

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

PRINTED: 07/13/2011  
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  06/30/2011
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NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220
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F 000	INITIAL COMMENTS  A Standard Survey was conducted 06/28/11 through 06/30/11 and a Life Safety Code Survey was completed on 06/28/11. Deficiencies were cited with the highest scope and severity of a "F".	F 000	This plan of correction constitutes a written allegation of compliance for deficiencies cited on June 30, 2011. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by federal and state law.	
F 160 SS=B	483.10(c)(6) CONVEYANCE OF PERSONAL FUNDS UPON DEATH  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.  This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to convey within 30 days of death, the resident funds and final accounting of those funds to the individual administering the residents estate for three (3) of five (5) sampled resident records, Residents #25, #26, and #27.  The findings include:  Record review for Resident #25's financial record revealed Resident #25 expired on 09/10/10. Resident #25's financial account was closed on 12/16/10, three (3) months after Resident #25's death.  Record review for Resident #26's financial record revealed Resident #26 expired on 08/28/10. Resident #26's financial account was closed on 02/16/11, approximately six (6) months after	F 160	<b>F - 160 B</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Resident's # 25, # 26, & # 27 funds and final accounting of those funds to the individual administering their estate has been completed and accounts closed. <b>Date of completion: July 6, 2011</b>  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) A facility resident trust audit was completed to determine proper final accounting of funds to the individual administering the resident's estate of all discharged residents. <b>The audit found no accounts out of compliance. Date of completion: July 5, 2011</b>	7/29/11

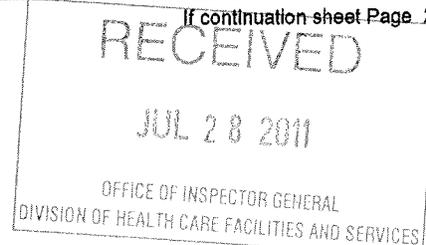
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE Administrator (X8) DATE 7-27-11

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

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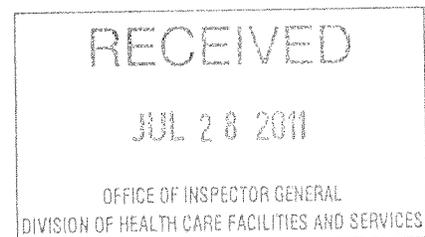
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F 160	Continued From page 1 Resident #26's death.  Record review for Resident #27's financial record revealed Resident #27 expired on 10/25/10. Resident #27's financial account was closed on 02/16/11, approximately four (4) months after Resident #27's death.  Interview with the Accountant, on 06/30/11 at 10:45AM, revealed that once a resident expires, their account should be closed within 30 days of passing.  Interview with the Administrator, on 06/30/11 at 3:30PM, revealed accounts are checked weekly and then reconciled monthly. Once this transaction is complete it is sent to the Corporate Business Office. The Administrator further stated there is a breakdown in the process when accounts are not checked timely.	F 160	<u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u>  A) The administrator re-educated the Business Office staff on the regulations and Policy & Procedures for final accounting of all discharged resident's funds. <i>Re-education was completed on July 5, 2011.</i>  B) The Business Office manager will maintain an up-to-date list of all discharge residents with their date of discharge. Business Office will close weekly all discharged resident's accounts per regulations and Policy & Procedure.	
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS  The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.  This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, review of the clinical record, care plan, resident information sheet, physician orders, restraint evaluation form, and facility restraint policy, it was determined the facility failed to ensure residents were not physically restrained unless for medical symptoms for one (1) of twenty-seven (27)	F 221	<u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u>  A) Business Office Manager will weekly QI monitor the resident trust to determine compliance to the final accounting of all discharged residents. All deficient accounts will be addressed immediately.  B) The Administrator will QI monitor the accounts randomly on a monthly basis. All inconsistencies will be brought to RMQI meeting monthly X 3 months for review and development of an action plan to ensure resident funds and final accounting will be completed in 30-days of their discharge.	7/27/11



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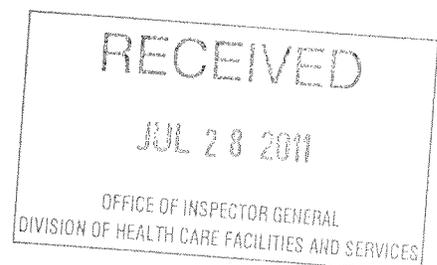
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F 221	<p>Continued From page 2</p> <p>sampled residents. Resident #9 was observed with a seat belt restraint applied when up in a wheelchair for extended period of time without release.</p> <p>The findings include:</p> <p>Review of facility's restraint policy for restraint management (with a revision date of 8/10) revealed a physical restraint may be indicated for medical symptoms, behaviors that threaten the safety of the residents or others, and alternative measures have been determined to be ineffective. The interdisciplinary team determines how a device will affect a resident and is responsible for restraint evaluation and management. The restraint impact on the resident is considered and the team is directed to re-evaluate the use of the physical restraint monthly for 90 days, then at least quarterly. Opportunities to reduce the frequency of restraint use and the amount of time in the restraint was to be considered during the restraint re-evaluation. In addition, the restraint policy stated staff would be educated on the type of restraint in use, how to apply, and length of time to be used. The resident is to be monitored more frequently (at least every 30 minutes) and the physical restraint is to be removed at least every two (2) hours and evaluate/provide the following: skin circulation, exercise including range of motion and ambulation, toileting, fluids, and position change.</p> <p>Review of Resident #9's clinical record revealed the resident had resided at the nursing facility since April 2009. The facility listed the most current diagnoses for Resident #9 as Alzheimer's Disease, Dementia with Behavior Disturbance,</p>	F 221	<p><b>F - 221 D</b></p> <p><u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u></p> <p>A) Resident # 9 was evaluated for the continued use of the seat belt restraint immediately on July 1<sup>st</sup> 2011. Resident # 9's care plan and resident information sheet were updated to ensure current interventions were being followed.</p> <p><u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>A) A facility restraint device audit was completed by <i>the Unit Managers on July 6, 2011, to determine proper compliance. No additional residents were identified utilizing restraints.</i></p> <p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) The Unit Manager re-educated <i>the licensed and non-licensed staff on the regulations and Policy &amp; Procedures for restraint management by July 8, 2011.</i></p>



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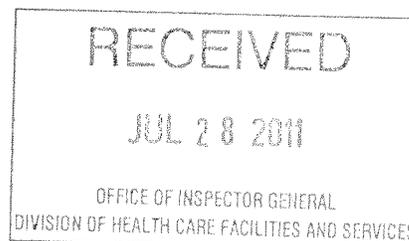
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F 221	<p>Continued From page 3</p> <p>Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD). Review of the most recent comprehensive MDS (minimum data set) assessment completed on 04/28/11 revealed the facility assessed the resident with a history of falling, balance deficient, and the use of a physical restraint. The facility assessed the resident to have a severe cognitive deficit in short and long term memory loss and decision making. In addition, the facility assessed the resident to require extensive assistance from staff for bed mobility, transfers, locomotion, and toilet use. The resident was assessed to be frequently incontinent of bowel and bladder.</p> <p>Review of Resident #9's care plan for falls and restraint reduction with an implementation date of 06/07/10 and revision date of 04/28/11 and 05/24/11 revealed the seat belt restraint was to be released at meals and every two (2) hours. In addition, the restraint was to be removed during supervised activities, meals, 1:1's, treatments, and family visits. Review of the clinical record revealed the resident had a chest (posey) vest restraint applied when up in a wheelchair prior to the use of the seat belt. The record revealed the vest restraint was ordered on 10/31/10. The record revealed the restraint was reviewed on 02/02/11 with continued use of the vest restraint. Review of a physician telephone order dated 05/24/11 revealed a seat belt to Resident #9's wheelchair was ordered related to poor impulse control and lack of safety awareness. The seat belt was to be released every two hours and at meals. The resident's skin was ordered to be assessed when the seat belt was released. On 05/24/11, the facility initiated the use of the seat belt restraint with medical symptoms of impaired</p>	F 221	<p>B) The Unit Manager will QI monitor resident restraint usage five times a week for 3 months <i>to ensure residents utilizing restraints are checked per policy and care plan.</i> All deficient practice will be corrected immediately.</p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of Nursing will QI monitor monthly on a random basis resident restraint usage. All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure restraints are managed appropriately.</p>



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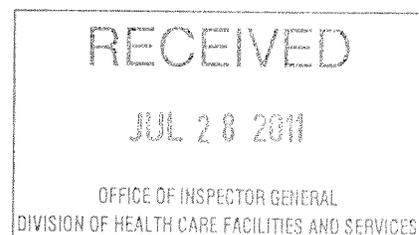
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F 221	<p>Continued From page 4</p> <p>balance and lack of coordination. Review of the Resident information sheet (guide for the nursing assistants) revealed instructions to release the seat belt every two (2) hours and at meals. The resident's skin was to be checked each time.</p> <p>Observation, on 06/28/11 at 11:55AM, revealed Resident #9 sitting in a wheelchair with a seat belt restraint applied. The seat belt looked like a car seat belt with a red button that was required to be pushed to release the restraint. At 12:40PM, the resident was observed in the 200 Unit dining room eating lunch. The resident was fed by CNA#1 (certified nursing assistant) with the seat belt restraint applied during the entire meal.</p> <p>On 06/29/11 at 8:05AM, the resident was observed sitting in a wheelchair in the common area of the 200 unit with the seat belt restraint applied. At 8:20AM, the resident was assisted to the dining room for breakfast. CNA#1 fed the resident breakfast with the seat belt restraint applied during the course of the meal.</p> <p>Observation at 9:00AM, revealed the resident had completed eating breakfast and CNA #1 had pushed the resident's wheelchair to the common area without releasing the seat belt. Observations at 10:00AM and 11:00AM, revealed the resident remained in the wheelchair, in the common area, with the seat belt restraint applied. At 12:45AM, the resident was assisted to the dining room for the lunch meal. Again, CNA#1 fed Resident #9 without the seat belt restraint removed.</p> <p>On 06/30/11 at 8:00AM, Resident #9 was observed sitting up in a wheelchair in the 200 unit dining room. The seat belt restraint was applied. At 8:20AM, the breakfast food tray was provided</p>	F 221	



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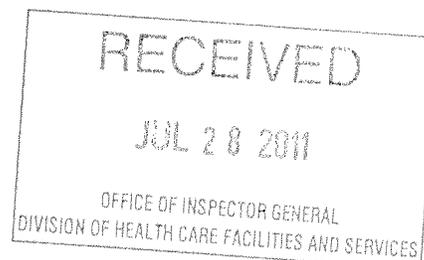
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F 221	<p>Continued From page 5 and CNA#1 started feeding the resident. The resident ate quickly, and at 8:35AM, the resident removed the clothing protector and attempted to leave the dining room table. The seat belt restraint was still applied.</p> <p>Interview with CNA#1, at 8:35AM on 06/30/11 (during the breakfast meal observation), revealed he had only worked at the facility for about a month. CNA#1 stated the seat belt restraint was suppose to be released during meals but he had forgotten. The CNA acknowledged he had fed the resident during breakfast and lunch the last three days (June 28-30, 2011) and had not removed the seat belt restraint either time. He stated instructions on how to care for each restraint was included on the the CNA book (resident information form) however he was not responsible for Resident #9 except for meals. The CNA stated he didn't know specific restraint release instructions for Resident #9.</p> <p>Review of the resident information sheet for Resident #9 revealed specific instructions to release the seat belt every two (2) hours and at meals.</p> <p>Continuous observation, on 06/30/11 from 9:00AM until 11:15AM revealed Resident #9 continued to sit in a wheelchair with the seat belt restraint applied. At 10:10AM, the resident was observed to lean over and play with the wheelchair's foot pedals. Another staff member brought juice and a cookie to the resident at that time. However, no staff came to release the restraint or provide care. At 10:25AM, the resident had finished eating the cookie and was observed to be pulling on the seat belt restraint.</p>	F 221	



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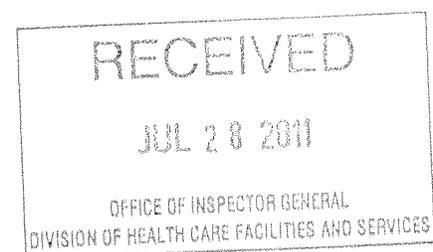
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F 221	Continued From page 6 At 10:55AM, another staff came over and talked with the resident, turned the television on and left. The seat belt was not released nor was incontinent care provided. At 11:00AM, the resident was observed attempting to unlock the seat belt but was not successful. At 11:15AM the surveyor requested a skin assessment. Refer to F314.  Interview with the 200 Unit Manager, on 06/30/11 at 1:30PM, revealed the seat belt restraint should have been released during meals and during incontinent care. However, it was observed and acknowledged by the unit manager that incontinent care, reposition, and release of the restraint was not provided from 9:00AM until after surveyor intervention at 11:15AM.	F 221	F - 253 E  <u>Criteria #1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Facility <i>housekeeping supervisor</i> immediately assessed the green chair and determined to remove chair from the unit and dispose properly. RM 219 Bedside tables / dresser; RM 220-2 Dresser; RM 201- Bedside table / footboards; RM 224-1 & 2 Bedside tables / dresser; RM 200 Footboards; RM 210 Hole in door; 200 Unit Handrails - all items identified are being replaced and/or restored.  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) A facility environmental audit was completed on <i>July 6, 2011 by the Director of Maintenance and Housekeeping supervisor to determine</i> proper environmental compliance as relating to furniture. The condition of the bedside tables, dressers, footboards, cracked finishes, and torn fabrics were identified facility wide.
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, review of the facility policy for the Guardian Angel Program, and interview, it was determined the facility failed to maintain services necessary to maintain a sanitary, orderly, and comfortable interior. Four (4) of nine (9) resident rooms on the 200 unit had bedside tables and/or dressers with rough chipped edges and bubbled cracked finishes exposing the fiberboard underneath. Two (2) rooms had rough	F 253	7/21/11



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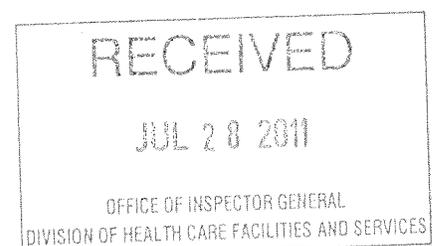
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F 253	Continued From page 7 chipped edges on the footboard, causing a splinter to the surveyors hand. A handrail on the 200 unit had partially stripped varnish and a rough finish, creating coarse interior edges. A green wingback chair in the dining area had ripped fabric on the arm rests and stains on the seat cushion, and a residents room had a hole in the bathroom door.  The findings include:  Review of the facility's policy for the Guardian Angel Program, which was dated 03/2011, revealed the facility guardian angel program monitors resident/patient satisfaction with their care and services and to address concerns. The guardian angel visits ten resident/patient regularly and addresses any concerns or issues at that time. The Guardian Angel conducts a follow up to verify issues are resolved in a timely manner. Guardian Angels are to inspect the resident/patient's environment for cleanliness, furniture and equipment in good repair, free from odors, etc.  Observation of room 219 bed 1 and bed 2, on 06/29/11 at 9:00AM, revealed both bedside tables had rough worn top edges with the finish chipped off the entire length of the table. Both dressers had chipped top surfaces, with the top finish bubbled up and cracked exposing the fiberboard beneath. Room 220, bed 2's dresser top had a bubbled up finish, with the top edges scuffed and chipped exposing fiberboard along entire edge of the dresser. Room 224, bed 1's dresser edges were worn exposing fiberboard, chipped along the edge and all the way down the side of the dresser. Room 224, bed 2's dresser top was	F 253	<b>B) The facility Director of Maintenance and Housekeeping supervisor developed and implemented a process to replace, restore and or fix all identified issues</b>  <u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u>  A) Director of Maintenance re-educate staff on July 8, 2011 concerning facility environmental rounds. A facility uniform form was implemented.  B) Environmental rounds will be completed with Guardian Angel Rounds, which take place daily M-F via assigned monitors. On weekends the rounds will be completed by the weekend manager. The uniform form will be utilized.  C) All deficient practices will be addressed at the Administrators daily operations meeting, with all department managers, for immediate correction.  D) The Director of Maintenance will monitor on a weekly basis via environmental rounds to determine facility compliance. All deficient practice will be corrected immediately.	



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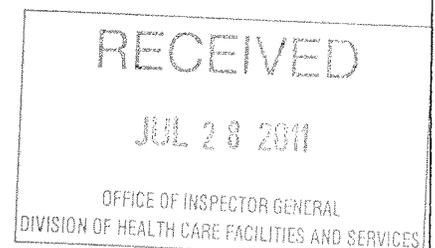
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F 253	<p>Continued From page 8</p> <p>chipped, and peeled with fiberboard exposed. The bedside table top had a bubbled up finish and rough chipped edges. Brown splatters were noted along the bottom of the bedside table and white spots were down the drawer facing. Room 201 bed 1's bedside table had chipped worn edges around entire top of the bedside table. Room 200 bed 1 and room 201 bed 2 had footboards that were chipped, rough and split creating splintered wood. While inspecting the texture of the footboard for room 200 bed 1, a splinter was acquired in the surveyors hand. Room 210 had a hole in the interior bathroom door which was approximately 5 inch in length. A green wingback chair in the dining room had torn fabric along both arm rests and the seat cushion had white and brown crusty spots and stains. A handrail on the 200 unit was partially stripped of it's finish, leaving the wood rough on the interior surface of the handrail.</p> <p>Interview with Certified Nursing Assistant #2, on 06/30/11 at 10:30AM, revealed he had been employed with the facility for 2 months. He stated he did not notice the handrail, but did remember maintenance working on the handrails a few months ago. He stated the handrail could potentially cause a splinter to a resident's hand from the rough edges. He stated the condition of the dressers and bedside tables were not maintained or homelike and he would not want them as furniture in his home. He further revealed the footboards were badly damaged and could cause a splinter or skin tear to the residents.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 06/30/11 at 11:00AM, revealed she had been employed with the facility for 2 months and</p>	F 253	<p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) <i>The Director of Maintenance and Administrator will monitor the facility through monthly environmental rounds.</i> All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure the facility maintains services necessary ensure a sanitary, orderly and comfortable environment.</p>



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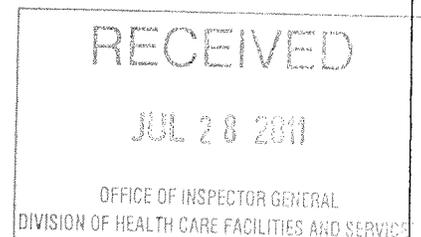
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F 253	<p>Continued From page 9</p> <p>usually floats throughout the facility. She stated the furniture on the 200 unit was not in good condition nor maintained. The footboards were damaged and could cause an abrasion or splinters to the residents.</p> <p>The LPN further revealed she would not allow such badly damaged furniture in her loved ones room.</p> <p>Interview with LPN #1, on 06/30/11 at 11:10AM, revealed the furniture was not well maintained and does not know what was on, or wrong with the dressers or bedside tables. He stated the furniture could potentially cause psychosocial harm to the residents by making them feel unworthy and sad. The LPN stated the green chair has been ripped and stained for 2 months. He stated the chair was dirty, in disrepair and he would not want to sit in the chair. He stated the chair was used by a resident during meal service.</p> <p>Interview with the 200 Unit Manager/Assistant Director of Nursing, on 06/30/11 at 12:10PM, revealed angel rounds are completed three (3) times a week. He stated the rounds consist of monitoring the residents environment and was performed by the interdisciplinary team (IDT). He further revealed the IDT used an audit tool which specified which areas to look for during rounds.</p> <p>Review of the Audit tool used by the IDT team did not include or address inspecting the resident's environment or condition of the furniture.</p> <p>Interview with the Maintenance Director, on 06/30/11 at 12:10PM, revealed angel rounds are completed three times a week, but he utilized the guardian angel worksheet that coincides with the</p>	F 253	



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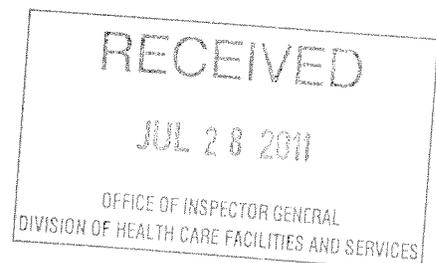
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F 253	<p>Continued From page 10</p> <p>facility's policy. He further revealed he was aware of the furniture's condition but stated the facility was in the process of refurnishing the 200 wing. However, the Maintenance Director was unable to produce any evidence that new furniture had been ordered or evidence that it was being refinished. He further stated he was not aware of the condition of the green, wing back chair in the dining room, the two footboards, or the hole in the bathroom. He stated the guardian angel worksheet was turned in to the administrator after each round and the team discussed any problems or concerns. He stated any concerns with the environment would be brought up at that time and he would repair any reported problems. He further stated, no concerns had been brought to his attention during the guardian angel meeting. He further revealed he did make rounds on the common living areas, but had not inspected the condition of the chairs. He stated the chair was not in good condition. It was dirty and could cause a problem with bacteria. He stated the handrail on the 200 unit was in the process of being refinished, but they had stopped working on the handrail due to the survey process. When asked to describe the texture of the unfinished handrail, he stated it was rough and could cause a potential problem for the residents.</p> <p>Interview with the Housekeeping Manager, on 06/30/11 at 12:10PM, revealed he was not aware of the sanitary condition of the green, wing back chair in the 200 dining area. He stated the chair was dirty and could grow bacteria.</p> <p>Review of the Guardian Angel Worksheet revealed the form did include inspecting the</p>	F 253	



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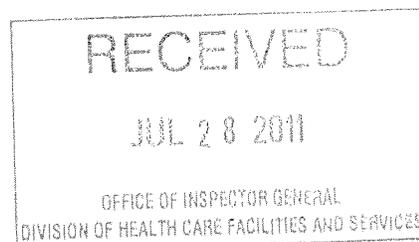
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F 253	Continued From page 11 condition of the furniture and residents room.  Interview with the Director of Nursing, on 06/30/11 at 4:15PM revealed the angel rounds should be including a check of the residents' environment and the condition of the residents' furniture. She further revealed the form the IDT was using was intended as a supplement developed by the previous administrator and they should not be using that form any longer. She stated there was a potential concern for developing psychosocial issues related to the condition of the furniture. she also stated there needed to be more education on intent and policy for the Guardian Angel Rounds.  Interview with the Administrator, on 06/30/11 at 4:25PM, revealed there had never been any mention of the furniture condition on the 200 unit during morning meetings and he had not noticed the residents' furniture. He was also not aware the Angel Round Team was using 2 different forms to perform the rounds. However, he had noticed an opportunity to improve the aesthetics of the 200 unit. He stated he had the ultimate responsibility for the appearance and maintenance of the facility.	F 253	<b>F - 282 D</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Resident # 9's was immediately assessed with the care plan and resident information sheet being updated to ensure current interventions are being followed.  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) All residents were re-assessed to determine level and type of incontinence care required.  B) The care plans of residents with incontinence care needs were reviewed and revised to address their incontinent care.	
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN  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:	F 282		7/29/11



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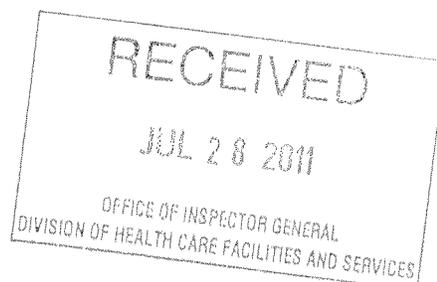
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F 282	<p>Continued From page 12</p> <p>Based on observation, interview, clinical record and care plan review it was determined the facility failed to provide care and services in accordance with one (Resident #9) care plan out of a sample of twenty-seven (27) residents. The facility assessed Resident #9 to be at risk for pressure sore development and developed preventative measures to be implemented. In addition, the facility placed a physical restraint on Resident #9's wheelchair. The facility developed release times of the restraint to be every two (2) hours and at meals. However, observation and interview revealed the facility failed to release the physical restraint or provide care and services (incontinent care) in accordance with the care plan.</p> <p>The findings include:</p> <p>Review of the pressure ulcer prevention care plan developed on 04/28/11 and revised on 06/16/11 revealed the facility developed the following measures: inspect skin weekly, keep skin clean and dry, assist in position change as needed, and remove restraint every two (2) hours and with meals and "check skin."</p> <p>Observation, on 06/30/11 from 9:00AM until 11:15AM revealed Resident #9 with a seat belt restraint applied while sitting in a wheelchair. At 10:10AM, a staff member brought juice and a cookie to the resident. However, no staff came to release the restraint or provide incontinent care. At 10:55AM, another staff came over, turned the television on and talked with the resident and left without releasing the seat belt or providing incontinent care. At 11:15AM, the surveyor requested a skin assessment. Refer to F221 and F314.</p>	F 282	<p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) The Unit Managers re-educated the <i>licensed nursing and certified aid staff</i> on the regulations and Policy &amp; Procedures for incontinent care on July 22, 2011. <i>T. Park 7/28/11</i></p> <p>B) The Unit Managers QI monitor facility incontinence care five times a week for 3 months to ensure proper incontinence care. All deficient practice will be corrected immediately. All deficient practice will be corrected immediately. <i>T. Park 7/28/11</i></p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of Nursing will QI monitor monthly on a random basis resident incontinence care. All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure incontinent care is managed appropriately.</p>	



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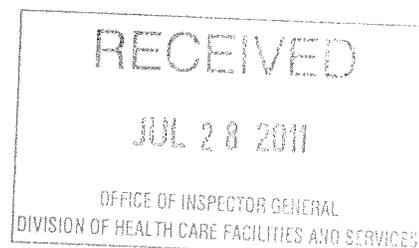
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F 282	Continued From page 13  At 1:00PM on 06/30/11, Resident #9 was observed to be in bed. Upon interview, it was found facility staff had laid the resident down after the noon meal. Incontinent care was provided then. (Lunch was scheduled at 12:20PM on the 200 unit). Observation of the resident's skin at 1:00PM revealed no skin breakdown. However, the incontinent brief had not been disposed of and observation of the brief revealed it was saturated with urine.  Interview with the 200 unit manager, on 06/30/11 at 1:30PM, revealed he considered the urine soaked brief as evidence the staff had failed to check and change the resident that morning. The unit manager stated he had spoken with the CNA (certified nursing assistant) who was assigned to Resident #9 and the CNA had told him they were too busy and did not get a chance to check or change Resident #9. The CNA was unavailable for interview. The unit manager acknowledged the resident's physical restraint had not been released as care planned. The unit manager stated that information was on the Resident information sheet for all nursing staff to review.	F 282	<b>F - 314 D</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Resident # 9 was immediately evaluated for skin breakdown. Resident # 9's care plan and resident information sheet were updated to ensure current interventions are being followed.  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>	
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES  Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314	A) A facility audit was <i>completed by Unit Managers on July 5, 2011</i> for residents at moderate to high risk for skin breakdown to ensure appropriate incontinence care is provided for the resident. <i>The audit determined no additional resident skin break down was identified.</i> The residents care plans were reviewed and revised <i>as appropriate</i> by IDT.	7/29/11



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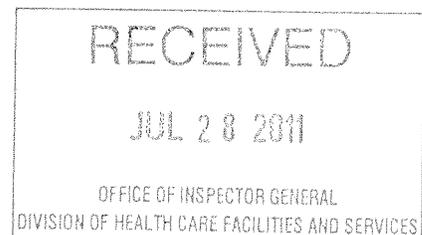
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F 314	<p>Continued From page 14</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and review of the clinical record it was determined the facility failed to provide care and services to prevent pressure sore development for one (1) of twenty-seven (27) sampled residents. The facility assessed Resident #9 to be at moderate risk for development of a pressure sore and developed preventative measures of keeping the skin clean and dry, and assist in position change. In addition, the resident's skin was to be assessed when the seat belt restraint was released. Observation revealed the resident sat in a wheelchair for extended periods of time without the staff providing incontinent care or releasing the seat belt restraint. Request for a skin assessment on 06/30/11 revealed a urine saturated brief. The record revealed Resident #9 has a history of pressure sore development on the buttocks (healed on 06/16/11) with preventive cream to be applied.</p> <p>The findings include: Review of Resident #9's clinical record revealed the facility admitted the resident on April 2009. The facility listed the most current diagnoses for Resident #9 as Alzheimer's Disease, Dementia with Behavior Disturbance, Congestive Heart Failure, and Chronic Obstructive Pulmonary Disease (COPD). Review of the most recent comprehensive MDS (minimum data set) assessment completed on 04/28/11 revealed the facility assessed the resident with a severe cognitive deficit in short and long term memory</p>	F 314	<p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) The Unit Manager re-educated the licensed nursing and certified aid staff on July 8, 2011 concerning the regulations and Policy &amp; Procedures for skin management. <i>TH Daily 7/28/11</i></p> <p>B) The Unit Managers QI monitor facility resident's with moderate to high risk skin breakdown five times a week for 3 months. <i>The residents will be monitored through observation, interview of resident and staff, and correlating resident care plan with care being received.</i> All deficient practice will be corrected immediately.</p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of Nursing will QI monitor monthly on a random basis resident skin management. <i>Skin management will be monitored through observation, interview of resident and staff, and correlating resident care plan with care being received.</i> All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure pressure ulcer breakdown is managed appropriately.</p>



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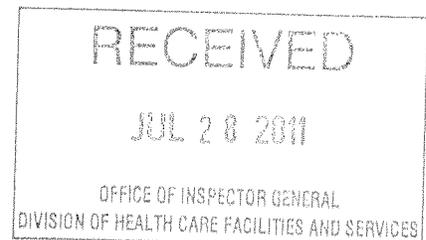
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F 314	<p>Continued From page 15</p> <p>recall and decision making ability. The facility assessed the resident to require extensive assistance from staff for bed mobility, transfers, locomotion, and toilet use. The resident was assessed to be frequently incontinent of bowel and bladder. Review of the care plan revealed the resident was assessed to be moderate risk for pressure sore development (Braden Score=16) and developed the following measures: inspect skin weekly, keep skin clean and dry, assist in position change as needed, and remove restraint every two (2) hours and with meals and "check skin."</p> <p>Continuous observation from 9:00AM to 11:15AM revealed the resident on the 200 unit, sitting in a wheelchair with a seat belt restraint applied. Refer to F221.</p> <p>At 11:15AM, the surveyor requested a skin assessment and incontinent care observation. The resident did not understand the staff and failed to allow staff to push the wheelchair to the resident's room for the skin assessment. The resident would only smile and turn the wheelchair another way. The surveyor requested observation whenever staff could provide incontinent care. However, at 1:00PM the resident was observed to be in bed. Upon interview, it was found facility staff had laid the resident down after the noon meal. Incontinent care was provided then. (Lunch is scheduled at 12:20PM on the 200 unit). Observation of the resident's skin at 1:00PM revealed no skin breakdown. However, the incontinent brief had not been disposed of and observation of the brief revealed it was saturated with urine.</p>	F 314	



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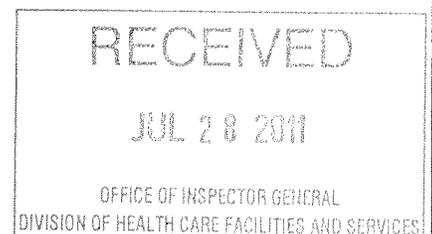
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F 314	Continued From page 16 Interview with the 200 unit manager, on 06/30/11 at 1:30PM, revealed he considered the urine soaked brief as evidence the staff had failed to check and change the resident that morning. The unit manager stated he had spoken with the CNA (certified nursing assistant) who was assigned to Resident #9 and the CNA had told him they did not get a chance to check or change Resident #9 as they were too busy. The CNA was unavailable for interview. The unit manager acknowledged the resident was at risk for pressure sore development and the facility had just healed a pressure sore on the resident's buttocks.	F 314	
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY  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 observation, interview and policy review of Sanitation and Food Production Cooking and Sanitation Overview it was determined the facility failed to store, prepare, distribute and serve food under sanitary conditions. Dietary staff was using hand sanitizer instead of soap and water to wash their hands, there were two food items in the freezer that were open and exposed to the air and the food server failed to check the	F 371	F - 371 F <span style="float: right;">7/29/11</span>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) The Director of Dining Services immediately re-educated the dietary staff on the regulations and Policy & Procedures for dining services as they relate to 1 proper Hand washing; 2 proper Food Temp; 3 proper Storage of food. <i>The re-education was completed on July 1, 2011.</i>  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) All residents have the potential to be affected by the alleged deficient practice.



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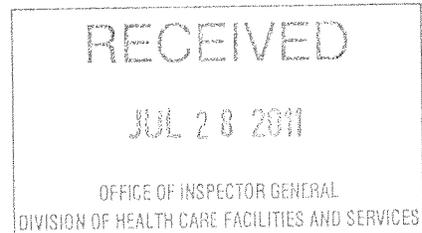
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F 371	Continued From page 17 temperature of the gravy prior to serving to the residents.  The findings include:  Policy review of Sanitation and Food Production Cooking 6.2 revealed the facility was to record food temperatures prior to serving residents/patients.  Policy review of Sanitation Overview 9.1.1 #9 revealed Wash hands after the following activities, including, but not limited to: After using the restroom, before and after handling raw foods, after touching the hair, face, or body, after sneezing, coughing, or using a handkerchief or tissue, after a break, after using a cleaning, polishing, or sanitizing chemical, after taking out the trash, after clearing tables or busing dirty dishes, after touching clothing or apron, and after touching anything that may contaminate hands, such as unsanitized equipment, work surfaces, or wash cloths.  Policy review of Sanitation Freezer Storage 9.3.2 revealed there was no mention that opened food in freezer should be covered.  Observation, on 06/29/11 at 11:45AM, revealed Dietary Aides #1 and #2 used hand sanitizer prior to working with Resident food trays. Dietary Aide #2 left the kitchen to deliver carts to the floors and upon return to the kitchen used hand sanitizer instead of washing hands.  Observation, on 06/29/11 at 12:25PM, revealed the tray line ran out of gravy. The Server/Cook removed gloves, went to the stove, made new	F 371	<u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u>  A) Certified Dietary will QI monitor hand washing, food temps, and food storage daily for 4 weeks. <b>Monitoring will be completed through observation, interview, inspections, and temperature logs.</b> All deficient practice will be corrected immediately.  <u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u>  A) The Dietician will QI monitor monthly on a random basis hand washing, food temperatures, and proper food storage. <b>Monitoring will be completed through observation, interview, inspections, and temperature logs.</b> All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to <b>ensure hand washing, food storage, and food temperatures are managed appropriately.</b>		



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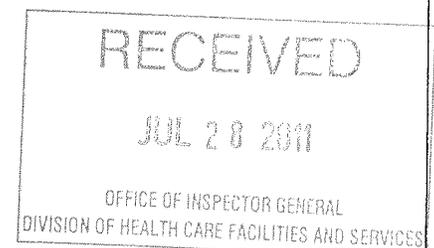
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  06/30/2011
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
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F 371	Continued From page 18 gravy and added the new gravy to the pan on the tray line that had already contained gravy. The server then washed her hands, donned new gloves and continued serving resident's trays. The Server did not check the temperature of the new gravy prior to serving it to the residents.  Observation, on 06/29/11 at 2:40PM, during Kitchen Sanitation Tour revealed the freezer contained frozen chicken patties and frozen omelets that had been opened and exposed to air.  Interview, on 06/29/11 at 3:00PM, with the Dietary Manager (DM) revealed she was unaware hand sanitizer was not a substitute for hand washing in the kitchen area and that proper hand hygiene was extremely important in the kitchen area to prevent contamination of food that was being served to residents. The DM stated all opened food should be dated and sealed after use in order to prevent freezer burn and potential change in nutritive value. The DM also stated all foods placed on the tray line should be checked for correct temperature prior to serving that food to the residents in order to prevent a food borne illness that may be caused by serving food at an improper temperature.	F 371	F - 441 E  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  <i>A) Resident's # 13 and # 11 were immediately evaluated for infection, skin breakdown, and pain. The residents had no s/s of infections, skin breakdown, and no complaints of pain.</i>  <i>B) Resident's #13 &amp; # 11 had their dressing re-changed at time of assessment. Date of assessment was July 1, 2011.</i>
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS  The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.  (a) Infection Control Program	F 441	C) The Unit Manager immediately re-educated the nurse to the dressing change policy and procedure. The dressing change policy states that after staff removes a soiled dressing with gloved hands they are to: remove gloves, wash hands, set up supplies, apply new gloves and finish procedure.  7/29/11



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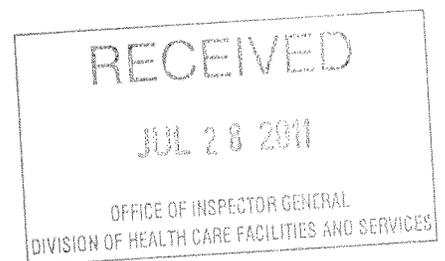
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F 441	<p>Continued From page 19</p> <p>The facility must establish an Infection Control Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(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.</p> <p>(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.</p> <p>(c) Linens</p> <p>Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews and review of the facility's Dressing Change Policy it was determined the facility failed to assure aseptic technique was maintained while performing dressing change on two (2) of twenty seven (27)</p>	F 441	<p><u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>A) Residents having the potential to be affected by the alleged deficient practice, (those with dressing changes) were assessed to determine if the alleged deficient practice was detrimental to their condition.</p> <p><i>B) Resident's with dressing changes were evaluated for infection, skin breakdown, and pain. The residents had no s/s of infections, skin breakdown, and no complaints of pain. Date of assessment was July 1, 2011.</i></p> <p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) The Unit Managers <i>re-educate the licensed staff on July 8, 2011</i> concerning on proper policy &amp; procedures for dressing changes.</p>



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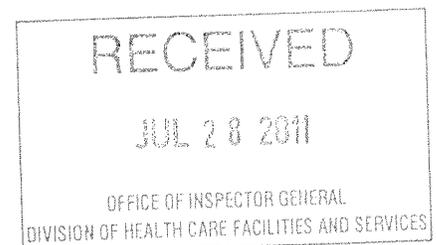
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F 441	<p>Continued From page 20 residents (Residents #11 and #13).</p> <p>The finding include:</p> <p>Policy Review of Dressing Change Policy, Clean D 4.0 #8-11 revealed after staff remove a soiled dressing with gloved hands they are to remove gloves, wash hands, set up supplies, apply new gloves and finish procedure.</p> <p>1. Record review revealed the facility admitted Resident #13 on 01/11/11 with the following diagnoses of Protein/Calcium Malnutrition, Venous Thrombosis and Urinary Tract Infection. Resident # 13 was hospitalized and discharged back to the facility on 06/27/11 with additional diagnoses of MRSA and Candida in her urine.</p> <p>Observation, on 06/28/11 at 2:30PM, revealed LPN #1 performed a dressing change for Resident #13. LPN #1 washed his hands, applied gloves and removed the dressing on the resident's left elbow and then changed gloves without washing his hands. LPN #1 then completed the dressing change, cleaned the area, removed his gloves (did not wash his hands), returned to the treatment cart and retrieved additional supplies. LPN #1 then returned to Resident #13's room, set up the supplies, washed his hands, put on gloves, removed the dressing on the resident's right foot. He then removed his gloves (did not wash his hands), put on new gloves and applied a new dressing to the resident's right foot. LPN #1 then cleaned the area around the resident, threw away the trash, removed his gloves (did not wash his hands) and returned to the nurse's desk and started doing paperwork.</p>	F 441	<p>B) The Unit Managers will QI monitor facility resident's with dressing changes five times a week for 3 months to ensure proper dressing change. <i>Monitoring will be completed via observation, investigation, skill checks. All deficient practice will be corrected immediately.</i></p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of nursing will QI monitor on a monthly basis resident dressing change protocol. All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to <i>ensure dressing changes are managed and completed appropriately.</i></p>



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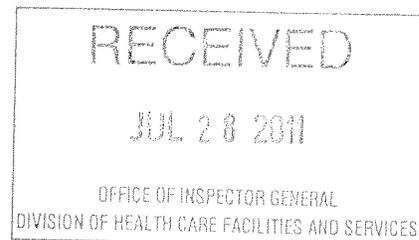
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F 441	Continued From page 21  Interview with LPN #1, on 06/30/11 at 10:40AM, revealed he forgot to wash his hands after changing gloves during the observed dressing change on 06/28/11. LPN #1 stated it was important to follow written procedure regarding washing hands between glove changes to prevent contamination and infection problems.  Interview with the 200 Unit Manager (UM), on 06/30/11 at 10:50AM, revealed it was an infection control issue not to wash your hands between glove changes or after finishing a procedure. This could cause contamination problems for the residents.  2. Record review revealed the facility admitted Resident #11 on 07/25/07 with the following diagnoses, End Stage Renal Disease, Hemodialysis (ESRD HD), Deep Vein Thrombosis (DVT), Diabetes Mellitus (DM), Congested Heart Failure (CHF), Myocardial Infarction with a Cardiac Stent Placement, Peripheral Vascular Disease (PVD), Wounds to bilateral lower extremities, Hypertension (HTN) and a Shunt to the right arm for Hemodialysis. The resident had a history of an infection to the Right Knee Replacement. Subsequently the hardware was removed and an antibiotic spacer was placed. The right surgical incision had two (2) open wounds and there were two (2) open friction wounds created by the knee immobilizer. All four (4) areas required daily dressing changes.  Observation, on 06/29/11 at 11:50AM, revealed during the dressing change for Resident #11, the	F 441		



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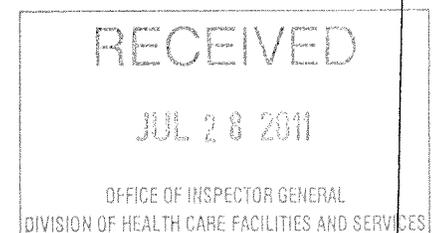
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F 441	Continued From page 22 200 Unit Manager (UM) assisted with the wound care. He donned clean gloves without washing his hands, cleaned the incisional wound to the right knee, and right lateral calf, removed the gloves and discarded them in the trash. The UM exited the room. The UM then re-entered the room with a pair of scissors and without washing his hands, put on a clean pair of gloves and continued to assist with the dressing change.  Interview with 200 Unit Manager (UM), on 06/30/11 at 12:30PM, revealed he did not wash his hands after cleaning the wound and did not wash his hands after exiting and re-entry of Resident #11's room. He was aware of the hand hygiene policy and should have washed his hands in between glove changes and coming in and out of the room.	F 441	F - 514 D  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Facility immediately notified the physician to clarify and re-write the verbal order to include dosage for the Hydrocodone & Potassium.  B) The Unit Manager re-educated the <i>licensed staff on that unit on July 1, 2011</i> to the policy & procedure that states, verbal physician's orders for medications should include: date of order, resident name, drug name, strength, dosage, time or frequency, and route of administration.
F 514 SS=D	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:	F 514	<u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) The facility Unit Managers completed a 30-day audit <i>on July 6, 2011</i> of physician's verbal orders to validate compliance to policy & procedure.  B) The audit found no other residents affected by the deficient practice.



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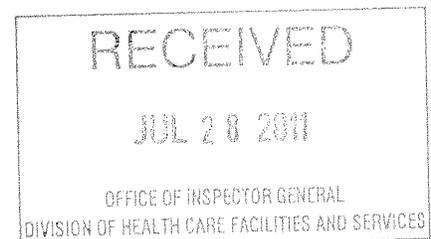
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F 514	<p>Continued From page 23</p> <p>Based on observation, interview, record review and review of the facility's policy 4.3 New Schedule III - V controlled Substance and non-Controlled Medication orders, it was determined the facility failed to maintain clinical records as evidenced by verbal physician orders that did not include dosage or the dosage was written incorrectly on one (1) (Resident #13) of twenty seven (27) residents.</p> <p>The findings include:</p> <ul style="list-style-type: none"> <li>Review of the facility's policy regarding verbal physician's orders revealed each medication order should include date of order, resident name, drug name, strength, dosage, time or frequency, and route of administration.</li> <li>Record review revealed the facility obtained a verbal physician's order, via the telephone for Resident #13 on 06/27/11 to include "Hydrocodone 1 tab PO Q 12 hr pain". There was no evidence that a dosage had been included in the order. There was a verbal order written the same day, 06/27/11, for "K+ 10 mg PO Q day (2 caps once a day) supplement".</li> <li>Interview with the 200 Unit Manager (UM), on 06/30/11 at 10:50AM, revealed the hydrocodone order was written incorrectly as there was no dosage indicated. Resident #13 had been on Hydrocodone 5/325 prior to hospitalization and upon return to the facility the resident was started on Hydrocodone 5/500 after the order from 06/27/11. The UM stated incorrectly writing a verbal order can lead to a resident getting the wrong dose of medicine or a delay in treatment while the order is being corrected. She also</li> </ul>	F 514	<p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) The Unit Manager re-educated the <i>facility licensed staff on July 8, 2011</i> to the policy &amp; procedure that states, verbal physician's orders for medications should include: date of order, resident name, drug name, strength, dosage, time or frequency, and route of administration.</p> <p>B) The Unit Managers will QI monitor all new verbal physicians orders, (24-hours) daily during morning clinical meeting. All deficient practice will be corrected immediately.</p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of Nursing will QI monitor monthly resident verbal doctor orders protocol. All inconsistencies will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure <i>verbal orders are written appropriately.</i></p>



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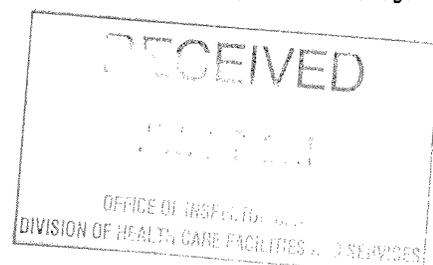
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F 514	Continued From page 24 stated the pharmacist should have picked up the error. The nurse that took the order was unavailable for interview. The UM stated the order for potassium chloride should have been written as KCl, not K+ and the dosage should have been 10 mEq and not 10 mg as it was written on the physician order. She stated Resident #13 had been getting the correct dosage but the order should have been clarified to avoid confusion.  Interview with LPN #1, on 06/30/11 at 1:25PM, revealed the components of writing a verbal order include drug, dosage, route, frequency and indication. LPN #1 stated that after writing the order it is recorded in the Medication Administration Record (MAR), written in the nurse's note, faxed to the pharmacy and put on a board so it can be double checked the next day.  Interview with the DON, on 06/30/11 at 1:34PM, revealed she is aware of the policy on taking verbal orders. The DON stated the orders for Resident #13 were incorrectly written, the hydrocodone order had no dosage and the order for KCl was written incorrectly. She stated the order should have been written per policy but the pharmacy should have gotten a clarification on the order. The DON stated the KCl was given at the right amount of 10 mEq but she was not sure about the hydrocodone 5/500 order since the resident had been on hydrocodone 5/325 prior to the recent hospitalization. The DON revealed there was no policy on approved abbreviations or a list of do not use abbreviations and that incorrectly written physician orders could lead to medication errors which could have a detrimental effect on the residents.	F 514		



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F 514	Continued From page 25  Interview with the Pharmacist Consultant, on 06/30/11 at 1:45PM, revealed the pharmacist had gotten a clarification on the Hydrocodone order from the physician and had read the K+ 10 mg order as KCl 10 mEq. He stated the resident had received the correct dosage but acknowledged the verbal orders had been written incorrectly by the nurse who took the orders.	F 514			



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K 000	INITIAL COMMENTS  A Life Safety Code Survey was initiated and concluded on 06/29/2011. The facility was found not to meet the minimal requirements with 42 Code of the Federal Regulations, Part 483.70. The highest Scope and Severity deficiency identified was an "D".	K 000	This plan of correction constitutes a written allegation of compliance for deficiencies cited on June 30, 2011. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet the requirements established by federal and state law.	
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1  This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) smoke compartment, residents, staff and visitors. The facility is licensed for one-hundred and thirty-two (132) beds and the census was one-hundred and twenty-one (121) on the day of the survey.  The findings include:	K 029	<b>K 029 D</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) <i>Director of Maintenance</i> immediately, ( <i>July 1, 2011</i> ) installed an automatic door closure on the Dry Storage Room Door.  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) <i>Director of Maintenance</i> completed a Life Safety inspection to all storage area rooms larger than 50 ft 2 in for need for door closures. <i>Audit was completed on July 1, 2011.</i> The facility storage <i>audit confirmed all</i> areas have the appropriate door closures.	7/29/11

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

(X8) DATE

*[Signature]*

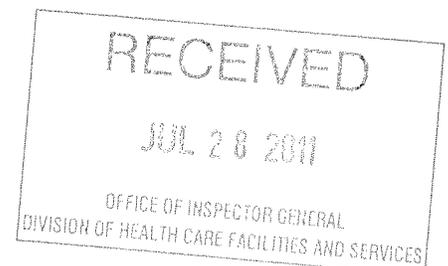
*[Signature]* 7-27-2011

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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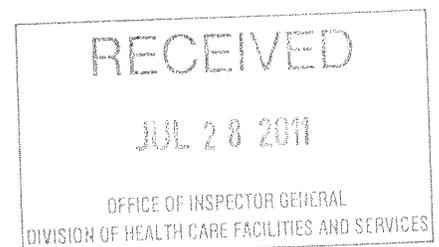
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED  06/29/2011	
NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK		STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
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K 029	<p>Continued From page 1</p> <p>Observation, on 06/29/2011 at 10:30 AM, with the Safety Director, Maintenance Director and Housekeeping Manager revealed the door to the Dry Storage Room, located in the Kitchen, did not have a self closing device installed on the door.</p> <p>Interview, on 06/29/2011 at 10:30 AM, with the Safety Director, revealed that the room was used to store combustible materials, was determined to be greater than fifty (50) square feet in area and should be equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft<sup>2</sup> (9.3 m<sup>2</sup>) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms</p>	K 029	<p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) Director of Maintenance, <i>who is the Life Safety coordinator</i>, will conduct weekly safety rounds. All areas of non-compliance will be addressed immediately at time of observation.</p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) The Director of Maintenance Services will <i>monitor all storage rooms for appropriate closures, on a monthly basis through a Life Safety audit</i>. All areas of non-compliance will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure <i>facilities storage rooms have the appropriate door closures</i>.</p>	



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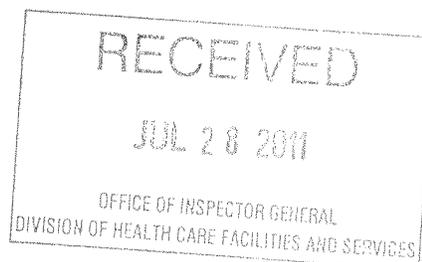
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K 029	Continued From page 2 (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops; used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		
K 074 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations in health care occupancies are in accordance with provisions of 10.3.1 and NFPA 13, Standards for the Installation of Sprinkler Systems. Shower curtains are in accordance with NFPA 701.  Newly introduced upholstered furniture within health care occupancies meets the criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3. 19.7.5.1, NFPA 13  Newly introduced mattresses meet the criteria specified when tested in accordance with the method cited in 10.3.2 (3), 10.3.4. 19.7.5.3	K 074	<b>K 074 D</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Director of Maintenance immediately installed a smoke detector in room # 37 and re-educated the maintenance personnel on Policy & Procedures concerning upholstered chairs and safety. <i>The installation and re-education was completed July 1, 2011.</i>  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) Director of Maintenance completed a Life Safety inspection to all facility rooms to determine compliance with smoke detectors in rooms with recliners. <i>Audit was completed on July 1, 2011 and established facility compliance.</i>	7/29/11



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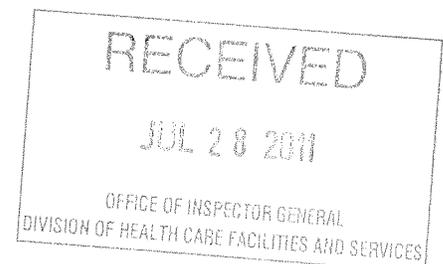
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K 074	<p>Continued From page 3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that upholstered furniture belonging to a resident was used in the facility, according to NFPA standards. The deficiency had the potential to affect one (1) smoke compartment, residents, staff and visitors. The facility is licensed for one-hundred and thirty-two (132) beds and the census was one-hundred and twenty-one (121) on the day of the survey.</p> <p>The findings include:</p> <p>Observation on 06/29/2011, at 9:55 AM, with the Safety Director, Maintenance Director and Housekeeping Manager, revealed two (2) upholstered reclining chairs belonging to the residents being used within their sleeping room. The room did not have a smoke detector located within the room.</p> <p>Interview on 06/29/2011 at 9:55 AM, with the Safety Director, revealed that a smoke detector had been installed in the room but was removed to make repairs to the wall where the smoke detector was located. The Maintenance Director was instructed to reinstall the smoke detector on the wall located behind the beds.</p> <p>Reference : NFPA 101 (2000 Edition)</p> <p>19.7.5.2 Newly introduced upholstered furniture within health care occupancies shall meet the</p>	K 074	<p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) <i>Director of Maintenance, who is our Life Safety supervisor, will conduct weekly rounds. Any areas of non-compliance will be addressed immediately at time of observation.</i></p> <p><u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u></p> <p>A) <i>The Director of Maintenance will monitor on a monthly basis facility rooms containing recliners to determine smoke detector compliance. All areas of non-compliance will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure facilities policy &amp; procedures are follow are as it relates to smoke detectors / recliners.</i></p>	



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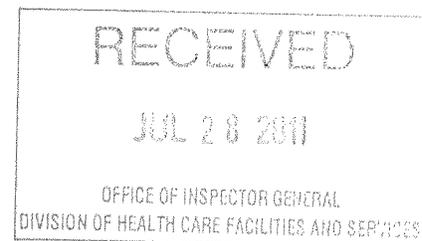
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K 074	Continued From page 4 criteria specified when tested in accordance with the methods cited in 10.3.2(2) and 10.3.3.  Exception: Upholstered furniture belonging to the patient in sleeping rooms of nursing homes, provided that a smoke detector is installed in such rooms. Battery- powered single station smoke detectors shall be permitted.	K 074		
K 130 SS=D	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress per NFPA standards. This deficiency had the potential to affect one (1) smoke compartment, residents, staff, and visitors. The facility is licensed for one-hundred and thirty-two (132) beds, with a census one-hundred and twenty-one (121) on the day of the survey.  The findings include:  Observation, on 06/29/2011, at 10:25 AM, with the Safety Director, Maintenance Director and Housekeeping Manager revealed an unapproved locking device (surface mounted pad lock) was installed on the outside of the Housekeeping Office for security purposes.	K 130	<b>K 130 D</b>  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>  A) Director of Maintenance immediately removed the unapproved locking device and hardware from the Housekeeping office and installed an approved locking device, a locking door knob. <i>The removal &amp; installation was completed July 1, 2011.</i>  <u>A) Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  Director of Maintenance completed a Life Safety inspection to facility to determine compliance to NAPF 101 19.2.2.2.4. <i>Audit was completed on July 1, 2011 and established facility compliance.</i>	7/29/11



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K 130	Continued From page 5 Interview, on 06/29/2011, at 10:25 AM, with the Safety Director and Housekeeping Manager revealed they were unaware of the lock being prohibited, and acknowledged that a person could potentially be locked in the room. The Pad lock was immediately removed from the door and a new, approved lockset would be applied to the door.	K 130	<u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u>  A) <i>Director of Maintenance, who is our Life Safety supervisor, will conduct weekly rounds to determine compliance with NAPF 101 19.2.2.2.4 – all doors having approved locking devices. Any areas of non-compliance will be addressed immediately at time of observation.</i>	
K 147 SS=D	NFPA 101 (2000 Edition) 19.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side. NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained according to NFPA standards. This deficient practice affected one (1) smoke compartment, residents, staff, and visitors. The facility is licensed for one-hundred and thirty-two (132) beds with a census of one-hundred and twenty-one (121) on the day of the survey.  The findings include:  Observation on 06/29/2011, at 9:15 AM, with the Safety Director, Maintenance Director and	K 147	<u>Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?</u>  A) The Director of Maintenance Services will monitor on a monthly basis. All areas of non-compliance will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure <i>facilities locking devices are all appropriate.</i>  K 147 D  <u>Criteria # 1: What corrective action will be accomplished for those residents found to have been affected by the deficient practice?</u>	7/27/11



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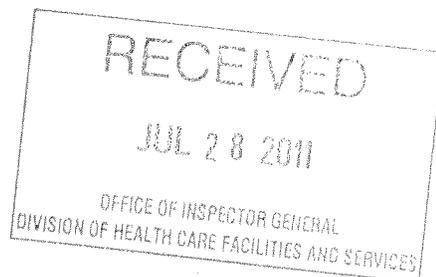
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NAME OF PROVIDER OR SUPPLIER  HURSTBOURNE CARE CENTRE AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220
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K 147	<p>Continued From page 6</p> <p>Housekeeping Manager revealed that the electrical panels located in the Janitor's Closet, in the Sub Acute 2 wing, had items stored in front of the panels and obstructing access.</p> <p>Interview on 06/29/2011, at 9:15 AM, with the Safety Director revealed that the stored items should not have been located in front of the electrical panels and immediately relocated by the Maintenance Director.</p> <p>Reference: NFPA 70 (1999 edition)</p> <p>110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p>	K 147	<p>A) Housekeeping supervisor immediately removed <i>stored items from in front of electrical panel and Janitor's closet</i> and re-educated <i>housekeeping staff</i> on proper storage procedures. <i>The removal and re-education was completed July 1, 2011.</i></p> <p><u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u></p> <p>A) A Life Safety inspection was performed by Life Safety supervisor with housekeeping supervisor to all housekeeping storage areas to determine compliance. <i>The inspection on July 1, 2011 revealed no improper storage in front of electrical panels. All facility storage areas are within compliance.</i></p> <p><u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u></p> <p>A) Life Safety coordinator &amp; Housekeeping Supervisor will conduct weekly rounds to determine compliance regarding proper storage in facility storage areas. All areas of non-compliance will be addressed immediately at time of observation.</p>	<p><i>Tom Park</i> <i>7-2-2011</i></p>
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K 147	Continued From page 6 Housekeeping Manager revealed that the electrical panels located in the Janitor's Closet, in the Sub Acute 2 wing, had items stored in front of the panels and obstructing access.  Interview on 06/29/2011, at 9:15 AM, with the Safety Director revealed that the stored items should not have been located in front of the electrical panels and immediately relocated by the Maintenance Director.  Reference: NFPA 70 (1999 edition)  110-26. Spaces  About Electrical Equipment. Sufficient access and working space shall be provided and maintained around all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.	K 147	A) Housekeeping supervisor immediately removed <i>stored items from in front of electrical panel and Janitor's closet</i> and re-educated staff on proper storage procedures. <i>The removal and re-education was completed July 1, 2011.</i>  <u>Criteria # 2: How the facility will identify other residents having the potential to be affected by the same deficient practice?</u>  A) A Life Safety inspection was performed by Life Safety supervisor with housekeeping supervisor to all housekeeping storage areas to determine compliance. <i>The inspection on July 1, 2011 revealed no improper storage in front of electrical panels. All facility storage areas are within compliance.</i>  <u>Criteria # 3: What measures will the facility put into place or systemic changes made to ensure that the deficient practice will not recur?</u>  A) Life Safety coordinator & Housekeeping Supervisor will conduct weekly rounds to determine compliance regarding proper storage in facility storage areas. All areas of non-compliance will be addressed immediately at time of observation.	

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Criteria # 4: How will the facility monitor its performance to ensure that solutions are sustained?

A) The Director of Maintenance Services will monitor ***all storage areas*** on a monthly basis. All areas of non-compliance will be brought to RMQI meeting monthly for 3 months for review and development of an action plan to ensure ***all items are stored correctly and no electrical panels are blocked.***

