-2012

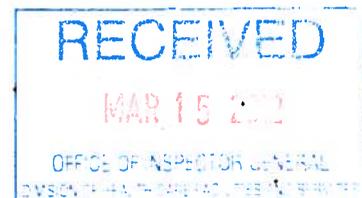
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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



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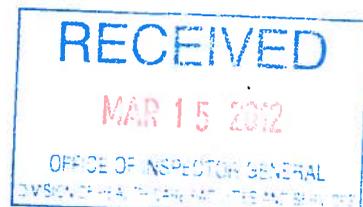
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K 000	Continued From page 1 noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)	K 000		
K 026 SS=E	Deficiencies were cited with the highest deficiency identified at F level. NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain smoke barriers that would resist the passage of smoke between smoke compartments, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, approximately forty-five (45) residents, staff and visitors. The facility is licensed for one-hundred and fifty-four (154) beds and the census was one-hundred and thirty-six (136) on the days of the survey. The findings include:	K 026	K 025 1. Maintenance Director repaired the B wing penetrations: 6x6 with new conduit passing through and a 12x18 with new data wires passing through on 2/9/12. 2. Maintenance Director has checked all other firewalls and found no other penetrations needing repair. 3. Administrator provided education on March 8, 2012 to the Maintenance Director related to K025 as it pertains to NFPA 19.3.7.3, 19.3.7.5, 19.1.6.3 and 19.1.6.4. Administrator created an inspection grid for auditing of all fire walls for penetrations; and grid has been added to the Maintenance Department's Preventative Maintenance calendar for quarterly inspections.	



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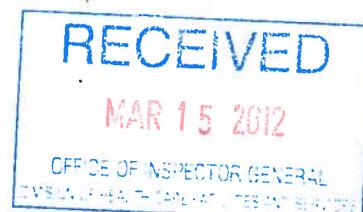
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K 026	Continued From page 2 Observation, on 02/08/12 at 11:20 AM, with the Maintenance Director revealed the one (1) hour rated smoke barrier located in the second floor B Wing, extended above the ceiling and had two (2) penetrations by recent, new construction: a 6 " x 6 " penetration with new conduit passing through it, and a 12 " x 18 " penetration with new data wires passing through it. The spaces around the penetrations were not filled with a material rated equal to the partition and could not resist the passage of smoke. Interview, on 02/08/12 at 11:20 AM, with the Maintenance Director revealed he was unaware of the penetrations in the smoke barrier and acknowledged new construction activity within the building. Reference: NFPA 101 (2000 Edition). 8.3.6.1 Pipes, conduits, bus ducts, cables, wires, air ducts, pneumatic tubes and ducts, and similar building service equipment that pass through floors and smoke barriers shall be protected as follows: (a) The space between the penetrating item and the smoke barrier shall 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (b) Where the penetrating item uses a sleeve to penetrate the smoke barrier, the sleeve shall be solidly set in the smoke barrier, and the space between the item and the sleeve shall	K 026	4. Maintenance Director will check fire walls monthly for four months on all units to determine if new penetrations become apparent and in need of repair. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by the Administrator and submitted to the QAA committee who will determine if any further interventions are required. 5. Facility alleges compliance on 3/9/12.	



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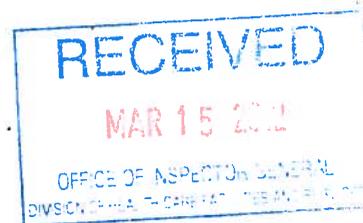
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K 025	Continued From page 3 1. Be filled with a material capable of maintaining the smoke resistance of the smoke barrier, or 2. Be protected by an approved device designed for the specific purpose. (c) Where designs take transmission of vibration into consideration, any vibration isolation shall 1. Be made on either side of the smoke barrier, or 2. Be made by an approved device designed for the specific purpose.	K 025	K 029 1. Maintenance Director placed a smoke resisting partition in the Dry Storage Room located in the Kitchen on 2/29/12; and placed self closing devices on Ground Floor C Wing Door on 2/9/12; and O2 room on unit 2B on 2/24/12. 2. Maintenance Director has checked all other Kitchen areas and found no additional hazardous storage areas needing smoke resisting partitions. Facility checked all other storage areas and found no additional needs for self closing devices. 3. Administrator provided education on March 8, 2012 to the Maintenance Director related to K029 as it pertains to NFPA 19.3.2.1. Administrator created an inspection grid for auditing of all storage areas for smoke resisting partitions; and self	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.6.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards in accordance with NFPA Standards. The deficiencies had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and fifty-four (154) beds and the census was one-hundred and thirty-six (136) on the days of the survey.	K 029		



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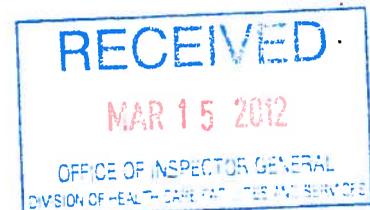
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 188039	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40208	
(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 029	Continued From page 4 The findings include: Observation, on 02/08/12 at 9:26 AM, with the Maintenance Director revealed a new air handling unit and ductwork had been installed in the Dry Storage Room located in the Kitchen. Interview, on 02/08/12 at 9:26 AM, with the Maintenance Director revealed he was not aware the Dry Storage Room was considered a hazardous storage area and required to be separated from other areas by smoke resisting partitions and doors with self closing devices. Observation, on 02/08/12 at 10:45 AM, with the Maintenance Director revealed the door to the storage room located in the Ground Floor, C Wing, was not equipped with a self closing device. Interview, on 02/08/12 at 10:45 AM, with the Maintenance Director revealed he was not aware of the self closing device being removed from the door. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic	K 029	closing devices on doors; and grid has been added to the Maintenance Department's Preventative Maintenance calendar for quarterly inspections. 4. Maintenance Director will conduct a monthly audit for four months to assure that no other storage areas are in need of smoke resistance partitions or self closing devices and will be repaired accordingly. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by the Administrator and submitted to the QAA committee who will determine if any further interventions are required. 5. Facility alleges compliance on 3/9/12.	



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185038	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 02/08/2012
NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 028	Continued From page 5 extinguishing shall be permitted to be in accordance with 19.3.6.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 028		
K 038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038	K 038 1. Maintenance Director placed proper signage on 2/23/12 for 15 second delayed egress doors leading to the stairs located on the second floor at the North and South	



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1706 STEVENS AVENUE LOUISVILLE, KY 40208	
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K 038	<p>Continued From page 6</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that exits were properly marked in accordance with NFPA standards. The deficiencies had the potential to affect each of the twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and fifty-four (154) beds and the census was one-hundred and thirty-six (136) on the days of the survey.</p> <p>The findings include:</p> <p>Observations, on 02/07/12 between 1:40 PM and 4:30 PM, and on 02/08/12 between 8:16 AM and 10:46 AM, with the Maintenance Director revealed the facility had fifteen (15) second delayed egress locks installed on the doors leading to the stairs located on the second floor, at the North and South ends of the "C" Wing, and the East and West ends of the "B" Wing; and on the first floor, at the East and West ends of the "B" Wing. On the ground floor, the facility had thirty (30) second delayed egress locks installed on the exterior door located at the South end of the "C" Wing and the door to the Entry Vestibule located in the North side Reception area. The referenced eight (8) doors equipped with delayed egress locks did not display the proper signage for egress. This was confirmed by the Director of Maintenance during the observations.</p> <p>Interviews, on 02/07/12 between 1:40 PM and</p>	K 038	<p>ends of the "C" wing and the East and West ends of the "B" Wing; and on the first floor at the East and West ends of "B" wing . The facility placed a proper signage on 2/23/12 for 30 second delayed egress doors located on the ground floor exterior door located at the south end of the C Wing and the door to the Entry Vestibule located in the North side Reception area.</p> <p>2. Maintenance Director has checked all other egress doors and found no signage needed.</p> <p>3. Administrator provided education on March 8, 2012 to the Maintenance Director related to K038 as it pertains to NFPA 7.2.1.6.1. Administrator created an inspection grid for auditing of all egress doors for signage; and grid has been added to the Maintenance Department's Preventative Maintenance calendar for quarterly inspections.</p>	



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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1708 STEVENS AVENUE LOUISVILLE, KY 40208	
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K 038	Continued From page 7 4:30 PM and on 02/08/12 between 8:15 AM and 10:45 AM, with the Director of Maintenance, revealed he was unaware that the doors did not display the required signage. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.6.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only.	K 038	4. Maintenance Director will conduct a monthly audit for four months to assure that all signage is in placed on all 15 second and 30 second egress doors. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by the Administrator and submitted to the QAA committee who will determine if any further interventions are required. 5. Facility alleges compliance on 3/9/12.	



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K 038	Continued From page 8 Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS NFPA 101 LIFE SAFETY CODE STANDARD	K 038		
K 062 SS=D	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 26, 9.7.6 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure fire extinguishers had the proper signage in accordance with NFPA standards. The deficiency had the potential to affect one (1) of twelve (12) smoke compartments, residents, staff, and visitors. The facility is licensed for one-hundred and fifty-four (154) beds, and the census was one-hundred and thirty-six (136) on the day of the survey. The findings include: Observation, on 02/08/12 at 9:20 AM, with the Maintenance Director revealed the portable "K" type fire extinguisher located next to the exhaust hood in the kitchen, did not have the required	K 062	K 062 1. Maintenance Director placed proper signage on 2/27/12 in the Kitchen near the fire extinguisher that stated the fire protection system shall be activated prior to using the fire extinguisher. 2. Registered Dietician inserviced the dietary staff on 2/28/12 that in case of fire, the ansul fire protection system will activate prior to use of the fire extinguisher. 3. Administrator provided education on March 8, 2012 to the Maintenance Director related to K062 as it pertains to NFPA 10.2-3.2.1. Administrator created an inspection grid for auditing	

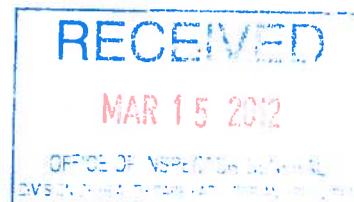


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K 062	Continued From page 9 signage on display. Interview, on 02/08/12 at 9:20 AM, with the Maintenance Director revealed he was unaware of the requirement that a sign was to be displayed near the "K" type fire extinguisher that stated the fire protection system shall be activated prior to using the fire extinguisher. Reference: NFPA 10 (1998 edition) 2-3.2.1 A placard shall be conspicuously placed near the extinguisher that states that the fire protection system shall be activated prior to using the fire extinguisher. NFPA 101 LIFE SAFETY CODE STANDARD Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the	K 062	Administrator provided education on March 8, 2012 to the Maintenance Director related to K062 as it pertains to NFPA 10.2-3.2.1. Administrator created an inspection grid for auditing the signage for the ansul system; and grid has been added to the Maintenance Department's Preventative Maintenance calendar for quarterly inspections. 4. Maintenance Director will conduct a monthly audit for four months to assure that the signage is in place near the fire extinguisher in the Kitchen. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by the Administrator and submitted to the QAA committee who will determine if any further interventions are required.	
K 076 SS=E		(PH) K 076		

5. Facility alleges compliance on 3/9/12.



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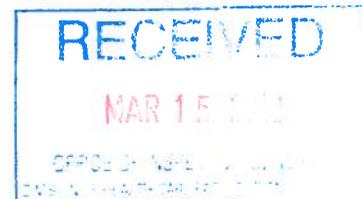
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40206
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K 078	<p>Continued From page 10</p> <p>Oxygen Storage Room was enclosed by a one-hour separation in accordance with NFPA standards. The deficiency had the potential to affect two (2) of twelve (12) smoke compartments, residents, staff and visitors. The facility is licensed for one-hundred and fifty-four (154) beds and the census was thirty-six (36) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 02/07/12 at 2:35 PM, with the Maintenance Director revealed the Second Floor " B " Wing, Oxygen Storage Room had the existing ceiling removed for the installation of new duct work. The removal of the ceiling voided the required one-hour fire resistance rating of the enclosed room.</p> <p>Interview, on 02/07/12 at 10:30 AM, with the Maintenance Director revealed The Second Floor " B " Wing Oxygen Storage Room was no longer separated by a one-hour rated enclosure.</p> <p>Reference NFPA 101 (2000 Edition). 19.3.2.4 Medical Gas.</p> <p>Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities.</p> <p>Reference: NFPA 99 (1999 Edition). 4-3.1.1.2 Oxygen storage locations of greater</p>	K 078	<p>K 078</p> <ol style="list-style-type: none"> The Maintenance Director moved the Oxygen Storage Room from its location to a location across the hall February 21, 2012. This location has the required 1-hour fire resistance rating and has a self closing device placed on the door and proper signage. Maintenance Director instructed all staff as to the new location of the Oxygen storage on February 21, 2012. All residents have the potential to be affected by inadequate storage of oxygen. Administrator created an inspection grid for auditing the signage for the O2 room and the self closing device for the door; and grid has been added to the Maintenance Department's Preventative Maintenance calendar for quarterly inspections. 	
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NAME OF PROVIDER OR SUPPLIER HIGHLANDS NURSING & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40208	
(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 078	Continued From page 11 than 3,000 cu. Ft. are enclosed by a one-hour separation	K 078	4. Maintenance Director will conduct a monthly audit for four months to assure that the the Oxygen Storage remains in place. Following the initial audits, this process will be reviewed again in August 2012 and October 2012 by the QAA committee. The QAA committee will validate that this process is occurring per regulation. The audit in August 2012 and October 2012 will be completed by the Administrator and submitted to the QAA committee who will determine if any further interventions are required. 5. Facility alleges compliance on 3/9/12.	

