

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2013
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
--------------------	--	---------------	---	----------------------

F 000	INITIAL COMMENTS	F 000	<p>This plan of correction is to serve as Hurstbourne Care Centre's credible allegation of compliance. Submission of this plan of correction does not constitute an admission by Hurstbourne Care Centre's or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p> <p><b>F 160</b> <b>CONVEYANCE UPON DEATH</b> It is the practice of Hurstbourne Care Centre to ensure upon death of a Resident with a personal fund deposited with the facility, that the facility will convey within 30 days the Resident's funds, an final accounting of those funds, to the individual or probate jurisdiction administering the Resident's estate.</p> <p>i. On 9/26/13, discharged Resident 1/4 account was reopened and closed for a 2nd time to initiate the Resident Fund Management Service Status Change Form. The Resident Fund Management</p>	
F 160 SS=C	<p>A standard health survey was initiated on 09/10/13 and concluded on 09/12/13 and a Life Safety Code survey was conducted on 09/10/13. Deficiencies were cited with the highest scope and severity of an "F", with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition.</p> <p>483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH</p> <p>Upon the death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the individual or probate jurisdiction administering the resident's estate.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to close resident accounts within thirty (30) days of their death for four (4) of four (4) accounts reviewed and failed to follow their admission agreement.</p> <p>The findings include:</p> <p>Review of the facility's Resident Admission &amp; Information Packet revealed the facility would convey, within thirty (30) days of the resident's death, their funds and a final accounting of funds to the resident's representative or probate jurisdiction administering the estate.</p> <p>Review of resident trust accounts revealed there were twenty (20) deaths between 01/01/13 to</p>	F 160		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *[Signature]* TITLE: *administration* (X6) DATE: *9/17/13*

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.

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/12/2013
--	--	--	--

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

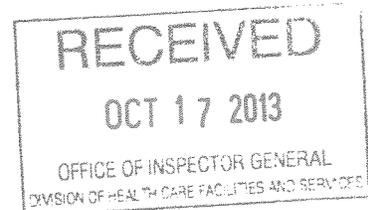
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 2</p> <p>F160 CONT page 1a</p>		<p>Service Status Change Form was faxed to National Datacare on 9/11/2013 by the Business Office Manager.</p> <p>Discharged Resident 2/4 account was reopened and re closed for a 2nd time to initiate the Resident Fund Management Service Status Change Form. The Resident Fund Management Service Status Change Form was faxed to National Datacare on 9/11/2013 by the Business Office Manager.</p> <p>Discharged Resident 3/4 had funds deposited into the Resident Trust Management Fund Account on 9/13/13 by the corporate office to offset negative balance left by Social Security take back. Funds cleared the Resident Trust Management Fund Account on 9/13/13. A Resident Fund Management Service Status Change Form was faxed to National Datacare on 9/13/13 by the Business Office Manager. The account was closed on 9/24/13.</p> <p>Discharged Resident 4/4 had funds deposited into the Resident Trust Management Fund Account on 9/11/13 by the corporate office to offset negative balance left by Social Security take back. Funds cleared the Resident Trust Management Fund Account on</p>	
--	---	--	---	--

STATE FORM

9899

S6HX11



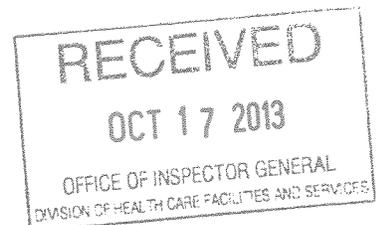
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BR		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	Continued From page 2  F160 CONST Page 2 b		<p>9/12/13. A Resident Fund Management Service Status Change Form was faxed to National Datacare on 9/13/13 by the Business Office Manager. The account was closed on 9/13/13.</p> <p>All Residents have the potential to be effected by the alleged deficient practice upon death. The Business Office Manager and the Business Office Assistant were reeducated by the Nursing Home Administrator on 9/26/13. Regarding Hurstbourne Care Centre's system that upon death of a Resident, the facility will convey within 30 days the Resident's funds, a final accounting of those funds, to the individual or probate jurisdiction administering the Resident's estate. The Business Office Manager will be notified of a Resident's death within 72 hours. The Business Office Manager will initiate the Resident account closing, complete the account closing and place the validation of account closing in the deceased Resident's financial file.</p> <p>IV. Upon death of a Resident, the Nursing Home Administrator will validate the Business Office Manager has initiated and completed closure of the Resident</p>	

STATE FORM

6899

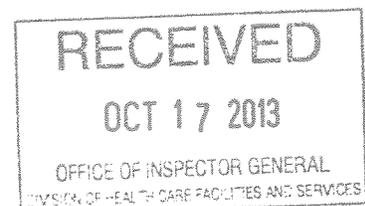
S8HX11



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

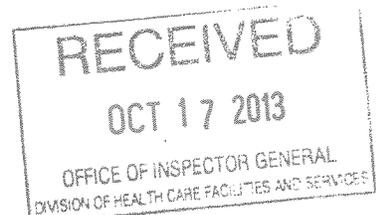
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 160	Continued From page 1 09/01/13. Of the residents with accounts, four (4) in all, two (2) of the accounts showed a negative balance with one closed and the other remaining open with a negative balance. The first resident account had a date of death of 06/14/13, the account closed 08/15/13, one month late. The second resident account had a date of death of 04/20/13. The closing of the account on 05/08/13 was rejected because of a negative balance of \$342.00. The account was not officially closed until 06/03/13, fourteen days late. The third resident account had a date of death of 03/27/13, the account closed 05/03/13, seven (7) days late. The fourth resident account had a date of death of 07/28/13. The account is still open as of 09/05/13 with a negative balance of \$653.74.  Interview with the facility Accountant, on 09/13/13 at 9:10 AM, revealed there were residents with accounts that were not closed within thirty (30) days of their deaths and two (2) of the resident accounts showed a negative balance. With a negative balance the facility has to replace the funds to create a zero balance before the account could be closed.	F 160	account using a QI Monitoring Tool by 10/24/2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet on October 18, 2013 to review the observed practice and audit tools, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate all Resident's accounts have been closed within thirty days of their death.		
F 241 SS=D	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:	F 241	V. Compliance Date: October 25, 2013		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>	
(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 241	<p>Continued From page 2</p> <p>Based on observation and interview, it was determined the facility failed to ensure residents were treated with dignity as evidenced by staff failing to knock on residents' doors prior to entering five (5) of eleven (11) residents' rooms on the Subacute II unit during breakfast delivery on 09/11/13.</p> <p>The findings include:</p> <p>Interview with the Director of Nursing, on 09/12/13 at 5:10 PM, revealed the facility did not have a policy for resident dignity.</p> <p>Observation of the breakfast room tray delivery, on 09/11/13 at 7:42 AM, revealed nursing staff delivering trays to resident rooms 28, 29, 36, 38 and 40 without knocking or requesting permission to enter the residents' rooms.</p> <p>Interview with Certified Nurse Aide (CNA) #3, on 09/11/13 at 2:08 PM, revealed she should have knocked on the doors prior to entering resident rooms. She stated she had received training on resident dignity and just forgot to knock. She stated the residents room was private and their home.</p> <p>Interview with CNA #4, on 09/11/13 at 2:12 PM, revealed she had received training on protecting resident dignity and respecting their room as home. She stated she should have knocked before entering residents' rooms.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/11/13 at 2:26 PM, revealed she supervised the CNAs on the unit and she had never noticed staff not knocking on doors prior to entry. She stated the residents' rooms were their homes and</p>	F 241	<p><b>F 241 DIGNITY</b></p> <p>It is the practice of Hurstbourne Care Centre to promote care for the 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 own individuality.</p> <ol style="list-style-type: none"> <li>I. Residents residing in rooms 28, 29, 36, 38 and 40 will be assessed by the Director of Nursing to ensure that no negative outcomes existed secondary to the alleged deficient practice. Completion date 10/24/2013. Staff will knock on the doors prior to entrance into a Resident's room.</li> <li>II. All Residents have the potential to be effected by the alleged deficient practice. Staff will knock on the doors prior to entrance into a Resident's room.</li> <li>III. The systemic change includes all staff will knock on the Resident door prior to entrance into a Resident room. All staff will be reeducated by the Nursing Home Administrator, Director of Nursing or the Assistant Director of Nursing regarding the Resident Rights and Dignity Policy and observed, daily, to ensure all staff is knocking prior to entry into a</li> </ol>	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

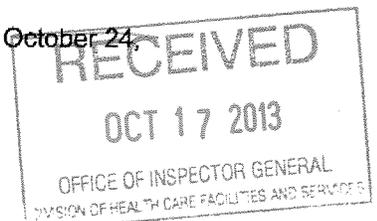
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 241	Continued From page 3 staff should respect that. She stated the staff was nervous due to the presence of surveyors.	F 241	Resident's room. Education will be completed by 10/24/2013. The Interdisciplinary Team Members consisting of Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Nurse Manager, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director) will conduct observations of 10 staff members entering the Resident's Rooms, to ensure staff is compliant with the systemic change of knocking on residents' doors prior to entering will be completed by 10/24/2013.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES  The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to maintain a sanitary, orderly and comfortable interior on four (4) of five (5) units within the facility. Stained, faded carpeting was observed throughout the hallways. Two (2) of three (3) shower rooms were found to be dirty. Damaged chests of drawers were observed in numerous resident rooms. The air conditioning unit in un-sampled Resident F's room was not functioning sufficiently to cool the room, and flies and gnats were observed in the building.  The Findings Include:  Review of the facility's Healthcare Services Group, Inc., Housekeeping: Floor Care In-service/Policy (Dated 01/01/2000), revealed the facility's carpets were to be vacuumed daily to remove dust and dirt. Carpet bonneting was to be performed monthly to remove clinging dirt from	F 253	V. The facility's Quality Assurance Committee will meet on 10/18/2013 to review the alleged deficient practice and subsequent plan of correction. The plan of correction and the audits 10 staff members entering the Resident's Rooms, to ensure staff is compliant with the systemic change of knocking on residents' doors prior to entering. will be completed on all 3 shifts including a weekend day to ensure staff is compliant with knocking on Resident's Room doors prior to entering the room was approved and accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to review the observed practice and 10 staff member observation audit tools, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate all is knocking prior to entry into a Resident's room.		

V. Compliance Date: October 24, 2013

10-25-13

R.T.C. Adm.

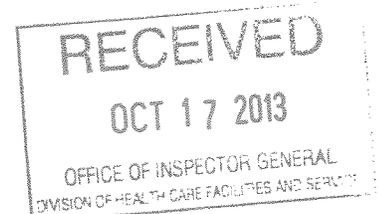
Ry/B 10/18/13



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

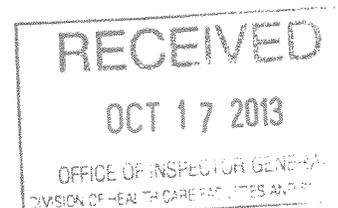
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>	
(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 253	<p>Continued From page 4</p> <p>carpet fibers, shampooing of the carpet was to occur at least annually, and stain removal chemicals were to be used as needed.</p> <p>Review of the Healthcare Services Group, Inc., House Keeping /In-service: 7-Step Daily Washroom Cleaning, Policy/In-service (Dated, 01/01/2000), revealed shower rooms were to be inspected and cleaned daily using a 7-step process. Trash should be picked up and discarded before the floor was mopped. Showers, toilets, sinks, and floors were to be disinfected with a germicidal agent. After disinfection, the metal fixtures were to be shined, mirrors were to be cleaned, trash was to be emptied, and fresh liners were to be placed in receptacles. Spot cleaning of walls, partitions, light switches, and door handles was to occur daily.</p> <p>The facility did not provide a policy regarding inspection, repair, or replacement of furnishings in the residents' rooms.</p> <p>Review of an air conditioning room audit performed on 08/16/13, and provided by the facility's Director of Operations, revealed sixty-one (61) of the seventy-six (76) air conditioning units in resident rooms were determined to be in bad working order. Fifteen (15) units were determined to be in good working order.</p> <p>Review of the commercial pest control agreement, dated 02/06/03, revealed a contract with Integrated Pest Management Services for scheduled inspections/treatments on a monthly basis, with unlimited on-call service to all areas of the facility interiors and perimeters.</p>	F 253	<p><b>F 253 HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>It is the practice of Hurstbourne Care Centre to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, comfortable interior.</p> <p>I. The carpet in the 100 hallway will be cleaned, repaired or ordered for replacement as necessary to maintain a sanitary, orderly and homelike environment by the Operations Director and/or third party contractor by 10/24/2013. The carpet in the sub acute 1unit will be cleaned, repaired or ordered for replacement as necessary to maintain a sanitary, orderly and homelike environment by the Operations Director and/or third party contractor by 10/24/2013. The carpet in the sub acute 1unit will be cleaned, repaired or ordered for replacement as necessary to maintain a sanitary, orderly and homelike environment by the Operations Director and/or third party contractor by 10/24/2013.</p>	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

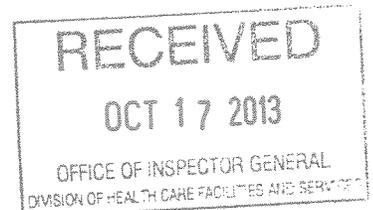
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 253	Continued From page 5  Observation, on 09/10/13 at 8:30 AM, during the initial tour of the facility revealed many stained and/or faded spots in the hallway carpeting on the following units in the facility: the 100 hallway, sub-acute 1, sub-acute 2, and the Dementia Unit. Large gouges and scratches were observed on dresser drawer sets and on bedside tables in resident rooms on the following units: the 100 hallway, rooms 106 A (also missing a drawer knob), and 106 B, 108 A, 109 A and B, 115, and 117 A and B; Sub Acute 1, rooms 22, and 30 B; Sub Acute 2, rooms 28, 33, 38, 35, and 40; and on the Dementia Unit, rooms 208, 209 (also a handle missing from a drawer and bottom drawer off its slides), 211 A (also the bottom dresser drawer off its slides), 212 A and B (also a missing handle from a drawer), 213 A and B, 214 A and B, 215 B, and 220.  Observation, on 09/11/13, at 11:25 AM, of the 100 hall shower room revealed wadded up pieces of paper toweling scattered about on the wet floor, a plastic disposable razor was found on the floor by the wall, a partially empty bottle of shower gel (no resident's name) was sitting on top of one of the grab bars in the shower stall area; two (2) plastic combs containing hair (no resident names) were found by the sink; and two pairs of disposable gloves were wadded up and lying on the sink counter top.  Observation, on 09/11/13 at 1:25 PM, of the Sub-Acute 1 and 2 Unit's shower room revealed two (2) pairs of plastic gloves that were wadded up and lying on the floor, a blue shirt balled up and lying in the corner of the room, two sinks, one of which was labeled as broken, and a black comb with a large amount of hair placed on the	F 253	The carpet in the dementia unit will be cleaned, repaired or ordered for replacement as necessary to maintain a sanitary, orderly and homelike environment by the Operations Director and/or third contractor by party 10/24/2013. The 100 Hallway furniture Room 106A missing knob was replaced. Room 106A & B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013. Room 108A the damaged dresser and overbed table will be repaired by the Operations Director by 10/24/2013. Room 109A & B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013. Room 115 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013. Room 117A & B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013.		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

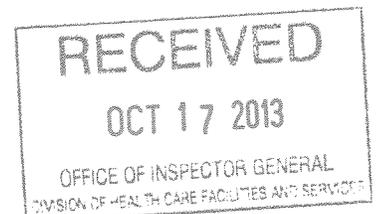
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	<p>Continued From page 6</p> <p>counter top near that sink. The black skid strips were significantly worn to the point of being almost non-existent across the shower room's tiled floor.</p> <p>Observation, on 09/12/12 at 11:20 AM, of the 100 hall shower room revealed a wadded up pair of disposable gloves was again on the sink in the same place the used gloves were observed on 09/11/13 at 11:25 AM. The same bottle of opened and unlabeled shower gel was sitting on the grab bar of the shower stall, a hair brush and a comb (both unlabeled, and with hair in them) were out on a counter top, and a container of open bleach wipes was sitting on top of a counter top, not stored. A small cabinet affixed to the wall was available for storage, but it was open and not secured in any way.</p> <p>Interview, on 09/12/13 at 11:00 AM, with Licensed Practical Nurse (LPN) #1, revealed a resident's clothing should be bagged and taken back to the resident's room for the facility's laundry services pick up. The residents' personal hygiene items should not be left unlabeled and un-stored in the shower room(s), and used disposable gloves should be disposed of in the trash immediately after use. The problem with improper storage, lack of labeling, and improper disposal of used items was the potential for a break in infection control, resulting in the spread of infections.</p> <p>Interview, on 09/12/13 at 11:30 AM, with the Unit Manager for the 100 hall revealed nursing staff was responsible for ensuring personal hygiene supplies were returned and stored in the residents room after showers. Disposable gloves should be disposed of in the trash immediately after use. Used plastic razors should be</p>	F 253	<p>Room 22 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 28 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 30B dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 33 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 35 dresser and overbed table gouges Scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 38 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 40 dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 208 dresser and</p>	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 253	<p>Continued From page 7</p> <p>disposed of in sharps containers, and combs and brushes should be labeled with the residents' names and should be appropriately stored after use. CNAs were responsible for cleaning up the shower room after each shower, and the housekeeping staff performed daily deep cleaning of the shower rooms. The problem with improper storage of personal hygiene items and improper disposal of gloves and razors was the potential for cross-contamination and disease transmission.</p> <p>Interview, on 09/12/13 at 2:50 PM, with the Director of Nursing Services (DNS), revealed CNAs were responsible for cleaning up the shower rooms after each shower and for sanitizing the equipment. Housekeeping staff was responsible for deep cleaning the shower rooms daily, and as needed. The concern with not keeping the residents' personal hygiene items labeled, separated, and stored would be the potential for the spread of infections.</p> <p>Observation, on 09/11/13 at 9:00 AM, revealed Unsampled Resident F sitting in his/her room in a wheelchair, near the air conditioner (a/c) unit.</p> <p>Interview, on 09/11/13 at 9:00 AM, with Unsampled Resident F revealed he/she did not think the a/c in his/her room was working sufficiently and the room had been uncomfortably warm during the summer months. Unsampled Resident F stated he/she had mentioned the a/c unit issue to two (2) Certified Nursing Assistants (CNAs) who said they would report the malfunctioning a/c unit, but Unsampled Resident F did not think it had been repaired.</p> <p>Observation, on 09/11/13 at 8:30 AM, revealed a</p>	F 253	<p>overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 209 missing handle from drawer was replaced and the bottom drawer was put back on it's slide, by the Operations Director by 10/24/2013.</p> <p>Room 211 the damaged dresser and the overbed table will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 212A &amp; B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 213A &amp; B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 214A &amp; B's dressers and overbed tables gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 215B dresser and overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Room 220 dresser and</p>		



Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2013
--	--	---	--

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

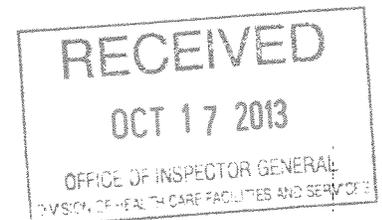
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

	<p>Continued From page 2</p> <p>F 253</p> <p>page 8a</p>		<p>comfortable environment not to exceed 81 degrees.</p> <p>Pest Control Company was notified on 9/12/13 regarding gnat like insects and flies by the Operations Director. The Pest Control Company provided treatment on <u>9/14/13</u></p> <p>A room to audit will be completed of all Resident rooms, common areas and shower rooms to identify the items requiring replacement or repair. The shower rooms were cleaned; all personal care items and bleach wipes were removed. The sink faucet was repaired. This worn skid stripes will be removed when shower room is renovated. A lock was installed on the shower room cabinet.</p> <p>II. All of the Residents have the potential to be effected by the alleged deficient practice.</p> <p>II. The systemic change includes Administrative development of a Quality Assurance Room Round Sheet to be utilized by leadership staff. Education completed by 10/24/2013. All staff will be reeducated by the Nursing Home Administrator, Director of Nursing or the Assistant Director of Nursing to communicate housekeeping and maintenance concerns by 10/24/2013.</p>	
--	--	--	--	--

STATE FORM

6899

36HX11



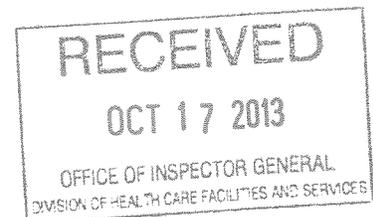
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BR		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
	Continued From page 2  F253 page 8b		<p>overbed table gouges scrapes will be repaired by the Operations Director by 10/24/2013.</p> <p>Sub-Acute 2 Shower Room was Cleaned and sanitized. The disposable gloves, hairbrush, comb and container of bleach wipes were discarded by the Director of Nursing on 9/12/2013. Clothing was removed &amp; taken to laundry by Director of Nursing on 9/12/2013. The small storage cabinet on was cleaned Sub Acute 1 and secured by the Director of Nursing on 09/12/13. The broken sink will be repaired by the Operations Director by 10/24/2013.</p> <p>The floor skid strips will be replaced by the Operations Director by 10/24/13.</p> <p>Resident F's air conditioner will be assessed by the Operations Director by 10/24/2013. The unit is functioning properly to ensure a comfortable environment not to exceed 81 degrees.</p> <p>HVAC units in the Resident Rooms will be assessed by the Operations Director by 10/24/2013 to ensure proper functioning and will be repaired or replaced as needed to provide a</p>

STATE FORM

6899

56HX11



P. 032/098

FAX NO.

OCT/17/2013/THU 11:34 AM

Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  09/12/2013
--	--	--	--

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
--------------------	--	---------------	---	--------------------

Continued From page 2

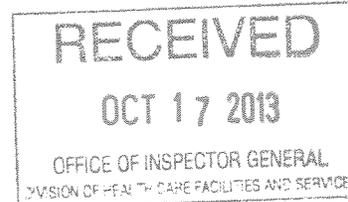
F 253 page 8c

IV. The Quality Assurance will be completed by leadership staff 3 times each week to monitor each Resident room to ensure the Resident Rooms, bathrooms and shower rooms are clean, furniture and flooring are in good repair. Any performance improvement opportunities will be documented on the Quality Assurance Round Sheets escalated to the Nursing Home Administrator and/or Manteca Director for immediate interventions. The Nursing Home Administrator and/or the Maintenance Director will complete a 10% audit of Quality Assurance Round Sheets. This audit of the Quality Assurance Round Sheets will ensure Resident Rooms, bathrooms and shower rooms are clean, furniture and flooring are in good repair will review the Quality Assurance Room Round Sheet and initiate appropriate interventions, 3 days/week for 4 weeks, weekly for 4 weeks, monthly for 3months and quarterly, thereafter. The facility's Quality Assurance Committee will meet on 10/18/13 to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all

STATE FORM

8899

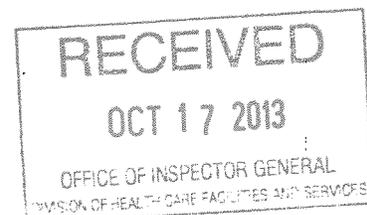
S6HX11



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

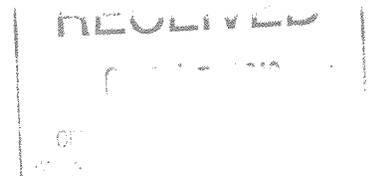
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>	
(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 253	<p>Continued From page 8</p> <p>fly circling the medication cart on the 100 hallway, near the common area.</p> <p>Observation, on 09/11/13 at 2:26 PM, revealed gnat-like insects buzzing around the medication cart on the Sub-Acute II unit.</p> <p>Observation, 09/12/13 at 10:50 AM, revealed gnat-like insects buzzing around the common area and the nurses' station on the Sub-Acute II Unit. Residents were seated in the common area at this time.</p> <p>Interview, on 09/12/13 at 2:30 PM, with the Director of Facility Operations revealed he performed room rounds on 08/15/13 and identified issues with in the building where repair/replacement of furnishing/fixtures/blinds, plaster/walls, etc., was necessary. He stated he had started patching scratched door surfaces, and planned to re-stain all doors to resident rooms. The Director of Facility Operations provided a copy of the room audit. He stated he would be obtaining three (3) bids for replacement of the air conditioning system for the entire facility. He had received two (2) of the necessary bids. He stated that until the new system was installed, Advanced Mechanical Company was making repairs to the existing air conditioning system. This agency also conducted weekly audits of the building and provided treatment for pests including flies, gnat-like insects, and any other insects/pests on an as needed basis.</p> <p>Interview, on 09/12/13 at 2:35 PM, with the Facility's Administrator, revealed the facility planned to replace the carpets and floors in all resident rooms and hallways by January 2014. The administrator stated chairs, bed spreads, and</p>	F 253	<p>Quality Assurance Team Members. The Quality Assurance Team will meet to review the observed practice and audit tools, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate all Resident rooms, common areas and shower rooms requiring cleaning, furniture replacement or repairs are resolved.</p> <p>V. Compliance Date: October 25, 2013</p>	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

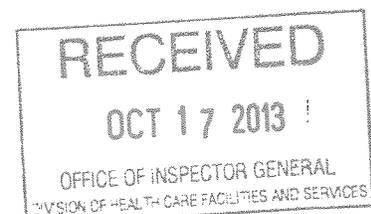
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>	
(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 253	Continued From page 9 window coverings would be replaced. She stated she had a bid from a designer, but she had not placed the order for the new furnishings, spreads, and window coverings. The administrator stated the facility had tried to repair/replace damaged chests of drawers and bedside tables when they were identified.	F 253		
F 279 SS=D	<b>483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS</b>  A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.  The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.  The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Care Plans, it was determined the facility failed to develop a comprehensive plan of care for four (4) of the	F 279	<b>F 279 COMPREHENSIVE CARE PLANS</b>  It is the practice of Hurstbourne Care Centre to use the results of the Resident's assessment to develop, review and revise the Resident's plan of care. The facility develops a comprehensive care plan for each Resident that includes measurable objectives and timetables to meet a Resident's psychosocial needs that are identified in the comprehensive assessment.  1. The Interdisciplinary Team (IDT) will review Residents #1, 2, 8 & 9's medical record, most recent MDS and care plans by 10/25/2013. Each care plan for Residents #1, 2, 8 & 9's were updated to reflect the current status of the Resident. The Resident and/or Responsible Party were consulted by a member of the IDT to discuss Resident preference and Interdisciplinary Team recommended interventions by 10/18/13. MD notified as needed. The Interdisciplinary Team consists of the Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator and the Registered Dietitian, Dietary	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

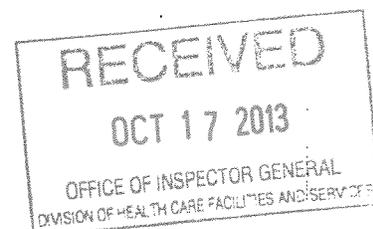
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 279	<p>Continued From page 10</p> <p>twenty-four (24) sampled residents (Residents #1, 2, 8, and 9). The facility failed to develop a plan of care addressing the nutritional needs of Resident #8. The facility failed to develop a comprehensive plan of care regarding the psychoactive medications ordered for Residents #1, 2, and 9.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Care Plans, revised 09/01/11, revealed the facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet the resident's nursing, medical, mental and psychosocial needs that are identified in the comprehensive assessment.</p> <p>1. Review of the clinical record for Resident #2 revealed the facility admitted the resident on 05/17/13, with the diagnoses of Agoraphobia, Anxiety, Panic Disorder, and Post Traumatic Stress Disorder. The facility assessed the resident using the Minimum Data Set (MDS), on 08/17/13, with a Brief Interview for Mental Status (BIMS) score of fifteen (15), indicating the resident was cognitively intact. The facility assessed the resident with a mood symptom frequency score of nine (9), indicating mild depression. Further review of the clinical record revealed the resident's refusal to leave the room, to go to therapy or activities, or get out of bed. The resident was started on two (2) psychoactive medications for Anxiety and Depression. However, review of Resident #2's care plan revealed neither the medications nor corresponding behavior were addressed.</p> <p>Observation and interview of Resident #2, on</p>	F 279	<p>Manager and Activities Director as needed.</p> <p>II. All Residents with a change in condition have the potential to be effected by not developing a nutritional or psychoactive care plan. The Director of Nursing and/or the Assistant Director of Nursing reviewed the Residents with nutritional concerns and/or psychoactive medications to ensure their plan of care was updated accordingly. Any Residents with a change of condition will be documented on the 24-Hour Status Change Report by 10/24/2013.</p> <p>III. The systemic change will include any Resident identified with a change in condition will be documented by a licensed nurse during the respective shift in which the change in status occurs on the 24-Hour Report by 10/24/2013. The Interdisciplinary Team will review the status changes, complete reassessments as appropriate, update the care plan to reflect the current status of the Resident the following business day, effective 10/24/2013. The Resident and/or Responsible Party were consulted to discuss Resident preference and Interdisciplinary Team recommended interventions. MD</p>	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	<p>Continued From page 11</p> <p>09/11/13 at 10:11 AM, revealed the resident lying in bed, watching television. The resident revealed he/she prefers to stay in room with the door closed.</p> <p>Interview with Registered Nurse (RN) #2, on 09/12/13 at 2:20 PM, revealed the care plan was used to inform the nursing staff how to care for a resident. The RN revealed the Unit Manager was responsible to ensure the care plans were completed and up to date.</p> <p>Interview with the Sub Acute 1 Unit Manager, on 09/12/13 at 2:22 PM, revealed Resident #2 was on the medication for Depression and Anxiety. The Unit Manager revealed nursing was responsible to document any side effects and to know any contraindications associated with the medication. The Unit Manager revealed this was the only responsibility of the nurse and this did not need to be care planned. The Unit Manager revealed the resident's physician was responsible to monitor for behavior, and improvement or decline with the medication. The Unit Manager revealed nursing was not responsible for the psychosocial aspects of the resident's care and the Social Service Director was responsible for any such related care plans.</p> <p>Interview with the Social Service Director, on 09/12/13 at 2:40 PM, revealed the facility had a Gradual Dose Reduction (GDR) meeting with the physician every third monday of the month. The Social Service Director revealed she maintained the behavior review record for the resident and developed a coordinating care plan to address the residents needs.</p> <p>Review of the Behavior Review Record provided</p>	F 279	<p>notified as appropriate. This will be completed by October 25, 2013.</p> <p>All licensed nurses will be reeducated by the Director of Nursing or the Assistant Director of Nursing to identify Resident status changes and note on the 24-Hour Status Change Report, review the status changes, complete assessments as appropriate and update the Resident plan of care by 10/24/2013 prior to returning to work. The Director of Nursing, the Assistant Director of Nursing and the Unit Managers will review the status changes Monday through Friday, to validate staff are identifying the Resident status changes and noting the changes on the 24 hour report and update the care plan to reflect the current status of the Resident by 10/24/13.</p> <p>IV. The Director of Nursing or the Assistant Director of Nursing will conduct an initial audit 10 Residents of the Resident care plans to validate staff are identifying the Resident status changes and noting changes on the 24-Hour Status Change Report, reviewing the status changes, completing reassessments as appropriate</p>		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	<p>Continued From page 12</p> <p>by the Social Service Director, dated 08/19/13, revealed the resident was stable, but refused to get out of bed. Review of the Comprehensive plan of care revealed a concern with inadequate sleep patterns related to refusal to wear a BiPAP at night with a goal to improve sleep.</p> <p>Further interview with the Social Service Director revealed the care plan did not address the resident's actual problem of refusal to get out of bed. In addition, the care plan did not include the targeted behavior, behavior monitoring, medications used, or nonpharmacologic interventions.</p> <p>Interview with the Director of Nursing (DON), on 09/12/13 at 5:12 PM, revealed resident care plans should include the residents psychosocial symptoms, medications being used, diagnosis, reason/rationale, exhibiting behavior, and any nonpharmacological interventions.</p> <p>2. Observation of Resident #1 on 09/10/13 at 11:20 AM, 11:52 AM, 3:14 PM, 4:05 PM, revealed the resident in bed and sleeping.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Dementia, Hypertension and Decubitus. The facility completed a Significant Change Minimum Data Set (MDS) assessment on 07/23/13 which revealed the resident had a cognitive impairment, required extensive assistance with daily living tasks, was incontinent of stool and received an antidepressant. The resident had lost over twenty (20) pounds in the last six months related to frequent illness and had</p>	F 279	<p>and updating the care plan to reflect the current status of the Resident by 10/24/2013. The monitoring will continue with an audit of 10 Residents/week for four weeks, 10 Residents for three months and 10 Residents, quarterly, thereafter. The facility's Quality Assurance Committee will meet on 10/18/13 to review the alleged deficient practice and subsequent plan of correction. The Quality Assurance Team will meet to review the observed practice and audit tools, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate care plans are current and consistent with Resident assessments.</p> <p>V. Compliance Date: <u>October 25, 2013</u> <i>10-26-13 pm JCA</i></p> <p><i>by PB 10-18-13</i></p>		

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	Continued From page 13 a poor appetite.  Review of the comprehensive care plan for Resident #1, revealed the resident received an antidepressant, added to the care plan on 01/05/12, to improve appetite. An activity care plan was initiated on 12/03/12 to address the resident's decline in activity attendance related to sleeping frequently. The resident was to be up in a gerichair and observed for mood changes, steadiness, balance, muscle coordination and ability to turn and position self as possible side effects of the antidepressant. The facility was unable to provide documentation showing a comprehensive care plan was developed to address the resident's weight loss.  Interview with CNA #3, on 09/11/13 at 2:12 PM, revealed Resident #1 slept most of the time and no longer got up in a chair during the day. She stated the resident was not able to turn or position self. She stated the resident had declined due to a poor appetite She stated the resident rarely yelled out any more and slept most of the time.  Interview with Licensed Practical Nurse (LPN) #1 and #4, on 09/11/13 at 2:26 PM, revealed the resident had lost over twenty (20) pounds in the last several months due to several illnesses. They stated the antidepressant was not effective as an appetite stimulant and the resident had a very poor appetite. They stated the side effects for Remeron included drowsiness and dizziness. They stated the resident never complained of dizziness; however, she said he was sleepy frequently and did nap most of the day.  Interview with the Director of Nursing, on	F 279			

**RECEIVED**  
OCT 17 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE REGULATION, LICENSING AND SERVICES

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

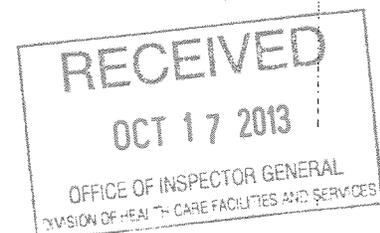
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 14</p> <p>09/12/13 at 5:10 PM, revealed Resident #1's care plan should have been developed to address the resident's weight loss with interventions to stop or minimize the weight loss and complications from the weight loss.</p> <p>3. Observation of Resident #9, on 09/10/13 at 12:32 PM, revealed Resident #9 sitting up in the room watching television.</p> <p>Review of the clinical record for Resident #9 revealed the facility admitted the resident with diagnoses of Dementia with Depression and Congestive Heart Failure. The facility completed a Annual MDS assessment on 07/05/13 which revealed the resident was cognitively intact, required assistance with daily living tasks and was continent of bowel and bladder. The resident received an antidepressant and a hypnotic for sleep.</p> <p>Review of the comprehensive care plan, dated 09/05/13, revealed Resident #9 received psychotropic medications for depression and insomnia and had the potential for changes in mood related to the diagnoses. Side effects were listed; however, they were not specific for the medications received. The facility was unable to provide documentation that a care plan was developed to address the specific psychotropic medications, the dosages and the specific side effects possible for each medication.</p> <p>Interview with LPN #6, on 09/11/13 at 2:26 PM, revealed the care plan did not address the specific medications or dosages Resident #9 received. She stated the possible side effects, for each of the medications, were not listed on the care plan. She stated some of the common side</p>	F 279			

RECEIVED  
OCT 17 2013  
OFFICE OF INSPECTOR GENERAL  
DEPARTMENT OF HEALTH CARE FACILITIES AND SERVICES  
OCT/17/2013 THU 11:36 AM

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

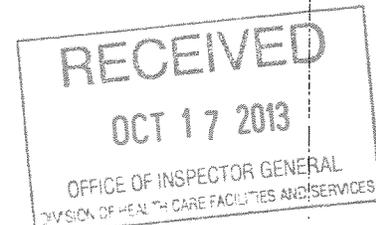
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	<p>Continued From page 15</p> <p>effects for both medications were missing.</p> <p>Interview with the DON, on 09/12/13 at 5:10 PM, revealed the care plan should include the medications and the specific side effects for each medication in order for staff to be aware of which drug was causing side effects.</p> <p>4. Review of the clinical record revealed Resident #8 was admitted to the facility on 08/02/13 with diagnoses of Dementia with Behaviors, Anxiety State, Chronic Anemia, Chronic Pulmonary Heart Disease, a history of Urinary Tract Infections (UTIs), and Stage II and Stage III Pressure Ulcers. The facility assessed Resident #8 using the Minimum Data Set (MDS) on 08/09/2013, and the Care Area Assessment Summary (CAAS) section of the document revealed the resident triggered for Nutritional Status. Further review of Resident #8's clinical record revealed there was no nutrition care plan.</p> <p>Review of the physician's orders revealed the following medications/nutritional supplements for Resident #8: Resource Arginaid, Thera M, Vitamin C, Zinc Sulfate, and Remeron 15 mg, daily. Further review of the clinical record revealed treatment orders for Resident #8's pressure ulcers and a Pureed Diet with Nectar Thickened Liquids. In addition, Resident #8's weight had changed from 153.0 pounds to 149.6 pounds (2.2%) since admission, and he/she required assistance with eating.</p> <p>Interview, on 09/12/13 at 1:05 PM with Registered Nurse (RN #1), revealed Resident #8 triggered for Nutrition during the initial MDS assessment, but a care plan did not currently exist for nutrition.</p>	F 279		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

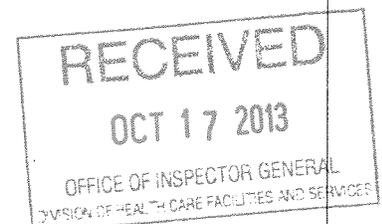
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	<p>Continued From page 16</p> <p>RN #1 stated the purpose of a comprehensive care plan was to ensure the interdisciplinary staff knew how to appropriately address all of Resident #8's care needs, and it should have included a plan with nutritional goals and interventions. RN #1 stated nutrition interventions were particularly important for Resident #8 because he/she was currently under treatment for pressure ulcers, his/her history of UTIs, and his/her need for assistance with eating.</p> <p>Interview, on 09/12/13 at 1:10 PM, with the facility's Registered Dietician (RD) revealed Nutritional Status was a necessary component for Resident #8's comprehensive care plan because adequate protein ingestion and hydration were key components for healing in the presence of skin breakdown.</p> <p>Interview, on 09/12/13 at 1:30 PM, with the MDS Director revealed Resident #8 should have had a nutrition care plan within his/her Comprehensive Plan of Care because it was an area that triggered via the MDS assessment. Resident #8's compromised skin condition, his/her need for a mechanically altered diet, and his/her need for assistance with eating should have been addressed with measurable goals and interventions, but apparently, this was not done.</p> <p>Interview, on 09/12/13 at 2:50 PM, with the Director of Nursing (DON) revealed the MDS staff was responsible for ensuring the care plan addressed all care areas triggered through the MDS assessment, and Resident #8 should have had a nutrition care plan. Resident #8 had risk factors, including, but not limited to his/her current skin breakdown that required careful attention to adequate protein, vitamin, mineral, and fluid</p>	F 279		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 279	Continued From page 17 intake.	F 279	<b>F282 SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  It is the practice of Hurstbourne Care Centre to ensure services provided and arranged by the facility are provided by qualified persons in accordance with each Resident's written plan of care.  I. Resident #1 will be reassessed by a licensed nurse to identify if Resident desired to be placed in the Geri Chair, be in the hall and/or participate in Activities for socialization. The assessment will be completed by 10/24/2013. The Resident and/or Responsible Party will be consulted to discuss Resident preference and Interdisciplinary Team recommended interventions. The Interdisciplinary Team will review the assessment and the care plan will be updated to reflect the current status of the Resident. MD notified as needed. The Interdisciplinary Team consists of the Director of Nursing, Assistant Director of Nursing, Social Services Director, MDS Coordinator and the Registered Dietitian, Dietary Manager and Activities Director.  II. All Residents with a Geri Chair have the potential to be effected		
F 282 SS=D	<b>483.20(k)(3)(II) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to follow the comprehensive care plan for one (1) of twenty-four (24) sampled residents (Resident #1). The facility failed to get Resident #1 out of bed and into a gerichair.  The findings include:  Review of the facility's policy regarding Care Plans, dated 09/01/2011, revealed the facility must develop a care plan to meet the residents' needs. The care plan was oriented to prevent a decline in function. All direct care staff must follow the care plan.  Observation of Resident #1, on 09/10/13 at 10:52 AM, 11:20 AM, 11:52 AM, 12:25 PM, 1:45 PM, 2:40 PM, 3:14 PM and 4:05 PM, revealed the resident was in bed.  Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Chronic Pressure Ulcer, Dementia, Diabetes, and Hypertension. The facility completed a Significant Change Minimum Data	F 282			



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

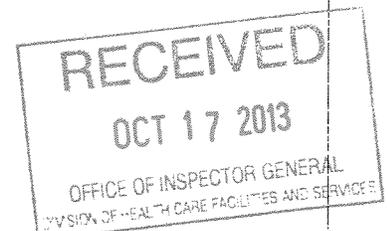
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 18</p> <p>Set (MDS) assessment on 07/23/13 which revealed the resident had a cognitive impairment and required total assistance with all daily living tasks. The resident was unable to assist with transfers out of bed. The resident was incontinent of stool.</p> <p>Review of the comprehensive care plan for Resident #1, revealed the resident had chronic pressure ulcers and the goal was to minimize the risk of further pressure ulcers. Staff were to assist the resident with mobility and transportation to activities. The resident enjoyed the out of doors, music events and sitting in the common area.</p> <p>Interview with the guardian of Resident #1, on 09/10/13 at 12:25 PM, revealed the gerichair, used for Resident #1's mobility outside the room, was no longer ever in the room. She stated the resident had not been out of bed for activities or socialization in a long time. She stated the resident had always enjoyed sitting in the common area and going to music events.</p> <p>Interview with Certified Nurse Aide (CNA) #5, on 09/11/13 at 2:08 PM, revealed the resident used to get up in the gerichair several times a week and she did not know when this stopped or why it stopped. She stated nothing had changed to prevent the resident from getting out of bed that she was aware of. She stated residents needed to be out of bed and room for enjoyment.</p> <p>Interview with Licensed Practical Nurse (LPN) #7, on 09/11/13 at 2:10 PM, revealed Resident #1 was to get up in a gerichair and needed total assistance of staff. She stated sometimes the resident refused to get up. She stated the nurse</p>	F 282	<p>by the alleged deficient practice of failure to follow the comprehensive care plan.</p> <p>III. The systemic change includes the development and implementation of Resident specific CNA Assignment Sheets to delineate Resident to ensure compliance with the Resident plan of care by 10/24/2013. All licensed nurses and CNA's will be reeducated by the Director of Nursing or the Assistant Director of Nursing to follow the Resident CNA's Assignment Sheets to ensure compliance with the Resident's written plan of care by 10/24/2013.</p> <p>IV. The Director of Nursing or the Assistant Director of Nursing will conduct an initial audit of 10 Resident care plans and Resident specific CNA Assignment Sheets to ensure compliance with the Resident's written plan of care by 10/24/2013. This audit will be completed weekly for four week, monthly for 3 months and quarterly, thereafter. The facility's Quality Assurance Committee will meet on 10/24/2013 to review the alleged deficient practice, subsequent plan of correction</p> <p>V. Compliance Date: October 25, 2013</p>		

RECEIVED  
OCT 17 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES  
OCT/17/2013 THU 11:27 AM

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>	
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(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 282	Continued From page 19 was responsible to ensure the care plan was followed by the CNA. She stated she had not seen the resident out of bed in weeks and was not sure when staff had stopped getting the resident up. She stated it was important for residents to be out of their rooms for socialization.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy Coordination of Hemodialysis Services, it was determined the facility failed to provide the necessary care and services for two (2) of the twenty-four (24) sampled residents (Resident's #1 and #7). The facility failed to ensure an interchange of information necessary for the care of Resident #7 existed between the facility and the dialysis center. In addition, the facility failed to designate	F 309	<b>309 QUALITY OF CARE</b>  It is the practice of Hurstbourne Care Centre to ensure each Resident receives and the facility provides the necessary care and services to attain and/or maintain the highest practicable physical, mental and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  I. Residents #1's Code Status was reviewed by the Social Services Director, new Physician's order was written and placed within the medical record on 10/5/13. Resident #7 no longer resides in the facility.  II. All Residents leaving the facility for dialysis have the potential to be effective when Resident specific clinical documentation is not sent with the Residents to dialysis. Current facility residents were reviewed by the Director of Nursing/ Director of Nursing /Nurse Manager to ensure that those receiving outside dialysis services have a dialysis communication form in use on dialysis days as a form of communication between the facility and the dialysis center by	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

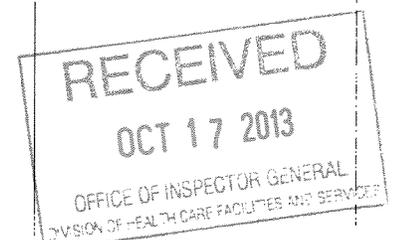
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 20 the code status of Resident #1 in the medical record.</p> <p>The findings include:</p> <p>1. Review of the facility's policy Coordination of Hemodialysis Services, revised 09/01/11, revealed residents requiring an outside End Stage Renal Disease (ESRD) facility would have services coordinated by the facility to include care planning, nursing, medications, nutritional, social services, activities, and physician services. There would be communication between the facility and the ESRD facility regarding the resident.</p> <p>Review of Resident #7's medical record revealed the facility admitted the resident on 11/02/11 with the diagnoses of Congestive Heart Failure, Cirrhosis of the Liver, Renal Disease, and Diabetes. The resident was readmitted, on 09/06/13, with ESRD and a dialysis catheter. The facility assessed the resident using the Minimum Data Set, dated 08/08/13, as having a Brief Interview for Mental Status (BIMS) score of 15 indicating the resident was cognitively intact.</p> <p>Interview with Resident #7, on 09/10/13 at 11:46 AM, revealed the resident started dialysis the day before and felt very tired and worn out. The resident revealed he/she was transferred to the dialysis center in an ambulance and was given a lunch to take with them. Observation of Resident #7, on 09/11/13 at 10:56 AM, revealed the resident was transferred to the dialysis center via ambulance.</p> <p>Further review of the medical record revealed no communication forms between the dialysis center</p>	F 309	<p>10/24/2013. Any discrepancies noted were immediately corrected by the Director of Nursing/ Director of Nursing /Nurse Manager. All Residents have the potential to be effected if the current Resident code status is not properly transcribed on the monthly physician order sheets. Current facility residents were reviewed by Director of Nursing/ Director of Nursing /Nurse Manager to ensure that the code status is transcribed on the monthly physician's order sheets, by 10/24/2013. Any discrepancies noted were immediately corrected by the Director of Nursing or the Assistant Director of Nursing.</p> <p>iii. The systemic change includes the development of dialysis communication folder in each of the respective Resident's Mar's to ensure a dialysis communication will be provided for each visit to the dialysis clinic. The Director of Nursing completed a reeducation of the licensed nurses, Social Services Director, Social Services Assistant and the Medical Records Clerk regarding the requirement to have a current and accurate code status in the medical record by 10/24/2013. The Director of Nursing or the</p>		

RECEIVED  
OCT 17 2013  
OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	<p>Continued From page 22 closed.</p> <p>Review of the clinical record for Resident #1, revealed the facility admitted the resident with diagnoses of Hypertension and Diabetes and physician orders for a Full Code in the event the resident had a cardiac arrest. The facility completed a Significant Change Minimum Data Set (MDS) assessment on 07/23/13 which revealed the resident had cognitive impairments and was dependent on staff for all care. The resident had declined over time and the guardian agreed the resident would become a Do Not Resuscitate (DNR) on 08/12/13. The physician wrote orders for the DNR on 08/12/13. Monthly orders to continue care and medications for 09/2013 were placed in the clinical record and signed by the physician on 09/06/13. These orders indicated the resident was a Full Code.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 09/11/13 at 10:42 AM, revealed the monthly orders did indicate Resident #1 was a Full Code and she was not aware of the error. She stated a nurse reviewed the monthly orders for accuracy each month then placed the orders on the clinical record for the physician to sign. She revealed she did not know how the DNR order was missed. She stated the monthly orders, for 09/2013, should have been changed to reflect the resident's DNR status. She stated the clinical record was the source of information regarding all residents resuscitation status. She stated the resident could have been resuscitated accidentally.</p> <p>Interview with the Director of Nursing, on 09/12/13 at 5:10 PM, revealed a 100% audit of code status had recently been completed by staff</p>	F 309	<p>is current and consistent with the most recent Physician Order by 10/24/13. The Director of Nursing and the Assistant Director of Nursing completed a 100% audit of Resident receiving dialysis to ensure interchange transpires between the dialysis clinic and the facility by 10/24/13. The Director of Nursing and/or the Assistant Director of Nursing will % Resident's medical records for the code status compliance and 5 Resident medical records for the dialysis communication process, weekly, for four weeks, monthly for three months and quarterly, thereafter.</p> <p>V. Compliance Date: October 25, 2013</p>		



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

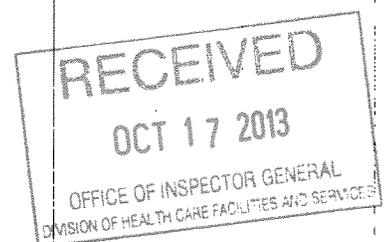
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  09/12/2013
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 309	Continued From page 23 and this error was not discovered. She stated the error should have been recognized and corrected. She stated this error could have resulted in incorrect action being taken by staff if a resident had a cardiac arrest.	F 309	<b>F 371 SANITARY CONDITIONS</b>  It is the practice of Hurstbourne Care Centre to store, prepare, distribute and serve food under sanitary conditions. I. The Residents on 100 Hall whom were served meal trays were assessed and the medical records were reviewed by the Unit Manager on October 8, 2013 to ensure there were no negative outcomes. II. All Residents receiving meal trays from the 2/5 nursing staff had the potential to be effected by the alleged deficient practice to ensure food is served in a sanitary manner. No Residents identified were negatively impacted related to meal services on 9/11/13, per the Director Nursing's Review. The Residents on 100 Hall whom were served meal trays were assessed and the medical records were reviewed by the Unit Manager on October 8, 2013 to ensure there were no negative outcomes as a result of the alleged deficient practice. III. The systemic change includes the Director of Nursing or the Assistant Director of Nursing reeducation of all CNA's		
F 371 SS=D	<b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b>  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure food was served, by two (2) of five (5) nursing staff members, using sanitary practices on the 100 Unit. Two staff members were observed to place one hand under a meal tray and lift the tray up to shoulder level while delivering the meal tray. This position allowed the staff members hair to touch the dishes on the trays.  The findings include:  Interview with the Director of Nursing (DON), on 09/12/13 at 5:10 PM, revealed there was no policy addressing how meal trays should be carried to avoid contamination.	F 371			



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
NAME OF PROVIDER OR SUPPLIER  <b>HURSTBOURNE CARE CENTRE AT STONY BROOK</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2200 STONY BROOK DR LOUISVILLE, KY 40220</b>	
(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 371	Continued From page 24 Observation of the 100 Unit during breakfast service, on 09/11/13 at 8:23 AM, revealed two (2) of five (5) nursing staff delivered meal trays to residents' rooms. The staff held the trays by placing one hand under the tray and lifting the tray up to shoulder level allowing their hair to touch dishes on the tray.  Interview with Certified Nurse Aide (CNA) #4, on 09/11/13 at 2:12 PM, revealed she had received no training on how to carry a meal tray and never thought about her hair contaminating the dishes on the tray. She stated the practice was not sanitary and any germs in her hair could be passed to the resident's food.  Interview with CNA #5, on 09/11/13 at 2:20 PM, revealed she was not aware her hair was touching the dishes on the residents meal trays and she had not received any training on carrying meal trays to avoid contamination. She stated it was an infection control problem and should not be done.  Interview with the Director of Nursing, on 09/12/13 at 5:10 PM, revealed meal trays should be delivered to residents without contamination from hair.	F 371	regarding the proper method to carry, deliver and serve Resident meal trays under sanitary conditions with subsequent return demonstration by October 24, 2013.  V. Effective October 18, 2013, the Nursing Home Administrator, Unit Managers and/or the Dietary Manager will observe meal tray delivery to ensure CNA's are properly carrying, delivering and serving Resident meal trays under sanitary conditions for 5 meals, weekly for four weeks, monthly for three months and quarterly thereafter. On 10/24/2013 the facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. Any deficient practice will be immediately addressed with appropriate interventions initiated.	
F 431 SS=F	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically	F 431	V. Compliance Date: October 25, 2013	



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

PRINTED: 09/24/2013  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185289</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/12/2013</b>
--	---	--	---

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

(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 431	<p>Continued From page 25 reconciled.</p> <p>Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.</p> <p>In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure medications were administered to residents under sanitary conditions. Eight (8) of eight (8) medication carts were found soiled inside and outside.</p> <p>The findings include: Interview with the Director of Nursing (DON), on</p>	F 431	<p><b>F 431 STORAGE OF DRUGS</b></p> <p>It is the practice of Hurstbourne Care Centre to ensure medications are administered to Residents under sanitary conditions.</p> <ol style="list-style-type: none"> <li>I. Eight of eight medication carts interior and exterior, pill crushers, cup bins, drawers and sharps containers will be cleaned and sanitized, by 10/24/2013, by the Unit Managers.</li> <li>II. All Residents have the potential to be effected by the alleged deficient practice of failing to ensure medications were administered under sanitary conditions.</li> <li>III. The systemic change includes the Director of Nursing's 10/5/2013 development of a cleaning schedule and reeducation of all licensed nurses to ensure the method of cleaning, proper sanitizing and overall cleanliness is maintained in an orderly fashion each respective medication cart. Reeducation of all licensed nursing staff by the Director of Nursing or the Assistant Director of Nursing was completed to ensure the method of cleaning, sanitizing and maintenance in an orderly fashion</li> </ol>	
-------	---	-------	---	--

