

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

PRINTED: 04/15/2014  
FORM APPROVED  
OMB NO. 0938-0391

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  04/03/2014
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS  A Standard Health Survey was initiated on 04/01/14 and concluded on 04/03/14 with deficiencies cited at the highest scope and severity of an "E". A Life Safety Code Survey was initiated and concluded on 04/01/14 with deficiencies cited at the highest scope and severity of an "F".  An Abbreviated Survey was conducted during the Standard Health Survey to investigate KY21517. The Division of Health Care unsubstantiated the allegation with no regulatory violations identified at this time.	F 000	Highlands POC:  To the best of my knowledge and belief, as an agent of Highlands Health and Rehabilitation Center, the following plan of correction constitutes a written allegation of substantial compliance with Federal Medicare and Medicaid requirements.  Preparation and execution of this plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the alleged deficiencies. This plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law.		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY  The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's Resident Handbook, it was determined the facility failed to ensure residents were cared for in an environment which enhanced each resident's dignity and respect for three (3) of twenty-five (25) Sampled Residents, Residents #5, #13 and #15 and five (5) of eighteen (18) Unsampled Residents, Unsampled Residents A, H, I, J & K. The staff were observed entering Resident #13's room without knocking. The staff failed to clean and file Resident #5,	F 241			

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

TITLE

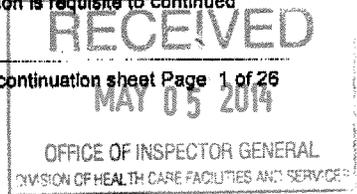
(X6) DATE

*X Robert Johnson*

*X Administrator*

*X 5/1/14*

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

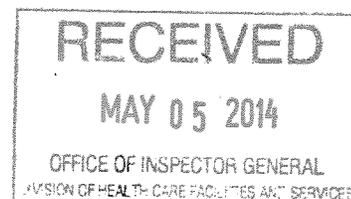


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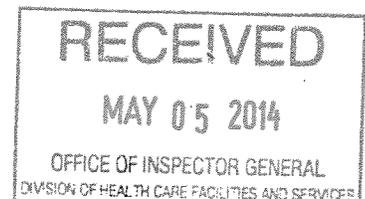
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F 241	<p>Continued From page 1</p> <p>Resident #15 and Unsampled Resident A's fingernails that also had a dark brown substance under the nails. In addition, the staff would adjust the heat/air conditioning in Residents H, I, J, and K's rooms to suit the staff, if they were too hot or too cold, and a Certified Nursing Assistant (CNA) rummaged in Resident I's bedside table drawer as reported by the resident.</p> <p>The findings include:</p> <p>Review of the facility's Resident Handbook, dated March 2007, revealed the resident had the right to a dignified existence and the facility strives to promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect. In addition, the Resident Handbook revealed the resident had the right to receive services in the facility with reasonable accomodation of individual needs and preferences.</p> <p>1. Interview with Unsampled Residents H, I, J and K during the group interview, on 04/01/14 at 2:30 PM, revealed they had seen staff adjust the personal heat/air conditioning units in their rooms and when asked why they were doing so the staff told them they were too hot or too cold on the nursing unit. Interview with Resident I, on 04/01/14 at 2:45 PM, during the group interview revealed he/she had seen a CNA rummaging in the bedside commode drawer in his/her room and the CNA told the resident she was looking for her car keys. Resident I indicated he/she did not remember the CNA's name and Resident I reported the incident to a staff, but the resident could not remember that person's name. Resident I stated he/she had not seen the CNA, who had rummaged in his/her commode drawer.</p>	F 241			



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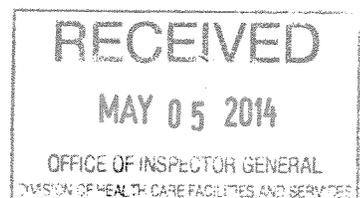
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F 241	<p>Continued From page 2 since then.</p> <p>Review of the facility's list of interviewable residents revealed the facility assessed Unsampled Resident H, Resident I, Resident J and Resident K as being interviewable with a Brief Interview of Mental Status (BIMS) score of fifteen (15) for Unsampled Residents H, I, and J and a score of thirteen (13) for Unsampled Resident K.</p> <p>2. Observation, on 04/02/14 at 12:20 PM, revealed Unsampled Resident A eating independently in the main dining room with long unfiled fingernails with a dark brown substance under the nails. Further observation on 04/02/14 at 12:30 PM revealed Resident #5 and Resident #15 eating independently in the main dining room with each having long unfiled fingernails with a dark brown substance under the nails.</p> <p>Review of the list of interviewable residents provided by the facility revealed the facility assessed Unsampled Resident A and Resident #5 with a BIMS score of nine (9) indicating they were interviewable. Further review of the interviewable residents list revealed Resident #15 was assessed by the facility as being non-interviewable.</p> <p>Interview with Unsampled Resident A, on 04/02/14 at 1:15 PM, revealed the facility would sometimes file his/her fingernails, they were sometimes cleaned when the resident had his/her showers and he/she did not prefer long and dirty appearing fingernails.</p> <p>Interview with Resident #5, on 04/01/14 at 12 PM, revealed the facility did not clean his/her</p>	F 241	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Residents #5, #15 and Unsampled Resident A had their nails cleaned by nursing staff on 4/3/14 upon identification of issue. Residents H, I, J and K were assessed by Social Services on 4/3/14 if their room temperature met their personal preference upon notification of issue and no concerns were voiced. Resident #13 was found not to have been negatively affected by the deficient practice. Resident I has been interviewed by Social Services on 4/22/14 to ensure that no items have been reported missing.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? An all staff education (to include each department in facility) on Dignity and Resident Rights to include knocking on doors, not adjusting residents' heating and AC for employee preference, and respect for personal belongings will be conducted by the Staff Development Coordinator to be completed for all employees by 4/30/14. Any employee such as PRN status, that may not have had the education, shall not begin their next shift until the education is completed. Education will be provided to nursing staff on appropriate resident nail care to be provided during showers and PRN by the Staff Development Coordinator to be completed by 4/30/14.</p>		



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F 241	<p>Continued From page 3 fingernails during showers.</p> <p>Interview with CNA #7, on 04/03/14 at 4:29 PM, revealed she would sometimes adjust the heat/air conditioning unit in a resident's room, if it was too hot or cold, to make her comfortable when working. CNA #7 stated that might be a sign of disrespect. She indicated the CNA's were to clean a resident's fingernails after the showers, but sometimes they did not have time. She further indicated they did not always have files to tend to the resident's nails.</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 at 5:30 PM, revealed the staff are not to adjust the heat/air conditioning units in resident rooms to suit their own temperature needs. She further stated the residents' nails should be cleaned after their showers and they should be filed as necessary. The DON further stated she did not know there was a lack of nail files and she did not do any monitoring of the residents' nails.</p> <p>3. Observation of Resident #13, on 04/03/14 at 11:20 AM, 11:32 AM and 11:50 AM, revealed Certified Nurse Aide (CNA) #6 entering the resident's room without knocking or verbally requesting permission to enter the resident's room.</p> <p>Interview with Resident #13, on 04/03/14 at 11:50 AM, revealed the resident preferred for staff to knock before entering as the resident might be busy or napping.</p> <p>Interview with CNA #6, on 04/03/14 at 11:54 AM, revealed he was trained, by the facility, to knock prior to entering a resident's room. He stated he</p>	F 241	<p>How will the facility monitor performance to ensure solutions are sustained? Audit nail care of 100% of residents to be completed by Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff by 4/23/14. (Exhibit A) Audits of nail care for a minimum of 5 residents per unit shall then be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff 3 times per week for 4 weeks (Exhibit A1); then once per week for 2 months, for a total of 12 week period. As this center has a Quality Assurance Process Improvement Meeting on a monthly basis versus the required quarterly, this will provide opportunity for the specific audit results to be reviewed for 3 consecutive months to determine if additional interventions would be required. Social Services shall interview a minimum of 20 interviewable residents, as well as observation of 5 non-interviewable residents per week for 4 weeks to evaluate for potential dignity and resident rights issues such as staff knocking on doors and staff respect of personal property, to include room temperature controls to the resident preference, then a minimum of 5 interviewable residents and observation of 5 non-interviewable residents weekly for an additional 2 months, for a total of 12 week period. (Exhibit B). The audits shall be maintained on the facility developed audit tools. (see attached Exhibits) Results of these audits shall be taken to the facility Quality Assurance and Process Improvement Committee for 3 months to determine if further interventions are warranted. As</p> <p style="text-align: right;">(cont.)</p>		



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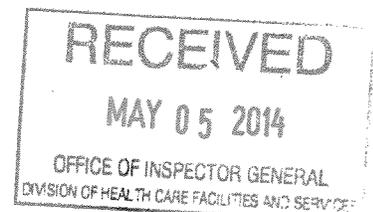
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F 241	Continued From page 4 did not knock because the resident was like his mother. He stated he was sorry and should have knocked to protect the resident's privacy.  Interview with the Unit Manager, on 04/03/14 at 5:30 PM, revealed the CNA should have knocked prior to entering any residents room. She stated there was no facility policy on knocking; however, that was the facility's expectation. She stated it showed respect for the residents room being their home.	F 241	(cont.) stated previously, this center has a Quality Assurance Process Improvement Meeting on a monthly basis versus the required quarterly, this will provide opportunity for the specific audit results to be reviewed for 3 consecutive months to determine if additional interventions are required. The survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.		
F 246 SS-E	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES  A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy regarding the Call Light System, it was determined the facility failed to ensure accessibility of resident call lights for four (4) of twenty-five (25) Sampled Residents, Residents #3, #7, #13 and #18, and six (6) of eighteen (18) Unsampled Residents, Unsampled Residents B, C, D, E, F and G. The staff failed to place the call lights within reach of the residents.  The findings include:	F 246		5-1-14	

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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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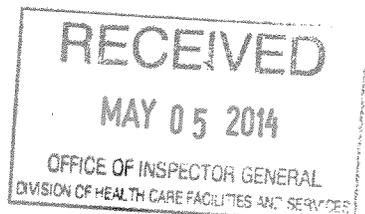
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F 246	<p>Continued From page 5</p> <p>Review of the facility's policy regarding the Call Light System, dated 11/01/11, revealed the resident call light must be placed within reach at all times, regardless of staff assessment of resident ability to use it.</p> <p>1. Observation of Resident #13, on 04/01/14 at 8:40 AM, during the initial tour revealed the resident was sitting upright in bed eating breakfast with his/her call light tied to the quarter bedrail below the mattress and out of reach. Further observation, on 04/01/14 at 2:00 PM, revealed Resident #13 sitting upright in bed watching television with his/her call light not accessible.</p> <p>Review of the record for Resident #13 revealed the facility had assessed him/her on 03/16/14 with a Brief Interview of Mental Status (BIMS) score of fifteen (15) indicating the resident was interviewable.</p> <p>Interview with Resident #13, on 04/01/14 at 2:00 PM, revealed he/she could not reach the call light to let the staff know he/she needed their assistance. Resident #13 further revealed the only way he/she had to contact the staff was to yell.</p> <p>2. Observations of Resident #7, Resident #18 and Residents B, C, D, E, F and G, on 04/03/14 at 10:00 AM and 2:48 PM, revealed all were sleeping and none had their call lights accessible to them whether they were lying in their beds or sitting in a chair by their beds.</p> <p>Interview with Certified Nursing Assistant (CNA) #9, on 04/01/14 at 2:15 PM, in Resident #13's room revealed the resident's call light should be</p>	F 246	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Call light placement was assessed and appropriate placement ensured for Residents #3, #7, #13, #18 and Unsampled residents B, C, D, E, F and G on 4/3/14 when issue identified.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice. An audit of 100% call lights to ensure functioning and clamp in place, accessibility to resident if applicable at that time, shall be completed by Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff by 4/23/14.(Exhibit C)</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? An audit of 100% call lights to ensure functioning and clamp in place, accessibility to resident if applicable at that time, shall be completed by Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff by 4/23/14.(Exhibit C) Education shall be provided by the Staff Development Coordinator to all staff, including all departments, in regards to call lights being placed and secured in reach of residents while in their room to be completed by 4/30/14.</p>		



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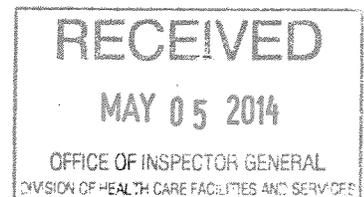
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F 246	<p>Continued From page 6</p> <p>within his/her reach at all times. She stated Resident #13's call light was tied around the bottom of the quarter siderail and inaccessible to the resident. CNA #9 indicated she was assigned to Resident #13 and she had failed to ensure the call light was accessible to the resident.</p> <p>Interview with CNA #8, on 04/03/14 at 4:50 PM, revealed it was the responsibility of all of the nursing staff to ensure the residents' call lights were accessible to them. He further stated he was not aware of any nursing staff monitoring the accessibility of call lights to residents.</p> <p>3. Observation of Resident #3, on 04/02/14 at 2:30 PM and 04/03/14 at 10:23 PM, revealed the resident was laying in bed with no accessible call light. Licensed Practical Nurse (LPN) #2 was notified and observed searching the room for the call light which was found on the floor near his/her roommate's bed.</p> <p>Interview with LPN #2, on 04/03/14 at 10:50 AM, revealed the call light did not have a clamp to attach the light to the resident's bed. The LPN revealed the resident should have the light in place to allow the resident a method of notifying staff of needs. The LPN revealed the call light was necessary for safety reasons. The LPN revealed she did monitor for call light placement, but did not notice the missing clip to help keep the call light attached.</p> <p>Interview with the Director of Nursing (DON), on 04/03/14 at 5:30 PM, revealed all residents should have their call lights accessible to them whether they were laying abed or in a chair in their rooms. She stated she had monitored the nursing units during the standard survey for call</p>	F 246	<p>How will the facility monitor performance to ensure solutions are sustained? Call light placement audit for 100% in-room residents to be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff for each shift for 7 days. (Exhibit C) Call light accessibility rounds shall then be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff for 100% of in-room residents daily for 3 additional weeks (Exhibit C1), and continue for 100% of in-room residents weekly for an additional 2 months (8 weeks). The results of the audits shall be taken to the facility Quality Assurance Process Improvement committee for 3 months to determine if additional interventions are warranted. This center has Quality Improvement Process Improvement meetings on a monthly basis versus the required quarterly basis, and thus the audit results shall be reviewed for 3 consecutive months to determine if additional interventions would be warranted. The survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.</p>	5-1-14	



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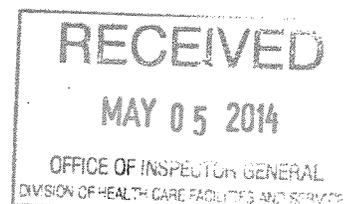
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F 246	Continued From page 7 light accessibility, but did not recognize a problem with the call lights. She could not give a reason why ten (10) residents were identified with inaccessible call lights from 04/01/14 to 04/03/14. The DON stated it was the responsibility of all nursing staff to ensure the residents had accessible call lights and it was her responsibility to monitor the work of all of the nursing staff.	F 246			
F 252 SS=E	483.15(h)(1) SAFE/CLEAN/COMFORTABLE/HOMELIKE ENVIRONMENT  The facility must provide a safe, clean, comfortable and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's corporate Resident Handbook, and the corporate Lighthouse Manual, it was determined the facility failed to provide a homelike environment for resident rooms on three (3) of four (4) resident living units, the Lighthouse Unit, Unit 1B and Unit 2B.  The findings include:  Review of the corporate Resident Handbook, dated March 2007, revealed "We cannot erase the fact that the facility is not home." Review of Section VI Physical Environment of the corporate Lighthouse Manual revealed the following design criteria had been identified as being associated with positive outcomes in specialized dementia care units. These guidelines represented goals	F 252			



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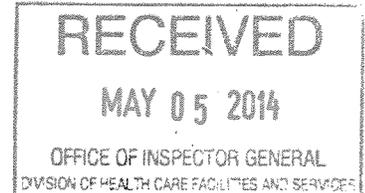
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F 252	<p>Continued From page 8</p> <p>that the Lighthouse unit could strive toward to ensure that residents remain as oriented and independent as possible. Specialized care units reported that residents living with dementia responded well to an overall residential ambience created by using residential finishes and furnishings. When possible a comforting atmosphere with familiar objects help residents maintain a sense of normalcy. Use residential furnishings and decorative objects to stimulate a home-like environment and avoid the color white as persons living with dementia can not see this color well. The use of color may provide sensory stimulation for persons living with dementia. Another aspect of the specialized care unit is the availability of easily accessible outdoor space to reduce problem behaviors. Outdoor spaces should provide comfortable and interesting walking and sitting areas, accessible gardens for resident gardening, and safe and attractive plantings may increase the residents' quality of life and help reduce problem behaviors.</p> <p>1. Observation of the Lighthouse Unit, on 04/01/14 during the entrance tour of the facility from 8:30 AM to 10:45 AM, revealed rooms 103B, 105B, 106, 112B, 119B, 121 and 122 were painted white with a lack of furnishings, accessories, or decorations to provide a homelike environment. In addition rooms 147 and 148B on 1B living unit and rooms 230 and 246B on 2B living unit had a lack of furnishings, accessories, or decorations to provide a homelike environment.</p> <p>Observations of the Lighthouse Unit, on 04/01/14 at 8:30 AM, 10:00 AM, 1:30 PM, 2:00 PM, and 4:00 PM and on 04/02/14 at 9:00 AM, and 10:00 AM, revealed none of the residents being taken</p>	F 252	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Letters were mailed on 4/30/14 to families/responsible parties for residents of Units 1B, 2B and the Lighthouse Unit to encourage bringing in personal items for the resident to assist in creating a homelike atmosphere for the resident. (see copy of letter attached) The identified rooms of 103B, 105B, 106, 112B, 119B, 121, 122, 147, 148B, 230, 246B were evaluated by social services for furnishings/decorations/accessories that are specific to the likes of the resident on 4/29/14 and items were purchased (see attached purchase orders) and put in place on 4/30/14 by the facility staff to enhance the homelike environment. Tablecloths were obtained from facility supply and put in place for the Lighthouse unit dining area starting on 4/29/14. The Activity Department has scheduled a minimum of weekly seasonal outdoor activities (weather permitting) for the residents of the secured unit that will include seasonal vegetable and flower beds. This is referenced on the attached "Event Calendar" as "Patio Time Thursdays @ 2:30."</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p>	



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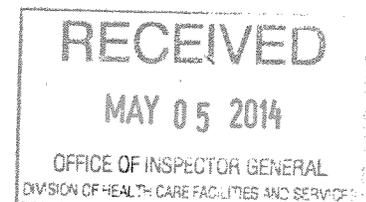
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F 252	<p>Continued From page 9</p> <p>out-of-doors to the facility's enclosed area or for a walk.</p> <p>Observation of the facility's enclosed outdoor area, on 04/02/14 at 11:00 AM, revealed the area was directly outside the facility resident smoking room and approximately twelve (12) feet deep by twenty (20) feet long. Further observation at that time revealed the area had a concrete pad outside the smoking room doors and a large mechanical unit at the left end of the space. There was minimal grass/dirt area observed in the space and pooled water in several areas of the space. Continued observation revealed no trees in the space, no evidence of garden plantings, either decorative or for food products, and a concrete wall enclosing the area approximately ten (10) feet high.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 04/03/14 at 4:56 PM, revealed she had worked on the Lighthouse unit for one (1) year and she was not aware if the staff had taken residents living there out-of-doors to the facility enclosed area or for a walk. She also stated the residents' rooms should have some decorations, but a lot of the residents there had State Guardians who did not provide room decorations or homelike decorations. She further stated she was not aware of anyone having the responsibility to ensure the residents had a homelike environment.</p> <p>2. Observation of the meal service on the Lighthouse Unit, on 04/02/14 at 11:52 AM, revealed none of the tables had tablecloths or placemats. The television was on but no volume, and no music was playing leaving the room very quiet.</p>	F 252	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? Letters were mailed on 4/30/14 to families/responsible parties for residents of Units 1B, 2B and the Lighthouse Unit to encourage bringing in personal items for the resident to assist in creating a homelike atmosphere for the resident. (see copy of letter attached) The identified rooms of 103B, 105B, 106, 112B, 119B, 121, 122, 147, 148B, 230, 246B were evaluated by social services for furnishings/decorations/accessories that are specific to the likes of the resident on 4/29/14 and items were purchased (see attached purchase orders) and put in place on 4/30/14 by the facility staff to enhance the homelike environment. Tablecloths were obtained from facility supply and put in place for the Lighthouse unit dining area starting on 4/29/14. The Activity Department has scheduled a minimum of weekly seasonal outdoor activities (weather permitting) for the residents of the secured unit that will include seasonal vegetable and flower beds. This is referenced on the attached "Event Calendar" as "Patio Time Thursdays @ 2:30."</p>		



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F 252	Continued From page 10  Interview with Certified Nursing Assistant (CNA) #2, on 04/03/14 at 1:17 PM, revealed the facility decided to remove the tablecloths during dining services on the Lighthouse Unit several weeks ago. The CNA revealed a couple of resident's were using them as napkins or Kleenex, others get fixated on stains on the table and keep rubbing at them instead of eating. So it was decided to remove them. However, the CNA revealed several residents ask what happened to the tablecloths because they liked them.  Interview with the Registered Nurse Unit Manager (RNUM) for the Lighthouse unit, on 04/03/14 at 5:05 PM, revealed the residents on that unit had minimal homelike environments because they had State Guardians and because some of them had behaviors of destroying property. She stated she did not know if it was anyone's responsibility in the facility to ensure the residents had a homelike environment. The RNUM indicated the staff were allowed to take the residents out-of-doors, but she was not aware of it having occurred in the past five (5) months since she had been the RNUM.  Interview with the Lighthouse Coordinator (LC), on 04/03/14 at 5:20 PM, revealed she had been the social worker for the Lighthouse Unit and the 1B Unit for one (1) and one-half (1/2) years. She stated she was hesitant to say she was the coordinator for the Lighthouse Unit because of corporate and administrative changes. The LC indicated the rooms on the Lighthouse Unit and on the 1B Unit should be decorated and have personal items in them and she had discussed the need for that with the Administrator. She further indicated she was not aware of anyone in	F 252	How will the facility monitor performance to ensure solutions are sustained? Upon admission, residents and families will be encouraged to utilize personal items for the creation of a homelike environment. For those residents that do not have their own personal items or access to them, the social service department shall alert administration to the need, and facility administration will ensure that items are obtained to enhance the homelike environment of the resident's room. New admissions are reviewed each morning in morning stand up Monday through Friday, and the Administrator will inquire of any identified needs in regards to assisting in creating a homelike environment for the resident room. Activities will work with residents in creating craft items for resident rooms. The administrator shall review and approve all activity calendars prior to distribution. Activities shall report monthly to the Quality Assurance Process Improvement committee of the scheduled off-unit/outdoor activities of the Lighthouse Unit. Social Services shall report monthly to the Quality Assurance and Process Improvement committee in regards rooms/residents in need of assistance to make room more homelike. This facility has monthly Quality Assurance Process Improvement meetings versus the required quarterly meetings. It shall be the responsibility of the Unit Manager as directed by the Administrator and Director of Nursing Services to ensure that tablecloths are in place daily for meals on the Lighthouse unit, and that appropriate music is at an acceptable volume to provide an acceptable dining experience. The survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.	5-1-14	



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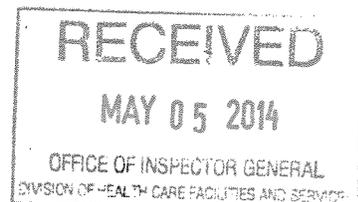
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F 252	Continued From page 11 the facility having the responsibility or the budget to ensure the resident rooms and environment were homelike. The LC revealed she was not aware if the residents on the Lighthouse went out-of-doors to the facility's enclosed area or on walks.  Interview with the Administrator, on 04/03/14 at 5:50 PM, revealed the LC had discussed the need for a homelike environment for some of the residents on the Lighthouse Unit and on the 1B Unit. He stated no one staff person had the responsibility to ensure that was done, but improvements had been made such as painting in the hallways. He further stated there was no budgetary concern regarding providing furnishings, accessories, or decorations to provide a homelike environment. He indicated it was the responsibility of everyone in the facility to ensure the residents had a homelike environment.	F 252			
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  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	F 431			

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F 431	<p>Continued From page 12 applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: It was determined the facility failed to ensure medications for residents were stored in a safe and clean environment as evidenced by eight (8) of eight (8) medication carts and six (6) of seven (7) pill crushers observed soiled. Observations of the medication carts revealed they were soiled on the inside with white and brown powdery substances, bits of paper, white and brown particles, dusty looking particles and smears of unknown substances. In addition, the pill crushers, located on top of the medication carts, were heavily coated with brown and black sticky substances.</p> <p>The findings include:</p> <p>1. Interview with the Unit Manager of Units 1B</p>	F 431			



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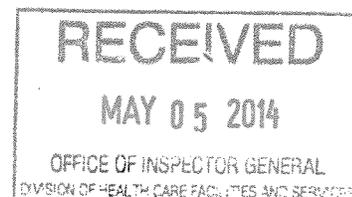
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F 431	<p>Continued From page 13 and 1C, on 04/03/14 at 5:30 PM, revealed there was no policy for cleaning medication carts and she was not sure there was a cleaning schedule. She stated she assumed management of these units in October of 2013. She stated she could not remember specifically checking the medication carts for cleanliness.</p> <p>Observation of Unit 2C, on 04/02/14 at 11:15 AM, revealed two (2) medication carts in use. The inside drawers of the medication carts were soiled with a yellow substance, powdery white particles, red particles and a brown dried substance. Each medication cart had a pill crusher. The pill crushers were heavily soiled with a greasy feeling, black and tan substance.</p> <p>Interview with Licensed Practical Nurse (LPN) # 1, on 04/02/14 at 12:03 PM, revealed the inside drawers of the medication carts were soiled and needed to be wiped down and cleaned. A soiled medication cart could cause the spread of infection and make residents sick. He stated the pill crushers were very soiled. He stated there was no designated person to clean the medication carts and he was not aware of a facility policy for cleaning the cart.</p> <p>Observation of Unit 2B, on 04/02/14 at 11:56 AM, revealed two (2) medication carts in use. The inside drawers of both carts had spills, dried substances, white powdery material, bits of paper and black/brown particles. The pill crushers on each medication cart were soiled with a black and brown sticky substance.</p> <p>Interview with LPN #8, on 04/02/14 at 12:03 PM, revealed the inside drawers of the medication carts were soiled. She stated the carts were to</p>	F 431	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. The medication carts and pill crushers were thoroughly cleaned on 4/3/14 as issue was identified.</p> <p>How will the facility identify other residents having the potential to be affected by the same deficient practice? All residents have the potential to be affected by the deficient practice.</p> <p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? Licensed nursing staff shall be inserviced in regards to appropriate medication cart cleaning to include the pill crusher by the Staff Development Coordinator by 4/30/14. The education shall also include review of the cleaning schedule that specifies assigned weekly cleaning as well as daily review for PRN cleaning needs. (Exhibit D)</p>		

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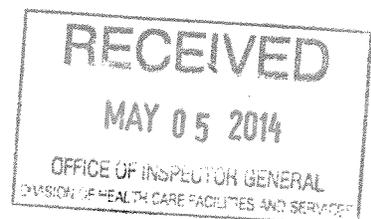
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F 431	<p>Continued From page 14</p> <p>be cleaned weekly and spills should be addressed right away to prevent the spread of infection. She stated the pill crushers were, also, soiled.</p> <p>Observation of Unit 1B, on 04/02/14 at 12:32 PM, revealed two (2) medication carts were in use. The inside drawers of the carts were soiled and contained a white powdery substance, a loose pill, and white and brown dried particles. The pill crusher on one medication cart was soiled with sticky black substance.</p> <p>Interview with LPN #5, on 04/02/14 at 12:35 PM, revealed the medication carts were to be cleaned on the night shift. She stated she was not aware of a policy for cleaning the carts or anything in writing with a cleaning schedule. She stated the carts were soiled and one pill crusher needed to be cleaned to prevent the spread of infection to residents.</p> <p>Observation of Unit 1C, on 04/02/14 at 12:32 PM, revealed small white and brown particles in the drawers of both medication carts along with a loose pill and a brown substance. The pill crushers were noted to have build-up of a brown and black sticky substance.</p> <p>Interview with LPN #7, on 04/02/14 at 12:35 PM, revealed the carts were cleaned on a weekly basis and the pill crushers were cleaned by the night shift. She stated the inside of the cart and the pill crusher were not clean. She stated the medications should be stored in clean environment to prevent spread of infection. She stated she had been trained on infection control.</p> <p>Interview with the Assistant Director of Nursing,</p>	F 431	<p>How will the facility monitor performance to ensure solutions are sustained? Med Cart audit shall be completed by Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff daily for 7 days. (Exhibit E) Reviews shall then be completed by Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff weekly for an additional 7 weeks, to total a 3 month period. Pharmacy Consultants shall also include review of cart on monthly report. Results of audit and subsequent reviews shall be reviewed at the facility Quality Assurance Performance Improvement committee meeting for 3 months to see if additional interventions are warranted. This center has a monthly Quality Assurance Process Improvement meeting versus the required quarterly; therefore the identified concern will be reviewed for 3 consecutive months to determine if additional interventions are warranted. The survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.</p>	5-1-14	



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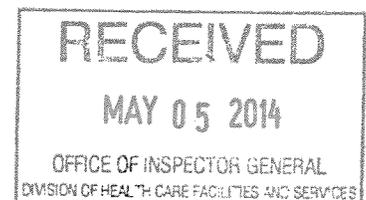
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F 431	Continued From page 15 on 04/02/14 at 11:20 AM, revealed medication carts were to be cleaned weekly. She stated the nurses had been trained to clean the carts. She stated she did not have a posted schedule. She indicated a clean medication cart prevented the spread of infection	F 431			
F 441 SS=E	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			



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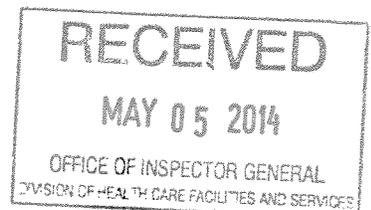
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F 441	Continued From page 16  (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to ensure staff practiced appropriate handwashing techniques to prevent the spread of infection to residents by one (1) of three (3) Certified Nurse Aides (CNA) during the lunch meal service on 04/02/14. CNA #4 was observed touching the palms of her just washed hands to the sink then continuing with passing meal trays to other residents in the dining room. CNA #4 washed her hands in a residents room then turned the water faucet off using her bare hands. She then continued to pass meal trays on the unit. In addition, the facility failed to ensure employees in one (1) of three (3) dining rooms were provided paper towels in order to dry their hands, without contamination, after handwashing. The facility failed to ensure blood glucose monitoring equipment, (used to determine multiple residents' blood glucose levels and the need for insulin therapy), was managed in a safe and clean environment as evidenced by two (2) of three (3) nurses placing clean equipment in an unclean area. Licensed Practical Nurse (LPN) #8 and #9 took a basket of blood glucose supplies from the medication cart and carried it from room to room then placed back onto the medication cart without ensuring the basket was protected from contamination. The facility failed to ensure	F 441	What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No resident was found to have been affected by the deficient practice. 100% of residents receiving enteral feedings were assessed for protective cap placement on 4/3/14 as issue was identified. Residents #21, #13 and #2 were observed by the Unit Managers on 4/3/14 for potential negative findings, with none identified. How will the facility identify other residents having the potential to be affected by the deficient practice? All residents have the potential to be affected by the deficient practice.	



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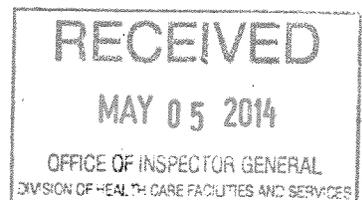
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185039	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  04/03/2014
NAME OF PROVIDER OR SUPPLIER  HIGHLANDS HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1705 STEVENS AVENUE LOUISVILLE, KY 40205	
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F 441	<p>Continued From page 17</p> <p>that one (1) of four (4) sampled residents (Resident #2) received care to prevent the tube feeding tubing from seperating and laying in direct contact with the floor.</p> <p>The findings include:</p> <p>1. Review of facility's policy regarding Handwashing/Hand Hygiene, dated 2012, revealed employees must rinse their hands thoroughly under running water after washing. Employees were not to touch their fingertips to the inside of the sink. Employees were to dry their hands with clean dry paper towels, then use clean paper towels to turn off the faucet.</p> <p>Observation of CNA #4, on 04/02/14 at 12:05 PM, revealed the CNA was washing her hands in a resident's room. She washed her hands then turned the water faucet off with her bare hands before obtaining a clean paper towel to dry her hands. She then proceeded to the dining room for meal service. The CNA was observed passing out meal trays in the dining room. At 12:12 PM and 12:19 PM, CNA #4 was observed at the sink in the dining room washing and rinsing her hands then rapping the edge of the sink repeatedly with the palms of her hands before obtaining clean paper towels to dry her hands.</p> <p>Interview with CNA #4, on 04/02/14 at 12:30 PM, revealed she was educated by the facility regarding handwashing procedures and verbalized that the water faucet was to be turned off using a clean paper towel after her hands were dried with clean paper towels. She stated she had no reason to explain why she turned the water faucet off using her bare hands. She stated this action could result in spreading germs</p>	F 441	<p>What measures will be put into place or systemic changes made to ensure the deficient practice will not recur? Education will be provided to all staff, to include each department on appropriate hand washing techniques by the Staff Development Coordinator by 4/30/14. Return demonstrations shall be required of C.N.A.#4 and C.N.A.#6, in addition to post testing of 100% of all employees post education. From this point, audits on appropriate hand washing technique shall be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff on 10 employees for 1 week, then 5 employees for 11 additional weeks.(Exhibit F) All licensed nursing staff shall be in-serviced in regards to establishing a clean field for the placement of reusable equipment/supplies in the resident room as well as disinfecting equipment post care when providing care by the Assistant Director of Nursing by 4/30/14. Audits shall be completed by the Director of Nursing, Assistant Director of Nursing, Unit Managers and/or assigned nursing staff on a minimum of 5 opportunities per week for 4 weeks, then a minimum of 2 opportunities for the next 6 weeks. 1:1 staff education will be provided if warranted during audits. (Exhibit G) All licensed nursing staff shall be in-serviced on tube feeding protective cap placement by the Staff Development Coordinator by 4/30/14. An audit of all residents with tube feeding shall be conducted by the Director of Nursing, Assistant Director of Nursing, Unit Managers, and/or assigned nursing staff daily for 7 days,(Exhibit H) then weekly for 11 weeks. The towel dispenser was replaced on the Lighthouse Unit on 4/3/14.</p>	



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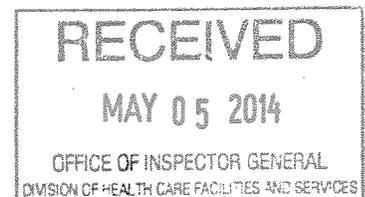
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F 441	<p>Continued From page 18</p> <p>from her hands to residents and causing illness. She stated she did not know that rapping her palms on the sink edge could recontaminant her clean hands and spread germs causing illnesses to the residents.</p> <p>Interview with CNA #6, on 04/03/13 at 11:10 AM, revealed failure to correctly wash hands led to the spread of germs that could make residents sick. He stated the water faucet was turned off at the end of handwashing using a clean dry paper towel. In addition, he stated touching any part of your hands to the inside of the sink after washing your hands caused germs to be back on your hands. He stated the staff were trained by the facility on handwashing often.</p> <p>Interview with the Assistant Director of Nursing (ADON), on 11/03/14 at 12:15 PM, revealed staff were trained in handwashing procedures by the facility frequently. She stated the water faucet was turned off using a clean dry paper towel after hands were washed, rinsed, and dried to prevent the spread of infection to residents. She stated touching the sink would re-contaminate the hands and require them to be re-washed.</p> <p>2. Review of the facility's policy regarding Blood Sampling, dated 2012, revealed blood glucose monitoring equipment would be placed on a clean field and reusable equipment would be cleaned and disinfected after every use.</p> <p>Observation of LPN #8, on 04/02/14 at 11:45 AM, revealed her entering Resident #19's room. She sat the blood glucose machine and a basket of testing supplies on the edge of the sink. No clean field was observed. After the resident's blood glucose level was tested, she left the room and</p>	F 441	<p>How will the facility monitor performance to ensure solutions are sustained? Results of audits shall be reviewed at the facility Quality Assurance Performance Improvement committee meeting for 3 months to see if additional interventions are warranted. The center has Quality Assurance Process Improvement meetings on a monthly basis versus the required quarterly providing the opportunity to review for 3 consecutive months to determine if additional interventions are warranted. The survey Plan of Correction is a standard component of the monthly Quality Assurance Process Improvement meeting; therefore any identified opportunities are reviewed for compliance on an on-going basis.</p>	5-1-14	



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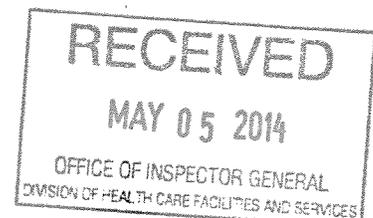
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F 441	<p>Continued From page 19</p> <p>shortly returned with the basket of supplies and a bottle of insulin. These items were placed on the edge of the sink where she drew up the insulin to be administered to the resident.</p> <p>Observation of LPN #8, on 04/02/14 at 11:50, revealed she entered Resident #21's room and sat a basket of blood glucose supplies and the blood glucose testing equipment on the resident's bedside table. No clean field was observed. After testing the resident's glucose level, she placed the blood glucose testing equipment in the basket containing clean supplies without disinfecting the equipment.</p> <p>Observation of LPN #8, on 04/03/14 at 11:40 AM, revealed she obtained a basket of blood glucose testing supplies from the top of a medication cart, entered Resident #13's room and sat the basket of blood glucose supplies on top of the resident's dresser. A clean field was not observed. After completion of the testing, she returned the basket to the top of the medication cart.</p> <p>Interview with LPN #8, on 04/03/14 at 10:25 AM, revealed she was not aware of the facility policy requiring blood glucose testing supplies to be placed on a clean field in the residents' rooms. She stated she felt the cleaning completed by housekeeping daily was adequate to prevent the spread of infection, then stated she should read the policy and follow it to prevent the spread of infection between residents.</p> <p>Interview with LPN #9, on 04/03/14 at 2:30 PM, revealed she felt carrying a basket of blood glucose supplies and sitting the basket of supplies down in residents' rooms without a clean field was not an issue. She stated she had not</p>	F 441			



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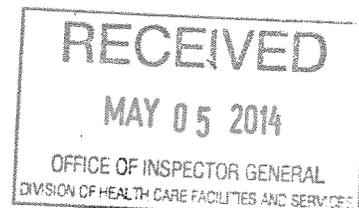
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F 441	<p>Continued From page 20</p> <p>thought about the basket being placed on top of the medication cart after being in numerous residents' rooms on surfaces that were not clean/safe. She stated germs could be spread and residents could become sick. She stated she had received training on infection control and accucheck machines.</p> <p>Interview with LPN #4, on 04/03/14 at 8:30 AM, revealed clean glucose testing supplies should be placed on a clean field when taken into a resident's room. The glucose testing equipment (reusable) should be disinfected after use, placed on a clean field and stored in a clean area. She stated this prevented residents from contracting infections from soiled equipment. She stated she had received training on infection control and blood glucose testing.</p> <p>Interview with Assistant Director of Nursing (ADON), on 04/03/14 at 12:15 PM, revealed the nurses received training on infection control and use of blood glucose testing equipment. She stated the clean equipment should be placed on a clean field in the resident's room to prevent the spread of infection.</p> <p>3. Observation of the meal service on the Lighthouse Unit, on 04/02/14 at 11:49 AM, revealed no paper towel dispenser by handwashing station. Staff were observed washing hands and opening the drawer to retrieve a paper towel to dry hands.</p> <p>Interview with Certified Nursing Assistant (CNA) #2, on 04/03/14 at 1:17 PM, revealed the paper towel dispenser was never put back up after they painted the room and were having to keep paper towels in the drawer. The CNA revealed she did</p>	F 441		



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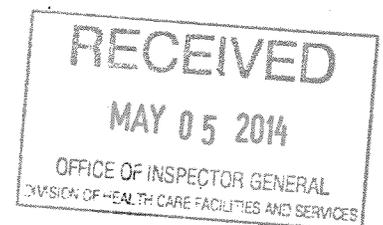
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F 441	<p>Continued From page 21 notify the manager.</p> <p>Interview with the Lighthouse Unit Manager, on 04/03/14 at 1:25 PM, revealed the remodel of the Lighthouse dining area was completed in March 2014. The Unit Manager revealed she did know the paper towel dispenser was missing and notified the Maintenance Department by filling out the work order. The Unit Manager revealed she did not follow up to ensure the dispenser was placed.</p> <p>Interview with the Maintenance Director, on 04/03/14 at 2:10 PM, revealed he had not received a work order to place a paper towel dispenser and had just been notified one was needed for the Lighthouse dining room.</p> <p>4. Observation, on 04/02/14 at 8:23 AM, revealed Resident #2's gastrostomy tube feeding bag containing water was hanging with the tubing in a pump at the bedside. Further observation at that time revealed the pump was turned off and the distal tubing and uncapped connector were laying on the floor.</p> <p>Interview with Licensed Practical Nurse (LPN) #8, on 04/03/14 at 4:05 PM, revealed she did disconnect Resident #2's tube feeding and placed the connector in the holder on the back of the pump earlier that day. She revealed she left the tube feeding disconnected while retrieving a pain medication. LPN #8 further revealed she did reconnect the tube feeding with the same contaminated tubing and connector. She indicated she did not remember the connector being on the floor but if it had been it would contaminate Resident #2's gastrostomy tube.</p>	F 441			



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F 514 F 514 SS=D	Continued From page 22 483.75(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.  This REQUIREMENT is not met as evidenced by: Based on interview, and record review, it was determined the facility failed to ensure accurate clinical records for two (2) of twenty-five (25) Sampled Residents, Resident #2 and Resident #5. The facility failed to document the administration of an as needed pain medication for Resident #2. The physician order sheets for December 2013 and March 2014 revealed Resident #5 was allergic to Purified Protein Derivative (PPD) (the drug used in a tuberculin skin test) both in the hard copy record and in the computer. However, there was documentation in red (usual method for documentation of resident allergies) in the hard copy chart that Resident #5 was not allergic to Purified Protein Derivative (PPD).	F 514 F 514		



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F 514	<p>Continued From page 23</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding maintaining an accurate clinical record.</p> <p>1. Review of Resident #5's hard copy clinical record on 04/01/14 revealed an undated/unlabeled page divider with documentation in red that the resident was allergic to Purified Protein Derivative (PPD). That statement had been crossed out in blue ink and the letters NKA (No Known Allergies) written in red above that statement with no date and no nurse's name or initials. Review of the physician orders, dated December 2013 and March 2014, revealed the resident was allergic to Purified Protein Derivative (PPD). Review of a form in the hard copy chart (and not in the computer) labeled Tuberculin Skin Test &amp; Chest X-ray revealed Resident #5 had a tuberculin skin test (using Purified Protein Derivative) on 12/01/13 with a result of zero (0) millimeters.</p> <p>Further review of Resident #5's clinical record revealed the facility had assessed the resident with a score of three (3) on the Brief Interview for Mental Status (BIMS) on 11/16/13 indicating the resident was not interviewable.</p> <p>Interview with Licensed Practical Nurse (LPN) #9, on 04/02/14 at 9:27 AM, revealed she used the hard copy chart and the computer chart for documentation on the residents. She stated she would look in the hard copy chart and the computer chart to search for resident information. LPN #9 also stated the information in the hard copy chart and the computer were different for Resident #5 and she was not sure if Resident #5 was allergic to PPD or not. She further indicated</p>	F 514	<p>What corrective action will be accomplished for those residents found to have been affected by the deficient practice? No residents were found to have been affected by the deficient practice. The documentation in question for Resident #5 was corrected to reflect there was no allergy to PPD derivatives on 4/2/14 by the Health Information Manager. A late entry was completed by LPN#8 on 4/3/14 in regards to administration and effectiveness of the PRN Tylenol pain med administration.</p> <p>How will the facility identify other residents having the potential to be affected by the deficient practice? All residents have the potential to be affected by the deficient practice.</p>	

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