

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

PRINTED: 08/05/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	<p>Continued From page 12</p> <p>with diagnoses to include Spinal Stenosis, Toxic Encephalopathy, and Depression. Record review also revealed Resident #16 had an indwelling urinary catheter due to urinary retention.</p> <p>Observation of peri-care (cleaning of the insertion area of an indwelling catheter and the catheter tubing) on 07/22/10 at 10:40am revealed CNA #4 picked up a trash can by the bedside with gloved hands and did not remove the dirty gloves, re-wash her hands, or change to clean gloves before touching Resident #16's skin.</p> <p>Interview with CNA #4 on 07/22/10 at 10:50am revealed she understood why she should not handle a trash can due to infection control issues and she stated she does not clean the catheter tubing leading away from the insertion site because she did not know how to do this. CNA #4 stated she had been in-serviced in the facility regarding infection control practices, but could not remember when that was last done.</p> <p>Interview with LPN #5 on 07/22/10 at 3:25pm revealed she would not personally handle a trash can while doing peri-care but it would not be an issue if the trash can was clean. She stated she did not view this as an infection control problem unless the trash can was dirty.</p> <p>Record review for Resident #10 revealed on 06/30/10 the resident was assessed by the doctor as having a Stage III pressure sore to the sacrum.</p> <p>Observation of wound care for Resident #10 on 07/20/10 at 2:45pm revealed that the resident needed total assistance of two (2) staff to be turned to the side. Upon turning Resident #10 to</p>	F 441		

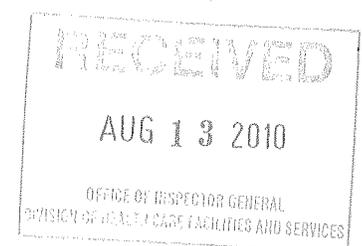
AUG 13 2010

OFFICE OF INSPECTOR GENERAL

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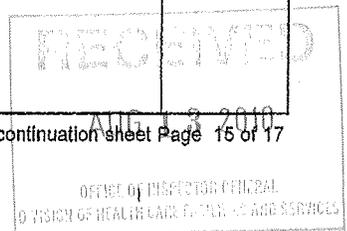
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F 441	<p>Continued From page 13</p> <p>complete the dressing change to the sacrum, RN #1 confirmed that there was no old dressing to the wound, and that she was not aware that the dressing had come off. RN # 1 stated the staff are to report to the nurse if the dressing gets soiled or comes off. She stated she had not been informed that the dressing had come off, and had no idea how long the wound was uncovered. Continued observation of the dressing change to the sacrum revealed RN#1 during the cleaning procedure cleaned the wound, then cleaned around the wound, then went back and forth over the wound with the contaminated gauze.</p> <p>An interview with RN# 1, after the dressing change to Resident #10's sacrum, revealed that she acknowledged she should not have gone back and forth over the wound after cleaning the skin around the wound. Due to contamination of the wound, especially since the wound was in close proximity of the per rectal area, should not have been done.</p> <p>An interview with the Director of Nursing (DON) on 07/22/10 at 10:00am revealed she did not know why the nurse documented a skin tear to the sacrum, or why the wound nurse documented a Stage II sore on 05/03/10 and 05/10/10. She could not give an explanation of the discrepancy in the Nursing Skin Assessment and the Wound Nurses assessment. The DON acknowledged that the Registered Dietician did not follow up with the resident's status after a supplement was started, and did not re-assess Resident #10 as recommended at the NAR meeting of 06/09/10. She agreed that Resident #10 should have been re-evaluated at least monthly by the Dietician as stated in the NAR Policy. She stated, "I do think there are some areas we need to be doing some</p>	F 441			



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F 441 F 514 SS=D	Continued From page 14 in-services for the staff". 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to maintain clinical records in accordance with acceptable professional standards and practices for two (2) of nineteen (19) sampled residents (#5 and #8). Resident #5's Aggrenox medication administration record (MAR) inaccurately stated the number of doses per day the resident was to receive the Aggrenox. Resident #8's Seroquel order was not transcribed on the physician thirty (30) day orders. The findings include: Record review of the medication administration record (MAR) revealed Aggrenox SA medication was written as "Give one (1) capsule by mouth once a day for CVA prevention" and was	F 441 F 514	Information cited in this deficiency as thirty (30) day physician orders are actually sixty (60) day physician orders. Resident # 5 suffered no actual harm as a result of the medication being "...transcribed incorrectly by the Pharmacy." The medication for Resident # 5 was administered correctly. The medication for Resident #8 was administered correctly and the resident suffered no actual harm as a result of the order not being transcribed on the July, 2010 physician orders. Resident #8's physician orders had not been signed by the physician nor were they due to be signed until August, 2010.		



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F 514	<p>Continued From page 15</p> <p>transcribed inaccurately as the intended order was to give one capsule by mouth twice a day; as noted in the previous months orders. The MAR revealed for twenty (20) days the Aggrenox SA transcription error was present.</p> <p>Interview with the Certified Medication Technician (CMT) on 07/22/10 at 10:15am revealed approximately six (6) different staff administered medications over the twenty (20) day period. CMT further stated she had no explanation why she did not notice the medication for the Aggrenox SA was written as once a day and given twice a day. If she had any questions about the MAR she would look it up on the chart or go to a supervisor for assistance.</p> <p>Interview with Unit Manager of the East Wing on 07/22/10 at 10:43am. revealed she usually completes the MAR checks, but this MAR check was done by the Assistant Director of Nursing (ADON).</p> <p>Interview with the ADON on 07/22/10 at 11:15am revealed it was her mistake that she did not read the orders for the Aggrenox SA medication as she had been trained to read the order and check the times.</p> <p>Record review for Resident #8 revealed the resident was admitted to the facility on 11/17/09 with diagnoses to include Congestive Heart Failure, Hypertension, Depression, and Anxiety. Record review further revealed a physician's order dated 05/10/10 for the medication Seroquel 25mg tablet to be given every bedtime for mood with behavioral disturbance documented on the July, 2010 30-day order sheet in the clinical record. Review of another physician's order</p>	F 514	<p>All physician orders were reviewed and compared to the medication administration records by the Unit Managers on August 3, 2010. Any discrepancies were clarified and corrected immediately.</p> <p>The DON will re-educate the nurses on the review of the physician orders and the medication administration record by August 20, 2010. The Unit Managers/designee will audit 20 % of the physician orders and medication administration records for four months and give a written report to the Director of Nursing. The results will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.</p>	8/24/2010	

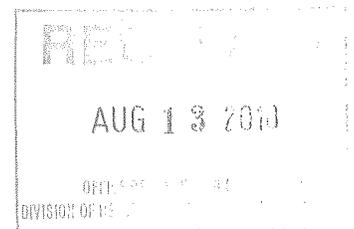
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F 514	Continued From page 16 dated 07/05/10 revealed the previous order was discontinued and the medication Seroquel's dosage was to be lowered to 12.5mg to be given every bedtime as a gradual dose reduction. Review of the current medication administration record revealed the correct order of the 12.5mg. of Seroquel but the order had not been changed in the clinical record on the 30-day order form. Interview with LPN #5 on 07/22/10 at 9:30am revealed the residents' medications are reviewed monthly and a new physician order should be updated on the 30-day order sheet in the clinical record for each resident. She stated the 30-day order sheets are checked by a nurse at the beginning of each month and the physician should check all of the medications before signing the 30-day order sheet. LPN #5 also stated the most important issue is that the current medication administration sheet was correct even though the order sheet in the clinical record was incorrect.	F 514			



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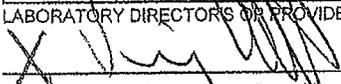
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K 000	INITIAL COMMENTS	K 000		
K 022 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure exits where maintained according to NFPA standards. Observation on 07/23/2010 at 11:15 AM, revealed that a door in the dining room area and the Hallway lobby could be confused as a exit. This was confirmed with the Director of Maintenance at the time of discovery. Interview on 07/23/2010 at 11:15 AM, with the Director of Maintenance, revealed that he was unaware of the door needing the marking of NO EXIT.</p> <p>Reference: NFPA 101 (2000 Edition).</p>	K 022	<p>All exit doors were checked only and the two doors mentioned (dining room & lobby hallway) doors require a sign that reads "NO EXIT" sign attached. This was completed on 8-10-2010.</p> <p>Doors will be monitored by maintenance supervisor to ensure that required signs remain posted. Doors will be monitored monthly for two quarters with finding submitted to safety committee and results submitted to Quality Assurance Committee. Will be reviewed by Q.A. Committee for two quarters and annually thereafter.</p>	8-10-2010

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 	TITLE X ADMINISTRATOR	(X6) DATE 8-12-10
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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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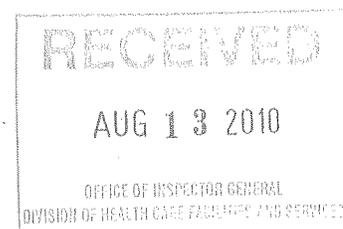
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K 022	Continued From page 1 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approved existing signs.	K 022		
K 038 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined that the facility failed to ensure that exits were properly marked according to NFPA standards. Observation on 07/23/2010 at 11:12 AM, revealed that the facility had delayed egress locks on a door leading from the kitchen to the outside, but there was no markings on the door indicating such. Further observations revealed the facility	K 038	All exit doors were checked. Doors with delayed egress locks have regulation-sized signs that read "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS". This was completed on 8-10-2010. Doors will be monitored monthly for two quarters, with finding submitted to Safety Committee and results submitted to Quality Assurance Committee. Will be reviewed by Q A Committee for two quarters and reviewed annually thereafter.	8-10-2010

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K 038	Continued From page 2 failed to properly mark total of (6) doors in the facility. This was confirmed by the Director of Maintenance during the observations. Interview on 07/23/2010 at 11:12 AM, with the Director of Maintenance, revealed that the doors had been marked at one time with the proper signage, and that the lettering must have wore off over time. Reference: NFPA 101 (2000 edition) 7.2.1.6.1 Delayed-Egress Locks. Approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided that the following criteria are met. (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lbf (67 N) nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device,	K 038		



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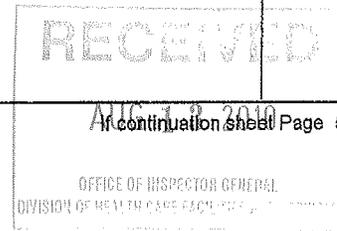
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K 038	Continued From page 3 relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay not exceeding 30 seconds shall be permitted. (d) * On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 in. (2.5 cm) high and not less than 1/8 in. (0.3 cm) in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS	K 038		
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. This STANDARD is not met as evidenced by: Based on record review, observation and interview, it was determined that the facility failed to ensure that the emergency generator was maintained according to NFPA standards. The findings include: Record review on 07/23/2010 at 9:00 AM, revealed that the emergency generator had not been ran under load a total of 30 minutes each month from the period of August 2009 till April 2010. Documentation showed that the hour meter readings start and end times did not reflect a run	K 144	The Director of Maintenance was in-serviced by the Generator vendor and the Regional Director of Maintenance regarding the proper procedure for testing, reading and recording the facility generator check that is done weekly. The new facility generator was tested under full load for a period of 30 minutes. This was done on 7-21-2010. The Regional Director of Maintenance will monitor monthly the generator run log to ensure the generator is being tested in accordance with Life Safety guidelines. This will be done monthly for Three Months and quarterly thereafter.	7-21-2010

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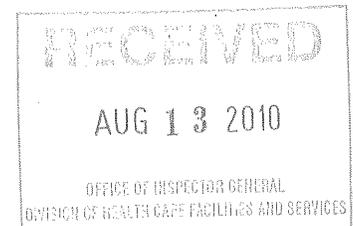
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K 144	<p>Continued From page 4</p> <p>time of (30) minutes. This was confirmed with the Maintenance Director.</p> <p>Interview on 07/23/2010 at 9:00 AM, with the Director of Maintenance, revealed that he thought the generator had ran monthly each month.</p> <p>Record review and observation on 07/23/2010 at 9:10 AM, revealed that from the time period of 04/03/2010 till 07/22/2010 that the facility could not switch over to emergency power within 10 seconds. This was confirmed with the Maintenance Director.</p> <p>Interview on 07/23/2010 at 9:10 AM, with the Maintenance Director, revealed that the facility's emergency generator had not been working from 04/03/2010 till 07/22/2010 and that the facility had relied on two portable generators during that time. The two emergency generators were not hooked directly to the facility. The Maintenance Director stated that he and the Assistant Maintenance Director was responsible for hooking the generators up if needed. The Maintenance Director states that he lives (5) minutes away from the facility and the Assistant Maintenance Director lives (20) minutes away.</p> <p>Observation on 07/23/2010 at 11:06 AM, revealed that the facility did not have a remote annunciator for the emergency generator.</p> <p>Interview on 07/23/2010 at 11:06 AM, with the Director Of Maintenance, revealed that he was not aware of the requirement to have a remote annunciator for the emergency generator.</p> <p>Reference: NFPA 99 (1999 edition)</p>	K 144	<p>A new diesel generator was installed and tested on 8-21-2010. The new generator is working properly. This generator provides emergency power within 10 seconds as required by Life Safety codes.</p>	8-21-2010



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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 144	<p>Continued From page 5</p> <p>3-5.4.1.1 Maintenance and Testing of Alternate Power Source and Transfer Switches.</p> <p>(a) Maintenance of Alternate Power Source. The generator set or other alternate power source and associated equipment, including all appurtenant parts, shall be so maintained as to be capable of supplying service within the shortest time practicable and within the 10-second interval specified in 3-4.1.1.8 and 3-5.3.1.</p> <p>(b) Inspection and Testing. Generator sets shall be inspected and tested in accordance with 3-4.4.1.1(b).</p> <p>NFPA 99 (1999 edition) 3-4.1.1.15 + Alarm Annunciator. A remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station (see NFPA 70, National Electrical Code, Section 700-12.) The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate the following: 1. When the emergency or auxiliary power source is operating to supply power to load 2. When the battery charger is malfunctioning (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate the following: 1. Low lubricating oil pressure 2. Low water temperature (below those required in 3-4.1.1.9) 3. Excessive water temperature 4. Low fuel - when the main fuel storage tank</p>	K 144	<p>A remote annunciator with storage battery powered was installed on 8-11-2010. This annunciator is located in an area that is readily observed 24/7/365. The annunciator is such that if any of the following occur, notification will be by audible and visual warning.</p> <ol style="list-style-type: none"> 1. Low lubricating oil pressure 2. Low water temperature 3. Excessive water temperature 4. Low fuel – when the main fuel storage contains less than 3 hour supply 5. Over crank 6. Over speed <p>The Director of Maintenance and the Regional Director of Maintenance have been in-serviced on both the new generator and annunciator.</p>	8-11-2010	



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

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K 144	Continued From page 6 contains less than a 3-hour operating supply 5. Overcrank (failed to start) 6. Overspeed Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur, but need not display these conditions individually. [110: 3-5.5.2]	K 144			

