

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

PRINTED: 04/14/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185196</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/31/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BASHFORD EAST HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3535 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>
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F 000	<p><b>INITIAL COMMENTS</b></p> <p>A standard health survey was conducted 03/28/10 through 03/31/10. Deficiencies were cited with the highest scope and severity of an "E" with the facility having the opportunity to correct the deficiencies before remedies would be recommended for imposition. This was a Nursing Home Initiative.</p>	F 000	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p>	
F 253 SS=E	<p><b>483.15(h)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</b></p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview it was determined the facility failed to ensure that the residents' equipment was clean, and in good repair. A tour of the facility revealed there were ten (10) wheelchairs in disrepair, six (6) fall mats in disrepair, one (1) fall mat covered with a brown substance, one (1) split mattress, one (1) seat cushion with a brown crust, and one (1) cracked electrical face plate.</p> <p>The findings include: Observation of the residents' equipment with the Housekeeping Director on 03/30/10 at 9:30am revealed a total of ten (10) wheelchairs with rough and cracked arm pads, six (6) fall mats were noted to be torn and/or cracked open with exposed foam, and one (1) fall mat was noted to be covered with brown, dusty grime. Also, one (1) Resident's mattress was split on the left side, and one electrical outlet (1) face plate in a</p>	F 253	<p><b>F253 SS=E Housekeeping &amp; Maintenance Services</b></p> <p><b>I. How the Corrective Action will be accomplished for those affected:</b> The ten (10) wheelchairs with rough and cracked arm pads were replaced on 3/31/2010, new fall mats were ordered and has come in and the six (6) fall mats were immediately replaced. The fall mat with the brown dusty grime was replaced as well, the seat cushion with brown crust was replaced on 3/31/2010, the cracked electrical face plate was replaced on 4/1/2010.</p> <p><b>II. How the corrective action will be accomplished for those residents having the potential to be affected:</b> Every resident wheelchair, fall mat, seat cushion and electrical plates in center will be inspected for serviceability, and cleanliness, and repaired or replaced</p> <p><b>III. What measures will be put in place/systemic changes made to ensure correction:</b> Housekeeping will report daily to maintenance supervisor any problems with serviceability of resident equipment using the facility Intrafacility Request for Repairs and Alterations form, Additionally through our angel care program for each</p>	<p>Completed 5/15/2010</p> <p>Completed 5/15/2010</p> <p>Completed 5/15/2010</p>

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X8) DATE 4/23/10

Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 60 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.

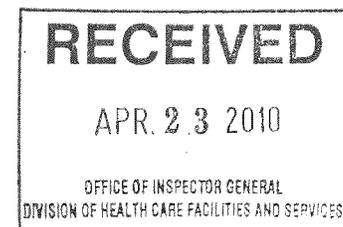
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OFFICE OF INSPECTOR GENERAL  
DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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F 253	Continued From page 1 Resident's room was cracked.  Interview with the Housekeeping Director on 03/30/10 at 9:30am revealed that nursing service usually notified either maintenance or housekeeping when equipment is noted to be in disrepair. Housekeeping is responsible to clean all the floor mats daily.  Interview with a Laundry/Housekeeper employee on 03/30/10 at 10:45am revealed that any observed cracks in the Resident's equipment should be reported to the Housekeeping Supervisor immediately. Cracked equipment can be dangerous to the residents, and can also be a place for infection to grow.  Interview with the Maintenance Director on 03/30/10 at 11:00am revealed he had not been notified of the cracked face plate. The Maintenance Department relied on nursing, and housekeeping to report broken equipment and he further stated he was unaware the face plate was cracked.  Record review of the facility Preventative Maintenance Task Sheet dated 04/01/10 at 1:00pm revealed no documentation that the tasks had been performed.	F 253	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>  observe and report and problems with equipment to maintenance supervisor using the Intrafacility Request for Repairs or Alterations form. The angel representative will also report finding at daily stand up meeting for tracking by ED and DNS. All identified items will be repaired or replaced to standard. Additionally all staff will be in service on reporting resident unserviceable equipment using the Intrafacility Reuest for Repair or Alterations form to management for resolution. The Ed will make facility rounds with the Maintenance supervisor and Housekeeping supervisor twice a month. <b>IV. How the facility plans to monitor its performances to make sure the solution is sustained:</b> The Performance Improvement Committee will monitor completion of all resident equipment reported as unserviceable until resolved monthly for six months. Performance and Improvement Committee will track and trend the results of monitoring rounds and provide inservices or corrective action with staff as needed.	Completed 5/15/2010
F 282 SS=E	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  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	F 282		



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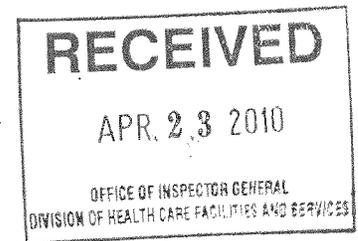
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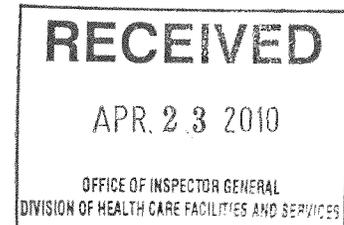
F 253	Continued From page 1 Resident's room was cracked.  Interview with the Housekeeping Director on 03/30/10 at 9:30am revealed that nursing service usually notified either maintenance or housekeeping when equipment is noted to be in disrepair. Housekeeping is responsible to clean all the floor mats daily.  Interview with a Laundry/Housekeeper employee on 03/30/10 at 10:45am revealed that any observed cracks in the Resident's equipment should be reported to the Housekeeping Supervisor immediately. Cracked equipment can be dangerous to the residents, and can also be a place for infection to grow.  Interview with the Maintenance Director on 03/30/10 at 11:00am revealed he had not been notified of the cracked face plate. The Maintenance Department relied on nursing, and housekeeping to report broken equipment and he further stated he was unaware the face plate was cracked.  Record review of the facility Preventative Maintenance Task Sheet dated 04/01/10 at 1:00pm revealed no documentation that the tasks had been performed.	F 253	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 282 SS=E	<b>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</b>  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	F 282	Enter Plan Of Correction Here. <b>F 282- Services by Qualified Persons/Per Care Plan</b> <b>I. How the Correction Action will be accomplished for those affected.</b> Resident #7 care plan and nursing assistant assignment sheet was revised on 4/22/10 to state, resident should be placed in a high visible area when in a wheelchair. When the resident wants to watch cartoons in his room staff should encourage resident to rest in bed and watch cartoons in his room. This has been validated by the Director of Nursing. Resident #12 heel lift boot for her right foot has been returned to her and she wears the boot daily as ordered. Her name has been placed in the heel lift boot and an additional heel lift boot has been ordered for her in the event the boot becomes soiled. This has been validated by the Director of Nursing. Resident #21 has 2 fall mats at her bedside on the floor while she is resting in bed. This is validated by the Director of Nursing via random audits while the resident is resting in bed.  <b>II. How Correction Action will be accomplished for those residents having potential to be affected.</b>	Enter Date Here.  Completed 5/15/10



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F 282	<p>Continued From page 2</p> <p>by: The facility failed to provide services in accordance with the resident's plan of care for three (3) of the twenty five (25) sampled residents (#7, #12 and #21). Resident #7 was not placed in a high visible area when in a wheelchair, Resident #12 did not have the heel lift boot in place, and Resident #21 did not have fall mats in place as written in the care plans.</p> <p>The findings include:</p> <p>1. Record review for Resident #7 revealed an admission diagnosis of Cerebral Palsy with contractures.</p> <p>Observations on 03/28/10 at 4:45pm, on 03/29/10 at 8:20am, 9:00am, 10:30am, and 11:00am, and on 03/30/10 at 9:00am and 12:40pm revealed the resident was in a wheelchair in his/her room watching television alone.</p> <p>Record review of the Minimum Data Set dated 02/24/10 detailed the resident with cognition of a 3 (severely impaired). The care plan dated 03/04/10 stated the resident was to be kept in a high visible area when up in a wheelchair. Review of the certified nursing assistant care plan updated on 03/29/10 did not state the resident was to be kept in a high visible area when up in a wheelchair.</p> <p>Interview on 03/31/10 at 10:55am with Licensed Practical Nurse (LPN) #1, revealed her perception of keeping Resident #7 in a high visible area meant to have the resident in front of the nurse's station or in a group activity. She stated it was important to keep the resident in view because of his/her history of falls.</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>any concerns of the resident/family) will perform an audit on all their assigned residents. The audit will be performed utilizing the resident care plan to ensure the resident has all equipment as stated on the care plan and to ensure the Nursing Assistant assignment sheet, physician orders and care plan all have the same interventions. Care plans will be updated immediately by the Angel with any updated interventions. Nursing Assistant assignment sheet will be updated by the DNS/ADNS, Unit manager within 24 hours upon being made aware of any additions or changes to the residents care plan interventions.</p> <p><b>III. What measures will be put in place/systemic changes made to ensure correction.</b> All Nursing staff will be in serviced and reeducated by the Staff Development Coordinator and/or Director of Nursing/ADNS to the process of in the event a residents equipment becomes soiled or damaged, until the equipment is replaced they should notify the M.D for further instructions/orders and document on the facility 24 hour report log for follow-up by the DNS/ADNS, Unit manager, and/or</p>	Completed by 5/15/2010



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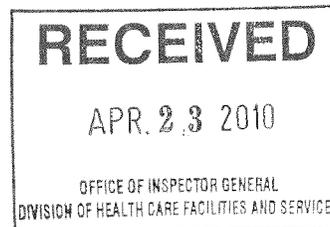
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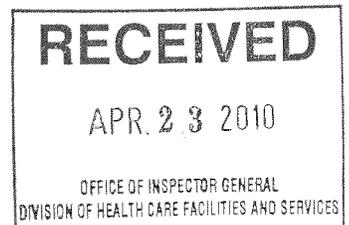
F 282	<p>Continued From page 3</p> <p>Interview with the Unit Manager of the 100 Hall on 03/31/10 at 10:58am revealed the care plan did state the resident should be in a high visible area when in a wheelchair because of the history of falls. However, the resident is often kept in his/her room when in the wheelchair because the resident likes to watch cartoons. When the resident is in a wheelchair in the room, he/she is kept at the foot of the bed so staff can observe the resident as they walk past the room. However, no explanation was given how supervision was accomplished if staff were not passing by the resident's room or if the staff did not look into the room as they passed by to observe the resident.</p> <p>2. Record review for Resident#12 revealed the resident was admitted to the facility on 10/19/09 with Anemia, Pressure Ulcer on the heel, Congestive Heart Failure, Hypertension, history of Falls, Alzheimer's Disease and Diabetes. Review of the Resident's Comprehensive Care Plan Report revealed the resident was to wear a right heel lift boot at all times.</p> <p>Observations of Resident #12 on 03/29/10 at 8:20am revealed the resident sitting in a wheelchair in the dining room, on 03/29/10 at 9:15am sitting in the hallway in a wheelchair, and on 03/29/10 at 10:00am sitting in the wheelchair, next to his/her bed with no Heel Lift Boot observed on the resident's right foot.</p> <p>Interview with CNA#2 on 03/31/10 at 9:10am revealed Resident#12's boot had been soiled with stool on 03/28/10 and was sent to the laundry to be cleaned. The CNA reported this to the nurse, and was unsure why the boot had not yet been</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>nursing assistant assignment sheet to ensure care plan interventions are being implemented on a daily basis during all shifts.</p> <p>An audit utilizing the <i>Review of Process Measures-Providing ADLs/Grooming</i> form (form includes resident grooming, equipment use, and reviewing the care plan and nursing assistant assignment sheet for accuracy) will be completed weekly for three residents per unit per week as of 4/26/10 by Unit Managers or designee. All findings during the audit will be immediately corrected with education provided to the employee whom was deficient in following the residents care intervention. Any employee found to continuously be deficient in following the resident's care plan interventions will be placed on the performance improvement process. This audit will be ongoing weekly for one year.</p> <p><b>IV. How the facility plans to monitor its performance to make sure the solutions are sustained.</b></p> <p>Findings from the <i>Review of Process Measures-Providing ADLs/Grooming</i> form will be reported to the Director of Nursing Services on a weekly basis. The findings</p>	<p>Completed by 5/15/10</p>
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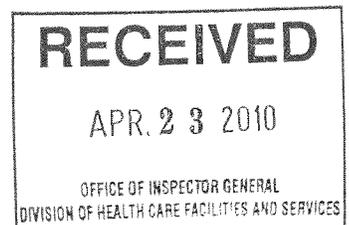
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F 282	<p>Continued From page 4 replaced since that day.</p> <p>Interview with LPN #3 on 03/31/10 at 1:00pm revealed that the boot had indeed become soiled on Sunday 03/28/09, and had been sent to the laundry. She had not followed up on replacing the boot. The boot was soiled right at the shift change, and she did not even think about replacing it despite the fact that the intervention was a part of the resident's Plan of Care.</p> <p>Interview with the Director of Nurses on 03/31/10 at 10:05am revealed that the nurse providing care to Resident#12 on Sunday 03/28/10 should have followed up on the soiled boot. The facility would need to develop a backup plan regarding how to obtain necessary resident equipment on the weekends.</p> <p>3. Record review for Resident #21 revealed an admission date of 03/06/09 with diagnoses of Congestive Heart Failure, Alzheimer's, Transient Cerebral Ischemia, Cardiomyopathy, Urinary Tract Infection, and Pressure Ulcer.</p> <p>Observations revealed the resident in bed awake, involved with a word find magazine. Observation of the resident on 03/28/10 at 4:46pm revealed one (1) floor mat on the right side of the bed, and no floor mats in place on the left side of bed. Observation revealed a folded floor mat standing in the corner of the resident's room between the wall and the night stand. Observation of the resident on 03/30/10 at 3:13pm revealed the left side of the bed remained without a floor mat. Continued observation of the resident on 03/31/10 at 7:55am, 8:29am, 9:11am, and 9:45am, revealed he/she remained in bed without a floor mat on the left side of the bed.</p>	F 282	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>Committee monthly for the next 6 months and thereafter as needed. The Performance Improvement Committee will address any repeated concerns for further plan of actions to prevent the deficient practice from reoccurring.</p>		



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F 282	<p>Continued From page 5</p> <p>Record review of the physician orders for March, 2010 revealed orders for a Hi/Lo bed with mats on the floor.</p> <p>Record review of the Minimum Data Set (MDS) dated 03/02/10 detailed the resident with cognition of a 2 (moderately impaired). The care plan dated 03/02/10 stated the resident was to be in a Hi/Lo Bed with mats. Review of the certified nursing assistant care plan updated on 03/31/10 revealed the resident has a Hi/Lo Bed with Mats, identified as a fall risk, and as a Falling Star.</p> <p>Interview with LPN #2 on 03/28/10 at 4:46pm during tour revealed the resident has two (2) floor mats, one for each side of the bed. She reported both floor mats are to be used for Resident #21 at all times.</p> <p>Interview with Certified Nurse Assistant (CNA) #1 on 03/31/10 at 9:55am revealed the resident has a CNA care plan that included the resident was to have floor mats. She indicated the care plan did include the word mats meaning two (2) mats, one for each side of the bed. They usually did not have the one down on the left side of the bed for Resident #21 because the resident in the middle bed, of this three bed ward, liked to be out of the bed, and the mats interfere with that resident's mobility.</p> <p>Interview with LPN #1 on 03/31/10 at 10:15am revealed the resident has a nursing care plan that included the resident was to have floor mats. The care plan did include the word mats meaning two (2) mats, one for each side of the bed.</p> <p>Interview with the Unit Manager of the 300 Hall on</p>	F 282			



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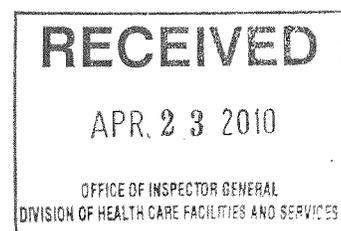
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F 282	Continued From page 6 03/31/10 at 10:15am revealed the resident had a current physician order, nursing care plan, and a CNA care plan in place for the use of floor mats. The mats were to maintain a safe environment for the resident, and the resident was to remain safe from fall injury. She was not aware staff had not placed the fall mats on both sides of Resident #21's bed.	F 282	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 309 SS=E	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING  Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.  This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, it was determined the facility failed to provide the necessary care and services for four (4) of twenty-five (25) sampled residents (#13, #3, #2, and #23). The facility failed to pre-medicate Resident #13 with Tylenol thirty (30) minutes prior to Physical Therapy as per physician order. The Tylenol order was also transcribed incorrectly on the resident's medication record. The facility administered Resident #3 a PPD even though the allergy sticker on the resident's chart stated a past positive reaction to PPD. In addition, the facility failed to administer Resident #2's pain medication for a total of nine (9) doses and failed to ensure physician ordered labs were completed in a timely manner. Resident #2 had a physician's order to obtain a stool sample for	F 309	Enter Plan Of Correction Here. <b>F 309- Providing Care/Services for Highest Well Being.</b> <b>I. How the Correction Action will be accomplished for those affected.</b> Clarification orders were written for resident #13 on 4/22/10. The therapy department was consulted and agreed to a time of when resident #13 would receive her daily therapy services. Resident #13 clarification orders were written on the routine medication record to be given 30 minutes prior to the time therapy agreed to administer the resident #13 therapy. The RCS Coordinator corrected resident #13 Tylenol order in the computer system to ensure the order prints out with her routine medication monthly or until the resident is discontinued from therapy services. Resident #3 received a chest x ray due to his history of positive tuberculin reaction. Chest X-ray results returned with "No Active Disease". A medication variance form was completed notifying the physician, and responsible party of the variance. Resident #2 is receiving her pain medication routinely as ordered. Her stool sample for C-diff has been discontinued due to resident has had no further episodes of diarrhea. Resident #23	Enter Date Here.  Completed by 5/15/10



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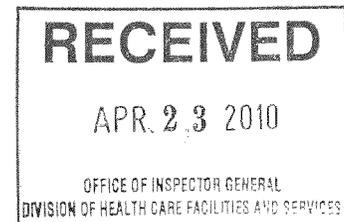
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NAME OF PROVIDER OR SUPPLIER  <b>BASHFORD EAST HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3536 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>		
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F 309	<p>Continued From page 7</p> <p>Clostridium Difficile, and Resident #23 had a physician's order for a stool sample for Ova and Parasites which were not completed.</p> <p>The findings include:</p> <p>Record Review on 03/31/10 of the Physician Order Policy stated that the nurse, Certified Medication Aides (CMAs), or other qualified staff are to verify dosages and/or orders that appear inappropriate considering the resident's age, condition, drug contraindications, allergies or diagnosis. Clarify any orders observed to be incomplete, illegible, or presents any other concerns, prior to administering the medication. If transcribing onto an order sheet when placing the order with the pharmacy, double check the order to validate that there are no transcription errors. Double check to ensure there were no transcription errors.</p> <p>Record review for Resident #13 revealed an admission date to the facility of 07/27/09 with Colitis, Urinary Tract Infection, Sepsis, status post Brain and Epidural Abscess, Encephalopathy, Percutaneous Tube, and Hypertension. The Physician Order dated 12/16/09 revealed the resident was to receive Tylenol ES 500mg two (2) tablets thirty (30) minutes prior to daily Physical Therapy. This order was transcribed incorrectly on the resident's monthly medication records dated for the months of January 2010, February 2010, and March 2010. The incorrect order was transcribed as Tylenol PM Extra Strength (Acetaminophen PM) 500mg Tablet Give 2 tabs=1000mg by mouth 30 minutes prior to physical therapy.</p> <p>Observation on 03/29/10 at noon revealed</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>on resident #23.</p> <p><b>II. How Correction Action will be accomplished for those residents having potential to be affected.</b></p> <p>The RCS Coordinator audited all PRN pain medication records on 3/31/10 of all residents in the facility to validate the physician order is reflected as a PRN order on the medication record versus a routine pain medication order.</p> <p>A facility audit of all residents PPD for the year of 2009 until current date was completed on 4/1/10 to ensure all residents are up to date. The medical records clerk has received clarification instruction by the Director of Nursing Services and Kindred policies and procedures related to any overdue PPD vaccinations.</p> <p>All current residents with a history of positive PPD reaction will have clarification orders written and transcribed to the medication record to alert licensed nurses of residents with a history of positive PPD/tuberculin. All current residents will have this alert placed on the sticker on the inside of the chart to identify the resident's history of PPD reaction.</p> <p>An audit will be conducted dating back from</p>	Completed by 5/15/10	

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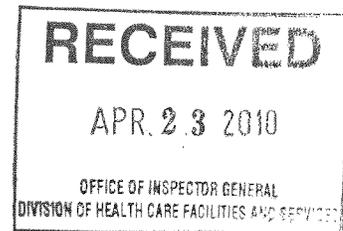
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F 309	<p>Continued From page 8</p> <p>Resident #13 was assisted to Physical Therapy. The resident did not receive a pre-medication prior to therapy, nor did the Physical Therapist notify the nursing staff prior to the resident's therapy.</p> <p>Interview on 03/29/10 at noon with the Physical Therapist revealed residents are seen for therapy throughout the day, and the nursing staff are not necessarily notified when the resident's engage in physical therapy. Continued interview with the Physical Therapist on 03/31/10 at 11:10am revealed that she would not know a resident needed to be pre-medicated prior to Physical Therapy unless she actually reviewed the resident's chart and the physician's orders, which she does not routinely do. She was unaware of Resident #13's physician order for pre-medication prior to therapy. She stated that if new orders related to pre-medication prior to Physical Therapy could be placed on the Daily Twenty-Four Hour Report then Physician pre-medication orders could be more accurately followed.</p> <p>Interview on 03/29/10 at 3:00pm with Licensed Practical Nurse (LPN) #4 revealed that the Resident Care Services (RCS) Coordinator initially entered all the new physician orders. Next, the new orders are reviewed in the daily morning meeting. LPN #4 further stated this specific Tylenol order apparently was not corrected. The nursing staff should be the ones to inform physical therapy about an order for a pre-medication prior to therapy.</p> <p>Interview on 03/29/10 at 3:15pm with the RCS Coordinator revealed that she transcribed any new Physician Orders daily. She stated that</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>to the facility with M.D notification Any labs found to be deficient will have an event report completed with M.D notification for further interventions.</p> <p><b>III. What measures will be put in place/systemic changes made to ensure correction.</b></p> <p>All licensed nurses will receive an in service by the Staff Development Coordinator and/or Director of Nursing/ADNS related to transcription of physician orders (routine versus PRN), tuberculin administration versus chest X-ray policy and procedure, and transcription of lab orders/collection of labs. The RCS coordinator will validate correct transcription of physician orders to ensure the nurses transcription on the medication administration record and/or treatment administration record correlates with the computerized RCS orders. At the end of the month for changeover of the proceeding month's medication/treatment administration records, the Unit Managers/designee will check all the current months physician orders transcribed by the licensed nurses to ensure the computerized physician orders have been imputed into the RCS system correctly. Any orders found to be deficient</p>	Completed by 5/15/10	



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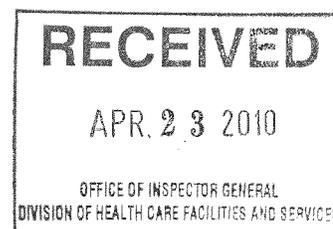
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F 309	<p>Continued From page 9</p> <p>Resident #13's order was transcribed incorrectly and fell through the facility's safety system. Once the new orders were transcribed, orders are then reviewed by the Nurse Manager.</p> <p>Interview on 03/29/10 at 3:30pm with the Unit Manager revealed any new Physician Orders are reviewed by her daily against the original physician order. She stated this particular physician's order had fallen between the cracks and had not been transcribed correctly nor corrected by her during the resident's chart review.</p> <p>Record Review of Resident #13's Physical Therapy Logs revealed he/she had participated in Physical Therapy a total of twenty-eight (28) sessions in which no pre-medication had been administered.</p> <p>Record review for Resident #2 revealed an admission date of 11/25/09 with diagnoses of Decubitus Ulcer, Immobilization Syndrome, Spastic Hemiplegia and Peripheral Neuropathy. The resident was to receive Norco 10/325 mg via gastrostomy tube every four (4) hours for pain per physician's order dated 02/11/10. The Medication Administration Record (MAR) indicated the resident did not receive nine doses of this medication from 03/05/10 at 6:00pm through 03/06/10 at 2:00am. The back side of the MAR was blank with no explanation why the medication was circled. A pharmacy delivery sheet dated 03/06/10 indicated the medication was received at 9:00pm on the 6th. A note faxed to the physician dated 03/08/10 at 1:00pm stated the resident did not receive the medication as it was not available. The pharmacy had been notified several times to deliver the medication but it was</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>correction of the order into the system. All new and readmissions with a history of positive PPD reaction will receive a physician order for a CXR to be completed due to their history of positive PPD. A sticker indicating "positive PPD" will be placed on the inside of the chart to alert all licensed nurses. The Medical Records clerk will validate the placement of the sticker on the charts and that the PPD and/or chest x-ray was actually administered or conducted on the resident. All admission/readmission and annual PPDs will be tracked by the medical records clerk. The Medical Records clerk will validate the resident PPDs/CXR has been transcribed onto the medication administration record and administered by validation of documentation by the licensed nurses in a timely manner per Kindred's policy and procedure. All deficient practices will be corrected immediately with an event report, notification of the M.D for further instruction and notification of the Unit Manager and Director of Nursing Services/ADNS.</p> <p>All labs will be validated by the Unit Manager/ weekend supervisor that they were transcribed into the lab binder. Any labs that were not collected will have an event report</p>		



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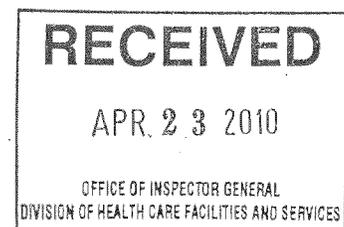
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F 309	<p>Continued From page 10</p> <p>not delivered until 03/07/10. The resident did not receive a dose of the pain medication until 03/07/10 at 6:00am. The physician responded the same day and requested the DON (Director of Nursing) or the ADON (Assistant Director of Nursing) be notified to see what needed to be done about this. Review of the facility's investigation dated 03/30/10 revealed an error occurred but the error did not reach the resident.</p> <p>Interview with the Unit Manager (UM) on 03/30/10 at 1:00pm revealed the resident was on pain medication as needed and changed to a routine pain medication for pain management. The physician was faxed on 03/08/10 regarding the error; however, there was no medication error report completed until it was brought to her attention today. The pharmacy was notified several times to deliver the medication but the physician was not notified until March 8, 2010. The physician should have been notified sooner.</p> <p>Interview with the pharmacy representative on 03/30/10 at 4:15pm revealed they did receive a fax from the facility regarding the resident's pain medication on 03/05/10 at 12:45am. He had no way of knowing if the facility called on several occasions. The next delivery would have been the next day on 03/06/10. However, if it was needed sooner the facility should have requested a stat delivery.</p> <p>Interview with the Administrator on 03/31/10 at 1:00pm revealed he was not made aware of the medication error regarding this resident, or the untimely delivery by pharmacy, nor the multiple calls made to the pharmacy by staff.</p> <p>Review of the facility policy regarding Medication</p>	F 309	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>back on the lab calendar to be collected the next lab date.</p> <p><b>IV. How the facility plans to monitor its performance to make sure the solutions are sustained.</b></p> <p>The Performance Improvement Committee will monitor the compliance of Tuberculin administration and lab collection. The DNS will audit all PPDs of new/readmits and annual resident due for testing on a monthly basis. Audit findings will be tracked and trended by the Director of Nursing and reported to the Performance Improvement Committee for the next 6 months. The Performance Improvement Committee will develop any further plan of action if any noted continued deficient practices in these areas.</p>	Completed as of 5/15/10	



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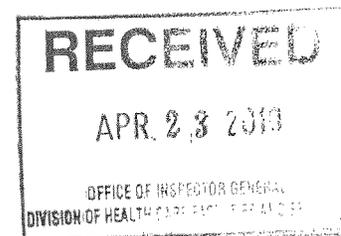
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F 309	<p>Continued From page 11</p> <p>Ordering and Receiving dated 10/31/09 stated medications and related products are received from the provider pharmacy on a timely basis. The center maintains accurate records of medication order and receipt that accounts for all medications including controlled medications. Reorder medications in advance (three to four days) of need to assure an adequate supply is on hand as established by the pharmacy process. If needed before the next regular delivery, fax/phone the medication order to the pharmacy immediately upon receipt. Inform the pharmacy of prompt delivery. Medications are delivered so that medication administration is not delayed. If the pharmacy is closed, deliver stat/emergency medications within two hours upon receipt of the order. If the medication is not available in the emergency kit or through the provider pharmacy, contact the back-up pharmacy for the medication. If the medication continues to be unavailable, contact the physician for further instructions (i.e. alternate medications, is it possible to delay the medication).</p> <p>In addition, record review for Resident #2 indicated the physician ordered a stool specimen for C-Diff (Clostridium Difficile) on 03/18/10 due to the resident experiencing loose stools and had just completed two different antibiotics on 03/17/10. Review did not reveal any laboratory results for this stool specimen. The Flow Sheet Record indicated the resident had seventeen (17) stools from 03/18/10 until 03/30/10. Review revealed a physician's order dated 03/31/10 to discontinue the order for the stool specimen.</p> <p>Interview and record review with the UM on 03/30/10 at 2:00pm revealed the original lab requisition was still in the clinical record and had</p>	F 309			



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F 309	<p>Continued From page 12</p> <p>not been placed in the lab box or placed on the 24 hour report as it should have been. In addition, the lab should have been carried on the 24 hour report until it was completed. The UM stated there had been no follow through with the lab request.</p> <p>Additionally, review of the closed record for Resident #23 revealed a physician's order for stool for O&amp;P (ova and parasites) dated 11/07/09. Review of the lab results indicated the stool specimen provided was not suitable for the test requested. The facility was contacted on 11/08/10 at 8:51am; spoke with an identified employee who stated another specimen would be collected. Review of the Flow Sheet Record for November, 2009 revealed the resident had 26 stools from 11/08/09 through 11/30/09 and 26 stools from 12/01/09 through 12/30/09 for a total of 52 opportunities to obtain the specimen.</p> <p>Interview and record review with the UM on 03/31/10 at 1:10pm revealed there was no documentation in the nurse's notes to indicate the specimen had been obtained and should have been there. Research of all laboratory results did not reveal any evidence the specimen had been recollected. The specimen would have been documented in the lab book and the 24 hour report; however, these are only maintained by the facility for 90 days. The facility does not know if the specimen was ever recollected.</p> <p>Interview with the Administrator on 03/31/10 at 1:00pm revealed labs are monitored through the morning stand up meetings and tracked for resolution. However, the administrator was not aware these labs had not been completed and could not state how they were missed.</p>	F 309			



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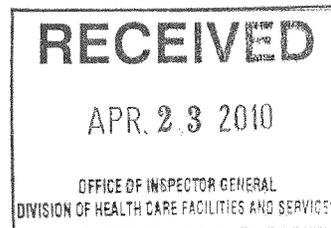
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F 309	<p>Continued From page 13</p> <p>Review of the facility's policy regarding Laboratory Services revealed lab services are obtained to meet the needs of the residents. Services are both accurate and timely. Services are considered timely if lab tests are completed and results provided to the physician within time frames normal for appropriate interventions. The facility is responsible for, obtaining, promptly notifying the physician, and maintaining lab reports in the clinical record.</p> <p>Record review of Resident #3 revealed an admission date of 12/30/09 with diagnoses of Malnutrition, Esophageal Stricture, Esophageal Reflux, Tuberculosis (TB) History, Meningitis History, and a Malignant Neoplasm of the Prostate. Record review of the 12/23/09 history and physical sent to the facility with the admission packet for this facility included the past medical history of "TB with Meningitis". Record review of the Medication Administration Record (MAR) dated 12/30/09 revealed "TB with meningitis" listed in the diagnosis group, and a first step and second step listed in the medication section. The first step was documented as given in left forearm on 12/30/09 with documentation that the resident had a diagnosis of TB with meningitis history, and the physician was notified. There were no adverse reactions identified as a result of the first step TB skin test administered.</p> <p>Record review of the facility's policy on Tuberculosis Exposure Control Plan dated 10/31/09 revealed a Tuberculosis (TB) infection control plan that is part of the overall infection control plan in place to prevent the transmission of TB. Section 9 in the facility's plan revealed new residents are screened for symptoms and</p>	F 309		
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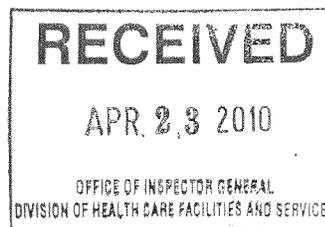
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F 309	Continued From page 14 tested for TB. Section 9 a. Exempted from this requirement are: 1. Persons with a documented history of positive TB skin test results.  Interview with the unit manager on 03/30/10 at 2:00pm on the 300 Wing reported the TB skin test should not have been given to a resident with a known history of TB. She reported it is a standard for this facility to screen for TB, but was unable to provide any information on why the resident received a TB skin test with a known history of TB.	F 309	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 371 SS=E	<b>483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</b>  The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions  This REQUIREMENT is not met as evidenced by: The facility failed to store, prepare, distribute, and serve food under sanitary conditions. Observation of the kitchen revealed a brown colored greasy substance on the double oven doors, the ice machine had an orange colored substance on the ice guard, the mixer guard had dried particles between the metal rings, the meat slicer had a tan colored substance at the base of the handle, and the front of the stove had a brown colored substance near the knobs.	F 371	<b>F371 SS=E Food Procure,Store/Prepare/Serve-Sanitary</b>  <b>I. How the Corrective Action will be accomplished for those affected:</b> The brown colored greasy substance on the double oven doors has been clean and additionally working with manufacture to replace glass in oven door. The orange colored substance on the ice machine guard has been clean completely, the mixer guard has been clean and is free of dried particles between the metal rings, the meat slicer that had the tan colored substance at the base of handle has been clean completely, and the brown colored substance near the knobs on the stove has been clean.  <b>II. How the Corrective Action will be accomplished for those residents having the potential to be affected:</b> Dietary staff has been inservice on the proper cleaning of equipment after use. Equipment that cannot be clean to standard will be requested to be replaced. All other staff will be inservice on reporting ice machine anytime there is an issue with cleanliness to maintenance for servicing between schedule services.  <b>III. What Measures will be put in</b>	Completed 5/15/2010  Completed 5/15/2010  Completed



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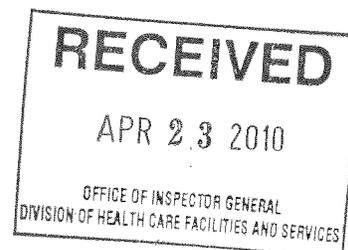
PRINTED: 04/14/2010  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185196	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  03/31/2010
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NAME OF PROVIDER OR SUPPLIER  BASHFORD EAST HEALTH CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218
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(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)	(X6) COMPLETION DATE
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F 371	<p>Continued From page 15</p> <p>The findings include:</p> <p>Observation of the kitchen on 03/28/10 at 2:00pm revealed the meat slicer was covered in plastic and when the plastic was removed a tan colored substance was observed at the base of the handle, the ice machine revealed an orange colored substance on the ice guard, the mixer was covered in plastic and when the plastic was removed a tan colored substance was observed between the metal of the mixer guard, and the double oven revealed a brown colored substance between the oven doors, a substance running down the glass on the doors, and on the front of the stove there was a brown colored substance near the knobs.</p> <p>The Dietary Service Manager stated the double ovens were on a Monday/Thursday cleaning schedule. However, observation of the double oven on 03/30/10 at 11:45pm revealed the doors had the same exact substance as previously noted on 03/28/10. The stove had a brown colored substance on the front near the knobs which the Dietary Service Manager acknowledged could be removed with cleaning. It was acknowledged that to thoroughly clean the double ovens and the stove, a staff member would need to do the cleaning during off hours. She stated the ice machine was the responsibility of maintenance.</p> <p>Interview with the Director of Maintenance on 03/31/10 at 1:05pm revealed he cleaned the ice machine monthly. He did not notice the ice guard had an orange substance on the bottom of the guard. He acknowledged ice could come in contact with the substance if the ice machine was at capacity. The Director of Maintenance stated</p>	F 371	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>The Dietary Manager will conduct daily rounds to ensure that equipment is clean to standard, the Executive Director will conduct weekly rounds of kitchen to ensure that equipment is clean and periodic random checks during the week, the Dietician will conduct monthly rounds to ensure cleanliness of equipment. Maintenance Supervisor will make weekly checks of ice machine for cleanliness. Correction will be made immediately and staff educated appropriately on anything found not to be to standard.</p> <p><b>IV. How the facility plans to monitor its performances to make sure the solution is sustained:</b></p> <p>The dietary Manager will conduct and record daily monitoring of the above equipment using the nutrition services rounding form for six month and report the finding to the Executive Director, The Executive Director will conduct weekly rounds and record findings on nutrition services form for six months, the Dietitian will conduct monthly rounds in kitchen and record findings on Nutrition Services Evaluation form and report findings to Executive Director. The Performance Improvement Committee will monitor the process on a monthly basis based</p>	Completed 5/15/2010
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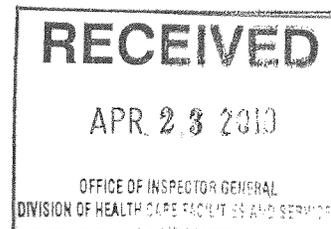
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185196</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>03/31/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BASHFORD EAST HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3635 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>
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F 371	Continued From page 16 the staff should inform him if the ice machine needs cleaning.  The facility policy dated 04/28/06 states the mixer and slicer should be cleaned after each use, taking removable parts and placing them in the dishwasher or cleaning them in a three compartment sink. The stationary parts should be cleaned with warm soapy water. The ovens should be lightly cleaned daily and thoroughly cleaned weekly with degreaser detergent, oven cleaner, stainless steel cleaner, and dish detergent as indicated.	F 371	<i>This Plan of Correction is the center's credible allegation of compliance.</i>  <i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i>	
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431	monitoring rounds and provide in-services or corrective action with staff as needed.	



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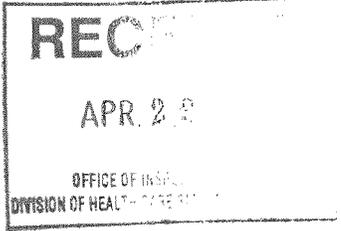
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F 371	Continued From page 16 the staff should inform him if the ice machine needs cleaning.	F 371	<i>This Plan of Correction is the center's credible allegation of compliance.</i>	
F 431 SS=D	483.80(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.  Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.  In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.  The facility must provide separately locked,	F 431	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</p> <p>Enter Plan Of Correction Here. <b>F 431- Drug Records, Label/Store Drugs and Biologicals.</b></p> <p><b>I. How the Correction Action will be accomplished for those affected.</b> The bottle of Omeprazole 2 mg/ml suspension for resident #11 discarded on 3/31/10. The label was pulled and the medication was reordered from pharmacy for resident #11. The Tuberculin PPD vial was discarded on 3/31/10 due to no date on the vial itself.</p> <p><b>II. How Correction Action will be accomplished for those residents having potential to be affected.</b> All medication carts and refrigerators have were audited on 3/31/10 to ensure all multi-dose vials and bottles is labeled with a "date opened" or was discarded due to no date or expired date. All discarded medications were reordered from pharmacy to ensure the resident received their prescribed medications as ordered.</p> <p><b>III. What measures will be put in place/systemic changes made to ensure correction.</b></p>	<p>Enter Date Here.</p> <p>Completed by 5/15/10</p> <p>Completed by 5/15/10</p>

All nurses will be in service and readmitted by the Staff Development Coordinator and/or Director of Nursing/ADNS to the  
Completed by 5/15/10  
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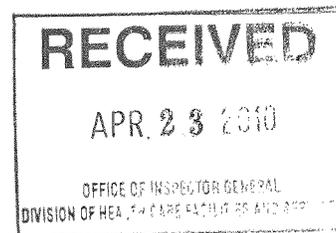
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NAME OF PROVIDER OR SUPPLIER  <b>BASHFORD EAST HEALTH CARE</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>3535 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>
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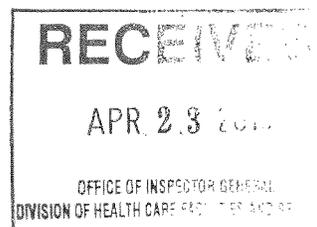
F 431	<p>Continued From page 17</p> <p>permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to ensure expired medications were removed, and not available, or accessible for resident use in the East Wing Medication Refrigerator, also a Tuberculin, PPD open vial was left in the East Wing Medication Refrigerator and it was not labeled according to the facility's policy.</p> <p>The findings include:</p> <p>Observation on 03/31/10 at 10:50am revealed expired medication in the East Wing refrigerator for Resident #11. The expired medication identified in the refrigerator was labeled as Omeprazole 2 mg/ml suspension, one hundred twenty (120) milliliters (ml) suspension in a bottle, and had a label that identified to refrigerate with an expiration label dated 03/25/10. Observation on 03/31/10 at 10:50am revealed a Tuberculin PPD vial was not labeled with a date when opened and initialed in accordance with the facility's policy.</p> <p>Record review of the facility's policy on Medication Labels and Packaging dated 10/30/09</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <p>policy and procedure of proper labeling of multi-dose vials and bottles and the discarding of expired medications. The DNS or designee will audit the Medication refrigerators on all units 3x/week to validate there are no expired medications in the refrigerator and all bottle/vials have been properly labeled. The Unit Manager/designee will audit the medication cart once/week to ensure all bottles/vials have been properly labeled and no expired bottles/vials remain on the cart.</p> <p><b>IV. How the facility plans to monitor its performance to make sure the solutions are sustained.</b></p> <p>The Performance Improvement Committee will monitor the compliance of medication labeling and storage. The Unit Managers will communicate all cart audit findings via documentation to the Director of Nursing. The Director of Nursing/ADNS will track and trend all cart audit findings and Medication refrigerator audits for the next 6 months and report to the Performance Improvement Committee. Findings will also be reported as needed with any variances noted by the Pharmacy consultant visits on a monthly basis. The Performance</p>	Completed by 5/15/10
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NAME OF PROVIDER OR SUPPLIER  BASHFORD EAST HEALTH CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 3535 BARDSTOWN ROAD LOUISVILLE, KY 40218	
(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 431	<p>Continued From page 18</p> <p>revealed the facility's staff administered medications are labeled in accordance with center requirements, and State and Federal regulations. Medications are provided in packaging to facilitate proper storage and administration of the medication using the agreed upon distribution system. Medications that may require special packaging other than unit dose include: medications requiring refrigeration, liquid medications, or injectable medications. According to the facility's policy the staff are to validate that each prescription medication label includes 1. h. expiration date, 1. k. accessory labels indicating storage requirements, precautionary labels, and special procedures. The facility's policy on Medication Labels and Packaging dated 10/31/09 referenced Multi-Dose Vials and Bottles, revealed #9:... if the efficacy of the drug is affected by opening a multi-dose vial/bottle, initial and date the vial/bottle when opening for the first time.</p> <p>Interview on 03/31/10 at 10:55am with Licensed Practical Nurse (LPN) #3 revealed she would read the Omeprazole as expired by the label dated 03/25/10 on the side of the bottle. She stated the Tuberculin PPD should have a date written on the vial and initialed by the staff that opened the Tuberculin PPD. She revealed she would not use the PPD vial since it did not have a date or initial written on the vial.</p> <p>Interview on 03/31/10 at 11:00am with the Pharmacist revealed the best practice is to order medications before the expiration date. She reported Omeprazole suspension can be kept under refrigeration for thirty (30) days. She stated the bottle was labeled for refrigeration, and had an expiration date of 03/25/10. She revealed</p>	F 431	<p><i>This Plan of Correction is the center's credible allegation of compliance.</i></p> <p><i>Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.</i></p> <hr/> <p>practices occur.</p>	

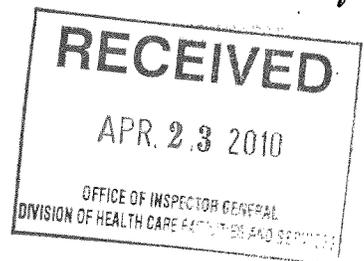


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NAME OF PROVIDER OR SUPPLIER  <b>BASHFORD EAST HEALTH CARE</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3635 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>		
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F 431	Continued From page 19 some staff know it is good for up to thirty (30) days under refrigeration, and others do not. She was not able to ensure the medication had been keep under the appropriate refrigeration since it had left her location, and that is why they put the shorter expiration date on the label. She stated she found it to be acceptable to dispense this type of medication after the expiration date on the bottle.	F 431			

*2/20/22*



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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185196</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING</b> B. WING _____		(X3) DATE SURVEY COMPLETED  <b>04/15/2010</b>
NAME OF PROVIDER OR SUPPLIER  <b>KINDRED NURSING AND REHABILITATION-BASHFORD</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>3535 BARDSTOWN ROAD LOUISVILLE, KY 40218</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
K 000	INITIAL COMMENTS  A Life Safety Code Survey was conducted on 04/15/10 to determine the facility's compliance with Title 42, Code of Federal Regulations, 482.41(b) (Life Safety from Fire) relating to NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	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.