

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

PRINTED: 04/22/2010  
FORM APPROVED  
OMB NO. 0938-0391



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  04/09/2010
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NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS	F 000		
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure provision of care in accordance with the plan of care for one resident (#9), in the selected sample of 15. Resident #9's care plan interventions included the need for two staff to assist with transfers with the use of a mechanical lift. One Certified Nurse Aide (CNA) attached the mechanical lift to a lift pad beneath the resident, (while the resident sat in a shower chair) and used the lift to reposition the resident. The resident leaned to the side and fell out of the chair. The resident sustained no injuries. Findings include:</p> <p>A record review revealed Resident #9 was admitted to the facility with diagnoses to include Depressive Disorder, Multiple Sclerosis, and Bipolar Disorder.</p> <p>A review of the quarterly Minimum-Data Set (MDS), dated 01/26/10, revealed the facility</p>	F 282	<p>"This Plan of Correction is prepared and submitted as required by law. By submitting this Plan of Correction, Hillside Villa Care &amp; Rehabilitation Center does not admit that the deficiency listed on this form exist, nor does the Center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The Center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts, and conclusions that form the basis for the deficiency."</p> <p><b>F 282</b> The center will continue to ensure that services are provided by qualified persons in accordance with each resident's written plan of care.</p> <p><u>With respect to resident(s) affected by the alleged deficient practice:</u> Resident #9's care plan/cna care card was reviewed by the Assistant Director of Nursing on 3/2/10. The resident was care planned to be transferred by mechanical lift with assist of two staff.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michelle Glover, Director Administrator TITLE: Director Administrator (X6) DATE: 4/30/10

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.

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NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
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F 282	<p>Continued From page 1</p> <p>assessed and identified Resident #9 as independent in decision making and requiring extensive assistance of two staff members for transfers with a mechanical lift. A review of the comprehensive care plan entitled "Potential for falls", dated 06/26/07 and updated 03/01/10, revealed an intervention for the use of a mechanical lift for all transfers with the assistance of two staff members. The Nursing Assistant Care Card, dated 03/20/10, revealed Resident #9 required the assistance of two staff members with the mechanical lift for transfers.</p> <p>A review of the Nurse's Notes, dated 03/01/10 at 10:30 AM, revealed the resident was observed sitting on the floor on his/her buttocks. CNA #1 stated she used the mechanical lift to raise the resident approximately two inches to adjust the mechanical lift pad. The resident leaned to the left and fell sideways from the sling and landed on top of CNA #1. CNA #1 called for help and additional staff members responded and assessed the resident and assisted the resident to bed.</p> <p>An interview with Resident #9, on 04/08/10 at 3:08 PM, revealed he/she was in a shower chair with the lift pad underneath. The resident stated, "CNA #1 was trying to transfer me to the bed so she could get me dressed. CNA #1 was by herself when she tried to transfer me. They usually have two people with the lift when they transfer me. She just thought she could get me in the bed by herself".</p> <p>An interview with the Staff Development Coordinator (SDC), on 04/08/10 at 10:31 AM, revealed she responded to the call for help by CNA #1. She did not witness the fall and upon</p>	F 282	<p><u>With respect to residents having the potential to be affected by the alleged deficient practice:</u> On 4/9/10, residents care plan and cna care cards requiring transfer assist with mechanical lift were reviewed by the interdisciplinary team to ensure staff assistance of two is provided during transfers.</p> <p><u>With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur:</u> Staff re-education was completed by SDC for F282, which included following care plans/cna care cards, and mechanical lift transfers with two staff assist on 4/27/10. CNA was re-educated on 3/2/10 on mechanical lift transfers by the Assistant Director of Nursing. The Licensed Nurse will ensure the care plan is followed with assist of two.</p> <p><u>With respect to how the facility will monitor performance to ensure that solutions are sustained:</u> To monitor performance and to ensure that the solutions are sustained, Nursing Management will audit four care plans per week for three weeks to ensure the plan of care is followed for transfers as indicated. The Licensed Nurse will ensure the care plan is followed with assist of two.</p>		

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F 282	<p>Continued From page 2</p> <p>entering the room she observed Resident #9 lying on the floor. The SDC stated CNA #1 told her she was readjusting the resident and not attempting to transfer him/her. The resident required the assistance of two staff members and the use of a mechanical lift for all transfers.</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/08/10 at 10:45 AM, revealed CNA #1 gave the resident a shower and hooked the resident up to the Hoyer lift and repositioned the resident without asking for assistance from another staff member. She was informed Resident #9 fell on top of CNA #1. Upon entering the room, Resident #9 was observed seated on the floor and CNA #1 was bracing the resident to prevent the resident from falling backwards. She asked the resident if he/she was hurt and Resident #9 stated "no". LPN #1 stated she assessed the resident while the resident remained on the floor and four staff members assisted the resident to bed. She stated a head to toe assessment was completed on the resident once he/she was placed back on the bed. LPN #1 stated "There should have been two staff members with the resident. The resident is a two person assist with everything. He/she is a transfer with the assistance of two staff and a mechanical lift".</p> <p>An interview with CNA #1, on 04/09/10 at 8:58 AM, revealed she had the resident in the shower room and had returned Resident #9 to the bedroom. The resident was leaning to one side and the CNA raised the resident using the mechanical lift to adjust the pad. She stated, "I wanted (him/her) to be in the sling completely and when I lifted (him/her) up, the resident leaned further out but I caught (the resident). The</p>	F 282	<p>The results will be submitted to the Performance Improvement Committee for review with recommendations and ongoing monitoring as indicated.</p> <p>Completion date</p>	5/1/10	

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F 282	Continued From page 3 resident ended up on the floor cause I eased (him/her) down and I screamed for help. (The resident) is a one person assist with bathing and a two person assist with a mechanical lift for transfers. Hind site is 20/20 and it would have been better for me to holler for somebody to come help me than to adjust (the resident) by myself".  An interview, on 04/09/10 at 1:10 PM, with the Director of Nursing (DON) revealed she was called to the room and was informed the resident had slipped out of the lift. The resident was lying on the floor as she entered the room. She stated, "The resident was to be transferred with a lift and the assistance of two staff. The CNA did not follow the resident's care plan. Staff should be reviewing the CNA care cards prior to going out to the floor to provide care. I would expect the staff to review the care cards before providing care because things change."	F 282			
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES  The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  This REQUIREMENT is not met as evidenced by: Based on interviews and record reviews, it was determined the facility failed to provide adequate supervision and ensure the resident environment was as free of accident hazards as is possible for	F 323	F 323 The center will ensure that the resident's environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.  <u>With respect to resident(s) affected by the alleged deficient practice:</u> Resident #9 was immediately assisted back to bed and a head to toe assessment completed by licensed nurse. No injury was noted. Resident #9's care plan/cna care card was		

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F 323	<p>Continued From page 4 one resident (#9), in the selected sample of 15.</p> <p>On 03/01/10 at 10:30 AM, Resident #9 fell from a mechanical lift pad and sustained no injury. One CNA was assisting the resident. The resident's care plan interventions revealed two staff were required for assistance with transfers and the use of the mechanical lift. Findings include:</p> <p>A record review revealed Resident #9 was admitted to the facility with diagnoses to include Depressive Disorder, Multiple Sclerosis, and Bipolar Disorder.</p> <p>A review of the quarterly Minimum Data Set (MDS), dated 01/26/10, revealed the facility assessed and identified the resident as independent in decision making and requiring extensive assistance of two staff members for transfers using a mechanical lift. A review of the care plan entitled "Potential for falls," dated 06/26/07 and updated 03/01/10, and the Nurse Aide Care Card revealed interventions specified that two staff members would provide assistance with transfers and the use of a mechanical lift.</p> <p>A review of the Nurse's Notes, dated 03/01/10 at 10:30 AM, revealed the nurse was called to the resident's room and Certified Nursing Assistant (CNA) #1, the medication nurse and the Assistant Director of Nursing (ADON) were present. The resident was observed seated on the floor on his/her buttocks. CNA#1 informed the nurse the lift pad had become unaligned beneath the resident during the shower and the resident was leaning over the arm of the chair to the left side. CNA #1 connected the lift pad to the mechanical lift without assistance and raised the resident</p>	F 323	<p>reviewed by the Assistant Director of Nursing on 3/2/10. The resident was care planned to be transferred by mechanical lift with assist of two staff, which remain to be the safest mode of transfer for resident.</p> <p><u>With respect to residents having the potential to be affected by the alleged deficient practice:</u> On 4/9/10, residents care plan and CNA care cards requiring transfer assist with mechanical lift were reviewed by the interdisciplinary team to ensure staff assistance of two is provided during transfers.</p> <p><u>With respect to measures to effect systemic changes to ensure the alleged deficient practice does not recur:</u> Staff re-education was completed by SDC on 4/27/10 for F323, which included the following incidents and accidents, care plans/ cna care cards, positioning, and mechanical lift transfers with assist of two. CNA was re-educated on 3/2/10 on mechanical lift transfers by the Assistant Director of Nursing. The Licensed Nurse will ensure the care plan is followed with assist of two.</p>	

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F 323	<p>Continued From page 5</p> <p>approximately two inches. Resident #9 leaned further to the left and fell sideways from the lift pad and landed on top of CNA #1. CNA #1 told the nurse she grabbed the resident's leg and eased him/her to the floor and called for help.</p> <p>An interview with Resident #9, on 04/08/10 at 3:08 PM, revealed the resident was in the shower chair with the lift pad underneath. The lift pad was not straight. CNA #1 connected the pad to the mechanical lift and raised him/her up. The resident stated he/she was going to tell the CNA, "This lift feels funny", and then he/she fell out of the lift pad. The resident stated the CNA caught him/her and prevented him/her from striking the floor. Resident #9 stated, "(CNA #1) was trying to transfer me to the bed so she could get me dressed. (CNA #1) was by herself when she tried to transfer me. They usually have two people with the lift when they transfer me". Resident #9 stated he/she did not get hurt and no one had transferred him/her by themselves before. Resident #9 stated, "She just thought she could get me in the bed by herself".</p> <p>Interviews with CNA #1, on 04/09/10 at 8:58 AM and 3:13 AM, revealed she was with the resident when the resident fell from the lift pad. She had given the resident a shower and returned him/her to the bedroom. When they got to the bedroom, Resident #9 was leaning to one side and the CNA wanted the resident to be in the sling completely. CNA #1 connected the lift pad to the mechanical lift and raised the resident approximately two inches to adjust the lift pad, when Resident #9 leaned further out and fell. She stated she caught the resident and eased him/her to the floor. CNA #1 stated she screamed for help. She stated she knew the resident required the assistance of two</p>	F 323	<p><u>With respect to how the facility will monitor performance to ensure that solutions are sustained:</u></p> <p>To monitor performance and to ensure that the solutions are sustained Nursing Management will audit four care plans per week for three weeks to ensure the plan of care is followed for transfers as indicated. The results will be submitted to the Performance Improvement Committee for review with recommendations and ongoing monitoring as indicated.</p> <p>5. Completion date</p>	5/1/10

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F 323	<p>Continued From page 6</p> <p>staff with a mechanical lift for all transfers. She stated she wanted to get the resident back to bed, finish drying him/her off, get him/her dressed, and back in the wheelchair. She stated, "Hind site is 20/20. It would have been better to holler for somebody to come help me than try to do it all by myself".</p> <p>An interview with Licensed Practical Nurse (LPN) #1, on 04/08/10 at 10:45 AM, revealed CNA #1 made the decision to hook the resident up to the mechanical lift and reposition him/her by herself without asking for help from another staff member. She asked the resident if he/she was hurt and Resident #9 stated "no". LPN #1 stated she assessed the resident while the resident was on the floor and then four staff members assisted the resident to bed. She stated CNA #1 should have had another staff member with her to transfer the resident. The resident required the assistance of two staff with the mechanical lift for all transfers and CNA #1 did not follow the resident's plan of care.</p> <p>An interview with the Director of Nursing (DON), on 04/09/10 at 1:10 PM, revealed she was called to the resident's room and was informed the resident had slipped out of the lift. CNA #1 was in the room and told her she was trying to raise the resident up by herself to readjust the lift pad. The resident slid out of the lift pad after CNA #1 hooked him/her up and raised him/her up by herself. The DON stated CNA #1 did not follow the resident's care plan which resulted in the resident receiving minor injuries (redden area to calf, ankle, foot, and buttocks). Resident #9 was supposed to be transferred with the assistance of two staff members and the mechanical lift. The DON stated, "CNAs should be reviewing CNA</p>	F 323			

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F 323	Continued From page 7 care cards prior to going out to the floor to provide care. I would expect the staff to review and follow the care cards before providing care."	F 323			

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K 000	INITIAL COMMENTS  A Life Safety Code survey was initiated and conducted on 04/07/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) and found the facility not in compliance with NFPA 101 Life Safety Code 2000 Edition. Deficiencies were cited with the highest deficiency identified at an F.	K 000	The plan of correction is being submitted in compliance with specific regulatory requirements. Neither its completion nor content is to be construed as an admission by the provider of the validity of any findings or citations contained herein.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4  This STANDARD is not met as evidenced by: Based on observation and interview conducted on 04/07/10, it was determined the facility failed to ensure that the space between the ceiling and the trim ring was flush or filled with a material capable of limiting the transfer of smoke as required by NFPA 8.3.1.  The findings include:  Observations during the Life Safety Code inspection on, 04/07/10 between 9:30 AM and 11:30 AM, revealed the trim rings on the sprinkler	K 025	<b>K025</b> 1. Sprinkler heads throughout 300 and 400 halls were sealed by an outside contractor, KR Associates on 4/9/09.  2. Sprinkler heads have been visually inspected throughout the facility by KR Associates by 5/1/10 to ensure proper maintenance in accordance with NFPA 101 Life Safety Standard.  3. Maintenance Supervisor will maintain sprinkler heads per Preventative Maintenance Schedule.  4. Housekeeping/Maintenance Supervisor will conduct audits per the maintenance schedule. Issues found will be taken to the Administrator immediately and addressed with the Performance improvement Committee for three months for further recommendations. 5. Completion date	5/1/10

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

*Michelle Hoover, Interim Administrator*

TITLE

(X6) DATE

4/30/10

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K 025	Continued From page 1 heads throughout the 300 hall and 400 hall did not fit flush to the ceiling, allowing a quarter inch gap between the ceiling and the rings. The space between the ceiling and trim was not filled with a material that would limit the transfer of smoke.  An interview conducted with the Maintenance Director, on 04/07/10 at 11:30 AM, revealed he was not aware of the space between the ceiling and trim ring for the sprinkler head.	K 025		
K 062 SS=D	<b>NFPA 101 LIFE SAFETY CODE STANDARD</b>  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on observation and staff interview conducted on 04/07/10, it was determined the facility failed to ensure sprinkler heads were free of paint as required by NFPA 25 1999 Edition.  The findings to include:  A tour of the facility, conducted 04/07/10 at 11:00 AM, revealed six sprinkler heads on the front porch were stained with a brown substance.  An interview with the Maintenance Director, on 04/07/10 at 11:05 AM, revealed he was aware of the brown substance on the sprinkler heads.  Reference to: NFPA 25 1999 Edition 2-2 Inspection.	K 062	<b>KO62</b> 1. Premier, an outside contractor was contacted and came to center on 4/28/10 to inspect and repair/replace sprinklers on the front porch.  2. All sprinklers throughout the center were inspected by Premier to ensure compliance with NFPA 13, NFPA 25, 9.7.5  3. Administrator will receive bids to replace sprinkler heads, as indicated. Maintenance Supervisor will maintain sprinkler heads per Preventative Maintenance Schedule  4. Housekeeping/Maintenance Supervisor will conduct audits per the maintenance schedule. Issues found will be taken to the Administrator immediately and addressed with the Performance Improvement Committee for three months for further recommendations.  5. Completion date	5/1/10

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185012	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  04/07/2010
NAME OF PROVIDER OR SUPPLIER  HILLSIDE VILLA CARE AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 1500 PRIDE AVENUE MADISONVILLE, KY 42431		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 062	Continued From page 2 2-2.1 Sprinklers. 2-2.1.1* Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation.	K 062			
K 135 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD  Flammable and combustible liquids are used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals. Storage cabinets for flammable and combustible liquids are constructed in accordance with NFPA 30, Flammable and Combustible Liquids Code, NFPA 99. 4.3, 10.7.2.1.  This STANDARD is not met as evidenced by: Based on observations and staff interviews, conducted on 04/07/10, it was determined the facility failed to properly store flammable and combustible liquids.  The findings include:  Observations during the Life Safety Code inspection, on 04/07/10 at 9:45 AM, revealed seven cans of deep gloss and two cans of oven cleaner were stored on a cart in the laundry. Five cans of hair spray were stored in a wooden	K 135	K 135  1. Cans of deep gloss, oven cleaner and hair spray were discarded on 4/9/10.  2. Housekeeping checked rooms throughout the center on 4/9/10 to ensure compliance with NFPA 99. 4.3, 10.7.2.1  3. Flammable and combustible liquids will now be stored in an outside storage building.  4. Housekeeping will conduct random audits and submit to the Performance Improvement Committee for three months for further recommendations.  5. Completion date	5/1/10	

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K 135	Continued From page 3 cabinet in the beauty shop. The label on the above items stated combustible, danger, extremely flammable. All flammable materials shall be stored in a flammable proof cabinet  An interview conducted with the Maintenance Director, on 04/07/10 at 10:00 AM, revealed the facility did not have a flammable proof cabinet	K 135			