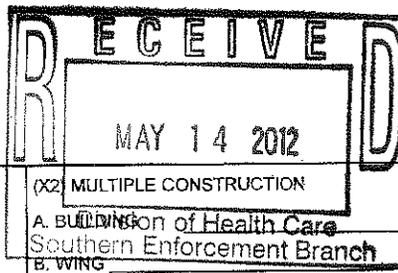


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES



PRINTED: 05/03/2012
FORM APPROVED
OMB NO. 0938-0391

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185003 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: <u>Division of Health Care Southern Enforcement Branch</u> B. WING: _____ | (X3) DATE SURVEY COMPLETED 04/19/2012 |
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| NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY | STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743 |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| F 000 | INITIAL COMMENTS | F 000 | | |
| F 221 SS=D | <p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, it was determined the facility failed to ensure one of twenty-four sampled residents was free from physical restraints (Resident #14). Resident #14 was observed to be in a reclined Geri-chair (chair that prevents rising) and/or a "falls chair" (chair that prevents rising), however, there was no evidence the facility had conducted a restraint assessment or identified the presence of a medical symptom prior to placing the resident in the reclined Geri-chair and/or "falls chair." In addition, there was no evidence the facility had informed the resident's responsible party of the risks/benefits related to the use of placing Resident #14 in the reclined Geri-chair or "falls chair."</p> <p>The findings include:</p> <p>A review of the facility's Physical Restraint Policy (no date) revealed physical restraints were defined as anything that keeps the resident from accessing their body or restricts movement of the</p> | F 221 | <p>F221 RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>(1.) The following corrective action was accomplished for the resident affected by the deficient practice:</p> <ul style="list-style-type: none"> > Following the survey exit interview on 04/19/12, a restraint assessment was conducted for resident #14. The assessment was inclusive of the Geri chair and falls chair. The resident's RP was informed of the risks and the benefits related to the Geri chair and the falls chair. (Copies of Assessment and Consent Form Attached) <p>(2.) Other residents with the potential to be affected by the same deficient practice were identified by the following:</p> <ul style="list-style-type: none"> > Beginning on 04/20/12 and continuing thru 04/23/12 a physical restraint audit was conducted on all residents. There were a total of 16 residents with physical restraints. The audit which was conducted looked for eight restraint parameters listed below: <ol style="list-style-type: none"> 1. Type of restraint 2. Wheel Chair / recliner assessment 3. Pre-Restraint Assessment Tool 4. Physician Order | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathey K. Young TITLE: Administrator (X6) DATE: 5/11/12

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

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| F 221 | <p>Continued From page 1</p> <p>resident. The policy revealed restraints were to be utilized after other interventions had failed to control the resident's clinical symptoms which required the use of the restraint device. The policy further noted a nurse was required to assess the resident and utilize other interventions prior to the use of a restraint device. The policy also revealed a medical symptom was required to support the use of the restraint, the least restrictive device would be used, and a physician's order for the restraint would be obtained.</p> <p>A review of the medical record for Resident #14 revealed the facility admitted the resident on 03/22/11, with diagnoses that included Status-post Right Femoral Neck fracture with Open Reduction Internal Fixation (ORIF), Dementia, Parkinson's, Alzheimer's Disease, and Coronary Artery Disease.</p> <p>A review of the significant change comprehensive assessment with a reference date of 02/23/12, revealed Resident #14 required total assistance of two staff persons for bed mobility, transfers, and toileting. The resident's ambulation status was assessed as "did not occur," and the resident was assessed to have bilateral limitation in range of motion of both sides. Resident #14 was also noted to be receiving restorative nursing services for passive range of motion (PROM). Further review of the assessment revealed restraints were not utilized for Resident #14.</p> <p>Resident #14 was observed on 04/17/12, at 3:10 PM, to be sitting in an area designated by the facility as the Falls Lounge in a "falls chair." The "falls chair" was noted to position the resident's</p> | F 221 | <ol style="list-style-type: none"> 5. Restraint Consent 6. Restraint Elimination Tool 7. Restraint Care Plan 8. Restraint on CFR <p>➤ If any of the above parameters were listed as or said to be "no" on the Physical Restraint Audit they were corrected immediately. There were two outliers found in the audit, one pertained to a physician order and one pertained to a restraint consent. (See attached audit)</p> <p>(3.) Quality Improvement measures implemented to ensure that the deficient practice will not recur include:</p> <p>➤ On 04/23/12 a multi-disciplinary committee was convened to review the facility's Physical Restraint Program. The committee consisted of the following disciplines: Nursing, Administration, Pharmacy, Occupational Therapy, Physical Therapy, RAI, Social Services, and Activities. The interdisciplinary committee reviewed the current Physical Restraint Program and made changes to the physical restraint program structure as well as the program process. (See attached program changes shaded in Gray)</p> <p>(4.) Monitoring the compliance of the revised Physical Restraint Program will include:</p> <p>➤ The newly formed Multi-Disciplinary Restraint Review committee will review and monitor the performance standards and process related to physical restraints. The committee process will include:</p> | |

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| F 221 | <p>Continued From page 2</p> <p>buttocks in a lower seated position with the resident's legs extended and in an elevated position on the lower end of the chair. On 04/18/12, at 10:30 AM and 3:45 PM, Resident #14 was observed to be sitting in a reclined Geri-chair with the foot of the chair in a raised position. On 04/19/12, Resident #14 was again observed at 10:05 AM, to be sitting in the reclined Geri-chair with the foot of the chair in a raised position. However, a review of documentation in the medical record revealed no evidence the facility had conducted an assessment of Resident #14 for a specific medical symptom for the use of the reclined Geri-chair or "falls chair." In addition, the facility failed to assess how use of the chair would protect the resident's safety, or how use of the chair would assist the resident to attain/maintain his or her highest practicable level of physical and psychosocial well-being.</p> <p>Interview conducted with Certified Nurse Aide (CNA) #1 on 04/19/12, at 10:10 AM, revealed Resident #14 was out of bed in the "falls chair" or the reclined Geri-chair for most of the day. CNA #1 stated the resident would attempt to get out of the chairs by pushing against the lower foot rest of both the fall chair and Geri-chair.</p> <p>An interview conducted with CNA #2 on 04/19/12, at 11:10 AM, revealed Resident #14 was transferred out of bed to either the "falls chair" or reclined Geri-chair for most of the day. CNA #2 stated the resident would attempt to slide down or throw the resident's legs over the sides of the chair in an effort to get out of the "falls chair" or Geri-chair. The CNA believed the resident required the "falls chair" or Geri-chair due to high fall risk, but was not aware of any recent falls.</p> | F 221 | <ul style="list-style-type: none"> • Reviewing all new orders for physical restraints within 72 hours using the New Order Physical Restraint Review Form/Summary (See Attached) • Conduct quarterly reviews of all ongoing restraints using the Quarterly Review Physical Restraint Review Form/Summary (See Attached) • Making recommendations to correct any deficient practice as well as changes to the Plan of Care <p>➤ (See attached committee structure and related forms)</p> <p>CORRECTIVE ACTION TAG #F221 COMPLETED ON</p> | 05/11/12 | |

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| F 221 | Continued From page 3 Interview with Registered Nurse #1 on 04/19/12, at 2:45 PM, revealed the RN was responsible to conduct a pre-restraint assessment when a restraint device was determined to be needed for a resident. The RN stated a physician's order with a medical symptom was also required prior to using a restraint device. RN #1 stated the "falls chair" and Geri-chair were used to prevent falls for Resident #14. The RN stated the fall chair and Geri-chair had not been considered a restraint device and the restraint assessments or responsible party consent had not been completed. Interview with the Director of Nurses (DON) on 04/19/12, at 5:10 PM, revealed the DON did not believe the "falls chair" or reclined Geri-chair was a restraint device for Resident #14 and did not require a restraint assessment. | F 221 | | | |

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| NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY | | | STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40313 | | | |
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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: 1965</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 11 (000)</p> <p>SMOKE COMPARTMENTS: 5</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 04/17/12. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid.</p> <p>Deficiencies were cited with the highest deficiency identified at "F" level.</p> | K 000 | | | | |
| K 062 SS=F | <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating</p> | K 062 | <p>K062</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> | | | |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Kathleen Young* TITLE: *Administrator* (X6) DATE: *5/11/12*

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| K 062 | <p>Continued From page 1</p> <p>condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview, and record review, the facility failed to maintain their sprinkler system by NFPA standards. This deficient practice would affect smoke compartments, staff, and all the residents. The facility has the capacity for 155 beds with a census of 145 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 04/17/12, at 12:10 PM, a review of the facility's quarterly fire alarm record revealed no evidence the gauge to the sprinkler system had been replaced or calibrated every five years as required. Continued review of the quarterly fire alarm record revealed, based on the facility's documentation, the gauges were not required to be maintained. Interview with the Director of Maintenance (DOM) at the facility's sprinkler room revealed the DOM was unaware the gauges to the sprinkler system had to be replaced or recalibrated every five years.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-3.2* Gauges. Gauges shall be replaced every 5 years or tested every 5 years by comparison with a calibrated gauge. Gauges not accurate to within 3 percent of the full scale shall be recalibrated or replaced.</p> | K 062 | <p>(1.) Corrective action for deficient practice includes:</p> <ul style="list-style-type: none"> > Replacement of gages one and two on 04/26/12. (See attached copy of <u>Landmark Sprinkler Inspection Form</u>) <p>(2.) The facility has implemented the following to insure compliance of NFPA standards for the sprinkler system as outlined in K062:</p> <ul style="list-style-type: none"> > An In-service was conducted on 05/07/12 for the Maintenance Staff on K062, <u>Sprinkler System/NFPA Standards, Fire Riser Pressure Check Policy, Pressure Check Audit Form, and Sprinkler System Compliance Monitoring Report</u> (See Attached) <p>(3.) The Quality Improvement measures implemented to ensure the sprinkler system has been replaced or calibrated every 5 years and appropriate pressure is maintained on gages include:</p> <ul style="list-style-type: none"> > Utilizing the <u>Monthly Fire Riser Pressure Check Form</u>, <u>Maintenance Staff</u> will audit and document the pressure gage reading to ensure appropriate water supply pressure is being maintained. > Pressure Reading falling outside the acceptable variance level will be <u>immediately reported</u> to the <u>Maintenance Director</u> > The <u>Maintenance Director</u> will notify the Sprinkler System Monitoring Company immediately regarding all necessary repairs. | |

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| K 062 | Continued From page 2 2-2.4.1* Gauges on wet pipe sprinkler systems shall be inspected monthly to ensure that they are in good condition and that normal water supply pressure is being maintained. | K 062 | <ul style="list-style-type: none"> ➤ <u>Maintenance Staff</u> will submit their <u>monthly audit</u> checks to the <u>Maintenance Director</u> <p>(4.) Monitoring the compliance of NFPA standards for normal water supply pressure and recalibration or replacement every 5 years includes:</p> <ul style="list-style-type: none"> ➤ The <u>Maintenance Director</u> will conduct compliance monitoring <u>monthly</u> utilizing the Sprinkler System Compliance Monitoring Report (attached) ➤ Areas of non-compliance will be corrected immediately ➤ The <u>Maintenance Director</u> will submit compliance monitoring results <u>monthly</u> to the <u>Quality Improvement Committee</u> ➤ Areas of non-compliance will be identified and resolved through the interdisciplinary approach of the committee. <p>CORRECTIVE ACTION TAG #K062 COMPLETED ON</p> | 05/07/12 |