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

PRINTED: 12/01/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
	185348		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

(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 An abbreviated survey was initiated on 11/15/11 and concluded on 11/17/11 to investigate KY17377, KY17139, KY17242, KY17413 and KY17202. The Division of Health Care unsubstantiated the allegation for KY17377, KY17139, KY17242 and KY17413 due to lack of sufficient evidence; therefore, no regulatory violations were identified. The Division of Health Care unsubstantiated the allegation for KY17202 due to lack of sufficient evidence; however, unrelated federal deficiencies were cited.	F 000	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that the deficiencies are accurate. The Plan of Correction is submitted as a written allegation of compliance.	
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: Based on observation, interview, record review, and facility policy review for medication administration, it was determined the facility failed to promote care of residents in a manner, and in an environment that maintained or enhanced each resident's dignity and respect for one (1) of seven (7) sampled residents, and one (1) Unsampled Resident. The nurse told Resident #5 to wait for assistance to change a wet brief until staff passed dinner trays, and finished assisting residents to feed. In addition, the nurse failed to provide visual privacy to Unsampled Resident A, during provision of gastrostomy tube (feeding tube) medications.	F 241	It is the facilities policy to be in compliance with this regulation. 1)Resident #5 – Care was provided by C.N.A. #1. As stated in 2567 this resident had just returned from dialysis; so, toileting program would not have alleviated this issue. Resident is not capable of participating in bowel/bladder retraining program per reassessment completed 11/17/11. Toileting Program has been ineffective related to this residents diagnoses of ESRD – inability to determine when she needs to void; and unable to establish routine voiding schedule related to same diagnoses. LPN#5 received Employee Coaching on 11/17/11 for Poor Work Quality related to failure to meet resident rights to dignity, failure to assist resident with care, taking a meal break when she was aware that her resident was in need of assistance. This Employee Coaching was given by the DON. LPN #5 felt that the facility expectations were stringent and chose to resign 11/17/11.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X Marianne Kelly
TITLE: X Administrator
(X6) DATE: X 12-9-2011

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

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F 241	Continued From page 1 The findings include: 1. Record review of the clinical record for Resident #5 revealed the facility admitted the resident on 07/06/11 with diagnoses: End-stage Renal Disease; Chronic Respiratory Failure; Hypertension; and Tracheostomy. The MDS, dated 08/24/11, revealed the facility assessed the resident as alert and oriented and incontinent of urine which was addressed by the facility with a plan of care. Interview, on 11/16/11 at 8:05 AM, with Resident #5 revealed he/she experienced delays in response to requests for toileting and/or brief changes. Resident #5 stated he/she was incontinent of bladder and wore incontinent briefs. Resident #5 stated on 11/15/11 he/she went to Hemodialysis and returned to the facility at 5:00 PM with a wet brief and wanted to change clothing. The resident needed assistance to remove linen, left wrinkled under the resident, from the transfers onto and off of the stretcher used for transportation. Resident #5 was uncomfortable and requested staff assistance by use of the call light, but was told the staff did not know which CNA was assigned to him/her. Resident #5 was told by staff several times they were looking for the assigned CNA to assist the resident. Resident #5 called a family member to report the delay of care, and then the nurse told Resident #5 the assigned CNA was assisting with the dinner trays and feeding, and would not be available to assist the resident until after the meal was finished. Resident #5 said the CNA assisted with the wet brief at 7:00 PM, and the resident did not understand why the nurse or another CNA	F 241	Resident A – care was provided by LPN #4 . Resident A will be included in the QI monitoring that is completed by SSD weekly x4 weeks, monthly x3 months, then quarterly. LPN #4 received Verbal Coaching on 11/17/11 by the DON for the failure to provide privacy to the resident during enteral administration of medications. LPN #4 received Teachable Moment on 12/2/11 by RN Supervisor on meeting residents rights to dignity during administration of g/tube medications. This Teachable Moment entailed re-education; and return demonstration. 2)All residents that are not capable of promoting their own dignity and respect have the potential to be affected. 3)All departments will be re-educated by SSD and Administrator by 12/15/11 on Resident Dignity and Respect.	

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F 241	Continued From page 2 could not have assisted to change the wet brief and clothing. Interview, on 11/16/11 at 4:15 PM, with CNA #1 revealed she worked the 3:00 PM-11:00 PM shift on 11/15/11 and was aware Resident #5 returned from Hemodialysis about 5:00 PM. CNA #1 said she was assigned to the care of Resident #5, and was also assigned to pass dinner trays and assist in the Restorative Dining Room with resident feeding. CNA #1 said that CNA #2 came to the Restorative Dining Room to advise her Resident #5 needed assistance to change a wet brief and clothing. CNA #1 told CNA #2 she could not leave the current feeding assignment. CNA #1 said the dinner meal assignment was completed, and she returned to the unit about 6:45 PM and assisted Resident #5 with the brief and clothing change. CNA #1 did not know why CNA #2 or the nurse did not assist Resident #5 with the brief and clothing change. Interview, on 11/16/11 at 4:25 PM, with LPN #6 revealed that while meals are served and residents were assisted to feed, the nurses on the units were responsible to ensure resident call lights and resident needs are addressed. LPN #6 said staff are encouraged by the facility to take a thirty (30) minute dinner break during the second shift. Interview, on 11/16/11 at 4:30 PM, with CNA #2 revealed that when Resident #5 requested assistance to change clothing and the wet brief, she was busy passing trays and could not assist Resident #5 during that time. CNA #2 said LPN #5 asked her twice to go to the Restorative Dining Room to request that CNA #1 assist Resident #5.	F 241	Facility has developed QI Date Collection Tool which includes: -Observation of Knocking On Doors -Observation of Closing Doors -Observation of Utilizing Privacy Curtain -Interview of Residents On Answering Call Lights Timely -Interview of Residents on Receiving Timely Care -Interview of Residents on Dignity, Privacy, and Respect SSD will QI Monitor Random 10% of average daily census (to include Resident A and Resident #5) to assure residents right to dignity, privacy, and respect are being promoted weekly x4 weeks, monthly x3 months, then quarterly. 4)QI Monitoring will be reviewed in the RM/QI process monthly x3 months, then quarterly to assure facility promotes 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/her individuality.	12/16/2011

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F 241	Continued From page 3 CNA #2 said meal times are always a busy time because the CNA's are passing trays and assisting residents to feed, which limits staff ability to respond to call lights. Interview, on 11/16/11 at 4:35 PM, with LPN #5 revealed that she was aware Resident #5 needed assistance to change clothing and a wet brief, but was not able to determine which CNA was assigned to the care of the resident. LPN #5 was told that CNA #1 was assigned to the care of Resident #5, and was assigned to the Restorative Dining Area to assist with dinner. LPN #5 said she overheard Resident #5 call a family member on the phone to report the delay in care. LPN #5 said she explained to Resident #5, that CNA #1 would assist with the clothing and brief change after the meal service was finished. LPN #5 said she assisted CNA #2 to answer resident call lights while CNA #1 was off of the unit except for the thirty (30) minutes when she took her evening meal break. LPN #5 said she should have assisted Resident #5 with the clothing and brief change, and could not recall why she did not. Interview, on 11/17/11 at 12:00 PM, with the Director of Nursing (DON) revealed all staff were responsible to answer call lights, and nurses were responsible to assist with resident call lights during meal service. The DON said it would not be appropriate to advise a resident to wait until meal service is completed to provide incontinent care. The DON said LPN #5 or CNA #2 should have assisted Resident #5 to change his/her clothing and wet brief. 2. Record review of the facility policy for Medication Administration (Enteral Tubes), dated	F 241		

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F 241	Continued From page 4 04/2009 revealed that prior to medication administration, privacy should be provided to the resident. Observation, on 11/17/11 at 8:15 AM, of medication administration performed by LPN #4 for Unsampled Resident A, revealed medications were administered by gastrostomy tube. LPN #4 raised the gown and exposed the abdomen of Unsampled Resident A to access the gastrostomy tube without provision of visual privacy. The privacy curtain was not drawn, and the door to the resident's room was open to the hallway. Interview, on 11/17/11 at 8:30 AM, with LPN #4 revealed that he was aware of the need to provide visual privacy during gastrostomy tube medication administration. LPN #4 said he thought the curtain was closed, and said he should have closed the resident's door before the gastrostomy tube was accessed and the resident's abdomen was exposed. Interview, on 11/17/111 at 12:00 PM, with the DON revealed all residents have a right to privacy. The DON said LPN #4 should have ensured the curtain and the door was closed prior to medication administration per gastrostomy tube to provide visual privacy.	F 241		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities,	F 322	It is the facilities policy to be in compliance with this regulation.	

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F 322	Continued From page 5 and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review for Medication Administration, it was determined the facility failed to ensure residents received appropriate treatment and services to prevent vomiting or aspiration pneumonia, and failed to ensure residents received complete doses of medications, as ordered by the physician, via the gastrostomy tube for two (2) of seven (7) sampled residents. Resident #6 received a gastrostomy tube feeding at a free-flow rate, when the physician order stated the feeding was to infuse at 65cc (sixty-five cubic centimeters) per hour. Unsampled Resident A received gastrostomy tube medications without proper technique and necessary precautions to ensure the complete dose of the medications was administered to the resident as ordered by the physician. The findings include: Record review of the facility policy for Medication Administration (Enteral tubes), dated 04/2009 reveal the purpose of enteral tube medication administration was to safely administer medications via an enteral tube and to prevent occlusion of the enteral tube. Medication and flushes should be provided to flow by gravity. 1. Record review of the clinical record for Resident #6 revealed the facility admitted the	F 322	1)Resident #6 – Resident was immediately assessed for adverse effects; none were noted. Treatment Error Report completed on 11/15/11 with notification made to physician, POA, and Medical Director. LPN #2 received re-education on 11/15/11 by DON on the following: -Following Physician Orders -What To Do When Out of Supplies -Reporting Of Lack of Supplies On 11/16/11 re-observation of g/tube residents on all units (to include LPN #2) was completed by the DON and ADON. LPN #2 received Employee Coaching on 11/15/11 from DON for Poor Work Quality and Productivity related to the following: -Failure To Follow Physician Orders -Failure To Check Central Supply -Failure To Notify Supervisor -Failure To Notify DON/ADON -Failure To Notify MD of Need For Alternate Orders	

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F 322	Continued From page 6 resident on 08/26/11 with diagnoses: Respiratory Failure; Encephalopathy; and Acute CVA. Review of the physician's order detailed an order for Jevity 1.5 tube feeding per gastrostomy tube at the rate of 65cc (sixty-five) per hour. Observation, on 11/15/11 at 2:15 PM, of Resident #6 revealed a gastrostomy tube feeding was infusing at a free flow rate to gravity. The volume of product in the bag was measured as 325cc (three hundred twenty-five). Further observation, on 11/15/11 at 3:45 PM revealed the gastrostomy tube feeding continued at a free flow rate, with the volume of product in the bag measured as 75cc (seventy-five). The gastrostomy tube feeding ran at 167cc/hr (one hundred sixty-seven cubic centimeters per hour) instead of the physician ordered 65cc/hr. Interview, on 11/15/11 at 3:50 PM, with LPN #2 revealed she was told by the third shift nurse during shift report there was no more ready-to-hang tube feeding with the pump tubing attached in the facility. LPN #2 said she was told by the third shift nurse that the tube feeding was not running on the pump, but the feeding was set to run at the physician ordered rate. LPN #2 said she did not check the rate of the tube feeding infusion, because she was told by the third shift nurse it was correct. LPN #2 did not realize the tube feeding had infused at approximately 167cc/hr, and said she was not sure how she could ensure the tube feeding infused at the proper rate unless it was placed on a pump. Interview, on 11/15/11 at 4:00 PM, with the Assistant Director of Nursing (ADON) revealed all tube feeding should be administered with a pump	F 322	3rd Shift Nurse received Employee Coaching 11/21/11 from DON for Poor Work Quality and Productivity related to the following: -Failure To Follow Physician Orders -Failure To Check Central Supply -Failure To Notify Supervisor -Failure To Notify DON/ADON -Failure To Notify MD of Need For Alternate Orders On 11/21/11 re-observation of g/tube residents was completed by ADON on 3rd Shift Nurses Assigned Hall. Resident A – Care Provided by LPN #4. LPN #4 received Teachable Moment by RN, Unit Manager on 12/2/11. This Teachable Moment included re-education on administering medications per g/tube, flushing g/tube, procedure to follow when the enteral tube is clogged, and return demonstration. 2)Residents with gastrostomy tubes have the potential to be affected. Visual assessment completed on residents with g/tubes on 11/15/11 to assure they were receiving the enterals as ordered; no negative findings. Re-observation following re-education was completed on 11/16/11, 11/21/11 to assure the residents were receiving the enterals as ordered; no negative findings.	

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F 322	Continued From page 7 to ensure the proper rate was maintained as ordered by the physician. Interview, on 11/15/11 at 4:10 PM, with the Unit Manager (UM) revealed the pump tubing with the ready-to hang tube feeding was available in the facility, but not on the E Hall, and explained the large supply/medication room is located on another unit. The UM was not sure how much tube feeding Resident #6 received since the tubing was changed on third shift, but said, "it was way too much." Interview, on 11/17/11 at 12:00 PM, with the Director of Nursing (DON) revealed that unless a physician ordered a bolus tube feeding, all tube feeding should be infused on a pump to ensure the proper rate. The DON stated if the tube feeding is infused at a free flow rate, the resident would be at risk for vomiting and aspiration. 2. Observation, on 10/17/11 at 8:15 AM, of gastrostomy tube medication administration performed by LPN #4 for Unsampled Resident A, revealed that the gastrostomy tube became clogged and would not infuse by gravity after administration of a medication. LPN #4 aspirated the tube multiple times, and the residual medication solutions in the tubing ran out of the open side-port and onto the abdomen of Unsampled Resident A. LPN #4 replaced the plunger into the syringe and forcefully bolused the remainder of the medication and solution through the tube. Interview, on 10/17/11 at 8:30 AM, with LPN #4 revealed he worked third shift and had agreed to continued to work until the facility could find his	F 322	3)Licensed Nurses were re-educated 11/15/11 by DON/ADON/RN Unit Manager and RN Supervisor on: -Following Physician Orders -Process When Out Of Supplies -Reporting When Out Of Supplies -Procedure For Clogged Tubes DON/ADON will QI monitor 100% of residents with g/tubes weekly x4 weeks, monthly x3 months, then quarterly. 4)QI monitoring will be reviewed in the RM/QI process monthly x3 months, then quarterly to ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasopharyngeal ulcers, and to restore, if possible, normal eating skills.	12/16/2011

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F 322	Continued From page 8 replacement for first shift on this morning. LPN #4 said he works third shift, and usually doesn't give many medications through the gastrostomy tube. LPN #4 was not sure what he could have done when the gastrostomy tube became clogged as he was providing medication to Unsampled Resident A. LPN #4 said he was trained to administer medications by gastrostomy tube by gravity. Interview, on 10/17/11 at 12:00 PM, with the DON revealed LPN #4 should have called the physician when Unsampled Resident's gastrostomy tube became clogged. The DON said the physician could have provided direction to unclog the tube with soda, or changed the medication to an alternate medication that could be provided as a solution. The DON said when the medication solution was aspirated from the gastrostomy tube and spilled out of the side-port, it could not be ensured the resident received the full dose of medication as ordered by the physician.	F 322		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and	F 441	It is the facilities policy to be in compliance with this regulation. 1)Resident #4 – Tracheostomy Care of the outer flange was completed again by the Unit Manager on 11/17/11 (once surveyor informed DON that LPN #1 had contaminated gauze used to clean the outer flange).	

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F 441	Continued From page 9 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and review of the facility's policy for Trach Care, it was determined the facility failed to establish and maintain an Infection Control program designed to provide a safe, sanitary environment to prevent development and transmission of disease for one (1) of seven (7) sampled residents. Tracheostomy care provided to Resident #4 was provided without precautions to avoid cross-contamination; one (1) gauze was placed directly on the bedside table, and one (1) gauze	F 441	Facility Policy and Procedure does not state the cleaning of the outer flange is to be done per Sterile Technique. Only cleaning of the inner cannula is done utilizing Sterile Technique. Tracheostomy Policy & Procedures do note state "with the use of a sterile pre-packaged tracheostomy care kit" as stated in the 2567. It states tracheostomy care kit or equivalent supplies. While it does make mention of sterile 4x4's; this is in relation to cleaning of the inner cannula. The mention of split drain sponge does not state sterile because it comes in contact with the outer flange (which is not sterile) and the skin. If you used sterile gauze to clean a quadrant of the flange, then you would have to change your gloves because they would no longer be sterile; to clean each quadrant of the outer flange.	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED
	185348		C 11/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

(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	Continued From page 10 was placed directly on the resident's bed (both pieces of gauze were used to clean the tracheostomy face plate). The findings include: Review of the facility's policy for Tracheostomy Care, revision date 09/2008 revealed the purpose of tracheostomy care was to maintain an open airway and prevent infection in a resident with a tracheostomy. Tracheostomy care was to be provided with the use of a sterile prepackaged tracheostomy care kit which included sterile gauze (4x4) and gloves. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 07/28/11 with diagnoses: Acute Respiratory Failure; Chronic Airway Obstruction; and Tracheostomy. Observation, on 11/17/11 at 2:05 PM, of tracheostomy care provided by LPN #1 (Licensed Practical Nurse) for Resident #4 revealed a prepackaged sterile tracheostomy kit was opened. LPN #1 removed the sterile gauze and placed one (1) gauze on the bedside table without a sterile barrier, and placed one (1) gauze on the resident's bed without a sterile barrier. Both pieces of gauze were soaked in sterile normal saline by LPN #1, then used to clean the tracheostomy face plate. Interview, on 11/17/11 at 2:20 PM, with LPN #1 revealed she was aware that care must be exercised by the nurse to avoid cross-contamination during tracheostomy care. LPN #1 said she was not sure if tracheostomy	F 441	**Per Perry, A.G.S. Potter, P.A. (2006) Clinical Nursing Skills and Techniques (6th Ed). St.Louis:CV Mosby Co. P815-853. "Clean no-touch technique is used for all aspects of trach care and for stoma care after the first seven post-operative days".** 2)Residents receiving tracheostomy care have the potential to be affected. LPN #1 received Verbal Coaching by DON on 11/17/11 regarding utilizing infection control techniques during tracheostomy care. LPN #1 received Teachable Moment by RN Supervisor on 12/2/11 which included re-education, and return demonstration of providing trach care per Policy and Procedure. 3)Licensed Nurses will be re-educated by12/9/11 on the following topics: -Infection Control Practices During Tracheostomy Care -Tracheostomy Care Policy and Procedures -Clean vs. Sterile Technique of Trach Care DON/ADON will QI monitor 100% of residents with orders for trach care weekly x4 weeks, then monthly x3 months, then quarterly.	

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DIVISION OF HEALTH CARE FACILITIES MANAGEMENT

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED
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BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 441	Continued From page 11 care should be performed as a sterile or a clean procedure. LPN #1 said the pieces of gauze should not be placed on the bedside table or the bed without a sterile barrier, as this could be a source of cross-contamination that could lead to infection. Interview, on 11/17/11 at 4:00 PM, with the Director of Nursing (DON) revealed tracheostomy care should be performed as a clean procedure, and said it was not appropriate to place sterile gauze on the bedside table or the resident's bed as this was a source of cross-contamination, which could lead to complications such as infection. The DON stated staff nurses are not trained to perform tracheostomy care during orientation, it was expected that the nurse was capable of this skill upon completion of nursing education. The DON said during the orientation period, the preceptor observed the newly hired nurse to validate correct technique and indicated competency by use of a orientation check-list.	F 441	Tracheostomy Care Policy and Procedures were last revised 9/2008; and Medical Director signed off on the revisions. DON contacted RN Nurse Consultant 12/8/11 regarding questions regarding "sterile" vs. "clean" technique in our Tracheostomy Policy & Procedures to confirm that cleaning of the outer flange is considered "clean" and not "sterile" per policy. 4)QI Monitoring will be reviewed in the RM/QI process monthly x3 months, then quarterly to ensure facility provides a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	12/16/2011

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