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

PRINTED: 06/10/2010
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185003 | | 05/12/2010 |
| NAME OF PROVIDER OR SUPPLIER: LAUREL HEIGHTS HOME FOR THE ELDERLY | | STREET ADDRESS, CITY, STATE, ZIP CODE: 208 WEST TWELFTH STREET, LONDON, KY 40743 | |

RECEIVED JUN 10 2010 Division of Health Care Southern Enforcement Branch

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| F 000 | INITIAL COMMENTS<br><br>An abbreviated standard survey (KY14702) was initiated by phone on May 7, 2010, and concluded on-site on May 12, 2010. No deficient practice was identified related to the allegation.<br><br>A standard health survey was conducted on May 10-12, 2010. Deficient practice was identified with the highest scope and severity being at an 'E' level. | F 000 | | |
| F 170<br>SS=B | 483.10(i)(1) RIGHT TO PRIVACY - SEND/RECEIVE UNOPENED MAIL<br><br>The resident has the right to privacy in written communications, including the right to send and promptly receive mail that is unopened.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interviews, the facility failed to ensure residents received mail promptly. During a group interview with six (6) alert, oriented residents, it was determined the facility did not deliver mail to residents on Saturdays.<br><br>The findings include:<br><br>A group interview was conducted with six alert, oriented residents on May 11, 2010, at 10:30 a.m. (residents #15, #26, #27, #28, #29, and #30). The residents stated mail was delivered to them daily except on weekends.<br><br>A review of the facility's policy/procedure for mail delivery revealed the residents were to receive mail within 24 hours of delivery to the facility or to the facility's post office box. | F 170 | **F170**<br>**Right To Privacy – Send/Receive Unopened Mail**<br><br>(1.) To ensure resident #'s 15, 26, 27, 28, 29 and 30, and all other residents receive their mail promptly and on Saturdays, the Resident Mail Policy was revised to include mail pick-up and delivery on Saturdays. (Copy of Policy Attached)<br><br>(2.) To ensure all residents receive their mail promptly, (including Saturdays), and **in-service** was conducted on **06/04/10 for business office, activity and nursing staff** on the following:<br>➢ **Resident Mail Policy**<br>➢ **Resident Rights – Mail and Telephone Probes Checklist**<br>➢ **Review on Tag F170**<br>➢ **Review of Business Office and Activity Staff duties as they relate to resident Saturday mail**<br>(Copies of audits and policy attached) | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathey Young — TITLE: Administrator — (X6) DATE: 6/10/10

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 170 | Continued From page 1<br><br>An interview conducted with the Facility Administrator on May 11, 2010, at 3:20 p.m., revealed the facility had a designated employee at one time who was to pick up mail at the post office on Saturday and bring it to the facility for distribution; however, that employee's schedule was changed. The Administrator stated no other employee had been assigned to obtain mail on Saturdays since that time. | F 170 | (3.) Quality Improvement measures implemented to ensure residents receive their mail promptly and on Saturdays include:<br>➢ The **Activity Director** will conduct **monthly** audits of resident mail delivery utilizing the **Resident Rights – Mail Audit Form**.<br>(Copy of Audit Form attached) | |
| F 225<br>SS=D | 483.13(c)(1)(ii)-(iii), (c)(2) - (4)<br>INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS<br><br>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.<br><br>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).<br><br>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. | F 225 | (4.) Monitoring the compliance of prompt resident mail delivery includes:<br>➢ The **Activity Director** will analyze the results of the **Resident Mail Audit** documenting the findings on the **Compliance Monitoring and Plan of Correction Form** and submit to the **Quality Improvement Committee monthly**.<br>➢ Compliance monitoring will be conducted **every month for 6 months. One third of the residents** will be audited each **month.** All residents will have participated in **2 interviews within the 6 month period.**<br>➢ Areas of non-compliance will be identified and resolved through the interdisciplinary approach of the committee.<br><br>**CORRECTIVE ACTION TAG #F170 COMPLETED ON** | 06/04/10 |

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| F 225 | Continued From page 2<br><br>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on interview and record review, the facility failed to ensure that all alleged violations involving mistreatment, neglect, or abuse were immediately reported to officials in accordance with state law. The facility also failed to ensure the results of all investigations were reported to state agencies in accordance with state law. An allegation of abuse involving resident #15 was reported to facility administration; however, the facility failed to report the allegation to state agencies.<br><br>The findings include:<br><br>A review of the medical record for resident #15 revealed the resident was alert, oriented, and able to make her needs known.<br><br>An interview with resident #15 conducted on May 11, 2010, at 10:30 a.m., revealed resident #15 had reported to the facility staff that a nurse aide had been mean to the resident. Resident #15 stated the nurse aide had been rude/disrespectful and had upset the resident. The resident further stated that the resident had reported the incident to other facility staff who informed the Administrator. Resident #15 stated the nurse | F 225 | **F225**<br>**Investigate/Report Allegations/Individuals**<br><br>(1.) The Administrator conducted an interview with resident #15 on May 25, 2010, regarding her care and satisfaction with solution concerning stated employee and to ensure that there was no further incident involving resident #15 and stated employee. **Resident #15 stated that there was no further incident and is satisfied with the solution.**<br><br>(2.) To ensure that all alleged resident reports of abuse or mistreatment and results of investigations involving abuse and mistreatment are reported to state agencies in accordance with state law, the facility **Administrator conducted in-services** on **05/25/10, 05/27/10, 05/28/10 and 06/04/10** which included the following:<br>➢ **Abuse Policy and Procedure**<br>➢ **Resident Rights – Resident Abuse and Staff Treatment Audit Form**<br>➢ **Review of Tag F225 (reporting)**<br>(Copies of policy and form attached)<br><br>(3.) Quality Improvement measures implemented to ensure all resident reports of alleged abuse and mistreatment as well as investigation results will be immediately reported to State Agencies in accordance with state law include the following:<br>➢ The **Social Service Director** will conduct **monthly** audits using the **Resident Rights –** | |

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| F 225 | Continued From page 3<br>aide has not been permitted to care for the resident since and the resident was satisfied with the solution.<br><br>A review of the facility's investigation revealed the Administrator and social worker were informed of the incident and conducted an investigation. According to the results of the investigation, the nurse aide was counseled and required to complete some exercises regarding resident interaction. There was no evidence the facility reported the incident to the appropriate state agencies immediately or reported the results of the facility investigation within five days as required.<br><br>A review of the facility policy for the prevention of abuse/neglect revealed the facility policy was that all incidents involving potential abuse, mistreatment, neglect, and misappropriation of resident property are reported to the appropriate authorities according to regulation and thoroughly investigated by the Administrator.<br><br>An interview with the Facility Administrator conducted on May 11, 2010, at 3:20 p.m., revealed the Administrator did not report the allegation to the Department for Community Based Services or the Office of Inspector General as required. The Administrator stated that, following the investigation, he/she did not feel abuse had occurred and did not report it. | F 225 | **Resident Abuse and Staff Treatment Form. (<u>All reports of alleged abuse will be immediately reported to the Administrator who will report immediately to the appropriate agencies.</u>)**<br><br>(Copy of form attached)<br><br>(4.) Monitoring the compliance of reporting alleged resident abuse and mistreatment include:<br>➢ The **Social Services Director** will analyze the results of the **Individual Evaluation Probes Checklist – Resident Abuse and Staff Treatment audit** and submit the findings to the **Quality Improvement Committee monthly on the Compliance Monitoring Form.**<br>➢ **Areas of non-compliance will be immediately corrected.**<br>➢ Compliance monitoring will be conducted **on-going on a monthly basis** to include **one third of the residents each month. All** residents will have participated in **4 interviews annually.**<br>➢ Areas of non-compliance will be identified and resolved through the | |
| F 281<br>SS=D | 483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS<br><br>The services provided or arranged by the facility must meet professional standards of quality. | F 281 | | |

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| F 281 | Continued From page 4<br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to provide services to meet professional standards of quality for one (1) of twenty-four (24) sampled residents. The facility failed to obtain laboratory specimens for resident #8 as ordered by the resident's physician.<br><br>The findings include:<br><br>A review of the medical record for resident #8 revealed the resident had been admitted to the facility on November 27, 2007, with diagnoses of Dysphagia, Alzheimer's, Cerebral Vascular Accident (stroke), Diabetes Mellitus, and Congestive Heart Failure. A review of resident #8's physician's orders dated April 24, 2010, revealed the resident had a physician's order for a Hemoglobin A1C (a lab test used primarily to identify the average blood glucose concentration for the preceding three months) to be drawn every three months. A review of the resident's medical record revealed that the last Hemoglobin A1C drawn for resident #8 was on January 4, 2010. The Hemoglobin A1C was within normal limits.<br><br>An interview was conducted on May 12, 2010, at 10:02 a.m., with the Director of Nursing (DON) and the Charge Nurse (CN). The CN stated, "Looks like we missed the April A1C." The DON stated that residents' physician's orders were validated monthly by nursing staff. The DON further stated the nurse who validated physician's orders filled out lab slips for all labs ordered by the residents' physicians and placed the lab slips in a lab book that was separated by day and | F 281 | interdisciplinary approach of the committee.<br><br>**CORRECTIVE ACTION TAG #F225 COMPLETED ON**<br><br>**F281**<br>**Services Provided Meet Professional Standards**<br><br>(1.) The physician for resident #8 was contacted on 05/12/10 regarding the missed A1C lab. The physician gave an order to discontinue the A1C lab. On 05/14/10 an A1C was ordered for resident #8 for every three months following facility protocol. (Copies of physician orders attached)<br><br>(2.) On **05/25/10, 05/27/10 and 05/28/10 mandatory in-services for nursing staff** were conducted on the following:<br>➢ **Protocols for Clinical Labs Monitoring Guidelines**<br>➢ **Medication – Laboratory Monitoring Guidelines Grid**<br>➢ **HgbA1C obtained at the time of admission and every 3 months for all residents with a diagnosis of diabetes**<br>➢ **Medication – Laboratory Monitoring Guidelines Policy**<br>➢ **Lab Test Log** | 06/04/10 |

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| F 281 | Continued From page 5<br>month. The DON stated the nurses obtained the lab slips from the book and obtained lab specimens that were ordered for that day. The DON stated the facility's protocol was to obtain a Hemoglobin A1C every three months for diabetic residents; however, a physician's order superseded the protocol. | F 281 | ➢ **Quality Improvement Clinical Lab Test Monitoring Form**<br>(Copies of policies and forms attached) | |
| F 282<br>SS=D | 483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN<br><br>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, record review, and interview, it was determined the facility failed to ensure services were provided in accordance with the written plan of care for two (2) of twenty-four (24) sampled residents. According to residents #8 and #14's care plan, the residents' beds were required to be kept in the lowest position. However, observations of residents #8 and #14's beds during the survey on May 10-12, 2010, revealed the beds were approximately two (2) to three (3) feet off the floor.<br><br>The findings include:<br><br>1. Observations of resident #14 on May 10, 2010, at 11:55 a.m., 4:03 p.m., 4:47 p.m., and 6:00 p.m., revealed the resident was in bed and the resident's bed was approximately two and one-half feet off the floor. Staff was not observed to be present in resident #14's room. | F 282 | (3.) Quality Improvement measures implemented to ensure laboratory specimens are obtained as ordered by the physician and per facility protocol in accordance with evidence-based guidelines include:<br>➢ Implementation of the **Medication – Laboratory Monitoring Guidelines Policy** (See attached policy)<br>➢ The **Admission Coordinator** will utilize the **Clinical Monitoring Guidelines Grid** as it relates to initiation of new medications, recent dose changes, and standard monitoring lab test frequency.<br>➢ The **Admission Coordinator, Unit-based Nurses, and Pharmacist** will notify the database manager of any laboratory test that has been ordered and the date which the laboratory test is to be drawn.<br>➢ The **unit-based clinical staff** is responsible for maintaining a **Lab Test Log** of all labs drawn and validation that the result has been received. A copy | |

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| F 282 | Continued From page 6<br>A review of resident #14's comprehensive care plan revealed the facility identified the resident was at risk for falls and developed an intervention for the bed to be in the "lowest position when not providing care." The Clinical Flow Sheet also revealed resident #14 was required to have the "bed in low position and locked." According to the resident's care plan and Clinical Flow Sheet, resident #14 required assistance with transferring to/from bed.<br><br>Observations of resident #14 on May 11, 2010, at 9:45 a.m., 10:20 a.m., and 4:25 p.m., revealed the resident was in bed and the resident's bed was approximately 12 inches off the floor. The bed was observed to be in a locked position.<br><br>An interview was conducted on May 12, 2010, at 9:55 a.m., with Licensed Practical Nurse (LPN) #3 who was caring for resident #14. LPN #3 stated that resident #14's bed was required to be in a low position. The LPN further stated that "low bed" meant the bed was to be all the way down to the floor. According to LPN #3, resident #14 required a low bed because the resident was a fall risk because the resident attempted to get out of bed unassisted to use the bedside commode.<br><br>An interview with CNA #1 on May 12, 2010, at 10:15 a.m., revealed resident #14's bed should be in the lowest position. The CNA stated he/she had observed resident #14's bed and when the resident's bed was approximately 12 inches off the floor, the bed was in the lowest position.<br><br>2. Observations of resident #8 on May 10, 2010, at 12:10 p.m., 2:08 p.m., 2:52 p.m., 3:57 p.m., 4:45 p.m., and 5:54 p.m.; on May 11, 2010, at 1:40 p.m., 2:00 p.m., 2:43 p.m., 3:30 p.m., and | F 282 | of the log will be forwarded to the **database manager/nursing office weekly on Monday by 3:00PM.** (Copy of log attached)<br><br>(4.) Monitoring the compliance to ensure that laboratory monitoring for special medications will be done in a timely manner in accordance with evidence-based guidelines include:<br>➢ The **Director of Nursing will utilize the Quality Improvement Clinical Lab Test Monitoring Form** to audit the compliance as reported on the **lab test log.**<br>➢ Compliance monitoring will be conducted **on-going on a monthly basis. All** residents will be **audited monthly.**<br>➢ **Areas of non-compliance will be corrected immediately**<br>➢ Negative results will be identified and resolved through the interdisciplinary approach of the committee<br><br>**CORRECTIVE ACTION TAG #F281 COMPLETED ON**<br><br>**F282**<br>**Services by Qualified Persons/Per Care Plan**<br><br>(1.) The bed's for resident #'s 8 and 14 were placed in the correct bed height position on | 05/28/10 |

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| F 282 | Continued From page 7<br>4:20 p.m.; and on May 12, 2010, at 1:20 p.m., revealed the resident's bed was not in the lowest position.<br><br>An interview conducted on May 12, 2010, at 9:45 a.m., with Licensed Practical Nurse (LPN) #1 revealed resident #8's bed should be in the lowest position. The LPN demonstrated resident #8's bed was required to be positioned approximately 12 inches from the floor. According to LPN #1, nurses were required to monitor to ensure residents' plans of care were being followed. The LPN further stated there was one to two staff persons assigned to "projects," who were also required to monitor to ensure beds were in the position that was care planned.<br><br>An interview was conducted on May 12, 2010, at 9:50 a.m., with CNA #1, who was assigned to "projects." The CNA stated the CNA did not monitor residents' bed height to ensure the beds were positioned according to the residents' care plan. However, the CNA stated he/she believed "low bed is on the care plan."<br><br>An interview conducted on May 12, 2010, at 2:10 p.m., with CNA #2 revealed resident #8's bed should be in low position, except when staff was providing care. The CNA further stated that resident #8 tried to get out of bed and the CNA had observed the resident with the resident's legs hanging over the side of the bed.<br><br>An interview conducted on May 12, 2010, at 2:17 p.m., with the Charge Nurse (CN) revealed nurses were required to check the Clinical Flow Record for accuracy. The CN further stated that resident #14 had a remote and the resident could raise the height of the bed. The RN also stated | F 282 | May 12, 2010. Resident #8 and #14 care plans were reviewed to ensure congruency with bed height.<br><br>(2.) To ensure that residents' plan of care are followed as they relate to bed heights, **in-services were conducted on 05/25/10, 05/27/10, and 05/28/10 for clinical staff** on the following:<br>➢ **Review of Tag # F282 as it relates to bed height and safety**<br>➢ **Results of audit on <u>all</u> resident care plans and appropriate bed height (Audit form attached)**<br>➢ **Grid for bed audits and Bed Audit Form (attached)**<br>• **Care Plans and Clinical Flow Records were revised** according to the results of the bed audits<br><br>(3.) Quality Improvement measures implemented to ensure resident bed heights are as specified in the resident care plan include:<br>➢ **<u>All</u>** resident care plans and bed heights were audited using the **Bed Height Audit Form**<br>➢ The **Charge Nurse** will **audit resident bed heights** to ensure they are congruent with resident care plans **monthly**. Audit reports will be turned in to the **DON monthly**.<br>➢ **Areas of non-compliance will be corrected immediately.** | |

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| F 282 | Continued From page 8<br>that "low" was not defined and that some of the beds in the facility could not be placed in the lowest position, because the wheels on the bed would not lock when the bed was in the lowest position. However, the CN demonstrated that when resident #8's bed was in the lowest position, the resident's bed continued to be locked. | F 282 | | |
| F 363<br>SS=E | 483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED<br><br>Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.<br><br>This REQUIREMENT is not met as evidenced by:<br>Based on observation, interview, and record review, it was determined that the facility failed to follow the menu on May 10, 2010 and May 11, 2010. The facility served mashed potatoes to residents who received a pureed diet for the lunch and evening meal on May 10, 2010. The menu had been changed and residents on a pureed diet were not supposed to receive mashed potatoes. In addition, the facility failed to follow the menu for all residents who received a mechanical soft diet on May 11, 2010.<br><br>The findings include:<br><br>Observation of resident #3 during the lunch meal on May 10, 2010, at 11:32 a.m., revealed the resident was served mashed potatoes with gravy, pureed chicken with gravy, pureed carrots, and applesauce. A review of the resident's tray card | F 363 | (4.) The **Director of Nursing** will conduct compliance monitoring on the results of the **monthly Bed Height Audit**.<br>➢ Using the **Plan of Correction – Bed Height Compliance Monitoring Form** the **Director of Nursing** will report Bed Height Audit results to the Quality Improvement Committee monthly.<br>➢ Compliance monitoring will be conducted **on-going on a monthly basis. All** resident bed heights will be **audited monthly** for compliance.<br>➢ Areas of non-compliance will be identified and resolved through the interdisciplinary approach of the committee.<br><br>**CORRECTION ACTION TAG #F282 COMPLETED ON**<br><br>**F363**<br>**Menus Meet Res Needs/Prep in Advance/Followed**<br><br>(1.) A Laurel Heights Food Preference Review was conducted for resident #'s 3, 4, 31, 32, & 33, on June 2, 2010. (copy of survey form attached) Tray cards for resident #'s 3, 4, 31, 32 and 33 were updated to reflect resident preferences and dislikes on June 3, 2010. | 05/28/10 |

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| | 185003 | | C<br>05/12/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| LAUREL HEIGHTS HOME FOR THE ELDERLY | 208 WEST TWELFTH STREET<br>LONDON, KY 40743 |

| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 363 | Continued From page 9<br>revealed the resident was to receive a pureed diet and the resident had no dislikes. A review of the facility's menu revealed residents on a pureed diet were supposed to receive mashed potatoes; however, the menu for the regular diet had been changed from mashed potatoes to potato salad.<br><br>Observation of the evening meal served on May 10, 2010, at 5:33 p.m., revealed resident #3 received mashed potatoes with gravy again, pureed turkey with gravy, pureed peaches, and pureed corn. Further observations of the evening meal revealed residents #31 and #32 received mashed potatoes with gravy. A review of the menu approved by the facility Registered Dietitian revealed residents on a pureed diet were to receive pureed au gratin potatoes, pureed roast turkey, pureed asparagus, applesauce, and sherbet.<br><br>Observation of resident #4 on May 11, 2010, at 11:00 a.m., revealed the resident received ground meat with gravy, mashed potatoes with gravy, and green beans. According to resident #4's tray card, the resident was to receive ground meat with soft "veges." The tray card revealed the resident did not dislike lasagna or Italian blend vegetables. An interview with the resident during the observation revealed the resident was served mashed potatoes "practically every day." A review of the menu revealed residents on a mechanical soft diet should have received lasagna and Italian blend vegetables.<br><br>An interview with resident #33 on May 11, 2010, at 11:10 a.m., revealed the resident received mashed potatoes with every lunch meal and with every evening meal. The resident stated he/she was "tired of mashed potatoes." | F 363 | (2.) To ensure menus/diets and residents food preferences are followed, an in-service was conducted on 06/02/10 by the **Registered Dietician** on the following:<br>➢ **Menus and production sheets**<br>➢ **Laurel Heights Food Preference Review Form**<br>➢ **Laurel Heights Food Production Sheet Quality Review Form**<br>➢ **Resident Food Survey Form**<br>(Copies of forms and audits attached)<br><br>(3.) Quality Improvement measures implemented to ensure menus/diets and resident food preferences are followed include:<br>➢ Utilizing the **Production Sheet Quality Review Form** the **Registered Dietician** will audit **Production Sheets three times a week** for menu compliance. Areas of non compliance will be corrected immediately.<br><br>(4.) Monitoring compliance of menus/diets and production sheets includes:<br>➢ Utilizing the **Dietary Production Sheet Quality Review Form** the **Registered Dietician** will conduct compliance monitoring on the results of the Production Sheet Audits **weekly**. Results of the compliance monitoring | |

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| LAUREL HEIGHTS HOME FOR THE ELDERLY | 208 WEST TWELFTH STREET<br>LONDON, KY 40743 |

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| F 363 | Continued From page 10<br><br>An interview was conducted on May 10, 2010, at 5:33 p.m., with the RN Charge Nurse for Shepard's Cove Unit. The RN stated residents who received extra gravy on their meal tray usually received mashed potatoes for most meals.<br><br>An interview was conducted on May 11, 2010, at 2:05 p.m., with the facility Registered Dietitian (RD). The RD stated the Dietary Manager (DM) documented on the production sheet if there was a change in the menu. The RD further stated that the DM could make changes to the menu without notifying the RD. According to the RD, residents should have received pureed au gratin potatoes for the evening meal on May 10, 2010.<br><br>An interview was conducted on May 11, 2010, at 2:30 p.m., with the DM. The DM stated he/she filled out a production sheet according to the menu for every meal. The DM explained that a production sheet listed the portions for each food item that would be needed for the meal. The DM stated residents who received "multi mix" (a protein supplement) received mashed potatoes with every meal, except breakfast, because multi mix was added to the mashed potatoes. The DM stated he/she changed the menu for the lunch meal on May 10, 2010, from mashed potatoes to potato salad because the residents had mashed potatoes on Sunday for Mother's Day. The DM stated he/she only changed the regular diet to potato salad because the residents on a pureed diet ate mashed potatoes better than potato salad. The Dietary Manager stated he/she changed the menu from au gratin potatoes to scalloped potatoes on May 10, 2010, for the evening meal; however, residents on a pureed | F 363 | will be submitted to the Quality Improvement Committee **monthly** on the **Dietary Production Sheet Plan of Correction Form.**<br>➢ The Resident Satisfaction Survey will be conducted **quarterly** for all residents. (Copy of survey attached)<br>➢ Non-compliant areas will be identified and resolved through the interdisciplinary approach of the committee.<br><br>**CORRECTED ACTION TAG #F363 COMPLETED ON** | 06/02/10 |

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| F 363 | Continued From page 11<br>diet did not receive scalloped potatoes for the evening meal on May 10, 2010, the residents received mashed potatoes. According to the DM, some residents wanted mashed potatoes every day; however, it was not indicated on the residents' tray card. The DM stated he/she was not sure why some of the residents on a mechanical soft diet received ground hamburger instead of lasagna. | F 363 | | |

PRINTED: 05/26/2010
FORM APPROVED
OMB NO. 0938-0391

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

RECEIVED JUN - 7 2010 Division of Health Care Southern Enforcement Branch

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185003 | A. BUILDING 01 - MAIN BUILDING<br>B. WING | 05/11/2010 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| LAUREL HEIGHTS HOME FOR THE ELDERLY | 208 WEST TWELFTH STREET<br>LONDON, KY 40743 |

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| K 000 | INITIAL COMMENTS<br><br>A life safety code survey was initiated and concluded on May 11, 2010, for compliance with Title 42, Code of Federal Regulations, §483.70. The facility was found not to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.<br><br>Deficiencies were cited with the highest deficiency identified at "F" level. | K 000 | | |
| K 046<br>SS=F | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 19.2.9.1.<br><br>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that all exterior exits contained emergency lighting serviced by the emergency generator as required. This deficient practice had the potential to affect all twelve (12) smoke compartments, staff, and all of the residents. The facility has the capacity for 175 beds with a census of 152 on the day of survey.<br><br>The findings include:<br><br>Observation during the Life Safety Code survey on May 11, 2010, at 11:55 a.m., revealed a bulb missing from the light fixture at the exterior exit of the BC stairwell. An interview revealed the Director of Maintenance was not aware the bulb was missing or if the light fixture was on the emergency generator. The Director of Maintenance stated other exits with exterior lighting may have been compromised when the facility underwent renovations. During the survey, other exterior exits that did not have light fixtures | K 046 | **K046**<br>**Emergency Lighting of at least 11/2 hour duration is provided in accordance with 7.9. 19.2.9.1.**<br><br>(1.) On 05/11/10, the bulb was replaced for the light fixture at the exterior exit of the BC Stairwell. On 06/07/10, exit access lights were installed at exterior exits as required by the Life Safety Code. (List of exterior access exits included on audit)<br><br>(2.) On **06/02/10, a Maintenance in-service was conducted by the Administrator with the Maintenance Director and Environmental Director** on the following:<br>➢ **Exit Access Ligbting Requirements as per K046**<br>➢ **Exit Access Lighting Audit**<br>➢ **Lighting Selection**<br>➢ **Life Safety Inspection Audit**<br><br>(3.) Quality Improvement measures to ensure exit access exterior doors are illuminated and serviced by the generator include: | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathey K. Young
TITLE: Administrator
(X6) DATE: 6/6/10

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.

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 185003 | | 05/11/2010 |

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| LAUREL HEIGHTS HOME FOR THE ELDERLY | 208 WEST TWELFTH STREET<br>LONDON, KY 40743 |

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| K 046 | Continued From page 1<br>or that the Director of Maintenance was unsure were connected to the emergency generator included but were not limited to the basement stairwell, ICF stairwell, and the front entrance.<br><br>Reference: NFPA 101 (2000 Edition).<br><br>7.9.1.1*<br>Emergency lighting facilities for means of egress shall be provided in accordance with Section 7.9 for the following:<br>(1) Buildings or structures where required in Chapters 11 through 42<br>(2) Underground and windowless structures as addressed in Section 11.7<br>(3) High-rise buildings as required by other sections of this Code<br>(4) Doors equipped with delayed egress locks<br>(5) The stair shaft and vestibule of smokeproof enclosures, which shall be permitted to include a standby generator that is installed for the smokeproof enclosure mechanical ventilation equipment and used for the stair shaft and vestibule emergency lighting power supply<br><br>For the purposes of this requirement, exit access shall include only designated stairs, aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, ramps, aisles, walkways, and escalators leading to a public way. | K 046 | ➢ **Emergency Exterior Exit Lighting Audit** to be conducted **weekly** by **Security Staff** (audit attached)<br>➢ A **Generator Load Test** will be conducted **quarterly** by the **Maintenance Director** to ensure exit access lights are illuminated.<br>➢ **Emergency Exterior Exit Light Audit** will be turned into the **Director of Maintenance**<br>➢ The **Director of Maintenance** will conduct a **Life Safety Code Audit quarterly** using the **Life Safety Code Inspection Form.** (attached)<br>➢ **Areas of non-compliance will be corrected immediately**<br><br>(4.) The **Director of Maintenance** will conduct compliance monitoring on the results of the **Emergency Exterior Exit Lighting Audit monthly.**<br>➢ Using the **Plan of Correction Compliance Monitoring Form for Emergency Lighting the Maintenance Director** will report the results of his analysis of the **Emergency Exit Lighting Audits monthly** to the **Quality Improvement Committee monthly.** | |
| K 052<br>SS=C | NFPA 101 LIFE SAFETY CODE STANDARD<br><br>A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable | K 052 | | |

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| K 052 | Continued From page 2<br>requirements of NFPA 70 and 72. 9.6.1.4<br><br>This STANDARD is not met as evidenced by:<br>Based on observation and interview, the facility failed to ensure the building fire alarm system functioned as required by NFPA standards.<br><br>The findings include:<br><br>During the Life Safety Code survey on May 11, 2010, at 2:30 p.m., with the Director of Maintenance, a test of the fire alarm automatic dialer panel revealed when the panel was placed in trouble from phone line failure the unit did send a trouble signal to a continuously occupied location within the facility, however, the monitoring station did not contact the facility of this phone line failure as required. A call to the monitoring station at 2:45 p.m. on May 11, 2010, by the Director of Maintenance revealed the monitoring station did not have instructions to notify the facility of this phone line failure. An interview with the Director of Maintenance revealed the facility has received calls in the past by the monitoring company for other trouble signals but was not aware the monitoring station did not contact the facility for a phone line failure signal. | K 052 | ➢ Negative Results will be identified and resolved through the interdisciplinary approach of the committee.<br><br>**CORRECTIVE ACTION TAG #K046 COMPLETED ON**<br><br>**K052**<br>**NFPA 101 Life Safety Code Standard**<br><br>(1.) On 06/02/10, a fax was submitted to the monitoring station requesting that the facility be contacted on all trouble conditions. On 06/03/10, the facility request was followed up with a letter sent to the Monitoring Station by Fed Ex. (Copy of faxes and letter attached)<br><br>(2.) On **06/02/10, an in-service** was conducted by the **Administrator with the Maintenance Director and Environmental Director** regarding Life Safety Code K052. (Copy of in-service attached)<br>➢ **The Fire Alarm System will be tested monthly placing the system under trouble to include phone line trouble.**<br>➢ **Fire Alarm/Monitoring Station Audit**<br><br>(3.) Quality Improvement measures implemented to ensure the Fire Alarm Monitoring Station responds on all trouble conditions include the following:<br>➢ The **Maintenance Staff** will place the Fire Alarm system under trouble conditions to **audit the** | 06/07/10 |

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| | 185003 | A. BUILDING 01 - MAIN BUILDING 01<br>B. WING | 05/11/2010 |

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| K 052 | Continued From page 3<br><br>Reference: NFPA 72 (1999 Edition).<br><br>5-2.6.1.4<br>Upon receipt of trouble signals or other signals pertaining solely to matters of equipment maintenance of the fire alarm systems, the central station shall perform the following actions:<br>(1) *Communicate immediately with persons designated by the subscriber<br>A-5-2.6.1.4(1)<br>The term immediately in this context is intended to mean "without unreasonable delay." Routine handling should take a maximum of 4 minutes from receipt of a trouble signal by the central station until initiation of the investigation by telephone.<br><br>5-5.3.2.1.6.2<br>The following requirements shall apply to all combinations in 5-5.3.2.1.6.1:<br>(1) Both channels shall be supervised in a manner approved for the means of transmission employed.<br>(3) The failure of either channel shall send a trouble signal on the other channel within 4 minutes.<br>(8) Failure of telephone lines (numbers) or cellular service shall be annunciated locally. | K 052 | **compliance of the alarm monitoring station.** Results of the audit will be recorded on the **Monthly Fire Alarm Monitoring Station Audit Report** (attached)<br>➢ **Areas of non-compliance will be corrected immediately**<br><br>(4.) The **Maintenance Director** will analyze the compliance of the **Fire Alarm Monitoring Station audit** and report the findings to the **Quality Improvement Committee monthly** on the **Plan of Correction Fire Alarm Monitoring Station Compliance Form**.<br>➢ Negative Results will be identified and resolved through the interdisciplinary approach of the committee.<br><br>**CORRECTIVE ACTION TAG #K052 COMPLETED ON** | 06/03/10 |