

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

PRINTED: 12/23/2015
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | (X3) DATE SURVEY COMPLETED R 12/22/2015 |
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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 |
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| {F 000} | <p>INITIAL COMMENTS</p> <p>An onsite re-visit was concluded on 12/22/15 and found the facility in compliance on 11/18/15 as alleged in their PoC.</p> | {F 000} | | |
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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 BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 |
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| F 000 | INITIAL COMMENTS A Recertification Survey was initiated on 10/13/15 and concluded on 10/15/15 with deficiencies cited at the highest scope and severity of a "G". The facility failed to have an effective system to ensure supervision and assistive devices to prevent accidents was provided per the residents' plan of care for three (3) residents. The residents sustained falls with injury. | F 000 | Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. | |
| F 250 SS=D | 483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to have a system in place to ensure Social Services assisted residents with discharge planning, and provided assistance with independent living arrangements for two (2) of sixteen (16) sampled residents (Residents #1 and #8). In addition, the facility also failed to ensure resident needs were met to reinforce self confidence for one (1) of one (1) unsampled residents (Unsampled Resident A). The facility failed to provide any evidence they made referrals to outside agencies for assessment for independent living for Resident #1 and Resident #8 after they had expressed a | F 250 | 1. Resident #1 no longer resides at the facility. Resident #8 was referred to Kentucky Transitions on 10-12-15 and 10-13-15 by the Social Services Director (SSD). Un-sampled Resident A now uses an aerosol hairspray and has received education as well as support from the SSD on 11-2-15 and 11-9-15. 2. Residents discharging from the facility have the potential to be affected by not ensuring Social Services assist residents with discharge planning and providing assistance with independent living arrangements. Residents who reside in the facility have the potential to be affected by not completing an assessment and finding options to meet the resident's needs. | 11-18-2015 |

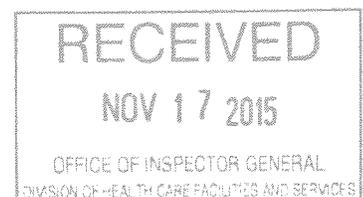
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| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i> | TITLE <i>Executive Director</i> | (X6) DATE <i>11/16/2015</i> |
|---|------------------------------------|--------------------------------|

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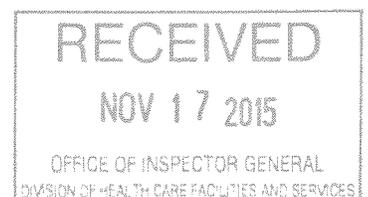
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| F 250 | <p>Continued From page 1</p> <p>desire to discharge from the facility to independent living.</p> <p>The facility failed to complete an assessment and find options that most met the needs of Unsamped Resident A who took pride in his/her appearance, but was no longer able to use a pump hairspray to maintain the desired hair style due to the physical limitation in their hands and could only use aerosol can hair spray. As a result, Unsamped Resident A had a decrease in attendance to group and social activities.</p> <p>The findings include:</p> <p>The facility did not provide a policy regarding Discharge Planning.</p> <p>The facility did not provide a policy regarding Social Service's Responsibilities.</p> <p>Review of the facility's policy regarding Episodic Notes, dated 11/30/14, revealed the facility would keep resident records current, and updated by documenting any incidents, unusual happenings, behaviors, complaints, and referrals for services. The policy further stated the facility would keep that documentation recorded in the Social Service Progress Notes.</p> <p>1. Review of Resident #1's record revealed the facility admitted the resident on 06/25/15, with diagnoses which included Quadriplegia and Quadriparesis, Pressure Ulcer to Lower Back, Chronic Pain, Renal Failure, Chronic Respiratory Failure, Depression, and Anxiety.</p> <p>Review of Resident #1's Minimum Data Set (MDS) assessment, completed on 09/21/15,</p> | F 250 | <p>The Corporate Administrative Registered Nurse interviewed the Department Managers regarding residents with a desire to be discharged from the facility on 10-20-15. From that interview, ten residents were identified as having expressed a desire to be discharged from the facility. The SSD will follow up with these ten residents and their discharge planning needs by November 13, 2015.</p> <p>Residents with a Brief Interview for Mental Status (BIMS) score of twelve or greater will be interviewed by the SSD and asked if their needs are being met by November 13, 2015.</p> <p>3. The Corporate Administrative Registered Nurse will re-educate the Social Services Director (SSD) and the Executive Director on the regulation F250 as well as the facility's discharge planning policy by November 13, 2015. Competency was determined by successful verbalization to the Corporate Administrative Registered Nurse.</p> | | |



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| F 250 | <p>Continued From page 2</p> <p>revealed the facility assessed Resident #1 as requiring the extensive two (2) person physical assistance to complete Activities of Daily Living (ADL) and transfers. The facility completed a Brief Interview for Mental Status (BIMS) examination with the resident scoring fifteen (15) out of fifteen (15), which indicated the resident was interviewable.</p> <p>Review of the Care Plan pertaining to discharge planning, dated 07/06/15, revealed the resident wanted to return to independent living. Interventions stated the Social Service's staff was to assist the resident with obtaining community resources for discharge as well as assisting the resident to obtain a place to live.</p> <p>Review of the Social Service's Progress Review, dated 07/06/15, revealed Resident #1 stated goal was to return to the community. Social Service's staff did not document any referrals to outside resources to arrange for discharge planning.</p> <p>Review of the Social Service's Progress Review, dated 09/21/15, revealed Social Service's noted Resident #1 continued to want to seek independent living in the community. Under the section for Referral Status revealed Social Service's staff documented none at this time.</p> <p>Review of the Interdisciplinary Progress Notes, dated 10/12/15, revealed the Interdisciplinary Team met with the resident to discuss the care plan. The note stated the resident expressed wanting to eventually return to the community.</p> <p>Interview with Resident #1, on 10/13/15 at 4:00 PM, revealed the resident attended care plan meetings and had discussed wanting to move out</p> | F 250 | <p>4. The SSD/ED will conduct QI monitoring of the regulation F 250 to ensure Social Services assist residents with discharge planning and conducts assessments to meet the resident's needs. QI monitoring will be conducted via resident interviews and resident medical record documentation using a sample size of 5 random residents five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained. The SSD/ED will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> | | |



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| F 250 | <p>Continued From page 3 of the facility. The resident stated he/she had expressed a desire to move back into independent living and even discussed looking into moving to another nursing facility. Resident #1 stated as far as he/she knew, the facility had taken no actions to assist in relocating to another nursing home or to independent living.</p> <p>Interview with the Social Service's Director (SSD), on 10/14/15 at 2:25 PM, revealed the responsibilities of the SSD was to assist residents to attain and maintain their highest practicable well-being, including discharge planning. She stated she did not have a process to ensure she followed up with each resident to ensure the facility had met all of their needs. However, she did state she met with each resident at least quarterly to complete assessments and attended Interdisciplinary Team (IDT) meetings to discuss the entire care of each resident.</p> <p>The Social Service Director further stated it was her responsibility to complete referrals to outside agencies for discharge planning. Discharge planning was a part of the SS assessment completed upon intake. However, since Resident #1 was part of the Long Term Care, the facility would not automatically assess the resident for discharge status. Resident #1 did have a history of discussing wanting to leave the facility.</p> <p>However, the Social Service Director stated she had not made a referral to the outside agency that assisted with finding independent housing options for long-term care residents. She stated she did not make the referral because she believed the resident had told her that he/she had worked with that particular agency in the past. The Social Service Director stated she did not</p> | F 250 | | |
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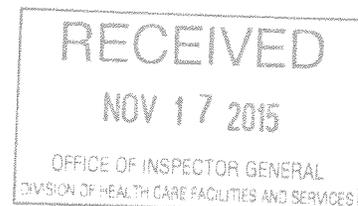
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| F 250 | <p>Continued From page 4</p> <p>document these conversations or the content of the conversations. She did not document where the resident wanted to go or any other information pertinent to discharge planning.</p> <p>Interview with the Director of Nursing (DON), on 10/15/15 at 6:00 PM, revealed the DON was not aware the SSD was not making referrals to outside agencies regarding discharge into the community. She stated that was a concern because residents should not have to continue to live in long term care if a lower level of care was warranted.</p> <p>2. Review of the Clinical Record for Resident #8 revealed the facility admitted the resident on 09/23/14 with Allergic Rhinitis, Benign Paroxysmal Positional Vertigo, Chronic Airway Obstruction, General Osteoarthritis Involving Multiple Sites, Lumbago, Personal History of Falls, Difficulty in walking, Muscle Weakness (Generalized), Abnormality of Gait, Lack of Coordination, and Unspecified Sinusitis.</p> <p>Review of Resident #8's Quarterly Minimum Data Set (MDS) assessment, completed on 06/22/15, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) out of fifteen (15), indicating the resident was interviewable.</p> <p>Review of the Comprehensive Care Plan for Resident #8 revealed the facility failed to develop a discharge care plan after admission and after self reported conversations with the SSD and Resident #8, with updated goals and target dates for discharge back into the community.</p> <p>Review of the Care Plan for Resident #8 dated</p> | F 250 | | |
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| F 250 | <p>Continued From page 5</p> <p>10/04/15, 10/06/15, 10/08/15, 01/07/15, 07/30/15, 08/04/15, 08/12/15, 08/21/15, and 09/01/15, revealed the facility failed to address discharge planning with Resident #8 regarding returning back to the community.</p> <p>Interview with Resident #8, on 10/13/15 at 5:30 PM, revealed he/she wanted to be discharged from the facility. The resident stated he/she was had been trying to move out of the facility, but was not allowed to move due to having Vertigo.</p> <p>Review of the Social Service Notes, dated 06/23/15 thru 08/06/15, revealed no documentation that the facility kept the family apprised of the progress of the discharge decisions and placement of the resident back into the community. Review of Resident #8's pre-transitional referral information confirmation faxed dated, 10/13/15 revealed the referral was imitated on 10/13/15.</p> <p>Interview with the Social Service Director (SSD), on 10/14/15 at 2:20 PM, revealed she was responsible for all social service needs for the residents residing in the facility. The SSD stated she had been employed at the facility for approximately five (5) months. The SSD stated she was aware of the wishes of Resident #8 to move out of the facility based on undocumented conversations with the resident on several occasions. The SSD further stated the resident would go back and forth wanting to leave the facility then wanting to stay in the facility. The SSD stated she faxed Resident #8's pre-transitional referral information on 10/12/13.</p> <p>Interview with the Administrator, on 10/15/15 at 6:30 PM, revealed he was not aware the SSD</p> | F 250 | | |
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| F 250 | <p>Continued From page 6</p> <p>had not completed referrals for discharge for residents wishing to return to independent living or lower level of care.</p> <p>3. Review of Unsampled Resident A's record revealed the facility admitted the resident on 04/23/14 with diagnoses of Chronic Respiratory Failure, Arthritis, Hypertension, Non-Alzheimer's Dementia, and Anxiety Disorder. The resident received oxygen therapy.</p> <p>Review of Unsampled Resident A's Minimum Data Set (MDS) assessment, completed on 08/11/15, revealed the resident functioned independently or required supervision or one person physical assist to complete ADL activities. The facility conducted a Brief Interview for Mental Status (BIMS) exam during the assessment with a score of fifteen (15) out of fifteen (15) meaning the resident was interviewable.</p> <p>Review of the Social Service Progress Review, dated 08/24/15, revealed the resident spent much of his/her time in the room and had periods of feeling or appearing down, depressed, or hopeless.</p> <p>Review of the care plan for Unsampled Resident A, with a review date of 07/03/15, revealed no interventions for the resident to use aerosol hairspray.</p> <p>Review of the Care Conference Record for Unsampled Resident A, dated 09/01/15, revealed the resident and the resident's family attended a Care Conference on 09/01/15 at the facility.</p> <p>Review of the Interdisciplinary Progress Note, dated 09/01/15, revealed the Interdisciplinary</p> | F 250 | | |
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| F 250 | <p>Continued From page 7</p> <p>Team met with the resident and the resident's family member to review the care plan. The Social Services Director completed this note and stated the resident would remain in the facility for Long Term Care. The note did not discuss any details of the meeting, discussions from the meeting, or changes to the care plan.</p> <p>Interview with Unsampled Resident A, on 10/15/15 at 10:00 AM, revealed the facility would not allow the resident to use aerosol hair spray on his/her hair. The resident stated his/her hair was a source of their pride and they enjoyed looking good every day. The resident further stated he/she was unable to use hair spray from a pump bottle due to arthritis in his/her hands. The resident's family had previously brought hairspray in an aerosol can to the resident, but the facility discussed with them the use of aerosol products was prohibited due to safety reasons and that the resident could not have it. The resident stated he/she felt naked without his/her hair looking nice and often stayed in his/her room instead of attending activities because he/she felt embarrassed.</p> <p>Interview with RN #2, on 10/15/15 at 10:35 AM, revealed nursing reported any resident requests for non-nursing items and services to the Social Service's staff. RN #2 further stated the facility allowed residents to use items deemed hazardous if the facility assessed the resident for safety and placed it on the resident's care plan. RN #2 stated the facility prohibited aerosol cans in resident's rooms because they could be hazardous to a resident's health. However, there was no reason why the facility could not have placed hair spray on a resident's care plan and kept the hair spray in a safe location for the</p> | F 250 | | | |

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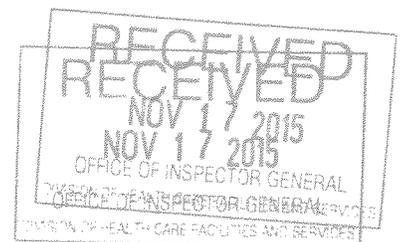
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| F 250 | <p>Continued From page 8 resident.</p> <p>Interview with Activity Director, on 10/15/15 at 11:00 AM, revealed the facility could allow a resident the use of a prohibited item if the facility placed that item on the resident's care plan. For example, the facility prohibited the use of aerosol cans; however, Unsampld Resident A had limited use of his/her hands that made using non-aerosol hairspray products not possible. The facility could have assessed the resident for safety and kept a can of aerosol hair spray in a safe location.</p> <p>Interview with the Social Service's Director, on 10/14/15 at 2:25 PM, revealed the responsibilities of the SSD was to assist residents to attain and maintain highest practicable well-being. She stated she did not have a process to ensure she followed up with each resident to ensure the facility had met all of their needs. However, she did state she met with each resident at least quarterly to complete assessments and attended Interdisciplinary Team (IDT) meetings to discuss the entire care of each resident.</p> <p>Further interview with the SSD, on 10/15/15 at 1:00 PM, revealed she spoke with Unsampld Resident A and the resident's family at the last care plan meeting about the possibility of obtaining aerosol cans for the resident. The SSD stated she did not document the conversation in the notes. She also did not follow up by placing on the care plan or discussing the need with nursing.</p> <p>Interview with the DON, on 10/15/15 at 6:00 PM, revealed the DON was not aware of Unsampld Resident A's desire to use aerosol hairspray. She</p> | F 250 | | |
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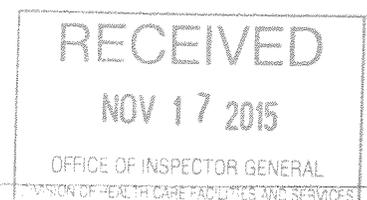
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/15/2015 |
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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| F 250 | Continued From page 9 stated due to possible dangers, the facility may not allow the resident to keep the hairspray in his/her room. However, the facility may be able to care plan and make other arrangements to ensure the resident had access to the item while still ensuring the safety of all of the residents. The DON stated this would fall under the scope of Social Services. She stated this situation was a concern because the item would fulfill the resident's psychosocial need. Continued interview with the Administrator, on 10/15/15 at 6:30 PM, revealed the Social Service Director should have been meeting with each resident more than one time per quarter to ensure the facility assessed or accessed all needed items, services, and referrals for each resident. He stated that was a problem because not completing these items did not support the psychosocial wellbeing of the residents. | F 250 | | | |
| F 282 SS=G | 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, record review, and review of the facility's policy, it was determined the facility failed to have a system in place to ensure the staff provided care in accordance with the Comprehensive Plan of Care for three (3) of sixteen (16) sampled residents (Residents #6, #12, and #13). Certified Nursing | F 282 | 1. On 11-12-15, Resident #6 was assessed by the Director of Clinical Services (DCS) to ensure safety interventions were in place and the plan of care was being followed. No issues were identified at that time. On 11-13-15, the Director of Clinical Services (DCS) re-educated Licensed Practical Nurse (LPN) #3 on the plan of care for Resident #6 and re-educated on supervision including the supervision of Certified Nursing Assistants (CNAs) to ensure the resident's plan of care is followed. Certified Nursing Assistant (CNA) #5 is no longer employed at the facility. | 11-18-2015 | |

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| F 282 | <p>Continued From page 10</p> <p>Assistant (CNA) #5 failed to follow Resident #6's care plan which stated the staff was to assist with meals and place fall mats next to the bed which resulted in a fracture from a fall. CNA #2 failed to utilize two assistants when care was provided to Resident #12 during a bed bath that resulted in a fall with a fracture. Resident #13's care plan stated staff was to utilize a wheelchair for transport only and transfer the resident to a mat or bean bag chair. Staff found Resident #13 on the floor face down with a bloody nose and cut lip.</p> <p>The findings include:</p> <p>Review of the facility's policy regarding Plans of Care, dated 09/01/15, revealed an interdisciplinary care plan would be established for each resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. Direct care staff would be aware, understand and follow their Resident's Plan of Care.</p> <p>Review of the facility's policy regarding the Nurse Tech Information Kardex, dated 11/30/14, revealed a Nurse Tech Information Kardex would be completed by the Unit Manager or Care Plan Coordinator or designee for each resident. The Nurse Tech would utilize the Kardex as a resource to provide care.</p> <p>1. Review of the medical record for Resident #6 revealed the facility admitted the resident on 09/22/10 with diagnoses of Alzheimers, Insulin Dependent Diabetes Mellitus, Osteoarthritis and Hypertension.</p> | F 282 | <p>On 11-12-15, Resident #12 was assessed by the DCS to ensure safety interventions were in place and the plan of care was being followed; no issues were identified at that time. The DCS will re-educate CNA #2 to follow the resident's plan of care by 11-15-15. The re-education will include notifying the supervisor when given directions contradicting the resident's plan of care.</p> <p>On 11-12-15, Resident #13 was assessed by the DCS to ensure safety interventions were in place and the plan of care was being followed; no issues were identified at that time. Resident #13 was assessed by the physician on 10-29-15 and no acute distress was noted at that time.</p> | | |



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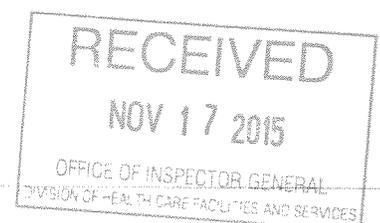
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| F 282 | <p>Continued From page 11</p> <p>Review of the Annual Minimum Data Set Assessment, dated 02/14/15, revealed the facility staff assessed Resident #6 as needing extensive assistance of two (2) persons with bed mobility and limited assistance of one (1) person with toileting and eating. Resident #6 was assessed by the facility using the Brief Interview for Mental Status (BIMS) and scored a three (3), meaning he/she was not interviewable.</p> <p>Review of the comprehensive care plan for Resident #6, dated 02/27/15 and reviewed on 05/06/15 and 07/11/15, revealed he/she was at risk for falls/injury. The facility set a goal to maintain preventative measures and manage any fall related injuries thru the next review. Resident #6 was care planned for assistance with turning and repositioning, fall mats were to remain at the bedside and staff was to provide assistance to the toilet before and after meals. The staff was to provide assistance with meals in the dining room and removal from dining room for toileting immediately following meals.</p> <p>Review of the Fall Root Cause Investigation Report Form for Resident #6, revealed he/she experienced a fall on 07/11/15, while pushing the over the bed table away from the bed. The fall mat was not at the bedside at the time of the fall. The fall mat was moved to accomodate the over the bed table. Changing the fall mat to a beveled mat was the intervention put in place to minimize future fall occurrences.</p> <p>Review of the Bowel and Bladder report, dated 07/11/15, revealed Resident #6 had an episode of incontinence at 4:08 AM, but there was no further documentation by the CNAs regarding the toileting of Resident #6 for the remainder of the</p> | F 282 | <p>2. Residents who reside in the facility have the potential to be affected by not providing care in accordance to the resident's comprehensive plan of care.</p> <p>The (IDT) Interdisciplinary Team (consisting of two or more of the following: Director of Clinical Services, Social Services Director, Activity Director, Therapy Director, Dietary Manager, Licensed Nurse, Minimum Data Set Nurse, Unit Manager, Executive Director) will review and update, if indicated, the care plans for in-house residents by November 15, 2015.</p> <p>3. The Corporate Administrative Registered Nurse/Regional Director of Clinical Services (RDCS) will re-educate the Department Mangers on the regulation F282 and the facility's care plan policy by November 13, 2015. The DCS/Nurse Manager will re-educate the nursing staff by November 15, 2015 on the facility's care plan and Nurse Tech Kardex policies emphasis will be placed on following the resident's written plan of care. The staff will complete a posttest to demonstrate understanding of the education.</p> | | |

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| F 282 | Continued From page 12 day. Telephone interview with the Interim Director of Nursing, on 10/15/15 at 11:49 AM, revealed she investigated Resident #6's 07/11/15 fall. She had concluded that CNA #5 brought Resident #6's dinner tray to his/her room, moved the fall mat aside to roll the over the bed table in place, left the dinner tray on his/her table. Per the investigation, it was determined CNA #5 did not assist Resident #6 with his/her meal or collect the tray. CNA #5 did not reposition the over the bed table; did not return the fall mat to the bedside; and, did not toilet Resident #6 following his/her meal as care planned. The facility provided an incorrect phone number for CNA #5, according to the individual answering that phone on 10/15/15 at 9:14 AM. No one responded to the two (2) voice mail messages left at CNA #5's emergency contact number, at 9:45 AM and 1:00 PM on 10/15/15. Interview with CNA #4, on 10/15/15 at 10:00 AM, revealed she always got Resident #6 up and out of bed as soon as Resident #6 woke up, otherwise he/she tried to get up by himself/herself and would fall. CNA #4 stated she finds out from the Kardex how to care for her assigned residents. Interview with LPN #3 by phone, on 10/15/15 at 9:18 AM, revealed he utilized the individualized plans of care to guide him in the care of his assigned residents. Interview with Unit Manager #1, on 10/15/15 at 9:00 AM, revealed the Plans of Care were everyone's responsibility. Care plans were | F 282 | 4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 282 to ensure the resident's care plan is followed. QI monitoring will be conducted randomly across all shifts via staff observation and resident medical record documentation using a sample size of 5 random residents five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained. The DCS/Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring. | |



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| F 282 | <p>Continued From page 13</p> <p>communicated to the CNAs through the Kardex and she made rounds on the staff to ensure interventions were implemented; however, she did not document those rounds.</p> <p>2. Review of the clinical record for Resident #12, revealed the facility re-admitted the resident on 08/02/12 with diagnoses of Other Specific Muscle Disorder, Esophageal Reflux, Malignant Neoplasm Bronchus and Lung, Rheumatoid Arthritis, Heart Disease, Hypertension, Gout, Osteoporosis, and Benign Paroxysmal Positional Vertigo.</p> <p>Review of the Quarterly Minimum Data Set Assessment, dated 06/22/15, revealed the facility assessed Resident #12 as interviewable with a score of twelve (12) on the Brief Interview for Mental Status. In addition, the resident required extensive assistance of two (2) staff for bed mobility.</p> <p>Review of Resident #12's comprehensive care plan, dated 01/20/15, with a target date of 10/03/15, revealed the resident was care planned for self-care deficit related to immobility syndrome and for all care needs to be provided with two (2) staff members.</p> <p>Review of Resident #12's Kardex, not dated, revealed the resident was an assist of two (2) for bed mobility.</p> <p>Review of the Fall Root Cause Investigation Report, dated 09/01/15, revealed Resident #12</p> | F 282 | | |
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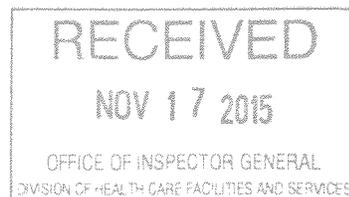
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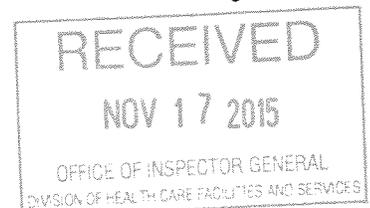
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| F 282 | <p>Continued From page 14</p> <p>rolled from the bed onto the floor during a bed bath and was sent to the acute hospital for assessment. The resident sustained right distal femur fracture.</p> <p>Interview with CNA #2, on 10/15/15 at 11:20 AM, revealed she checked the Kardex and was aware two (2) staff was to be present when providing care for Resident #12. She stated CNAs on the unit told her she would not need help because Resident #12 was able to roll himself/herself using the bed rails. She stated she gave the resident a bed bath and while she was changing the sheets, the resident rolled to the side of the bed and kept rolling and fell to the floor.</p> <p>Interview with LPN #1, on 10/15/15 at 2:15 PM, via telephone revealed she monitored care plans were followed by correcting the CNAs if she saw them do something wrong. However, she was unsure how many staff was needed to provide care for Resident #12.</p> <p>Interview with the A and D Hall Unit Manager (UM), on 10/15/15 at 2:25 PM, revealed Resident #12 required two (2) staff when care was provided. She stated she educated CNA #2 on checking the Kardex for assist required for resident care. She further stated she monitored care plans were being followed by sitting on the units frequently watching staff, doing rounds, and every week she would pick a different staff member and observe them completing tasks.</p> <p>Interview with Resident #12, on 10/15/15 at 2:50 PM, revealed two (2) CNAs were usually present when he/she would get a bath; however, on the</p> | F 282 | | |
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| F 282 | <p>Continued From page 15</p> <p>day of the fall, only one (1) CNA was in the room.</p> <p>3. Review of Resident #13's clinical record revealed the facility admitted the resident on 04/16/14 with diagnoses of Acute Respiratory Failure, Traumatic Brain Injury, Hypertension, Non-Alzheimer's Dementia, Falls, and Anxiety.</p> <p>Review of Resident #13's quarterly Minimum Data Set (MDS) assessment, completed on 07/31/15, revealed the facility assessed the resident as requiring extensive assistance from staff to toilet, and for all transfers. The resident required one-person supervision for locomotion in the facility. The facility assessed the resident as having been unable to complete a Brief Interview for Mental Status (BIMS) exam due to memory problems and was unable to be understood, with a score of 0, meaning the resident was not interviewable.</p> <p>Review of the Fall Root Cause Investigation Report, dated 07/30/15 at 12:00 PM, revealed the resident sustained a fall in his/her room. The facility staff found the resident on the floor in his/her room, but not on the mat provided. The investigation report stated the staff was unsure if the resident fell out of the wheelchair or if the resident transferred him/herself out of the wheelchair. No injuries were noted from this fall.</p> <p>Review of the Care Plan for Resident #13, last updated 07/20/15, revealed the facility added interventions to the care plan on 07/30/15. One intervention included nursing to allow the resident into his/her wheelchair to transfer to and from the dining room and activities only. Additional interventions included nursing staff was to assist the resident to the floor mat or beanbag chair in the resident's room when not in his/her</p> | F 282 | | | |



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| F 282 | <p>Continued From page 16</p> <p>wheelchair. The care plan further stated the resident required an assist of one (1) staff person for transfers and care. On 07/22/15, the facility discontinued an alarming seatbelt when the resident was in the wheelchair.</p> <p>Review of the Nurse Tech Information Kardex, not dated, revealed the facility identified a special need for Resident #13. Nursing staff was to use the wheelchair with the resident only for transferring to and from the dining room or activities. The Kardex also stated the resident was only to be in the wheelchair with supervision. The Kardex discussed safety measures for Resident #13, including a mat to the floor and the beanbag chair in the resident's room.</p> <p>Review of the Fall Root Cause Investigation Report, dated 09/02/15, revealed Resident #13 sustained a fall in the hallway of the facility. Next to Potential Causes, staff stated the resident was reaching for the handrail and slid off the wheelchair and onto the floor. Per the care plan the resident was only to be up in the wheelchair for transport to activities and meals with supervision of staff.</p> <p>Review of the Fall Root Cause Investigation Report, dated 09/10/15, revealed Resident #13 sustained a fall in the resident's room. Nursing staff found the resident on the floor of the room, face down with a bloody nose and a 0.5 cm cut on the inside of his/her lower lip. The facility sent the resident to the hospital. Resident #13 returned from the hospital with no injuries. On the form, staff stated they were unsure what the resident was doing prior to the fall. The staff did not implement the transfer to the mat or bean bag chair as care planned.</p> | F 282 | | | |

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| F 282 | Continued From page 17 Interview with CNA #7, on 10/15/15 at 9:47 AM, revealed CNAs provided assistance for transfers for Resident #13. The CNAs also provided supervision for Resident #13 when he/she was in the wheelchair due to a history of falls. Interview with the Unit Manager (UM) #1, on 10/15/15 at 5:50 PM, revealed Resident #13 had a history of many falls. The resident had several falls from his/her wheelchair in the hallway after reaching forward to pull along the wall. Due to all of the falls, staff was supposed to supervise the resident whenever he/she was in the wheelchair by keeping him/her in a public area of the facility and staying with him/her when ambulating in the wheelchair. However, the staff did not do this. Interview with the Administrator, 10/15/15 at 6:30 PM, revealed the facility had identified falls as an issue. He stated he expected nursing staff to follow interventions put in place and by not following the interventions could lead to resident injury. | F 282 | | | |
| F 323 SS=G | 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: | F 323 | 1. On 11-12-15, Resident #6 was assessed by the Director of Clinical Services (DCS) to ensure safety interventions were in place and the plan of care was being followed. No issues were identified at that time. On 11-13-15, the Director of Clinical Services (DCS) re-educated Licensed Practical Nurse (LPN) #3 on the plan of care for Resident #6 and re-educated on supervision including the supervision of Certified Nursing | 11-18-2016 | |

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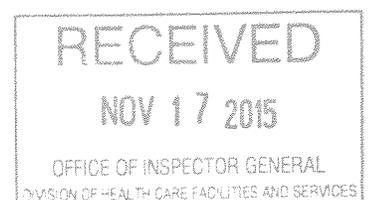
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OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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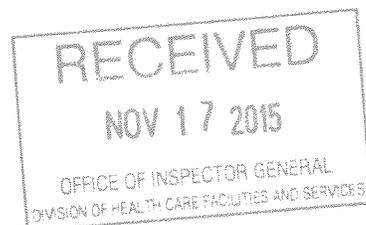
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/15/2015 |
| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| F 323 | <p>Continued From page 18</p> <p>Based on interview, record review and review of the facility's policy, it was determined the facility failed to have an effective system in place to provide supervision and assistive devices to prevent accidents for three (3) of sixteen (16) sampled residents (Resident #6, #12 and #13). Certified Nursing Assistant (CNA) #5 failed to assist Resident #6 with their meal, and failed to reposition the fall mat next to the bed that resulted in a fall and scapular fracture and subdural hematoma. The resident required hospital intervention. CNA #2 failed to utilize two assistants when providing a bed bath to Resident #12 and he/she fell from the bed onto the floor and sustained a right distal femur fracture. The resident was transported to a local hospital. Resident #13 sustained a fall on 07/30/15 and 09/02/15, without injury. On 09/10/15 the resident was found by staff face down with a bloody nose and a cut inside the lower lip. The resident was transferred to the hospital for evaluation.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure regarding Accident and Incident Investigations, dated 11/30/14, revealed a Fall Root Cause Investigation must be completed for all falls. The Fall Root Cause Investigation form included the designation of interventions minimizing future occurrences.</p> <p>1. Review of the clinical record for Resident #6 revealed the facility admitted the resident on 09/22/10 with diagnoses of Alzheimer's, Insulin Dependent Diabetes Mellitus, Osteoarthritis and Hypertension.</p> | F 323 | <p>Assistants (CNAs) to ensure the resident's plan of care is followed. Certified Nursing Assistant (CNA) #5 is no longer employed at the facility.</p> <p>On 11-12-15, Resident #12 was assessed by the DCS to ensure safety interventions were in place and the plan of care was being followed; no issues were identified at that time. The DCS will re-educate CNA #2 to follow the resident's plan of care by 11-15-15. The re-education will include notifying the supervisor when given directions contradicting the resident's plan of care.</p> <p>On 11-12-15, Resident #13 was assessed by the DCS to ensure safety interventions were in place and the plan of care was being followed; no issues were identified at that time. Resident #13 was assessed by the physician on 10-29-15 and no acute distress was noted at that time.</p> | | |



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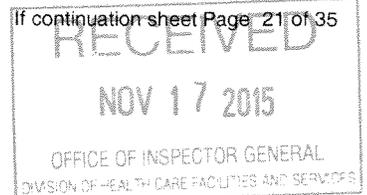
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| F 323 | <p>Continued From page 19</p> <p>Review of the Annual Minimum Data Set (MDS) Assessment, dated 02/14/15, revealed the facility assessed Resident #6 as requiring extensive assistance of two (2) persons with bed mobility and limited assistance of one (1) person with toileting and eating. The facility assessed Resident #6 using the Brief Interview for Mental Status (BIMS) and scored a three (3), indicating the resident was not interviewable.</p> <p>Review of the comprehensive care plan for Resident #6, dated 02/27/15 and reviewed on 05/06/15 and 07/11/15, revealed he/she was at risk for falls/injury. The facility set a goal to maintain preventative measures and manage any fall related injuries through next review. Resident #6 was care planned for assistance with turning and repositioning, fall mats to remain at the bedside and for assistance to the toilet before and after meals.</p> <p>Review of the Fall Root Cause Investigation Report Form for Resident #6, revealed he/she experienced a fall on 07/11/15 with no time documented, while pushing the over the bed table away from the bed. The facility changed the fall mat to a beveled mat as the intervention put in place to minimize future fall occurrences.</p> <p>Review of the Situation Background Assessment Recommendation Communication Form, dated 07/11/15, revealed a fall on 07/11/15, resulting in a laceration above the resident's right eye.</p> <p>Review of the Nursing Home to Hospital Transfer Form, dated 07/11/15, revealed the facility obtained vital signs at 10:38 PM for Resident #6, and revealed he/she was transferred to the</p> | F 323 | <p>2. Residents who reside in the facility have the potential to be affected by not providing supervision and assistive devices to prevent accidents. On 11-4-15, the IDT (consisting of two or more of the following: Director of Clinical Services, Social Services Director, Activity Director, Therapy Director, Dietary Manager, Licensed Nurse, Minimum Data Set Nurse, Unit Manager, Executive Director) reviewed residents with a fall in the last sixty days (9/04-11/04/15) to ensure fall prevention interventions were in place, appropriate for the resident and documentation was present in the medical record. Additionally, the DCS reviewed the Fall Root Cause Investigation Forms to ensure the documentation was complete. Any issues identified were corrected.</p> <p>3. The Corporate Administrative Registered Nurse re-educated the Department Managers on the regulation F323 on October 23, 2015. The Corporate Administrative Registered Nurse/RDCS will re-educate the Department Managers on the facility's accident and incident investigation policy by November 13, 2015. The DCS/Nurse Manager will re-educate the nursing staff on resident supervision as well as accident and incident prevention and investigation by November 15, 2015. The staff will complete a post test to demonstrate understanding of the education.</p> | | |



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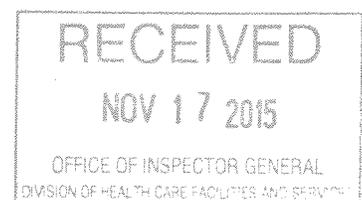
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| F 323 | <p>Continued From page 20 Emergency Department on 2nd shift.</p> <p>Review of the staffing sheets, dated 07/11/15, revealed CNA #5 and Licensed Practical Nurse (LPN) #3 were assigned to Hall C and Resident #6 when the resident fell.</p> <p>The facility provided an incorrect phone number for CNA #5, according to the individual answering that phone on 10/15/15 at 9:14 AM. No one responded to the two (2) voice mail messages left for CNA #5's emergency contact at 9:45 AM and 1:00 PM on 10/15/15.</p> <p>Interview with LPN #3 by phone, on 10/15/15 at 9:18 AM, revealed he took care of Resident #6 on the 2nd shift on 07/11/15. He stated Resident #6 was in bed prior to his/her fall, but did not recall the time of the incident and was unsure of what paperwork was completed following the incident. LPN #3 stated he heard Resident #6's bed alarm sounding and the sound of the fall, which alerted him to Resident #6's distress. LPN# 6 stated after running to the end of the hall, he found Resident #6 half on and half off the floor mat with his/her head on the tile. Resident #6 had a laceration over his/her right eye and he stabilized his/her neck until emergency personnel could arrive. LPN #3 could not remember when he had last seen Resident #6 before the fall. LPN #3 could not recall which CNA was responsible for Resident #6 on 07/11/15.</p> <p>Interview with CNA #4, on 10/15/15 at 10:00 AM, revealed she cared for Resident #6 for one (1) year on 1st shift and she was aware Resident #6 fell frequently on 2nd shift. CNA #4 stated she always got Resident #6 up and out of bed as soon as Resident #6 woke up, otherwise he/she</p> | F 323 | <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 323 to ensure resident supervision and assistive devices to prevent accidents. QI monitoring will be conducted randomly across all shifts via staff observation and resident medical record documentation using a sample size of 5 random residents five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained. The DCS/Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> | | |



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| F 323 | <p>Continued From page 21 would try to get up himself/herself and would fall.</p> <p>Telephone interview with the Interim Director of Nursing (DON), on 10/15/15 at 11:49 AM, revealed she investigated Resident #6's 07/11/15 fall. She had concluded CNA #5 brought Resident #6's dinner tray to his/her room, moved the fall mat aside to roll the over the bed table in place, and left the dinner tray on his/her table. CNA #5 did not assist Resident #6 with his/her meal; did not collect the tray after the mea; did not reposition the over the bed table; did not return the fall mat to the bedside; and, CNA #5 did not toilet Resident #6 following his/her meal. Continued interview revealed the Interim DON contacted Human Resources and requested the CNA, who was PRN, be terminated. The Interim DON stated she phoned the family of Resident #6 to let them know that it was her findings the facility was at fault for Resident #6's fall.</p> <p>Review of CNA #5's personnel file revealed CNA #5 resigned and she last worked on 07/11/15.</p> <p>Interview with the Regional Director of Clinical Services, on 10/15/15 at 10:30 AM, revealed she investigated Resident #6's fall on 07/11/15. She stated her findings were Resident #6's fall mat was not at the bedside when the fall occurred. CNA #5 had moved the fall mat aside to place the over the bed table. Resident #6 had fallen while pushing the over the bed table away from the bed when he/she had finished eating. She documented her findings on the Fall Root Cause Investigation Report Form. She stated that changing the fall mat to a beveled mat was the intervention put in place to minimize future fall occurrences.</p> | F 323 | | | |



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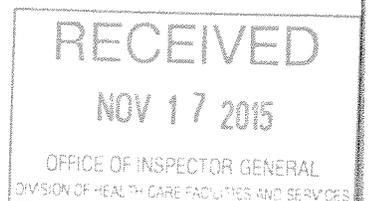
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| F 323 | <p>Continued From page 22</p> <p>2. Observation of Resident #12, on 10/14/15 at 4:45 PM, revealed the resident was in bed with his/her eyes closed. The bed had an air mattress with bolsters. There were fall mats on the floor on both sides of bed. The resident's call light was within reach.</p> <p>Review of Resident #12's clinical record, revealed the facility re-admitted the resident on 08/02/12 with diagnoses of Other Specific Muscle Disorder, Malignant Neoplasm Bronchus and Lung, Rheumatoid Arthritis, Heart Disease, Hypertension, Gout, Osteoporosis, and Benign Paroxysmal Positional Vertigo.</p> <p>Review of Resident #12's Quarterly Minimum Data Set assessment, completed on 06/22/15, revealed the facility assessed Resident #12's Brief Interview for Mental Status (BIMS) as twelve (12) which meant the resident was interviewable. In addition, the resident required extensive assistance of two (2) staff for bed mobility.</p> <p>Review of the Comprehensive Care Plan for Resident #12, dated 01/20/15, with a target date of 10/03/15, revealed the resident had a plan of care in place for self-care deficit related to immobility syndrome and for all care needs to be provided with two (2) staff members.</p> <p>Review of the Kardex for Resident #12, not dated, revealed the resident was an assist of two (2) for bed mobility.</p> | F 323 | | |
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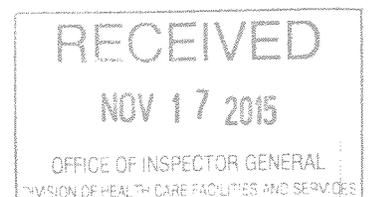
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| F 323 | <p>Continued From page 23</p> <p>Review of the Fall Root Cause Investigation Report, dated 09/01/15, revealed Resident #12 rolled from the bed onto the floor during a bed bath and was sent to the acute hospital for assessment.</p> <p>Review of the radiology report from the acute hospital, dated 09/01/15, revealed Resident #12 sustained an acute fracture of the distal femur to the right leg.</p> <p>Interview with CNA #2, on 10/15/15 at 11:20 AM, revealed she checked the Kardex for Resident #12 and was aware that two (2) staff was to be present when providing care. She stated other CNAs on the unit told her Resident #12 was able to roll himself/herself using the bed rails and did not require the assist of two (2) staff. She stated after she finished giving the resident a bed bath she changed the bed linens. CNA #2 stated when she was walking around to the left side of the bed, the resident rolled to the right side of the bed and kept rolling and fell to the floor.</p> <p>Interview, on 10/15/15 at 2:15 PM, with LPN #1 via telephone, revealed she was unsure how many staff were needed to provide care for Resident #12. She stated she worked as needed and floated to all the units. She stated on the day of the fall, she heard someone yell and when she entered Resident #12's room, the resident was on the floor. She stated there was plenty of staff available for resident care on the day of the fall.</p> <p>Interview with the A and D Hall Unit Manager</p> | F 323 | | |
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| F 323 | <p>Continued From page 24</p> <p>(UM), on 10/15/15 at 2:25 PM, revealed Resident #12 required the assist of two (2) staff when care was provided. She stated there was plenty of staff on the day of the fall for two (2) staff to provide care to Resident #12. She further stated CNA #2 was new and the day of the fall was CNA #2's second day working alone.</p> <p>Interview with Resident #12, on 10/15/15 at 2:50 PM, revealed there were usually two (2) CNAs present when he/she would get a bath; however, on the day of the fall, only one (1) CNA was in the room. The resident stated when he/she attempted to roll to the right side of the bed, he/she pulled his/her left leg over and the leg kept going and he/she fell off the bed and landed on his/her right knee.</p> <p>3. Observations of Resident #13's room, on 10/13/15 at 9:00 AM, revealed the facility provided mats and a bean bag chair for the resident to sit on in his/her room.</p> <p>Observations of Resident #13, on 10/13/15 at 9:12 AM, revealed the resident was in the hallway of the facility. The resident was propelling self in the hallway using the handrails. A staff person was standing and walking next to the resident.</p> <p>Review of Resident #13's clinical record revealed the facility admitted the resident on 04/16/14 with diagnoses of Acute Respiratory Failure, Traumatic Brain Injury, Hypertension, Non-Alzheimer's Dementia, Falls, and Anxiety.</p> <p>Review of Resident #13's quarterly Minimum Data Set (MDS) assessment, completed on 07/31/15, revealed he/she required extensive assistance from staff to toilet, and for all</p> | F 323 | | | |

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| F 323 | <p>Continued From page 25</p> <p>transfers. The resident required one-person supervision for locomotion in the facility. The facility assessed the resident as having been unable to complete a Brief Interview for Mental Status (BIMS) exam due to memory problems and was unable to be understood, meaning the resident was not interviewable.</p> <p>Review of the Care Plan for Resident #13, last updated 07/20/15, revealed the facility added interventions to the care plan on 07/30/15. One intervention included nursing to allow the resident into his/her wheelchair to transfer to and from the dining room and activities only. Secondly, the interventions revealed the nursing staff was to assist the resident to the floor mat or beanbag chair in the resident's room when not in his/her wheelchair. The care plan further revealed the resident required an assist of one (1) staff person for transfers and care. On 07/22/15, the facility discontinued the alarming seatbelt when the resident was in the wheelchair.</p> <p>Review of the Nurse Tech Information Kardex, not dated, revealed the facility identified a special consideration for Resident #13. Nursing staff was to use the wheelchair with the resident only for transferring to and from the dining room or activities. The Kardex also stated the resident was only to be in the wheelchair with supervision. The Kardex discussed safety measures for Resident #13, including a mat to the floor and the beanbag chair in the resident's room.</p> <p>Review of the Fall Root Cause Investigation Report, dated 07/30/15 at 12:00 PM, revealed the resident sustained a fall in his/her room. The facility staff found the resident on the floor in his/her room, but not on the mat provided. The</p> | F 323 | | |
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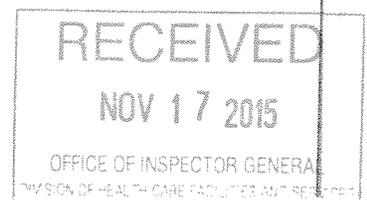
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| F 323 | <p>Continued From page 26</p> <p>investigation report stated the staff was unsure if the resident fell out of the wheelchair or if the resident transferred him/herself out of the wheelchair; however the resident was unsupervised. No injuries were noted from this fall. The facility added a bean bag chair to transfer the resident into after meals.</p> <p>Review of a second Fall Root Cause Investigation Report, dated 09/02/15, revealed Resident #13 sustained a fall in the hallway of the facility. Next to the Potential Causes, staff stated the resident was reaching for the handrail and slid off the wheelchair and onto the floor. No injuries were documented. The facility added new interventions of replacing the chair alarm.</p> <p>Review of the Fall Root Cause Investigation Report, dated 09/10/15, revealed Resident #13 sustained a fall in the resident's room. Nursing staff found the resident on the floor of the room, face down with a bloody nose and a 0.5 centimeter cut on the inside of his/her lower lip. The facility sent the resident to the hospital. Resident #13 returned from the hospital with no injuries. On the form, staff stated they were unsure what the resident was doing prior to the fall; however was unsupervised at the time. The facility added new interventions of continue bed and chair alarm, consider one on one supervision or put mattress on the floor.</p> <p>Interview with CNA #1, on 10/15/15 at 9:05 AM, revealed CNAs used the Kardex to guide the care they gave each resident. The Kardex told the CNAs what care and what level of assistance each resident required.</p> <p>Interview with CNA #7, on 10/15/15 at 9:47 AM,</p> | F 323 | | |
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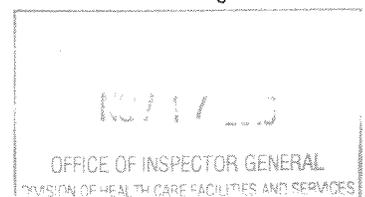
PRINTED: 10/29/2015
FORM APPROVED
OMB NO. 0938-0391

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/15/2015 |
|--|--|---|---|---|
| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
| F 323 | <p>Continued From page 27</p> <p>revealed CNAs provided assistance for transfers for Resident #13. CNAs also provided supervision for Resident #13 when he/she was in the wheelchair due to a history of falls.</p> <p>Interview with Unit Manager #1, on 10/15/15 at 5:50 PM, revealed resident #13 sustained several falls for which the facility introduced interventions. She stated the resident sustained several falls while in the wheelchair in the hallway. The resident was reaching forward to pull him/herself along the wall. The Unit Manager stated one of the interventions put in place was to increase supervision of the resident while he/she was in the wheelchair by keeping him/her in a public area of the facility. However, this was not on the care plan and not implemented.</p> <p>Interview with the Director of Nursing (DON), on 10/15/15 at 6:00 PM, revealed she was unaware of any falls for Resident #13 due to not following the care plan. The DON stated since her employment started less than three (3) weeks ago, she was not aware of any instances of falls and could not speak to instances prior to her employment.</p> <p>Interview with the Administrator, on 10/15/15 at 6:30 PM, revealed the facility had identified falls as an area of concern and had been incorporating a new plan to reduce falls in the past two (2) months. The facility was bringing information pertaining to falls to the morning meeting to discuss each fall. The facility was also tracking and trending the falls to look for any consistencies that may contribute to an individual's fall rate. The Administrator stated he discovered falls that had taken place due to nursing staff not following all care plan</p> | F 323 | | |

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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| F 323 | Continued From page 28 | F 323 | | | |
| F 497 SS=E | <p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's education records, it was determined the facility failed to provide evidence of the required twelve (12) hours per year of continued education for three (3) of ten (10) Certified Nursing Assistants (CNAs), CNA #8, #9, and #10.</p> <p>The findings include: Review of the facility's policy regarding Nurse Aide Training, dated 11/30/14, revealed the facility would provide and document at least twelve (12) hours of ongoing staff development training given annually to each CNA employed by the facility.</p> | F 497 | <p>1. No residents were identified. 2. Residents who reside in the facility have the potential to be affected by not providing the required twelve hours per year continued education for CNAs. The Assistant Director of Clinical Services (ADCS) and DCS will review the continued education for the CNAs to identify additional education needs and/or logging needs by November 15, 2015. Any issues identified will be corrected. CNA # 8 will have twelve in-service hours completed by November 15, 2015. CNA # 9 will have twelve in-service hours completed by November 15, 2015. CNA # 10 will have twelve in-service hours completed by November 15, 2015.</p> | 11-18-2015 | |



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| F 497 | <p>Continued From page 29</p> <p>Review of the Staff Development Department Employee Annual Attendance Education Record for CNA #10, not dated, revealed the CNA received 8.5 hours of mandatory education between the dates of 04/09/14 and 04/09/15. CNA #10 had a hire date of 04/09/11.</p> <p>Review of the Staff Development Department Employee Annual Attendance Education Record for CNA #9, not dated, revealed the CNA received 1.5 hours of mandatory education between the dates of 07/21/14 and 07/21/15. CNA #9 had a hire date of 07/21/04.</p> <p>Review for the Staff Development Department Employee Annual Attendance Education Record for CNA #8, not dated, revealed the CNA received 6.5 hours of mandatory education between the dates of 09/05/14 and 09/05/15. CNA #8 had a hire date of 09/05/12.</p> <p>Interview with the Director of Nursing (DON), on 10/15/15 at 3:45 PM, revealed the facility used Consulate University on the computer to conduct much of the state required trainings for CNAs. The facility conducted other trainings via in-services and face-to-face training. The facility tracked each CNAs training by recording the trainings in a binder containing a sheet for each CNA. Each sheet had a list of all of the required trainings. When training was completed, the Assistant Director of Nursing (ADON) would have placed a date next to the training the CNA completed. However, the sheets did not contain all of the in-services and face-to-face trainings nor did they contain the employee hire dates. Therefore, the DON stated she was unable to ensure all of the CNAs had the required twelve (12) hours of required training. The DON stated</p> | F 497 | <p>3. The Corporate Administrative Registered Nurse/RDCS will re-educate the Department Managers on the regulation F497 as well as the facility's in-service and education training policy by November 13, 2015.</p> <p>The DCS/Nurse Manager will re-educate the nursing staff on the facility's in-service and education policy by November 15, 2015. The staff will complete a post test to demonstrate understanding of the education.</p> <p>The ADCS and DCS will review the continued education for the CNAs to identify additional education needs and/or logging needs by November 15, 2015. Any issues identified will be corrected. The DCS/ADCS will validate that additional education is provided to certified nursing staff and will complete logging by November 15, 2015 to ensure that certified nursing staff have appropriate educational hours. The facility will provide regular in-service training sufficient to ensure the continuing competence of the nurse aides for at least 12 hours per year. The ADCS will monitor and document the in-service training hours of the CNAs. The DCS is responsible for the oversight of the process.</p> | |

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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 |
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| F 497 | <p>Continued From page 30</p> <p>the facility held a training blitz within the last three (3) months to ensure all the CNAs had the opportunity to complete all required trainings. However, the facility did not have records to ensure all CNAs attended the training fair at that time.</p> <p>Further interview with the DON, 10/15/15 at 6:00 PM, revealed the ADON would be in charge of maintaining the CNA Training hours once she was trained. The DON stated the previous employee who maintained the CNA training log was no longer with the company. The DON stated she only had binders with training information in them. The binders contained all of the in-services with the sign in sheets attached to verify employee attendance to the training. The binders also contained information about electronic trainings CNAs had taken. The DON stated the facility did not have a system in place to track each CNA's training hours to ensure each CNA received 12 hours of training per year from hire date to hire date.</p> <p>Interview with the Administrator, on 10/15/15 at 6:30 PM, revealed the facility did not have a system in place to keep accurate track of each of the CNAs training hours. The Administrator stated the DON and ADON were very new to the facility, within the last few weeks, and were unable to determine the system used to ensure all CNAs had received the required twelve (12) hours of continued education. The Administrator further stated the facility had a training blitz approximately two (2) months ago to ensure all of the CNAs received required trainings; however, the records did not indicate how many hours of training each CNA received. He stated that untrained CNAs placed residents at risk because</p> | F 497 | <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 497 to ensure the certified nursing assistants receive the required twelve hours per year continued education. QI monitoring will be conducted by identifying the CNA's date of hire and validating that twelve hours of education have been completed prior to their anniversary date. QI monitoring will be completed three times a week for four weeks, weekly for eight weeks and monthly for three months and/or until substantial compliance is obtained using a sample size of five CNAs. The DCS/Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> | |
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10/17/2015
OFFICE OF INSPECTOR GENERAL
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| F 497 | Continued From page 31 the CNA may not have had the latest skills available. | F 497 | | | |
| F 514 SS=D | 483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of the facility's policy, it was determined the facility failed to maintain clinical records in accordance with accepted professional standards and practices that were complete and accurately documented for one (1) of sixteen (16) sampled residents (Resident #6). The clinical records for Resident #6 were missing required information on the Fall Root Cause Investigation Report, the Situation, Background, Assessment Recommendation (SBAR) and the Bowel and Bladder tracking form. The findings include: | F 514 | 1. On 11-12-15, Resident #6 was assessed by the DCS to ensure safety interventions were in place and the plan of care was being followed. No issues were identified at that time. On 11-13-15, the DCS re-educated LPN #3 on maintaining a complete and accurate clinical record. The re-education included documenting assessments in full, including the date and time. The DCS also re-educated LPN #3 on the plan of care for Resident #6 and re-educated on supervision, including the supervision of CNAs to ensure the resident's plan of care is followed. CNA #5 is no longer employed at the facility. 2. Residents who reside in the facility have the potential to be affected by not maintaining complete and accurate clinical records in accordance with acceptable professional standards. On 11-4-15, the IDT (consisting of two or more of the following: Director of Clinical Services, Social Services Director, Activity Director, Therapy Director, Dietary Manager, Licensed Nurse, Minimum Data Set Nurse, Unit Manager, Executive Director) reviewed residents with a fall in the last sixty days (9/04-11/04/15) to ensure fall prevention interventions were in place, appropriate for the resident and documentation was present in the medical record. Additionally, the DCS reviewed the Fall Root Cause Investigation Forms to ensure the documentation was complete. Any issues identified were corrected. | 11-18-2015 | |

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| F 514 | Continued From page 32 The facility did not provide a policy regarding the documentation requirements for the Certified Nursing Assistants (CNA). Review of the facility policy, Nurse Progress Note, dated 11/30/14, revealed the nurse would utilize progress notes to document resident progress and would include the following: date, time, resident specific information and signature with credentials. Review of the facility's policy regarding the Accident and Incident Investigation, dated 11/30/14, revealed accidents and incidents would be investigated to determine the root cause and to provide an opportunity to decrease future occurrences of the event. If a fall occurred staff was to use the Fall Root Cause Investigation form. The Fall Root Cause Investigation form included the designation of interventions minimizing future occurrences. Review of Resident #6's Situation Background Assessment Recommendation (SBAR)/Progress Note and Root Fall Cause Investigation forms, both dated 05/03/15, did not specify the time the resident fell, a determination if the fall was with injury or no injury, nor was a new intervention detailed. Review of Resident #6's, 05/06/15, Fall Root Cause Investigation Report revealed an absence of contributing factors, the time the resident was last toileted, the name, title and signature of the person preparing the investigation, a summary, any new interventions, and the name and signature of the person reviewing the report and | F 514 | 3. The Corporate Administrative Registered Nurse/RDCS will re-educate the Department Managers on the facility's accident and incident investigation policy by November 13, 2015 emphasis will be placed on maintaining a complete and accurate clinical record. The DCS/Nurse Manager will re-educate the license nurses on resident supervision as well as accident and incident prevention and investigation by November 15, 2015 emphasis will be placed on maintaining a complete and accurate clinical record including but not limited to documentation on the Fall Root Cause Investigation Form, Nurse Progress Note and the Situation Background Assessment Recommendation (SBAR) form. The staff will complete a post test to demonstrate understanding of the education. The DCS/Nurse Manager will re-educate the nursing staff on the facility's ADL Flow Record policy by November 15, 2015. Activities of Daily Living (ADL) documentation will include but not be limited to bowel and bladder documentation. The staff will complete a post test to demonstrate understanding of the educations. | | |

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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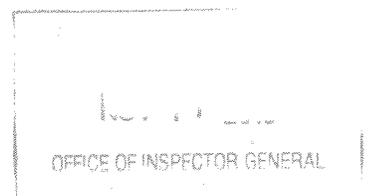
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| F 514 | <p>Continued From page 33 date of the review.</p> <p>Review of Resident #6's Fall Root Cause Investigation Report, dated 07/11/15, (the date the incident occurred), revealed an absence of the name, title and signature of the person preparing the investigation, the time the resident was last toileted, contributing factors and the date, the summary, any new interventions, and the name and signature of the person reviewing the report with a date of the review.</p> <p>Review of Resident #6's SBAR, dated 07/11/15, did not specify the time the resident fell, describe the incident or the name, title and signature of the person completing the SBAR was absent.</p> <p>Review of Resident #6's Bowel and Bladder Report, dated 07/11/15, revealed Resident #6 was incontinent of urine at 4:08 AM; however, there was no documentation present for the remainder of 07/11/15.</p> <p>Interview with Licensed Practical Nurse (LPN) #3, on 10/15/15 at 9:18 AM, revealed he cared for Resident #6 on 2nd shift for 05/03/15 and 07/11/15. He stated Resident #6 was in bed prior to his/her falls, but did not recall the time of the incidents and was unsure what paperwork was completed following the incidents.</p> <p>Interview with Unit Manager (UM) #1, on 10/14/15 at 11:15 AM, revealed all of the notes fell under the Nurse Progress Note policy in regards to the signatures and dates. The nursing documentation for the facility was done by exception, therefore, there were no daily notes for each resident. Upon review of the SBARS, dated 05/03/15 and 07/11/15 she stated those were badly written, and</p> | F 514 | <p>4. The DCS/Nurse Manager will conduct QI monitoring of the regulation F 514 to ensure a complete and accurate clinical records in accordance with acceptable professional standards. QI monitoring will be conducted via review of resident medical record documentation using a sample size of 5 random residents five times a week for four weeks, three times a week for four weeks, weekly for four weeks, then monthly for three months and/or until substantial compliance is obtained. The DCS/Nurse Manager will report the findings to two quarterly QAPI committee meetings. The QAPI committee will determine substantial compliance, determine if further action needs to be taken and determine the continued time schedule for further monitoring.</p> | | |

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| F 514 | Continued From page 34 incomplete. Upon review of the Bowel and Bladder report, dated 07/11/15 UM #1 stated the documentation was not completed. | F 514 | | | |



DEPARTMENT OF HEALTH AND HUMAN SERVICES
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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| {K 000} | INITIAL COMMENTS An onsite re-visit was conducted on 12/21/15 and found the facility in compliance on 11/25/15 as alleged in their PoC. | {K 000} | | | |

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

TITLE

(X6) DATE

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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| K 000 | <p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962, 1983, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (200).</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments on the ground floor where residents reside; a partial basement occupied by Staff only.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors.</p> <p>SPRINKLER SYSTEM: Complete, automatic, dry sprinkler system.</p> <p>GENERATOR: Type II 40KW generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 10/14/15. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire).</p> | K 000 | | |

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

TITLE

(X6) DATE

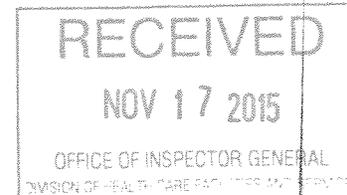
[Signature] *Executive Director* *11/16/2015*

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

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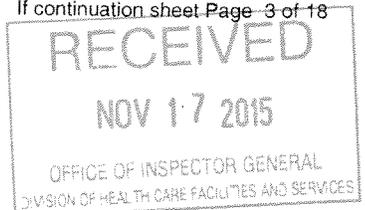
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | | (X3) DATE SURVEY COMPLETED 10/14/2015 |
| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | | |
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| K 000 | Continued From page 1 | K 000 | Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations. | 11-18-2015 | |
| K 018 SS=D | <p>Deficiencies were cited with the highest deficiency identified at F level.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would completely close, without any impediments, to prevent the passage of smoke in the event of an emergency, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments,</p> | K 018 | <p>1. The Door in room E-3 was adjusted and corrected on 10/14/15 by the Maintenance Tech and trash can was immediately removed on 10/14/15 by the Maintenance Tech.</p> <p>2. All other doors were checked by the Maintenance Tech on 10/14/2015 for potentially being propped open and to ensure doors were functioning properly</p> <p>3. The Mock Survey Team that consists of Department Managers will be educated by the Maintenance Director by 11/13/15 regarding doors are not to be propped open and to report any doors that are propped open or not working properly. The Mock Survey Team that is comprised of Department Managers will check for doors not working properly or propped during daily rounds 5 times per week for six months. Any doors that are not working properly will be communicated in the daily morning meeting and appropriate repairs or corrections to be made. The Maintenance Director and/or Maintenance Tech will conduct rounds weekly to ensure doors are working properly and/or not propped open</p> <p>4. Audits and any identified issues will be reported to the Quality Assurance Performance Improvement Committee that consists of the Executive Director, Director of Clinical Services,</p> | 11-18-2015 | |



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| K 018 | <p>Continued From page 2</p> <p>approximately twenty (20) residents, staff, and visitors. The facility has ninety-six (96) certified beds and the census was eighty (80) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 10/14/15 at 10:09 AM, with two (2) facility Administrators, the Maintenance Tech and the Area Manager of Housekeeping revealed the corridor door to Resident Room E-3, was being held open with a trash can and was an impediment to closing the door in the event of an emergency. When the trash can was removed, the door closed on its own and would not stay in the open position.</p> <p>Interviews, on 10/14/15 at 10:11 AM, with the two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were unaware the corridor door to Resident Room E-3 was being held open by a trash can and acknowledged it was an impediment to the closing of the door, to prevent the spread of smoke in the event of an emergency.</p> <p>The census of eighty (80) was verified by the Administrator, on 10/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Tech at the exit interview on 10/14/15.</p> <p>Reference NFPA 101 (2000 Edition). 19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than</p> | K 018 | <p>Assistant Director of Clinical Services, Unit Managers, Human Resources, Business Office Manager, Maintenance Director, Medical Records, Activity Director, Medical Director, MDS Coordinator, Housekeeping Director, Dietary Director and Social Services Director for six months for review and recommendations.</p> | |



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| K 018 | Continued From page 3 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service. | K 018 | | | |

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| K 018 | Continued From page 4 19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted. | K 018 | | |
| K 029 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of eight (8) smoke compartments, residents, staff and visitors. The facility has ninety-six (96) certified beds and the census was eighty (80) on the day of the survey. The findings include: 1. Observation, on 10/14/15 at 9:24 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed | K 029 | 1. The non- rated sealant was removed from the area in the Central Supply Room and Kitchen Storage by the Maintenance Tech on 10/14/2015 and sealed with fire rated material. 2. A complete audit was completed by the Maintenance Tech on 10/15/2015 to ensure no other areas existed that contained non-fire rated caulk. 3. The Maintenance Director and Maintenance Tech will be educated by the Executive Director by 11/13/2015 regarding proper sealant to be used in sealing around walls or ceiling penetrations. The Mock Survey Team that conducts rounds 5 times per week of individually assigned rooms will be educated by the Maintenance Director on proper fire rated material to be used by 11/13/2015. The Mock Survey Team will check for any areas not properly sealed 5 times per week for six months and report findings in the Daily Morning Meeting. The Maintenance Director and/or Maintenance Tech will make repairs as needed. 4. Audits will be presented to the Quality Assurance Performance Improvement Committee that consists of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Human Resources, Business Office Manager, Maintenance Director, Medical Records, Activity Director, Medical Director, Housekeeping Manager, Dietary Manager, MDS Coordinator and Social Services | 11-18-2015 |

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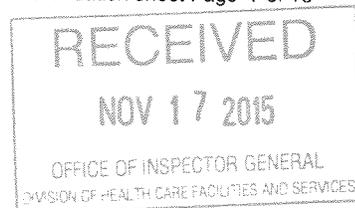
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| K 029 | <p>Continued From page 5</p> <p>the Central Supply Room had telephone lines that penetrated the ceiling, sealed with a non-rated sealant of combustible material.</p> <p>Interviews, on 10/14/15 at 9:26 AM, with two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the non-rated sealant of combustible materials was being used to seal the penetrations within the room.</p> <p>2. Observation, on 10/14/15 at 9:45 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the Kitchen Dry Storage Room had electrical conduits that penetrated the ceiling, sealed with a non-rated sealant of combustible material.</p> <p>Interviews, on 10/14/15 at 9:47 AM, with two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the non-rated sealant of combustible materials was being used to seal the penetrations within the room.</p> <p>The census of eighty (80) was verified by the Administrator, on 10/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Tech at the exit interview on 10/14/15.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in</p> | K 029 | Director for six months for review and recommendations. | | |

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| K 029 | Continued From page 6 accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than | K 029 | | |
| K 050 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded | K 050 | | |



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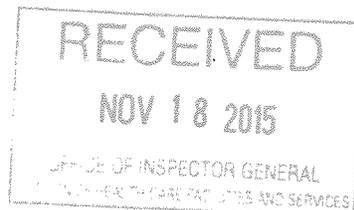
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| K 050 | <p>Continued From page 7 announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on interview and record review, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, residents, staff, and visitors. The facility has ninety-six (96) certified beds and the census was eighty (80) on the day of the survey.</p> <p>The findings include:</p> <p>Review of the facility's fire drills, on 10/14/15 at 2:59 PM, with the Maintenance Tech revealed the facility had no evidence of fire drills being conducted during the second and third shifts in the first quarters of 2015. Fire drills are required to be conducted, at a minimum of one (1) per shift, per quarter of the year.</p> <p>Interview, on 10/14/14 at 3:01 PM, with the Maintenance Tech revealed the facility had a change in maintenance personnel at the end of the first quarter of 2015 and had no written documentation that fire drills had been conducted during the second and third shifts during the first quarter of 2015.</p> <p>The census of eighty (80) was verified by the Administrator on 10/14/15. The findings were acknowledged by the Administrator and verified</p> | K 050 | <ol style="list-style-type: none"> No residents were identified as being affected by the alleged deficient practice. All residents have the potential to be affect by the alleged deficient practice. Fire drills were identified by the Quality Assurance Performance Improvement Committee in 7/2015 and has already been addressed. Fire alarms have been and are being conducted by the Maintenance Tech at least monthly on different shifts. The Maintenance Director and/or Maintenance Tech will continue conducting fire drills monthly on different shifts. In turn all three shifts will have fire drills per quarter. The Executive Director will provide oversight of the system and ensure fire drills are being conducted monthly on different shifts and in turn provided on every shift per quarter. Fire drills will be presented and reviewed by the Quality assurance Performance Improvement committee that consists of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Human Resources, Business Office Manager, Maintenance Director, Medical Records, Activity Director, Medical Director, MDS Coordinator, Dietary Manager, Housekeeping Manager and Social Services | 11-18-2015 | |

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| K 050 | Continued From page 8 by the Maintenance Tech at the exit interview on 10/14/15. Reference: NFPA 101 Life Safety Code (2000 Edition) 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts. | K 050 | Director for six months for review and recommendations. | |
| K 051 SS=F | NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system with approved components, devices or equipment is installed according to NFPA 72, National Fire Alarm Code, to provide effective warning of fire in any part of the building. Activation of the complete fire alarm system is by manual fire alarm initiation, automatic detection or extinguishing system operation. Pull stations in patient sleeping areas may be omitted provided that manual pull stations are within 200 feet of nurse's stations. Pull stations are located in the path of egress. Electronic or written records of tests are available. A reliable second source of power is provided. Fire alarm systems are maintained in accordance with NFPA 72 and records of maintenance are kept readily available. There is remote annunciation of the fire alarm system to an approved central station. 19.3.4, 9.6 | K 051 | 1. No residents were identified as being affected by the alleged deficient practice. 2. All residents have the potential to be affected by the alleged deficient practice. An audit was conducted by the Maintenance Tech on 10/14/15 to ensure all pull stations that weren't located by exits were identified. 3. The 5 pull stations that were identified as not being placed properly and bid was obtained from a contractor on 11/5/15. The pull stations will be moved by the contractor by 11/24/15. The Maintenance Director will inspect the fire alarms once the contractor completes the installation and weekly for six months to ensure all pull stations are properly located. 4. The Maintenance Director will present the installation documentation and any inspection or maintenance reports pertaining to the fire pull stations to the Quality assurance Performance Improvement committee that consists of the Executive Director, | 11-25-2015 |



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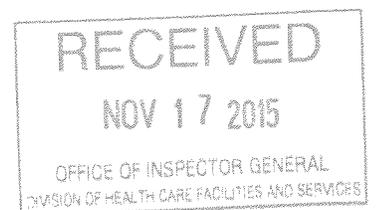
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| K 051 | Continued From page 9 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the building fire alarm system was installed in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, residents, staff and visitors. The facility has ninety-six (96) certified beds and the census was eighty (80) on the day of the survey. The findings include: 1. Observation, on 10/14/15 at 9:31 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the exit from the Service Corridor did not have a manually operated fire alarm box installed within five (5) feet from the exit door. Interviews, on 10/14/15 at 9:33 AM, with the two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the manually operated fire alarm box was not installed within five (5) feet of the exit doors. 2. Observation, on 10/14/15 at 10:22 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the exit from the A Wing did not have a manually operated fire alarm box installed within five (5) feet from the exit door. Interviews, on 10/14/15 at 10:24 AM, with the two (2) Administrators, the Maintenance Tech, and | K 051 | Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Human Resources, Business Office Manager, Maintenance Director, Medical Records, Activity Director, Medical Director, MDS Coordinator, Dietary Manager, Housekeeping Manager and Social Services Director for six months for review and recommendations. | 11-18-2015 |

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| K 051 | <p>Continued From page 10</p> <p>the Area Manager of Housekeeping revealed they were not aware the manually operated fire alarm box was not installed within five (5) feet of the exit doors.</p> <p>3. Observation, on 10/14/15 at 10:47 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the exit from the B Wing did not have a manually operated fire alarm box located within five (5) feet from the exit door.</p> <p>Interviews, on 10/14/15 at 10:49 AM, with the two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the manually operated fire alarm box was not installed within five (5) feet of the exit doors.</p> <p>4. Observation, on 10/14/15 at 11:18 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the exit from the E Wing did not have a manually operated fire alarm box installed within five (5) feet from the exit door.</p> <p>Interviews, on 10/14/15 at 11:20 AM, with the two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the manually operated fire alarm box was not installed within five (5) feet of the exit doors.</p> <p>5. Observation, on 10/14/15 at 11:48 AM, with two (2) facility Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed the exit from the Main Entrance did not have a manually operated fire alarm box installed within five (5) feet from the exit door.</p> | K 051 | | |



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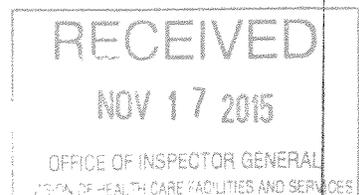
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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348 | (X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 10/14/2015 |
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| NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C | | | STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206 | |
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| K 051 | Continued From page 11 Interviews, on 10/14/15 at 11:50 AM, with the two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware the manually operated fire alarm box was not installed within five (5) feet of the exit doors. The census of eighty (80) was verified by the Administrator, on 10/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Tech at the exit interview on 10/14/15. Reference: NFPA 101 (2000 Edition) 9.6.1.4. A fire alarm system required for life safety shall be installed, tested, and maintained in accordance with the applicable requirements of NFPA 70, National Electrical Code, and NFPA 72, National Fire Alarm Code. Reference: NFPA 72 (1999 Edition). 5.12 Manually Actuated Alarm-Initiating Devices. 5.12.1 Manual fire alarm boxes shall be used only for fire alarm-initiating purposes. 5.12.2 Combination manual fire alarm boxes and guard 's signaling stations shall be permitted. 5.12.3 Each manual fire alarm box shall be securely mounted. 5.12.4 The operable part of each manual fire alarm box shall be not less than 1.1 m (3½ ft) and not more than 1.37 m (4½ ft) above floor level. 5.12.5* Manual fire alarm boxes shall be located throughout the protected area so that they are conspicuous, unobstructed, and accessible. 5.12.6 Manual fire alarm boxes shall be located within 1.5 m (5 ft) of the exit doorway opening at each exit on each floor. 5.12.7 Manual fire alarm boxes shall be mounted | K 051 | | |

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| K 051 | Continued From page 12 on both sides of grouped openings over 12.2 m (40 ft) in width, and within 1.5 m (5 ft) of each side of the opening. 5.12.8* Additional manual fire alarm boxes shall be provided so that the travel distance to the nearest fire alarm box will not be in excess of 61 m (200 ft) measured horizontally on the same floor. | K 051 | | |
| K 147 SS=D | NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff, and visitors. The facility has ninety- six (96) certified beds and the census was eighty (80) on the day of the survey. The findings include: Observation, on 10/14/15 at 10:59 AM, with two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed a hair dryer was plugged into an extension cord located within the facility's Beauty Shop. Further observation at that time revealed each of the two (2) electrical outlets located at the two (2) sinks were standard electrical outlets instead of the | K 147 | 1 No residents were identified as being affected by the alleged deficient practice. The extension cord was immediately removed from the beauty shop upon discovery on 10/14/2015. 2 All residents have the potential to be affected by the alleged deficient practice. An audit was conducted of the building for other extension cords and around sinks to ensure GFCI outlets were in place. No other issues were identified. 3 The Beauty Shop Employee will be educated by the Maintenance Director that extension cords cannot be used. The two identified electrical outlets were replaced with GFCI outlets by the Maintenance Director on 11/10/2015. The Maintenance Director and Maintenance Tech will be educated on 11/13/2015 by the Executive Director. The education will specify that GFCI outlets are to be installed around sinks. The Maintenance Director and/or Maintenance Tech will conduct | 11-18-2015 |



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| K 147 | <p>Continued From page 13</p> <p>required ground fault circuit interrupter (GFCI) receptacles at wet areas.</p> <p>Interviews, on 10/14/15 at 11:01 AM, with two (2) Administrators, the Maintenance Tech, and the Area Manager of Housekeeping revealed they were not aware an extension cord was used for a hair dryer within the Beauty Shop and the two (2) electrical outlets at the two (2) sinks were not GFCI receptacles.</p> <p>The census of eighty (80) was verified by the Administrator on 10/14/15. The findings were acknowledged by the Administrator and verified by the Maintenance Tech at the exit interview on 10/14/15.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 (D) Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition) 9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition) 400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a</p> | K 147 | <p>rounds bi-weekly when Beauty Shop Employee is scheduled to ensure extension cords are not being used.</p> <p>4 The completion of GFCI outlets being installed and audits will be presented to the Quality assurance Performance Improvement committee that consists of the Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Unit Managers, Human Resources, Business Office Manager, Maintenance Director, Medical Records, Activity Director, Medical Director, MDS Coordinator, Dietary Manager, Housekeeping Manager and Social Services Director for six months for review and recommendations.</p> | |

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| K 147 | <p>Continued From page 14</p> <p>structure</p> <p>(2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors</p> <p>(3) Where run through doorways, windows, or similar openings</p> <p>(4) Where attached to building surfaces</p> <p>Reference NFPA 70 (1999 Edition). National Electric Code, relating to ground fault protection for electric outlets near sinks in resident rooms. NFPA: 70 210.8 Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(6) Kitchens - where the receptacles are installed to serve the countertop surfaces</p> <p>(7) Wet bar sinks - where the receptacles are installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.</p> <p>210.8 Ground-Fault Circuit-Interrupter Protection for Personnel. FPN: See 215.9 for ground-fault circuit-interrupter protection for personnel on feeders. (A) Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1) through (8) shall have ground-fault circuit-interrupter protection for personnel.</p> <p>(1) Bathrooms</p> <p>(2) Garages, and also accessory buildings that have a floor located at or below grade level not intended as habitable rooms and limited to storage areas, work areas, and areas of similar use</p> <p>Exception No. 1: Receptacles that are not readily accessible.</p> <p>Exception No. 2: A single receptacle or a duplex</p> | K 147 | | | |

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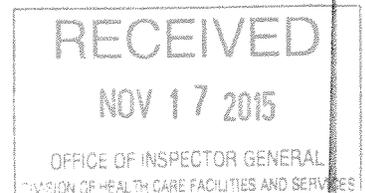
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| K 147 | <p>Continued From page 15</p> <p>receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Receptacles installed under the exceptions to 210.8(A)(2) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(3) Outdoors Exception: Receptacles that are not readily accessible and are supplied by a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426.</p> <p>(4) Crawl spaces - at or below grade level (5) Unfinished basements - for purposes of this section, unfinished basements are defined as portions or areas of the basement not intended as habitable rooms and limited to storage areas, work areas, and the like Exception No. 1: Receptacles that are not readily accessible. Exception No. 2: A single receptacle or a duplex receptacle for two appliances located within dedicated space for each appliance that, in normal use, is not easily moved from one place to another and that is cord-and-plug connected in accordance with 400.7(A)(6), (A)(7), or (A)(8). Exception No. 3: A receptacle supplying only a permanently installed fire alarm or burglar alarm system shall not be required to have ground-fault circuit-interrupter protection. Receptacles installed under the exceptions to 210.8(A)(5) shall not be considered as meeting the requirements of 210.52(G).</p> <p>(6) Kitchens - where the receptacles are installed to serve the countertop surfaces (7) Wet bar sinks - where the receptacles are</p> | K 147 | | |
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| K 147 | <p>Continued From page 16</p> <p>installed to serve the countertop surfaces and are located within 1.8 m (6 ft) of the outside edge of the wet bar sink.</p> <p>(8) Boathouses</p> <p>(B) Other Than Dwelling Units. All 125-volt, single-phase, 15- and 20-ampere receptacles installed in the locations specified in (1), (2), and (3) shall have ground-fault circuit-interrupter protection for personnel:</p> <p>(1) Bathrooms</p> <p>(2) Rooftops</p> <p>Exception: Receptacles that are not readily accessible and are supplied from a dedicated branch circuit for electric snow-melting or deicing equipment shall be permitted to be installed in accordance with the applicable provisions of Article 426.</p> <p>(406.8 Receptacles in Damp or Wet Locations.</p> <p>(A) Damp Locations. A receptacle installed outdoors in a location protected from the weather or in other damp locations shall have an enclosure for the receptacle that is weatherproof when the receptacle is covered (attachment plug cap not inserted and receptacle covers closed). An installation suitable for wet locations shall also be considered suitable for damp locations. A receptacle shall be considered to be in a location protected from the weather where located under roofed open porches, canopies, marquees, and the like, and will not be subjected to a beating rain or water runoff.</p> <p>(B) Wet Locations.</p> <p>(1) 15- and 20-Ampere Outdoor Receptacles. 15- and 20-ampere, 125- and 250-volt receptacles installed outdoors in a wet location shall have an enclosure that is weatherproof whether or not the attachment plug cap is inserted.</p> <p>(2) Other Receptacles. All other receptacles installed in a wet location shall comply with (a) or</p> | K 147 | | |

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| K 147 | Continued From page 17 (b): (a) A receptacle installed in a wet location where the product intended to be plugged into it is not attended while in use (e.g., sprinkler system controller, landscape lighting, holiday lights, and so forth) shall have an enclosure that is weatherproof with the attachment plug cap inserted or removed. (b) A receptacle installed in a wet location where the product intended to be plugged into it will be attended while in use (e.g., portable tools, and so forth) shall have an enclosure that is weatherproof when the attachment plug is removed. (C) Bathtub and Shower Space. A receptacle shall not be installed within a bathtub or shower space. | K 147 | | |
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