

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

PRINTED: 08/06/2010
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS A standard health survey was conducted on 07/20/10 - 07/22/10 and a Life Safety Code Survey was conducted on 07/23/10. Deficiencies were cited with the highest scope and severity of an "F" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. An abbreviated survey was conducted during the standard health survey from 07/20/2010 - 07/22/2010. KY#14968 was Substantiated without regulatory violation related to 42 CFR 483.13 Resident Behavior and Facility Practices.	F 000	This plan of correction is prepared and executed because it is required by provisions of State and Federal law and not because Meadowview Health & Rehabilitation agrees with the allegations and citations listed. Meadowview Health & Rehabilitation maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor is it of such character as to limit our capability to render adequate care. Please accept this plan of correction, as the facility's written credible allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the date or dates indicated. To remain in compliance with all federal and state regulation, the center has taken or will take the actions set forth in the following plan of correction.	
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money	F 278		

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

TITLE

(X6) DATE

[Signature]

ADMINISTRATOR

8-12-10

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.

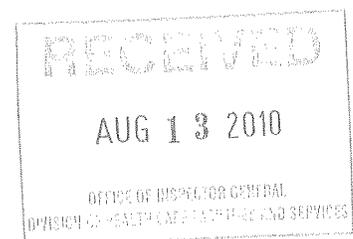
AUG 13 2010

nk

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

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

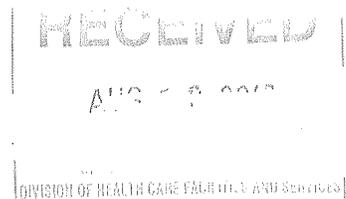
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 278	Continued From page 1 penalty of not more than \$5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to accurately conduct pressure sore assessments and documentation for one (1) of nineteen (19) sampled residents (Resident #10). Resident #10's skin care assessments and Minimum Data Set (MDS) assessments contained conflicting information. The findings include: A review of Resident #10's Medical Record revealed the facility admitted the resident on 06/11/09 with diagnosis which included Paralysis, Agitation, Spinal Stenosis, Chronic Obstructive Pulmonary Disease, Dementia, and Hydrocephalus. A review of the Initial Comprehensive Care Plan revealed on 06/13/09 a documented Stage II pressure sore. The Admission Minimum Data Set (MDS) Assessment dated 06/23/09 revealed the facility assessed the resident as having Cognition for daily decision making, required extensive assistance with Bed Mobility and Ambulation. Documentation on the admission MDS assessment revealed the resident was admitted with a Stage II wound. The Resident Assessment Protocol Summary (RAPS) dated 06/23/09 revealed the Stage II wound was to the left buttocks.	F 278	Resident # 10 suffered no adverse consequence as a result of "skin care assessments contained conflicting information." The resident has accurate weekly wound assessments documented and reflected in the medical record. Resident # 10 has Pressure Ulcer Risk Screen scores that accurately reflect the resident to be at "high risk" for skin breakdown and the risk screen assessment was updated by the LPN on August 8, 2010. All residents with pressure ulcers were audited for conflicting skin care assessments. This was completed on August 9, 2010 by the RN Skin/Wound nurse. Any discrepancies were corrected immediately and the staff members involved were re-educated.	8/24/2010



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 278	Continued From page 2 A review of the Quarterly MDS assessment dated 02/25/10 revealed no documentation of wounds. The current Annual MDS dated 05/27/10 revealed documentation of a Stage II wound. Review of the treatment record, nursing skin assessment, and wound nurse assessment for Resident #10 revealed a Stage II wound had developed to the Sacrum on 04/06/10. Continued review of the Medical Record for Resident #10 revealed a Pressure Ulcer Risk Screen completed quarterly from 06/17/09 - 02/24/10 that evaluated the resident's risk factors for skin breakdown. Facility staff documented that Resident #10 did not have a pressure sore or a history of pressure sores in the last year. An interview with the Unit Manager and the Wound Nurse on 07/21/10 at 3:30pm revealed they had no explanation of why there were discrepancies in the Skin Assessments for Resident #10. When asked about the resident's history of pressure sores and the inaccurate documentation that the resident did not have a history of pressure sores, the Wound Nurse stated that the charts were thinned, and she didn't know how they would find that information if it was thinned from the chart.	F 278	The RN Skin/Wound nurse will re-educate the nurses on skin assessments by August 20, 2010. The re-education will include identification, documentation and facility policy on when to perform. The Unit Managers/designee will audit 20% of the skin assessments for conflicting information weekly for four weeks and give a written report to the Director of Nursing. The results will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.	8/24/2010	
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial	F 279			



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 3</p> <p>needs that are identified in the comprehensive assessment.</p> <p>The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interview, it was determined the facility failed to develop, review, and revise the comprehensive care plan for two (2) of nineteen (19) sampled residents (Resident #9 and Resident #16). Resident #9's care plan did not specify the use of toe to knee hose, but did include bilateral heel lift boots that had been discontinued by the physician previously. Resident #16's care plan did not address the resident's need for an indwelling urinary catheter.</p> <p>The findings include:</p> <p>The facility presented no policy regarding development, review, or revision of comprehensive care plans.</p> <p>Record review for Resident #9 revealed the resident was admitted to the facility on 09/11/09 with diagnoses to include Coronary Artery Disease, Hypertension, Status Post Cerebrovascular Disease, and Glaucoma. The</p>	F 279	<p>Resident # 9's care plan has been revised to accurately reflect the physician orders for toe to knee hose and the heel lift boots have been discontinued. This was completed August 9, 2010.</p> <p>Resident # 16's care plan has been revised to reflect the need for an indwelling urinary catheter. This was completed August 11, 2010.</p> <p>All residents with indwelling urinary catheters will be audited by the MDS Coordinator to ensure the care plan reflects the need for the catheter. The audit will be completed by August 13, 2010. The DON, ADON & MDS Coordinators will audit care plans for appropriate development, review and revision by August 17, 2010. Any discrepancies will be corrected immediately.</p>	8/24/2010	

AUG 13 2010

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	<p>Continued From page 4</p> <p>minimum data set assessment (MDS) tool dated 03/30/10 revealed Resident #9 was at risk for impaired circulation due to Resident #9's coronary artery disease. A physician's order dated 06/14/10 was written to discontinue bilateral heel lift boots for Resident #9 and an order on 07/19/10 was written for Resident #9 to have bilateral toe to knee hose on during the day. Review of the comprehensive care plan for Resident #9 revealed an approach to use bilateral heel lift boots for the resident and no mention of the bilateral toe to knee hose application during the day.</p> <p>Observation of Resident #9 on 07/20/10 at 11:00am revealed the resident in the bed not wearing heel lift boots. Observation of Resident #9 on 07/21/10 at 8:20am revealed the resident in the bed not wearing bilateral heel lift boots or bilateral toe to knee hose. Observation of Resident #9 on 07/21/10 at 9:50am and at 10:25am revealed the resident had no bilateral heel lift boots or bilateral toe to knee hose on. Again, on 07/22/10 Resident #9 was observed to be without bilateral toe to knee hose on.</p> <p>Interview with CNA #5 on 07/22/10 at 10:00am revealed Resident #9 had not had morning care and the resident would have bilateral hose on when that was done, but CNA #5 could not explain why the hose were not applied on 07/20/10 or 07/21/10. Interview with LPN #5 on 07/22/10 at 9:30am revealed the comprehensive care plan is only done once a year based on the annual MDS assessment and that this practice "covers them". When asked about reviewing or revising the comprehensive care plan, LPN #5 stated that she could see why this might need to be done. However, she had no explanation as to</p>	F 279	<p>The DON will re-educate the nurses on the development, review, and revision of the comprehensive care plan by August 20, 2010.</p> <p>The ADON/designee will audit 20% of the care plans for appropriate development, review and revision. The audits will continue for four weeks and a written report will be given to the Director of Nursing. The results will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.</p>	8/24/2010	

RECEIVED

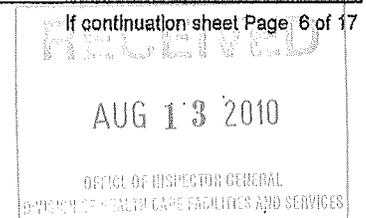
AUG 13 2010

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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

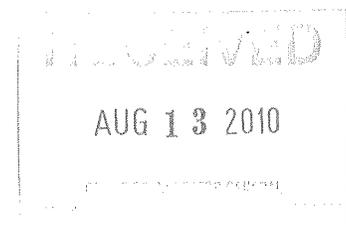
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 279	Continued From page 5 why the order for the bilateral heel lift boots had not been discontinued on the care plan. Record review for Resident #16 revealed the resident was admitted to the facility on 06/04/10 with diagnoses to include Spinal Stenosis, Toxic Encephalopathy, and Depression. Record review also revealed Resident #16 had an indwelling urinary catheter due to urinary retention. Review of the MDS revealed the resident was to have a problem/need addressed on the comprehensive care plan regarding an indwelling urinary catheter. Review of the comprehensive care plan revealed no problem/need addressed regarding an indwelling urinary catheter. Interview with LPN #5 on 07/22/10 at 9:30am revealed there was no care plan for Resident #16 addressing an indwelling urinary catheter and that it was primarily the responsibility of the MDS personnel to do so. However, LPN #5 stated it was the responsibility of all nursing staff to update the comprehensive care plan. She also stated that monitoring of Resident #5's urinary output would cover the absence of addressing an indwelling catheter on the care plan. Interview with the LPN MDS Coordinator on 07/22/10 at 11:15am revealed the unit nurses were responsible to update the comprehensive care plan with new physician orders. The LPN MDS Coordinator also stated the nursing care for an indwelling urinary catheter was standard practice and that this did not need to be care planned, even though the MDS assessment indicated it would be care planned. Interview with the ADON on 7/22/10 at 11:45am revealed there was no need to care plan something addressed as a standard of practice.	F 279			
F 281	483.20(k)(3)(i) SERVICES PROVIDED MEET	F 281			



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

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

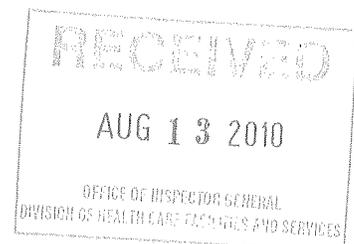
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281 SS=D	Continued From page 6 PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to assure that nursing services meet professional standards of quality, related to reviewing thirty (30) day physician orders and medication administration, for one (1) out of nineteen (19) sampled residents. Resident #5 had a prescription for Aggrenox SA one (1) tablet two times a day that was given correctly but transcribed incorrectly by the Pharmacy. Facility staff failed to recognize the error, and clarify with the Pharmacy. The findings include: Record review of the medication administration record (MAR) revealed Aggrenox SA medication was written as "Give one (1) capsule by mouth once a day for CVA prevention". The hours the medication was given was 7:00am and 7:00pm. The MAR revealed that for twenty (20) days the Aggrenox SA was given two (2) times a day. Observation of Resident #5's medication instructions on the box revealed the resident was to be given 1 capsule by mouth once a day for CVA prevention. Interview with a Certified Medication Technician (CMT) on 07/22/10 at 10:15am revealed she had no explanation on why she did not notice the Aggrenox SA medication was written once a day	F 281	Information cited in this deficiency as thirty (30) day physician orders are actually sixty (60) day physician orders. Resident # 5 suffered no actual harm as a result of the medication being "...transcribed incorrectly by the Pharmacy." The medication was administered correctly to Resident #5. All physician orders were reviewed and compared to the medication administration records by the Unit Managers on August 3, 2010. Any discrepancies were clarified and corrected immediately.	8/24/2010



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

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

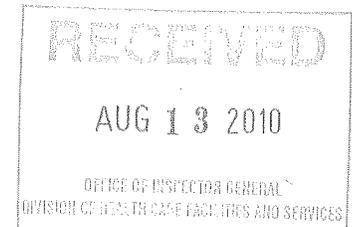
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 281	Continued From page 7 and given twice a day. The CMT stated that she gathered approximately six (6) different people's administered medications over a twenty (20) day period. Third shift nursing staff completes the MAR checks before they go out to the pharmacy, and it is everyone's responsibility to check medications for accuracy. The CMT further stated that many things can happen if a resident is not receiving the right dose of Aggrenox. Interview with Unit Manager of the East Wing on 07/22/10 at 10:43am revealed she was not aware the Aggrenox medication for Resident #5 was written as once a day and given twice a day. The Unit Manager further stated she usually completes the MAR checks, but this MAR check was done by the Assistant Director of Nursing (ADON). She stated the outcome for giving the wrong dose could result in blood becoming too thin. The Unit Manager further stated that approximately seven (7) to eight (8) people gave this medication and it is disheartening that many people administered this medication and did not read the medication order. Interview with the ADON on 07/22/10 at 11:15am revealed she was the one who completed the MAR check for Resident #5. The ADON further stated that she could understand the problem with the medication reading once a day but then given twice a day, and could result in Resident #5 being at risk for TIA's. Each nurse is responsible for medications to be given accurately. She further stated it was her mistake.	F 281	The DON will re-educate the nurses on the review of the physician orders and the medication administration record by August 20, 2010. The Unit Managers/designee will audit 20 % of the physician orders and medication administration records for four months and give a written report to the Director of Nursing. The results will be reported to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.	8/24/2010
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	F 282		



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

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

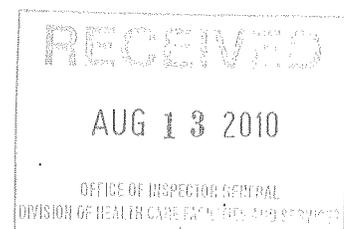
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	<p>Continued From page 8 accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined that the facility failed to correctly implement the comprehensive plan of care for one (1) of nineteen (19) sampled residents (#1). Resident #1 was care planned to wear ted hose daily and lamb's wool placed on the wheelchair armrests to prevent skin tears.</p> <p>The findings include:</p> <p>Observation of Resident #1 on 07/20/10 at 10:30am, 11:10am, 11:57am, 2:32pm, 3:58pm and 5:10pm revealed no ted hose on the resident's legs. Observation's on 07/21/10 at 11:30am during a full body skin assessment revealed no ted hose was on bilateral legs. Observation of the wheelchair on 07/20/10 at 12:00pm, 12:15pm, 2:32pm, 3:58pm and 5:10pm revealed no lamb's wool on the arm of wheelchair. Observation on 07/21/10 at 8:54am and observations on 07/22/10 at 7:53am and 8:32am revealed no lamb's wool on the wheelchair.</p> <p>Record review of Resident #1's care plan revealed the resident was at risk for injury related to impaired mobility and left sided weakness. The approach on the care plan was for the resident to use lamb's wool on the bilateral arm rests. Record review of the physician orders revealed the resident had issues with skin tears to the left and right elbows which were being treated with triple antibiotic ointment on many occasions.</p>	F 282	<p>Resident # 1's lamb's wool was discontinued on 7/23/2010 and TED hose were discontinued on 7/28/2010. This resident continues to receive care as listed on his care plan.</p> <p>The Unit Managers made rounds on their respective units to ensure residents are being cared for in accordance with their individual interventions listed on the care plans. Any discrepancies were corrected immediately and the staff member caring for the resident was informed. This was completed on August 4, 2010.</p> <p>The DON will in-service the nursing staff on the facility's requirement to follow the care planned interventions by August 20, 2010. The Staff Development Coordinator will in-service the nursing assistants on providing resident care as listed on the CNA assignment sheets/cheat sheets by August 20, 2010.</p>	8/24/2010



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 282	<p>Continued From page 9</p> <p>Record review of Resident #1's physician orders revealed the resident was to wear knee high ted hose every morning and off at bedtime. The ted hose were also documented on the Certified Nursing Assistant (CNA) cheat sheet.</p> <p>Interview with CNA #4 on 07/22/10 at 9:47am revealed that she used the cheat sheet to provide care for each of the residents. CNA #4 stated that the resident refused the ted hose and it was common for the resident to refuse. CNA #4 stated that she skimmed through the cheat sheet this morning and that she was not aware that she was to apply lambs wool to the wheelchair. She further stated that she knew that lamb's wool was used for prevention of skin tears.</p> <p>Interview with Licensed Practical Nurse (LPN) #3 on 07/22/10 at 9:55am revealed it was common for Resident #1 to refuse ted hose in the morning and that Resident #1 would not use lamb's wool on the wheelchair. LPN #3 further stated that she made the nurse manager of the East Wing aware, about 3 weeks ago, of Resident #1's refusal to wear ted hose and use lamb's wool. LPN #3 stated Resident #1 is prone to skin tears and the lamb's wool was used to prevent skin tears.</p> <p>Interview with the Unit Manager of the East Wing on 07/22/10 at 10:43am revealed she was not aware that Resident #1 was refusing to wear ted hose until that morning. She did notice the lamb's wool was not on the chair and it should have been on the wheelchair. She stated they should have discontinued the order related to the resident's refusal to use lamb's wool and ted hose. The Unit Manager further stated she did not know if other interventions to prevent skin tears had been</p>	F 282	<p>The Unit Managers/designee will conduct weekly random audits of the residents to ensure staff is providing care in accordance with their individual interventions as listed on the care plan and CNA assignment sheets/cheat sheets. The Unit Managers/designee will conduct these audits for four weeks, have all shifts reflective and give a written report to the Director of Nursing. The audit results will be presented to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.</p>	8/24/2010	



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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 10 looked into. Occupational Therapy usually assesses for interventions and safety. Interview with the Occupational Therapist (OT) on 07/22/10 at 11:35am revealed OT usually works on activities of daily living and assesses environmental changes, positioning and wheelchairs. They assess the arms and positioning of wheelchairs. The OT stated she was aware that Resident #1 was receiving lamb's wool to the wheelchair. She further stated that the last referral she received for Resident #1 was in April of 2010 related to weakness, and added a cushion to the wheelchair. The OT further stated that no one brought to her attention the information that Resident #1 did not like wool in the wheelchair. Nurses usually fill out a referral form to let them know what issues there were, but she had not received a referral from nursing staff about lamb's wool being an issue.	F 282		
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.	F 441	Resident # 16 suffered no actual harm as a result of the indwelling urinary catheter care. Resident # 10 suffered no adverse consequence as a result of the wound care. The RN involved in this isolated situation was re-educated on wound cleaning by the RN Skin/Wound nurse on August 9, 2010.	

RECEIVED

AUG 13 2010

OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITY SERVICES

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185278	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/22/2010
NAME OF PROVIDER OR SUPPLIER MEADOWVIEW HEALTH AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 9701 WHIPPS MILL RD. LOUISVILLE, KY 40223		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 441	<p>Continued From page 11</p> <p>(b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</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, record review, and interview it was determined the facility failed to maintain effective infection control practices regarding the indwelling urinary catheter care and wound care for two (2) of nineteen (19) sampled residents (Resident #16 and Resident #10).</p> <p>The findings include:</p> <p>The facility policy titled "Policies and Procedures Perineal Care" (undated) failed to address standard infection control practices throughout the perineal care procedure.</p> <p>Record review for Resident #16 revealed the resident was admitted to the facility on 06/04/10</p>	F 441	<p>The CNA involved in this isolated situation was re-educated on indwelling urinary catheter care by the CNA Preceptor on August 11, 2010.</p> <p>The Staff Development/Infection Control nurse will re-educate the nursing staff on infection control practices by August 20, 2010. The Infection Control nurse/designee will do random observations of catheter care and wound care for compliance with infection control practices for four weeks and give written report to the Director of Nursing. The audit results will be presented to the Quality Assurance Committee. The Quality Assurance Committee will determine if further action is needed and will determine the continued time schedule for further audits.</p>	8/24/2010	

AUG 13 2010