

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

PRINTED: 02/10/2011
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 01/27/2011
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NAME OF PROVIDER OR SUPPLIER BASHFORD EAST HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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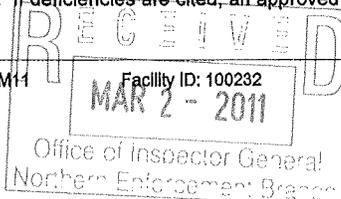
F 000	<p>INITIAL COMMENTS</p> <p>The standard survey was completed on 01/25 - 01/27/11 and Life Safety Code survey was conducted on 01/26/11. The facility was found not to meet the minimum regulatory requirements with deficiencies identified with the highest S/S of an "F". The facility has the opportunity to correct before remedies would be imposed.</p> <p>In addition, abbreviated surveys investigating two complaints were conducted. KY#15156 was substantiated with regulatory violations identified. KY#15603 was also investigated and determined to be unsubstantiated with no regulatory violations identified.</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 241 SS=D	<p>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</p> <p>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.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide respect and dignity during the noon meal service for one (1) of the twenty-nine (29) sampled residents (Resident #29). Resident #29 was observed being fed by a staff that was standing during the noon meal in the Reflections Unit Dining/Activity Room.</p> <p>The findings include: Record review of the facility's policy on Dining Standards states: "Staff sits down next to resident</p>	F 241	<p>F 241</p> <p>CNA # 1 has been counseled and provided a copy of the facility's policy on Dining Standards by DNS on February 14, 2011. Employee was reminded that "Staff sits down next to resident while feeding and/or assisting with feeding."</p> <p>Observations of resident #29 were conducted during meal service on 2/14/11 by the DNS to ensure staff was seated.</p> <p>Observations were conducted of meal service on February 14, 2011 by DNS with no other residents identified as having been affected by the deficient practice.</p> <p>A facility wide in-service was conducted, by the Staff Development Coordinator (SDC), on 2/3/11, for all employees, with emphasis on Quality of Life, Dignity, and Quality of Care.</p> <p>All direct care staff who participate in meal service, received in-service training by the SDC on 2/3-2/8/11. In-service</p>	3/1/11

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

[Signature]

training included Dining Standards, Quality of Life, Quality of Care, and ^{(X8) DATE} 3/2/11

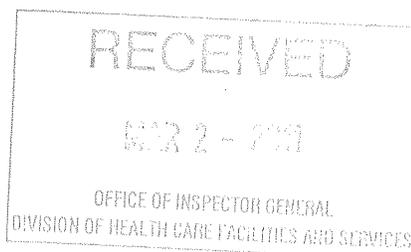
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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F 241	Continued From page 1 while feeding and/or assisting with feeding." Resident #29 was observed during the noon meal on 01/25/11 at 12:40pm being fed by certified nursing assistant (CNA) #1. During this time, CNA #1 was observed standing during the entire time Resident #29 was being fed. In an interview with CNA #1 on 01/27/11 at 2:30pm revealed she was aware she should have been sitting while feeding a resident. CNA #1 stated she received training on proper feeding techniques and knew that standing over a resident while feeding was inappropriate, further stating, "I was just trying to help." Interview with the Administrator, during the Quality Assurance interview on 01/27/11 at 3:00pm, revealed staff should sit while feeding residents in the dining room and this was an ongoing problem which had to be addressed periodically in meetings.	F 241	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> Dignity. A competency was completed for all direct care staff who participate in meal service, to validate staff are seated while feeding. All new hires will receive training during orientation related to resident Quality of Life, Dignity, and Quality of Care. The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this education will be included in agency orientation. The facility will offer a facility wide mandatory training on a yearly basis, and as needed, with emphasis on Quality of Life, Dignity, and Quality of Care to ensure the residents maintain the highest practicable, functional, emotional, and psychosocial well being. A Dining Service Monitoring schedule has been implemented utilizing the Interdisciplinary Team (IDT) to oversee the dining room process. IDT members	3/1/11
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: Based on observation, interview and record review it was determined the facility failed to ensure services were provided in accordance to the comprehensive care plan for one (1) of twenty-nine (29) sampled residents. Resident #22 was care planned for the use of a Hoyer lift	F 282	are seated during meal service when	

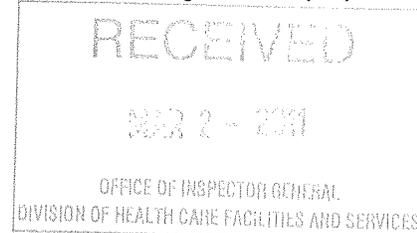


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F 282	<p>Continued From page 2</p> <p>transfer and two staff provided a two (2) person manual transfer.</p> <p>The findings include:</p> <p>Record review of the facility policy of Transfers and Ambulation revised on 10/31/08 revealed the resident is initially assessed and then with on-going assessments and the interdisciplinary team addresses the resident's needs for assistance with mobility and transfer. The facility's policy revealed the interdisciplinary team determines the appropriate assistance required with bed mobility, repositioning, and transfers based on the resident's individual needs.</p> <p>Record review of the facility procedure of the Mechanical Lift revised on 10/31/10 revealed the rationale for a mechanical lift is to allow two (2) staff members to transfer a patient safely.</p> <p>Closed record review on 01/25/11 revealed Resident #22 was admitted on 05/24/08 with diagnoses of Arthritis, Alzheimer's Disease, Dementia, Renal Insufficiency, Leukocytosis, Hypertension and Hypothyroidism. Resident #22's significant change Minimal Data Set (MDS) dated 10/05/09 revealed the resident was assessed for the use of a mechanical lift during transfers. Review of the comprehensive care plan dated 03/21/10 revealed Resident #22 was care planned for the use of a Hoyer lift and the assistance of two (2) staff when transferred.</p> <p>Record review on 01/27/11 of CNA #6's personnel file revealed the CNA was trained in the Hoyer lift and identified CNA #6 was aware of Resident #22 being care planned for a two person transfer and was aware of the Saf-lift icon placed on the</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>feeding residents.</p> <p>Observations of the IDT members will be reported daily (Monday through Friday) during morning Stand-Up meeting, and tracked and trended monthly during Performance Improvement Committee (PIC) meeting for the next three months and thereafter as needed.</p> <p>F 282</p> <p>Certified Nursing Assistants # 6 & # 7 were terminated as employees of Bashford East.</p> <p>A facility wide audit was performed by the Unit Managers to ensure all Care plans corresponded with the Nursing Assistant Assignment sheets. The MDS Coordinator performed a facility wide audit to ensure all Nursing Assistant Assignment sheets corresponded with the Saf-Lift icons on the doorways of the resident rooms.</p> <p>The Director of Nursing, Assistant Director of Nursing and Staff Development Coordinator began</p>	3/1/11

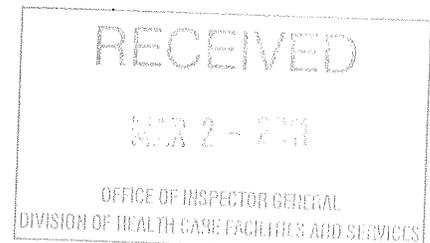
immediate Nursing department enter care staff in-servicing of the improper



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F 282	Continued From page 3 resident's door. Record review of the investigation completed by the facility on 08/06/10 revealed CNA #6 and CNA #7 made a manual two person transfer from the bed to the shower chair on 07/30/10. Interview with CNA #7 on 01/27/11 at 10:30am revealed he/she did assist CNA #6 with the transfer of Resident #22, although the CNA reported he/she did not remember the details or much about Resident #22 since he/she had not been employed by the facility since last year. The CNA did report Resident #22 was not assigned to him/her, but did assist another staff member with care. The CNA did report CNA #6 was the person he/she was assisting. CNA #7 reported he/she had been fired by the facility for not following a protocol, and stated the facility did not identify the specific protocol that was not followed. CNA #7 reported the facility did not reveal any condition status or injury status of Resident #22.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to provide the necessary care and services for one (1) of the twenty-nine (29) sampled residents	F 309	transfer, Nursing Assistant Assignment sheets, Care plans, Saf-Lift program, and transfer techniques (with the assistance of the therapy department for transfer techniques). All direct care employees continued to be in serviced prior to assuming care of residents in the facility. No nursing department direct care employee was allowed to work until he/she had been in serviced. The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this education will be included in agency orientation. The Unit Managers/designee continued for 30 days performing random audits on 2 residents per shift per day to ensure the Nursing assistant assignment sheet was being followed, and the correct transfer technique was being used to transfer the resident. The Performance Improvement Committee met on 8/2/10 and discussed the facility action plans, and monitoring of the action plans. The Medical Director was involved in this meeting.	3/1/11

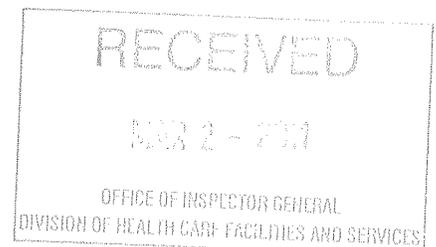


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F 309	<p>Continued From page 4</p> <p>(Resident #12) as evidenced by the facility failure to follow the written medication orders of the physician. The facility failed to document pre and post breath sounds, pre and post heart rate and pre and post respiratory rate in reference to Resident #12's nebulizer medication order.</p> <p>The findings include:</p> <p>The facility policy on Physician Orders revealed the nurse is responsible for the implementation of medication orders.</p> <p>The facility policy on Medication Administration reveals the nurse is to "Read the medication order....", and in the section Administering the Medication, number 12, "Re-read the medication order(s)".</p> <p>Review of the physician orders on 01/25/11 at 1:55pm revealed:</p> <ol style="list-style-type: none"> ALBUTEROL UNIT DOSE Nebulizer WITH ATOVENT (IPRATROPIUM BROMIDE) UNIT DOSE. Nebulizer Inhaler THREE Times daily at 9AM, 3PM and 9PM. DOCUMENT WITH EACH TX: PRE AND POST BREATH SOUNDS PRE AND POST HEART RATE PRE AND POST RESP RATE PATIENT ENCOURAGED TO DEEP BREATH AND COUGH POST TX: DOCUMENT AS FOLLOWS: 1) CLEAR 2) RHONCHI 	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Findings from the <i>Review of Process Measures-Proper Transfer of Resident per Saf-Lift Program and Nursing Assistant Assignment Sheets</i> were reported to Director of Nursing Services. The findings were additionally tracked and trended through the Performance Improvement Committee monthly for (3) months until it was determined compliance had been sustained. The Performance Improvement Committee will continue to address any concerns, as needed, for further plan of actions to prevent the deficient practice from reoccurring.</p> <p>F 309</p> <p>The DNS conducted an audit of Resident #12's Medication Administration Record on 2/14/11. It was noted 100% compliance with documentation of "Pre HR, Pre Resp, Post HR, and Post Resp". Additionally, 100% compliance with "Pre Code, Post Code" of "1) Clear 2) Rhonchi 3) Rales 4) Wheezes" with each nebulizer administration time.</p>	3/1/11

A facility wide audit was completed on February 14, 2011 on all documentation



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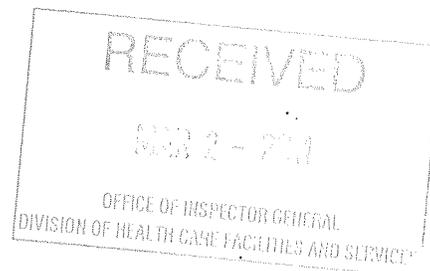
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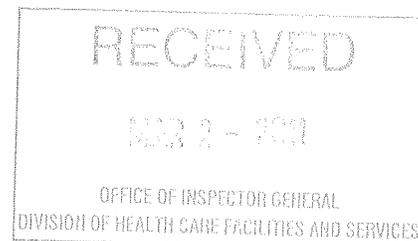
F 309	<p>Continued From page 5</p> <p>3) RALES 4) WHEEZES</p> <p>Review of the Medication Administration Record (MAR) on 01/25/11 at 2:00pm for dates 01/01/11 to 01/26/11 revealed no documented evidence to indicate the order was followed.</p> <p>Review of the MAR kept in the clinical record of Resident #12 on 01/25/11 at 2:05pm revealed for September, October, and November 2010, there was no documentation entered to indicate the order was followed.</p> <p>Observation of Resident #12 on 01/26/11 at 1:25pm to 1:45pm revealed Resident #12 completed a nebulizer treatment; however, no staff were observed checking the status of the resident following the treatment.</p> <p>Interview with Resident #12 on 01/26/11 at 1:25pm revealed when his/her neb treatment is completed, the staff does "nothing". It was further revealed the resident does not recall a time when the staff listened to his/ her chest with a stethoscope or took the resident's pulse before or after a nebulizer treatment.</p> <p>Review of the Care Plan on 01/27/11 at 3:00pm for Resident #12 stated "MINI NEBS AS ORDERED."</p> <p>Review on 01/27/11 at 3:05pm of the MDS, dated 01/22/11, revealed Resident #12 was interviewable.</p> <p>Interview with CMT/CNA #5 on 01/27/11 at 10:45am revealed physician's orders on the MAR should be followed. CMT/CNA #5 also revealed</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>of nebulizer and inhaler treatments to ensure documentation was current on the Medication Administration Record.</p> <p>Immediate in-servicing began on all licensed nurses on January 25, 2011. The RCS system was updated so that all Medication Administration Records reflect Kindred policy on proper assessment pre and post nebulizer/inhaler treatment. Inhaler treatments require documentation of "Pre Heart Rate, Pre Respiratory Rate, Post Heart Rate, and Post Respiratory Rate". Nebulizer treatments require documentation of "Pre and Post Breath Sounds". These codes include: (1) Clear (2) Rhonchi (3) Rales (4) Wheezes. Adequate space and clear direction of what documentation is required is now listed on the Medication Administration Record effective 2/1/2011. All licensed staff will be in serviced by 2/28/11.</p> <p>The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this education will be included in agency orientation.</p>	3/1/11
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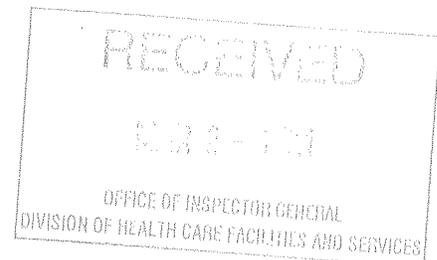
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F 309	Continued From page 6 that, to her knowledge, a nurse has not gone back in the room of Resident #12 to listen to his/her chest following nebulizer treatments. Interview with Licensed Practical Nurse (LPN) #3 on 01/27/11 at 10:15am revealed she follows the orders as written, then stated she does not check breathe sounds after each treatment on Resident #12. Interview with Registered Nurse (RN) #1 on 01/27/11 at 10:40am revealed she became aware of the "med variance" of Resident #12 during the survey. It was revealed the medication sheets are reviewed daily by nurses to check "to see if there are holes" in the record "so they can correct it." RN #1 also revealed that staff are responsible for the passing of the medications and received in-service with a competency once a year.	F 309	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
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 (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection	F 441	The DNS/ADNS/Unit Managers/designee will continue performing random audits on (5) residents per week to ensure the policy is being followed, and to validate the correct assessment and documentation of the resident is represented on the Medication Administration Record. This will include not only verification of the documentation, but also speaking with interviewable residents to validate the nurses are performing physical assessments using stethoscope and heart rate monitoring tools. Findings from the <i>Review of Process Measures</i> will be reported to Director of Nursing Services. The findings will additionally be tracked and trended through the Performance Improvement Committee monthly until it is determined compliance had been sustained. The Performance Improvement Committee will continue to address any repeated concerns for further plan of actions to prevent the deficient practice from reoccurring.	3/1/11



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F 441	<p>Continued From page 7</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 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, interview and record review, it was determined the facility failed to follow infection control practices for three (3) of twenty-nine (29) sampled residents (#25, #26, and #12). The facility failed to serve and handle food in a sanitary manner during the meal service for Resident #25 whose overbed table was observed with a urinal replaced by the lunch tray with no sanitation completed.</p> <p>In addition, the facility failed to store oxygen and nebulizer masks in a sanitary manner as evidenced by nasal cannulas lying on the bedside chairs uncovered and unlabeled as well as unlabeled hand held nebulizer for Residents #26 and #12.</p>	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>F 441</p> <p>A Teachable Moment was held with CNA #4 regarding the sandwich being cut in half and touched with bare hands for the resident in room 122. CNA #4 received further education on serving and handling food in a sanitary manner during meal service.</p> <p>Resident # 26's nasal cannula has been covered and labeled.</p> <p>Resident # 12's hand-held nebulizer is labeled with her name, room number, and date changed 2/11/2011. Resident's nebulizer was also being cleaned by 7a-7p LPN during DNS round. Resident # 12 was educated on the proper cleaning and storage of nebulizer equipment after/when not in use. A self-administration assessment was updated validating resident # 12 is capable of administering own nebulizer and education documentation has been signed by resident # 12.</p> <p>A facility wide audit was conducted of all residents who utilize nasal cannulas and hand held nebulizers. The audit validated that all nasal cannulas were</p>	Completed 3/1/2011	

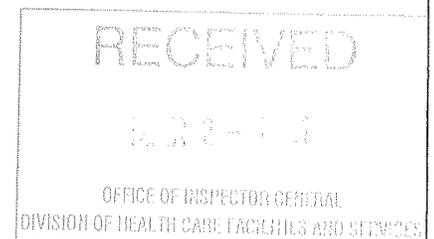


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 01/27/2011
NAME OF PROVIDER OR SUPPLIER BASHFORD EAST HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218		
(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 8 The findings include: Review of the Infection Control Policy provided by the facility revealed an infection control program which included "Implementing policies and procedures to prevent the spread of infections that include promoting consistent adherence to Standard Precautions and other infection control practices". Review of the facility Respiratory Equipment Change and Cleaning Guidelines reveal all nasal cannulas are to be labeled with the date which they were changed. It was further revealed hand held nebulizers are to be labeled with the residents name, room number and date. Observation on 01/25/11 at 12:42pm revealed an unsampled resident in room 122 having his/her sandwich cut in half and touched with the bare hands of CNA #4. In addition, CNA #4 was observed removing a urinal from an overbed table for Resident #25 and a lunch tray was then placed on the overbed table without sanitization. Observation on 01/25/11 at 8:35am, 01/26/11 at 1:25pm, and 01/27/11 at 10:00am revealed an uncovered and unlabeled nasal cannula in room 106 on a chair by the bedside of Resident #26. In addition, there was an unlabeled hand held nebulizer of Resident #12's. Interview with Resident #12 on 01/26/11 at 3:50pm revealed the resident had been instructed to place his/her equipment in a plastic bag after the nebulizer treatments. However, no cleaning instructions were provided.	F 441	<i>This Plan of Correction is the center's credible allegation of compliance.</i> <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> appropriately covered and that hand held nebulizers were labeled with the resident's name, room number and date. Corrections were made during the audit as identified. In-servicing began on all direct care staff on February 3, 2011. Staff have been educated and continue to be educated on Dining Standards, Feeding the Resident, Infection Control Practices and Oxygen Administration. This education will be completed by February 28, 2011. The facility does not employ agency personnel. If the facility should employ agency personnel in the future, this education will be included in agency orientation. RCS Coordinator has corrected the Medication Administration Record to display a signature box for licensed nurses to sign that they have cleaned the nebulizer equipment according to Kindred Policy. In-servicing will be completed by 2/28/11.	Completed 3/1/2011	

Weekly oxygen monitoring will be



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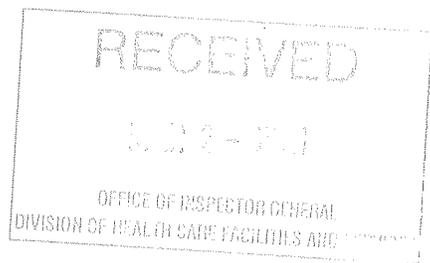
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NAME OF PROVIDER OR SUPPLIER BASHFORD EAST HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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F 441	Continued From page 9 Interview with the Administrator on 01/27/11 at 2:30pm revealed infection control is reviewed in every Performance Improvement meeting with monthly tracking and trending. He stated that dining issues with handling of food is something that is looked at on a continuing basis, as well as the issues with masks and cannulas. The Administrator stated these issues are discussed frequently in the monthly Performance Improvement meeting and monthly nurses meetings.	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>completed by ADNS/designee. This monitoring will include ensuring physician order matches flow/rate setting, name/date/and room number on all nebulizer equipment, covered and labeled nasal cannula's appropriately positioned according to Kindred policy of infection control practices, and review of equipment for cleanliness.</p> <p>A Dining Service Monitoring schedule has been implemented utilizing the Interdisciplinary Team (IDT) to oversee the dining room process. IDT members will observe and ensure food is served and handled in a sanitary manner during each dining service; this is to include the service in the Main Dining Room, Reflections Dining Room, and In-Room meals.</p> <p>This will include observation of sanitation of surfaces prior to placement of meal trays, and serving and handling food in a sanitary manner during the meal service.</p> <p>In addition, DNS/ADNS/designee will</p>	Completed 3/1/2011
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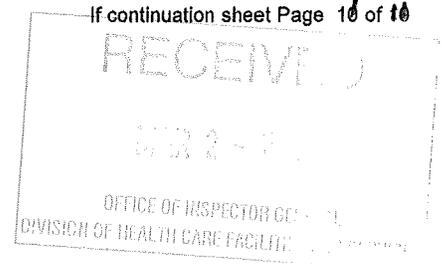
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F 441	Continued From page 9 Interview with the Administrator on 01/27/11 at 2:30pm revealed infection control is reviewed in every Performance Improvement meeting with monthly tracking and trending. He stated that dining issues with handling of food is something that is looked at on a continuing basis, as well as the issues with masks and cannulas. The Administrator stated these issues are discussed frequently in the monthly Performance Improvement meeting and monthly nurses meetings.	F 441	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Findings from the <i>Review of Process Measures</i> will be reported to Executive Director and Director of Nursing Services. The findings will additionally be tracked and trended through the Performance Improvement Committee monthly until it is determined compliance had been sustained. The Performance Improvement Committee will continue to address any repeated concerns for further plan of actions to prevent the deficient practice from reoccurring.</p>	3/1/11 Completed 3/1/2011
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 01/26/2011
NAME OF PROVIDER OR SUPPLIER BASHFORD EAST HEALTH CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	INSPECTOR GENERAL ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS	K 000	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
K 072 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure that corridors were maintained free from obstructions in the case of fire or other emergencies. The findings include: Observation on 01/26/11 at 11:32am revealed benches were located in a vestibule area of the West Wing, next to the South exit door (Bardstown Rd). Interview with the Maintenance Director revealed he was not aware the benches would be considered obstructions or impediments to a means of egress during a fire or other emergency. The Maintenance Director acknowledged that the vestibule benches were located in a direct means of egress/exit from the facility.	K 072	<i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i> K072 SS=F NFPA 101 LIFE SAFETY CODE STANDARD The benches located in vestibule area of the West Wing, next to the South exit door (Bardstown Road) will be removed. A facility wide audit was performed of all to ensure all means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency Maintenance Director will monitor on monthly basis for compliance with Life Safety Code requirements. Also will review during monthly safety meeting for any action needed. The Executive Director, Maintenance Director and Weekend supervisor will monitor daily to ensure compliance with Life Safety Code regulation. The Safety Committee will review monthly findings for any actions needed.	Completed 3/1/2011 Completed 3/1/2011 Completed 3/1/2011 Completed 3/1/2011

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *[Signature]* TITLE *x Administrator* (X6) DATE *2/18/11*

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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NAME OF PROVIDER OR SUPPLIER BASHFORD EAST HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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K 072	Continued From page 1 Reference: NFPA 101 (2000 edition) 7.1.10 Means of Egress Reliability. 7.1.10.1* Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency	K 072		
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