

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

PRINTED: 08/03/2011
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 07/21/2011
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			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 000	INITIAL COMMENTS A standard health survey was initiated on 07/19/11 and concluded on 07/21/11 and a Life Safety Code survey was conducted on 07/21/11 with deficiencies cited at the highest scope and severity of an "E". An abbreviated survey was initiated on 07/19/11 and concluded on 07/21/11 to investigate KY16552. KY16552 was unsubstantiated with no deficiencies cited related to the allegation.	F 000	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that any deficiencies are accurate. The Plan of correction is submitted as a written allegation of compliance.	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable environment. The facility had six (6) of twenty five (25) doors with chipped wood, marred and chipped paint. Flickering lights with burned out light bulbs in three (3) of sixteen (16) facility room locations. The facility had one (1) corridor (F9) of the six (6) corridors with peeling wallpaper. The findings include: The facility could not provide evidence of a policy for Housekeeping or Maintenance.	F 253	It is the facilities policy to be in compliance with this regulation. 1) All 4 IV poles have been cleaned including the pole base, pump, and the cord. The geri chair in room C-2 was deep cleaned. Base boards in rooms A-6, C-2 and C-5 have been secured. Doors in rooms A-3, A-6, A-7, B-6, C-2, C-5 and D-4 have been repaired and painted. Window blinds in rooms C-1, C-2 and F-2 have been replaced. Curtains in C-5 were changed. Hole in room F-9 has been repaired and painted. Wall paper between rooms F-4 and F-5 has been replaced. Peeling wall paper between rooms F-4 and F-5 has been secured to the wall. The flickering ceiling lights in the lounge area between A and D hall has been fixed and cleaned of all loose debris, the light bulbs in A6 and F1 have been replaced with new working bulbs. The missing pull cords in A6, F9 and F11 have been replaced. The missing outlet plug in F9 has been replaced with a new cover.	

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

TITLE

(X6) DATE

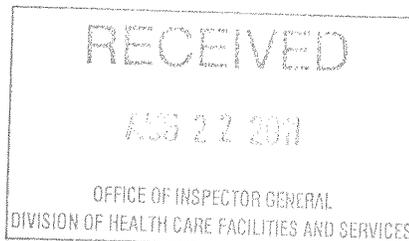
[Signature] Administrator 08-22-2011

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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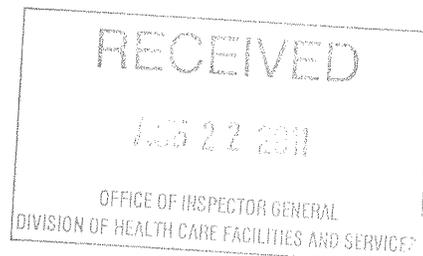
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F 253	<p>Continued From page 1</p> <p>Observations during the environmental tour of the facility, on 07/21/11 at 4:46 PM, revealed the following items were in need of repair and or cleaning:</p> <ol style="list-style-type: none"> Four (4) Soiled IV poles with a brownish, tan colored substance caked on the poles and the leg bases in the clean medication room ready for patient use. The Geri-chair in Room C2 with yellowish, brown, dried, caked particles in the seat and on the legs of the chair. Loose baseboards in rooms A6, C2, and C5. Chipped wood and marred paint were observed on doors in resident rooms A3, A6, A7, B6, C2, C5, and D4. Window blinds were broken in rooms C1, C2 and F2 and the curtains were soiled in Room C5. A hole in the wall (2"X1.5") was observed in Room F9. A brown discolored area (18"X18") was observed on the wallpaper in the F Hallway between rooms F4 and F5. Peeling wallpaper at the seam in two (2) areas, each seven (7) inches in length was observed in the F Hallway between rooms F4 and F5. A flickering ceiling light in the resident lounge area between A and D Hall. The ceiling light area had brown, dried, loose debris in the light fixture 	F 253	<p>2) All IV poles have been checked and cleaned. All geri chairs have been check and cleaned. All rooms have been checked for loose baseboards and corrected when detected. All doors have been checked for chipped wood and marred paint and corrected when detected. All window blinds have been checked and replaced or repaired when detected. All curtains have been checked for cleanliness and cleaned or changed out when detected. All rooms have been checked for holes and repaired when detected. All wall paper has been checked for stains and peeling and have been cleaned, replaced and secured when detected. All ceiling lights have been checked for cleanliness and cleaned if detected to be dirty. All light bulbs have been checked to be working and replaced when detected to be out. All lights were checked for missing cords and were replaced when detected. All outlets have been checked to be in place and replaced when detected to be missing</p> <p>3) Housekeepers have been reeducated by the new Environmental Services Director on 08/19/2011 on proper cleaning of IV poles, curtains, wallpaper, geri chairs and ceiling lights. Maintenance has been reeducated on checking for loose base boards, marred and chipped doors broken window blinds, holes in resident rooms, wall paper peeling and stained, burned out light bulbs, missing lightcords and missing plug covers. A new cleaning schedule has been developed. Staff have been reeducated on the use of maintenance orders for reporting broken or damaged items. The new Environmental Services Director and the</p>



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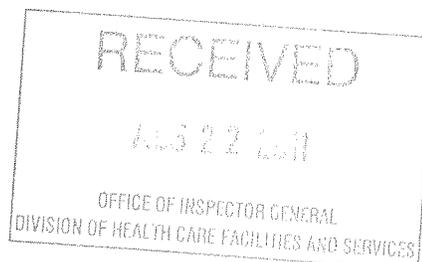
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F 253	Continued From page 2 with burned out light bulbs. In addition, room A6 and F1, bathrooms had light bulbs burned out. 11. Missing pull cord from the light above the bed in room A6, F9, and F11. 12. Missing outlet plug cover in room F9. An interview and a walking tour was conducted with the Housekeeping Director (HD) and a Maintenance Assistant (MA), on 07/21/11 at 4:46 PM. The MA stated the facility utilized a work order system to alert maintenance staff of concerns related to the environment. He reported he did not have a preventive maintenance program in place. The HD stated she conducts a tour on a daily basis to observe for cleanliness on each nursing unit. Based on interview with the HD, if any concerns related to maintenance of the facility were identified during the tour, a report would be submitted to the Maintenance Department.	F 253	Maintenance Director have been reeducated by the Administrator on 08/19/2011. They were trained on the use of the QI tool that will be used to detect and record items that need cleaned, replaced or fixed. The QI tool will be used in resident rooms and the common areas to detect areas that need to cleaned, replaced or fixed. Environmental Director and Maintenance Director were in-serviced on the use of the QI Tool by the Administrator on 8/19/11. Both the Environmental Service Director and Maintenance Director will utilize the tool. The QI Tool will be used weekly x 4 weeks, monthly x3 months, then quarterly. 4) The Administrator will review the monitoring tool monthly. The findings will be reviewed in RM/QI process 1 X a month X's 3 months, quarterly for 3 months then annually to ensure a sanitary, orderly and comfortable interior.	
F 281 SS=E	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and policy review, the facility failed to obtain a physician's order for oxygen for one (1) of twenty (20) residents, (Resident #1). Resident #1 was administered oxygen at five (5) liters/minute for twenty-four (24) hours without a physician's order. The facility failed to ensure documentation of	F 281	It is the facilities policy to be in compliance with this regulation. 1) Resident #1 expired. Residents #3, #4, #11: Physician and Medical Director notified of potential medication omissions as evidenced by omissions on resident MAR's - no new orders per physician.	08/20/2011



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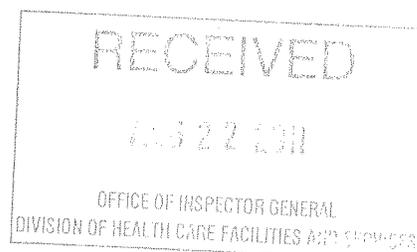
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F 281	<p>Continued From page 3</p> <p>administered medications on the Medication Administration Record (MAR) for three (3) of twenty (20) residents, Resident #3, #4 and #11. In addition, the facility failed to ensure fourteen (14) medications were administered in a timely manner to two (2) of eleven (11)unsampled residents.</p> <p>The findings include:</p> <p>1. Review of the Admission Process-Nursing & Clinical Team 1.3 policy revealed the staff was to contact the attending physician immediately upon admission to review and confirm the physician orders, to clarify any questions or recommendations, and to obtain additional physician orders as indicated.</p> <p>Record review revealed the facility readmitted Resident #1 on 07/18/11 with the diagnoses of Aspiration Pneumonia, Toxic Metabolic Encephalopathy, Reflux, and Dehydration. Review of a nurse's note dated 07/12/11, from the previous admission, revealed the resident had an axillary temperature of 99.7 degrees. The Power of Attorney requested the resident be transported to a local hospital for treatment. Review of the hospital discharge summary dated 07/18/11 revealed discharge orders were Morphine Sulfate 10 milligrams per 5 milliliters, give 2.5 milliliters sublingually every 3 hours as needed and to call the hospital discharge physician to verify the discharge orders once the resident arrived at the facility. There was no order for oxygen to be administered.</p> <p>Observation, on 07/19/11 at 11:10 AM, 12:05 AM, 12:45 PM, 2:15 PM, 3:00 PM and 4:45 PM,</p>	F 281	<p>2) Seven (7) other residents in the facility were identified as having oxygen in place; orders for oxygen were verified as being in place for all seven (7) of these residents. Current residents with medication orders have the potential to be affected by this practice. Audit of all resident MAR's was conducted and findings concluded that all residents had omissions in MAR documentation. Physician's and Medical Director notified of findings; no new orders were received. RN #2 received Employee Coaching related to not obtaining oxygen orders for Resident #1. All Licensed Nurses received Employee Coaching related to omissions on MAR's.</p> <p>3) All Licensed Nurses and CMT's will be re-educated on the following :</p> <p>Obtaining MD orders for oxygen Documentation of administered meds on MAR Policy on Medication Administration Policy on Medication Administration Pass Times Procedure to Follow When Unable To Pass Meds Timely MAR Documentation Validation Tool</p>	



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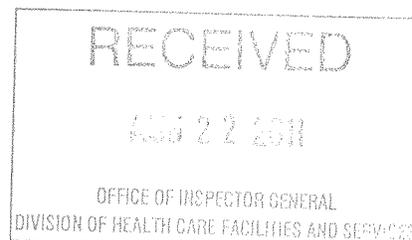
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F 281	<p>Continued From page 4</p> <p>revealed Resident #1 was receiving oxygen at five (5) liters/minute per nasal oximyzer.</p> <p>Observation, on 07/20/11 at 8:30 AM, revealed the resident receiving oxygen at 2 liters/minute per nasal oximyzer.</p> <p>Review of the physician's orders dated 07/19/11 revealed an order for oxygen at 2 liters/minute to maintain the oxygen saturation level above 90%.</p> <p>Interview with RN #2, on 07/20/11 at 4:30 PM, revealed when a resident is transferred from a hospital to the facility it is usually necessary to call the physician in order to clarify the discharge orders because the discharge orders are rarely complete. RN #2 stated Resident #1 was transferred from a local hospital to the facility on 07/18/11 with oxygen at 5 liters/minute per nasal oximyzer. RN #2 stated Resident #1 was in no apparent distress upon readmission to the facility. Upon her review of the discharge orders for Resident #1 she stated there were no orders for oxygen. RN #2 stated it was not necessary to obtain a physician's order for oxygen. She stated the need for supplemental oxygen is a nursing judgement and did not require a physician's order.</p> <p>Interview with the Director on Nursing, on 07/20/11 at 4:50 PM and 07/21/11 at 11:30 AM, revealed it was necessary to have a physician's order for oxygen to be administered to a resident. She stated only in an emergency, for example when a resident is in distress, can oxygen be initiated without first obtaining a physician's order. The DON also stated even in an emergency it would be necessary to obtain a physician's order</p>	F 281	<p>MAR Documentation Validation Tool will be created and put in place. This tool will be utilized by the Licensed Nurses and CMT's everyday for auditing shift-to-shift for completion of MAR documentation.</p> <p>Unit Manager & RN Weekend Supervisor will be re-educated on <u>New Admission/Readmission Audit Tool</u>. This tool to be completed by the RN Unit Manager M-F and RN Weekend Supervisor on Weekends on all New Admissions and Readmissions to assure completeness and accuracy of orders. The Health Information Manager will QI Monitor 10% of resident MAR's to determine any holes in MAR documentation weekly x4 weeks, then monthly x3 months then quarterly.</p> <p>4) The findings will be reviewed in the RM/QI process monthly x3 months, then quarterly to assure the services provided or arranged by the facility meets professional standards of quality.</p>	08/20/2011



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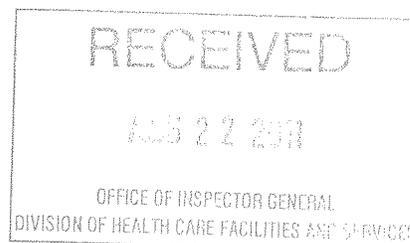
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F 281	<p>Continued From page 5 to continue the oxygen therapy on a resident.</p> <p>2. Review of the facility procedure titled Medication Administration dated 08/04 revealed item 12. Document medication administration on the MAR.</p> <p>Review of the current (07/11) Medication Administration Record (MAR) for Resident #3 revealed no documentation the ordered Metoprolol Tart 50 mg. was given 07/04/11 and 07/16/11. It further revealed no documentation Simvastatin 20 mg. was given on 07/04/11 and 07/16/11, or Coumadin 4 mg. was given on 07/04/11 and 07/16/11.</p> <p>Review of the current MAR for Resident #4, dated 07/01/11 through 07/19/11, revealed no nursing initials on nine (9) of thirty-eight (38) opportunities to document tube feedings. In addition, medications ordered on the MAR for Resident #4 were to be given via G-tube from 07/01/11 to 07/18/11. Each of the following were not documented three (3) of eighteen (18) opportunities: Aspirin 81 mg., Calcium 500 mg., Docusate Sodium 50 mg/5 ml liquid, Pepcid 20 mg., Glyburide 5 mg., Lisinopril 40 mg., Reglan 5 mg., Metoprolol Tart 50 mg., Potassium Chloride 10% 20 meq, and Terazosin 5 mg.</p> <p>Review of the current MAR for Resident #11, dated 07/01/11 through 07/18/11, revealed there was no documentation for monitoring the</p>	F 281		



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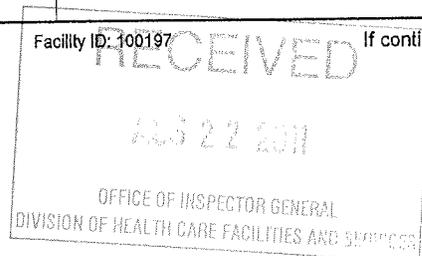
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F 281	<p>Continued From page 6</p> <p>Fentanyl Patch placement twelve (12) of fifty-four (54) opportunities. The medications Isentress 400 mg tablet and Metoprolol Tart 50 mg were not signed off on 07/13/11 and 07/16/11 for the 8 PM dose. Clonazepam 0.5 mg was not signed off on 07/15/11 at either time ordered, and Trazodone 50 mg was not signed off for the 8:00 PM dose on 07/13/11 and 07/15/11.</p> <p>Interview, on 07/20/11 at 8:30 AM, with the Minimum Data Set (MDS) Coordinator revealed if there is a blank on the MAR it may be due to the medication not being given or the nurse forgot to sign off the medication. She did not know who was responsible for monitoring the MAR documentation.</p> <p>Interview, on 07/20/11 at 9:07 AM, with Licensed Practical Nurse (LPN) #6 revealed a hole in the MAR meant the medication was not given. An additional interview, on 07/21/11 at 11:35 AM, revealed LPN #6 did give Resident #4 his/her G-tube medications on 07/17/11 but failed to sign the MAR. LPN #6 stated it was her responsibility to sign the MAR when a medication was given.</p> <p>Interview, on 07/20/11 at 9:25 AM, with LPN #7 revealed a hole in the MAR meant the medication was not given and the nurse did not sign it off.</p> <p>Interview, on 07/21/11 at 10:30 AM, with Certified Medication Technician #1 revealed a hole in the MAR meant the medication was not given.</p> <p>Phone interview, on 07/21/11 at 11:20 AM, with LPN #2 revealed she did not work the "B" Hall, where Resident #4 resided, on 07/18/11, and therefore, did not give Resident #4 his/her tube</p>	F 281			



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F 281	<p>Continued From page 7</p> <p>feedings on that date. Additional phone interview, on 07/21/11 at 11:55 AM, with LPN #2 revealed she was assigned to Resident #4 on 07/18/11 and did give the resident the ordered tube feedings. She stated "I got it down here (Resident #4's name) was fed" and "If I didn't put my initials it was an oversight."</p> <p>Phone interview, on 07/21/11 at 11:15 AM, with Registered Nurse #1 revealed she was assigned to Resident #4 on 07/10/11. She did give the resident his/her medications on that date and did not know why they were not signed off. If the MAR is not signed, the medication was not given. It was stated the Director of Nursing is responsible to ensure the MAR's are signed.</p> <p>Interview, on 07/21/11 at 11:55 AM, with the Assistant Director of Nursing (ADON) revealed the House Supervisor is responsible to monitor the MAR's for completeness.</p> <p>Interview, on 07/21/11 at 9:99 AM, with the Director of Nurses revealed a hole in the MAR could mean the nurse forgot to sign it. She stated it cannot be assumed the medication was not given. If a medication was not given, it should be signed and circled. The nurses explanation why it was not given should be on the back of the MAR.</p> <p>Record review of the MAR for Resident #4 revealed no circled areas on the current MAR, 07/01/11 through 07/19/11, holes present on the MAR, and no explanation on the back of the MAR.</p> <p>Interview, on 07/21/11 at 11:40 AM, with the DON revealed she is responsible to ensure the MAR's</p>	F 281		



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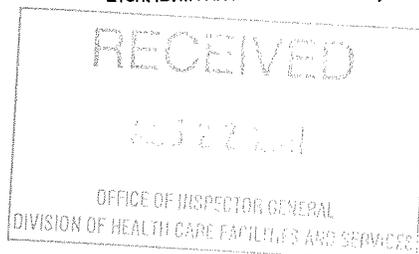
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F 281	<p>Continued From page 8 are signed.</p> <p>3. The facility failed to provide a policy related to Medication Pass Time.</p> <p>Interview with the Director of Nursing (DON), on 07/21/11 at 8:30 AM, revealed the facility did not have a policy related to med pass times. She reported the facility used the nursing standard, which is thirty minutes before or thirty minutes after the medication is due.</p> <p>Observation of the medication pass, on 07/19/11 at 10:55 AM and 11:18 AM, revealed the 8:00 AM medications were passed, a total of fourteen (14) medication was given two (2) hours late, to two (2) unsampled residents.</p> <p>Interview with Licensed LPN #1, on 07/21/11 at 12:05 PM, revealed she was behind with her medication pass as she had other duties early in the shift. She reported she did not ask for help or notify any of her managers. Her unit manager was off on 07/19/11 and she did not report to the Assistant Director of Nursing or her Director of Nursing the need for assistance with medication pass. She reported medications were to be given within thirty minutes before or thirty minutes after the ordered time.</p> <p>Continued interview with DON, on 07/21 at 8:30 AM, revealed the nurse was to follow the chain of command for assistance to ensure the medication pass was given on time. She</p>	F 281		

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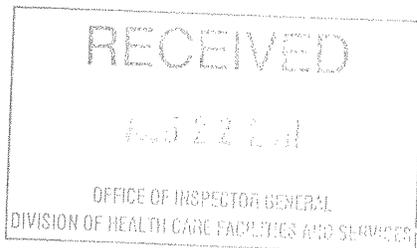
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F 281	Continued From page 9 reported she was not notified of any late medication on 07/19/11.	F 281		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services 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, interview, review of the resident's clinical record, review of the facility's policy for Skin Care and Wound Management and review of the facility's in-service titled Skin and Wound Care Guidelines it was determined the facility failed to ensure wound care treatments were completed as ordered by the physician for one (1) of twenty (20) sampled residents (Resident #2) for two (2) consecutive days. The findings include: Review of the facility's policy titled Skin Care and Wound Management, dated 08/2010, revealed ongoing monitoring includes 1. completion of the Braden scale. 2. completion of the Admission Skin Sweep. 3. Daily rounds to verify that the following occurred with resident/patient care: Frequent redistribution of areas of pressure; Resident/patient self mobility and activity is encouraged; Staff promptly attends to resident/patient request for toileting; Toileting	F 309	It is the facilities policy to be in compliance with this regulation. 1) Resident #2: MD notified of treatment not being done no new orders. Reassessed by Wound Care Consultant and there were no noted changes from last assessment. LPN #5 received Employee Coaching related to not completing treatments. 2) Six (6) other residents in the facility were identified as having wound care orders in place. Audit or resident TAR's revealed that all six (6) had omissions on their TAR's. MD's were notified of potential for treatments not being done in the month of July related to omissions on their TAR's; no new orders received. All six (6) residents will be reassessed by the Wound Care Consultant. All Licensed Nurses received Employee Coaching related to omissions on TAR's.	



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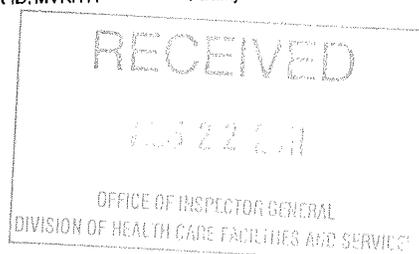
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F 309	Continued From page 10 schedules are followed; Appropriate wound treatment protocols are followed and documented; Assistance with nutrition and fluid intake is occurring. 4. Review the care plan for resident/patient specific intervention. 5. Reporting of any new skin impairments to the supervising nurse. 6. Implement appropriate treatment protocols as ordered. 7. Initiate appropriate skin grid. 8. Evaluate effectiveness of interventions and modify interventions as needed. 9. Communicate any changes to the caregiving staff, resident/patient, and/or family/responsible party. 10. Monitor pressure ulcer daily and document any complications or changes. Monitoring to include, but not be limited to: Evaluation of ulcer, if no dressing present; status of dressing, if present; status of area surrounding ulcer observable without removing dressing; complications, such as increasing area of tissue ulceration or soft tissue infection; pain and pain management if indicated. Review of Resident #2's clinical record revealed the facility admitted the resident on 08/18/10 with the following diagnoses: Vascular Ulcer to right heel; Hypertension; Peripheral Vascular Disease; Coronary Artery Disease; and a Left Above the Knee Amputation secondary to unhealing wounds, Peripheral Vascular Disease and Blood Clots. Review of the Skin Grid dated 07/14/11 revealed the facility assessed the right heel wound as 3.2 centimeters (cm) in length, 3.5 cm in width, and 0.3 cm in depth with a small amount of yellow, purulent, odorous drainage with redness surrounding the wound area. Review of the interdisciplinary care plan dated 07/11/11 revealed the following interventions: Braden scale upon admission and quarterly; Pressure reduction	F 309	3) Licensed Nurses will be re-educated on the following: Potential Negative Outcomes For Not Completing Wound Care Treatments Documentation of Wound Care Procedure to Follow When Unable To Complete Wound Care Treatments TAR Validation Tool TAR Documentation Validation Tool will be created and put in place. This tool will be utilized by the Licensed Nurses everyday for auditing shift-to-shift for completion of TAR documentation. The DON/ADON will audit 100% dressing changes/treatments to assure completion weekly x4 weeks, then monthly x3 months, then quarterly. The Health Information Manager will QI Monitor 10% of resident TAR's will entail review for any holes in the TAR documentation weekly x4 weeks, then monthly x3 months, then quarterly. 4. The findings will be reviewed in the RM/QI process monthly x3 months, then quarterly to assure each resident receives and the facility provides 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.	08/20/2011



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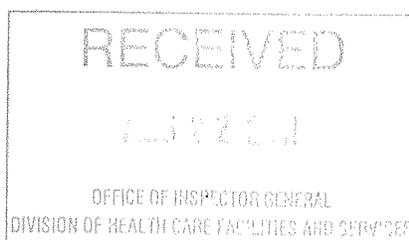
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F 309	<p>Continued From page 11</p> <p>mattress; Skin assessments per nurse; Treatment per order; Medication as ordered; Follow up with MD/ARNP as indicated; Observe labs per order.</p> <p>Review of the physician orders for wound care dated 07/14/11 revealed an order to cleanse the heel with saline, then apply Metrogel to the base of the wound followed by a Betadine wet to moist dressing twice a day, then cover the wound with a dry dressing. Review of physician progress notes dated 07/14/11 revealed the Resident continued to smoke, few options were given, and the Resident did not want an amputation. Review of the Treatment Administration Record (TAR) dated 07/2011 revealed the treatment was not initialed by a nurse as having been completed on 07/16/11 and 07/17/11.</p> <p>Observation, on 07/21/11 at 9:45 AM, of wound care revealed upon entering the room there was no dressing in place to the wound on the right foot . Licensed Practical Nurse (LPN) #3 cleaned the wound to the right heel with normal saline. Metrogel was applied to the wound base, and Betadine soaked gauze was applied to the wound. The dressing was then covered with gauze.</p> <p>Interview with LPN #5, on 07/21/11 at 11:35 PM, revealed she was the nurse working on 07/16/11 and 07/17/11 for sixteen (16) hours, which covered both first and second shift. LPN #5 stated she did not do the dressing on either shift for either day. The LPN further stated she had received wound care training, but could not remember when the training was done. She further revealed not doing the dressing change</p>	F 309		



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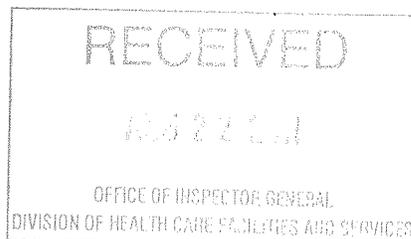
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F 309	Continued From page 12 could potentially cause the wound to become worse. Interview with the Assistant Director of Nursing (ADON), on 07/21/11 at 12:05 PM, revealed she provided the training and in-servicing for the facility. She stated the last wound care training was completed in the spring of 2011. She further revealed she follows all residents with wounds weekly and rounds with the wound physician or nurse practitioner and documents their findings. The ADON stated the nurse manager should monitor nurses to ensure they are completing the dressing changes as ordered by the physician. She stated she was not aware Resident #2 had not received dressing changes as ordered. She stated she is ultimately responsible to ensure all dressing changes are being completed as ordered. The ADON stated not completing dressing changes could potentially cause a wound infection or worsening of the wound. Review of the in-service record for Skin and Wound Care Guidelines dated 04/15/2011 revealed LPN #5 was in attendance, however the in-service did not contain potential negative outcomes for not completing wound care treatments. Interview with the Director of Nursing (DON), on 07/21/11 at 2:15 PM, revealed daily rounds are completed, but she did not monitor for completion of wound care. She was not aware Resident #2 had not been receiving wound care as ordered by the physician, but stated the dressing change was ordered for palliative care only for odor control. She further revealed the nurses should be monitoring each other for blank spaces on the	F 309		



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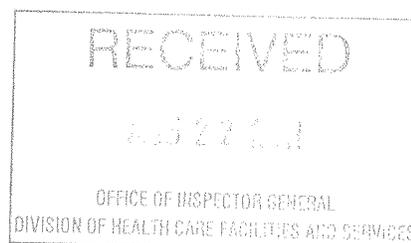
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F 309	Continued From page 13 TAR at shift change, however, this system was not working. The DON further stated she was ultimately responsible for ensuring nurses are completing physician ordered wound care. Interview with the Wound Physician's nurse (LPN), on 07/21/11 at 2:45 PM, revealed even though the ordered wound treatment was palliative care, without the wound treatment, the resident's wound could become infected, necrotic, and the resident could become septic.	F 309		
F 431 SS=E	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, permanently affixed compartments for storage of	F 431	It is the facilities policy to be in compliance with this regulation. 1) All identified medication on carts A,B,D and E were destroyed and new were ordered. 2) All residents with medication orders have potential to be affected by this practice. All Medication Carts checked for unlabeled, undated, expired meds; and none were found. 3) Licensed Nurse's and CMT's will be re-educated on Medication Storage Parameters based upon Manufacturer Recommendations. The DON/ADON will QI monitor medication carts weekly x4 weeks, monthly x3 months, then quarterly to assure medications are labeled per facility policy.	



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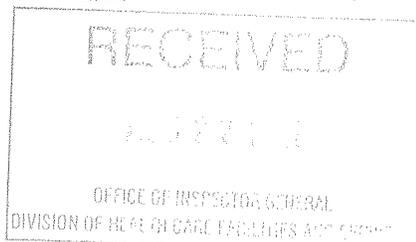
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F 431	Continued From page 14 controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and the facility policy on General Dose Preparation and Medication Administration review it was determined the facility failed to date drugs in accordance with the facility policy. Four (4) of four (4) Medication carts on the A, B, D and E Halls had medications opened and available for use; however, the bottles were not labeled with the opened date to determine the expiration date. The findings include: Record review of the facility's policy titled, "General Dose Preparation and Medication Administration" dated 12/01/07 revealed in section 3. Prior to Medication Administration: 3.2 Facility staff should check the expiration date of medications. Review of the facility's procedure on Medication Administration dated 06/08 revealed ...13. Verify the following prior to administration of medications: ... the expiration date. Observations of the B Hall medication cart, on 07/21/11 at 10:55 AM, revealed two (2) containers of Potassium Chloride 10%, one (1) bottle of Chlorhexidine, two (2) bottles of Docu liquid,	F 431	4) The findings will be reviewed in the RM/QI process monthly x3 months then quarterly to assure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles and include the expiration date when applicable.	08/20/2011



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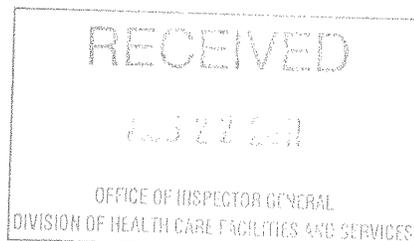
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F 431	<p>Continued From page 15</p> <p>three (3) bottles of Robafen, one (1) bottle of Megestrol and two (2) bottles of Milk of Magnesium was opened and not labeled with the opened date.</p> <p>Interview with LPN #9, on 07/21/11 at 10:55 AM, revealed the facility's policy directed the staff to date and time the medication bottles when opened.</p> <p>Observation of the E Hall, on 07/21/11 at 11:05 AM, revealed one (1) bottle each of Lactulose, Docu Liquid and Milk of Magnesium opened and not dated.</p> <p>Interview with LPN #8, on 07/21/11 at 11:05 AM, revealed opened medication bottles should be dated and labeled when opened. She reported the medications that were opened should be labeled with the open date and initials, otherwise, they should be thrown out if not labeled. The liquid medications such as Milk of Magnesium are good for 90 days after opened.</p> <p>Observations of the D Hall medication cart, on 07/21/11 at 11:52 AM, revealed two (2) containers of artificial tears, one (1) Flovent inhaler and one (1) Bacitracin ophthalmic ointment and two (2) bottles of Milk of Magnesium were opened and not labeled with the opened date.</p> <p>Interview with Licensed Practical Nurse (LPN) #1, on 07/21/11 at 11:52 AM, revealed opened medications should be dated after being opened. She reported if she knows someone just opened the medication, then she would date the medication and use; otherwise, she would discard it. She reported medications with unknown dates</p>	F 431			



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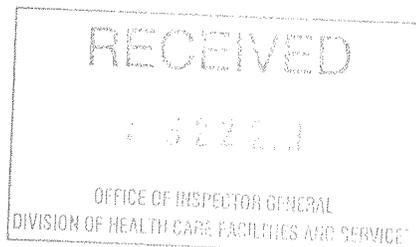
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F 431	Continued From page 16 of when the item was opened has the potential for harm to the resident and could render the medication not effective. Observations of the A Hall medication cart, on 07/21/11 at 12:00 PM, revealed one (1) Deep Sea Saline Spray, one (1) Mintox liquid, one (1) liquid Tylenol, two (2) containers of Chlorhexidine, one (1) Milk of Magnesium and one (1) Guaifenesin container were not labeled with date or initials when they were opened for resident use. Interview, on 07/21/11 at 12:00 Noon, with LPN #1 revealed she would discard the unlabeled medication due to the potential harm for the residents.	F 431		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441	It is the facilities policy to be in compliance with this regulation. 1) No residents were identified in the 2567. LPN #8 received Employee Coaching related to not washing hands during med pass. 2) Residents with medication orders have potential to be affected by this practice.	



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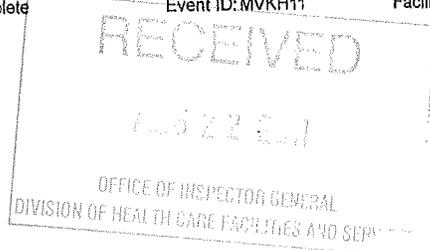
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F 441	Continued From page 17 prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's hand washing policy and the facility's medication administration policy it was determined the facility failed to ensure adherence to the facility's hand washing policy and medication administration policy during medication pass for one (1) of five (5) staff nurses. The findings include: Record review of the facility's policy on Infection Prevention Hand Washing 7.3, revised 02/2009, revealed hand washing was mandated between resident/patient contact in effort to prevent the spread of infection. Hands must be washed after the following, including, but not limited to contact	F 441	3) Licensed Nurses and CMT's will be re-educated on handwashing policy as it applies to the medication pass. DON/ADON will QI monitor handwashing during medication pass weekly x4 weeks, monthly x3 months, then quarterly. 4) The findings will be reviewed in RM/QI process monthly x3 months, then quarterly ensure adherence to the facility's hand washing policy during medication pass.	08/20/2011



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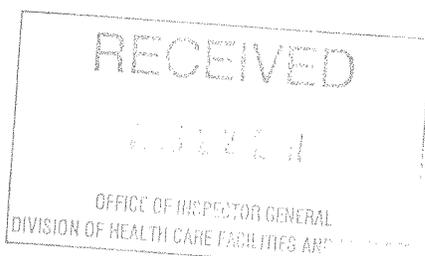
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F 441	<p>Continued From page 18</p> <p>with resident, prior to initiating a clean procedure, contact with contaminated items or surfaces and after removal of gloves.</p> <p>Record review of the facility's policy, on Medication Administration revised 06/2008, revealed the facility staff was to: 6. wash hands prior to the assembly of the equipment for medication administration and 18. wash hands upon completion of the medication administration.</p> <p>Observation of Licensed Practical Nurse (LPN) #8, on 07/20/11 at 8:33 AM, revealed she failed to complete hand hygiene prior to the assembly of medication administration items and failed to wash her hands at any time during the medication pass for two (2) of two (2) residents. She donned a set of clean gloves and applied eye drops to both eyes, in addition she provided six (6) pills and a dose of liquid medication without hand hygiene and continued to the next resident's medications without further hand hygiene.</p> <p>Interview with LPN #8, on 07/21/11 at 11:20 AM, revealed she did not wash her hands at the time she administered the two (2) residents their medications on the day before. She reported she was a little nervous and just simply did not wash her hands before she put the gloves on or when she removed the gloves. She reported clean gloves did not replace the need to wash her hands before or after glove use. LPN #8 reported the lack of hand hygiene can spread germs from one patient to another and was an infection control concern. She reported, she knew she was supposed to wash her hands before and after medication pass, as well as, before putting on gloves and after taking them off.</p>	F 441		



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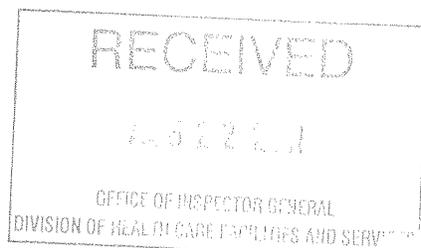
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
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F 441	Continued From page 19	F 441		
F 502 SS=E	<p>Interview with the Assistant Director of Nursing (ADON), on 07/21/11 at 03:02 PM, revealed the nursing staff was trained and inserviced on hand hygiene. She reported the lack of hand hygiene can spread germs from one patient to another. She reported a break in hand hygiene practices did place a concern for infection control and the potential for spread of germs to other residents. She reported clean gloves do not replace the need to wash hands before or after glove use.</p> <p>483.75(j)(1) ADMINISTRATION</p> <p>The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined the facility failed to monitor and ensure the laboratory supplies and nutritional supplements were not expired in three (3) of five (5) medication rooms. Observations revealed eight (8) containers of nutritional supplements with the expiration date of 03/01/11, six (6) dented and bulged containers of nutritional supplements, nine (9) angiocatheters expired as late as 01/2001, one (1) para-pak specimen kit with an expiration date of 08/2009 and laboratory collection tubes expired as late as 08/2007.</p> <p>The findings include: The facility failed to provide a policy on monitoring the medication supply rooms for expiration dates.</p>	F 502		



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F 502	<p>Continued From page 20</p> <p>Interview with the Director of Nursing, on 07/20/11 at 3:55 PM revealed the Director of Central Supply was responsible for the stocking the medication rooms and removing the out of date supplies.</p> <p>Interview with the Director of Central Supply, on 07/21/11 at 10:35 AM revealed she did not have a policy on storage and the expiration of items in the supply room. She reported she does not have a system in place to ensure each medication room is checked on a regular basis.</p> <p>Observation of the B Hall Medication Room, on 07/20/11 at 3:20 PM, revealed eight (8) containers of Nepro nutritional supplement with expiration date of 03/01/11, six (6) containers of Jevity were bulged, dented and crushed with dried, caked, cream colored substance on the containers, two (2) syringes of normal saline with an expiration date of 06/2011, one (1) Huber needle with the expired date of 10/2006, one safe site hub with the expired date of 06/2010, two (2) 24 gauge angiocatheters with the expired dates of 07/2003 and 04/2001, and a 20 gauge angiocatheter with the expired date of 01/2001.</p> <p>Interview with Licensed Practical Nurse (LPN) #10, on 07/20/11 at 3:20 PM, revealed she was a new hire and had been on her own for two days and did not know who was responsible for checking the expired dates of the the lab tubes, needles and supplies. She reported the supplies in the medication room are available for use during the care of the residents. The use of out dated supplies would place the resident at risk for infections. She reported she would have to ask</p>	F 502		



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F 502	<p>Continued From page 21 who takes care of the supply rooms.</p> <p>Observation of the E Hall Medication Room, on 07/20/11 at 4:15 PM, revealed one red top laboratory collection tube with the expired date of 03/2010.</p> <p>Interview with Registered Nurse (RN) #3, on 07/20/11 at 4:15 PM, reported items in the E Hall medication room are available for resident use. The red top collection tube had expired in 03/2010. She reported expired, out dated lab supplies could possibly cause the lab results not to be accurate.</p> <p>Observation of the F Hall Medication Room, on 07/21/11 at 10:05 AM, revealed expired lab supplies available for resident use. The lab supply cabinets contained the following expired items: one (1) para pak saf fixative that expired 08/2009, one (1) blue top tube that expired 08/2009, one (1) Introcan Safety 24 gauge that expired 03/2009, one (1) angio catheter that expired 04/2001, and Sepp Antiseptic that expired 06/2006.</p> <p>Continued interview with the Director of Central Supply, on 07/21/11 at 10:35 AM, revealed she was responsible to ensure the medication rooms are stocked with supplies. She did not on a routine basis go into the supply rooms to check on the expiration dates of items already in the supply room. She reported she did not have any tracking tool to ensure each medication supply room had been routinely checked to verify the integrity of the supplies.</p>	F 502			



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NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206
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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</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Manual initiating devices located at exits.</p> <p>SPRINKLER SYSTEM: Complete automatic (wet/dry) sprinkler system.</p> <p>GENERATOR: Type II</p> <p>A standard Life Safety Code survey was conducted on 07/21/11. Brownsboro Hills Nursing Home was found not in compliance with the requirements for participation in Medicare and Medicaid. The facility is licensed for ninety-six (96) beds and the census was eighty-seven (87) on the day of the survey.</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		
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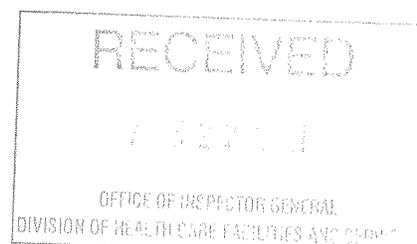
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE *Administrator* (X6) DATE *08/24/2011*

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 K 018 SS=E	Continued From page 1 Deficiencies were cited with the highest deficiency identified at E level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¼ 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 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors located in the corridor, according to National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect four (4) of eight (8) smoke compartments, approximately forty (40) residents, staff and visitors. The facility is licensed for ninety-six (96) beds and the census	K 000 K 018	Brownsboro Hills acknowledges receipt of the statement of deficiencies. The response to this statement of deficiencies and Plan of Correction does not constitute any admission that any deficiencies are accurate. The Plan of correction is submitted as a written allegation of compliance. It is the facilities policy to be in compliance with this regulation. 1) Resident doors C-2, C-5, B-3, B-7, B-14, E-5, A-5, A-6 and A-7 have been adjusted to latch appropriately to keep smoke from entering the room when door is closed. 2) All doors were assessed for appropriate latching to keep smoke from entering the room and adjusted as needed. 3) Maintenance has been re-educated on the Life Safety Codes as they pertain to the doors needing to be closed tight to keep smoke from entering the room in the case of a fire. Maintenance was re-educated by the Administrator on 8/19/11. Reviewed QI monitoring tool to be used to monitor the proper closure of doors no less than on a monthly basis. Maintenance will record doors not latching properly on the QI Tool and will make needed adjustments until the door latches properly. The QI tool will be taken to the monthly RM/QI meeting for review.	

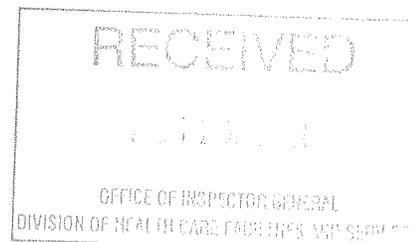


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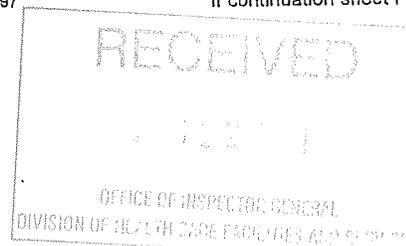
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K 018	<p>Continued From page 2 was eighty-seven (87) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/21/11 between 8:30 AM and 10:30 AM, with the Maintenance Assistant revealed resident room doors C2, C5, B3, B7, B14, E5, A5, A6, and A7 would not latch when closed to test for smoke tightness.</p> <p>Interview, on 07/21/11 at 8:30 AM, with the Maintenance Assistant revealed the doors needed to be worked on to ensure the doors would latch and keep smoke from entering the rooms in the event of a fire.</p> <p>Reference: NFPA 101 (2000 edition)</p> <p>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 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</p>	K 018	<p>4) The findings of the QI Tool will be reviewed in the monthly RM/QI meeting. The findings will be reviewed in the RM/QI process monthly for 3 months, quarterly for 3 months, then annually to ensure all doors have a tight close to prevent smoke from entering the room in the event of a fire.</p>	08/20/2011



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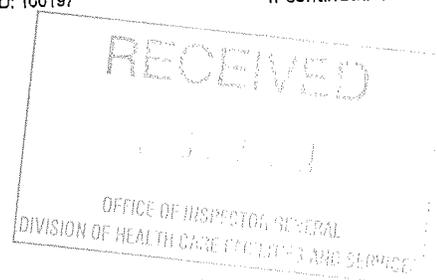
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K 018	Continued From page 3 for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments 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	K 018		



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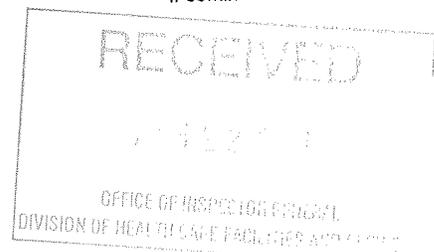
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K 018 K 022 SS=D	Continued From page 4 service. NFPA 101 LIFE SAFETY CODE STANDARD Access to exits is marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. 7.10.1.4 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exits according to NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, and all Kitchen personell. The findings include: Observation, on 07/21/11 at 9:40 AM, with the Maintenance Assistant revealed the kitchen doors, used as exit access, were not identified with an exit sign. Interview, on 07/21/11 at 9:40 AM, with the Maintenance Assistant revealed he was unaware of the doors not being marked according to NFPA standards and acknowledged the potential for hazard in the event of an emergency.	K 018 K 022	It is the facilities policy to be in compliance with this regulation. 1) Signs have been placed on the exit doors to the kitchen to read exit.. 2) All doors were assessed for visible signage for doors that might not be apparent to occupants as an exit route and signage put into place.. 3) Maintenance has been reeducated in the Comprehensiveness of the Life Safety codes pertaining to doors having visable signage for emergergecy exits. Maintenance Department will QI monitor for appropriate exit signage on a monthly bases and fix any identified doors needing signage. 4) The Administrator will review the monitoring tool monthly. The findings will be reviewed in the RM/QI process 1 X a month for 3 months, quarterly for 3 months then annually to ensure all doors have appropriate signage.	08/20/2011



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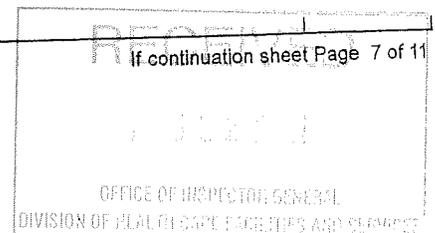
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K 022	Continued From page 5 Reference: NFPA 101 7.10.1.4* Exit Access. Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach the exit is not readily apparent to the occupants. Sign placement shall be such that no point in an exit access corridor is in excess of 100 ft (30 m) from the nearest externally illuminated sign and is not in excess of the marked rating for internally illuminated signs. Exception: Signs in exit access corridors in existing buildings shall not be required to meet the placement distance requirements. NFPA 101 7.10.8.1* No Exit. Any door, passage, or stairway that is neither an exit nor a way of exit access and that is located or arranged so that it is likely to be mistaken for an exit shall be identified by a sign that reads as follows: NO EXIT Such sign shall have the word NO in letters 2 in. (5 cm) high with a stroke width of 3/8 in. (1 cm) and the word EXIT in letters 1 in. (2.5 cm) high, with the word EXIT below the word NO. Exception: This requirement shall not apply to approve existing signs.	K 022		
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	K 029		



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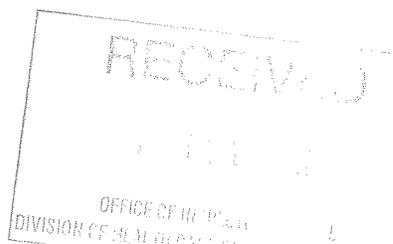
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K 029	Continued From page 6 field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements of Protection of Hazards, per NFPA Standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety-six (96) beds and the census was eighty-seven (87) on the day of the survey. The findings include: Observation, on 07/21/11 at 12:15 PM, with the Maintenance Assistant revealed the door to the Medical Records Room, located in the D Wing, did not have a self closing device installed on the door. Interview, on 07/21/11 at 12:15 PM, with the Maintenance Assistant revealed he was not aware the door to the Medical Records Room was not equipped with a self closing device. Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas	K 029	It is the facilities policy to be in compliance with this regulation. 1) The Medical Records door now has a self- closure on the door. 2) Facility doors have been inspected to assure self-closures are in place. 3) Maintenance has been re-educated on the Life Safety Codes as they pertain to doors needing self closures that contain combustible materials. Maintenance has been re-educated by the Administrator on 8/19/11. Reviewed QI tool to be used to determine need for self closure, properly functioning self closures and that self closures are being used properly, not being closed; and need for self closure. Adjustments will be made to correct any identified problems. The QI Tool will be taken to the monthly RM/QI meeting for review. 4) The findings of the QI Tool will be reviewed in the monthly RM/QI meeting. The findings will be reviewed in the RM/QI process monthly for 3 months, quarterly x3 months, then annually to ensure rooms with combustible materials will have self closure and will shut to enhance safety in the event of a fire.	08/20/2011



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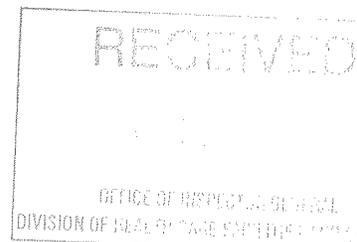
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 07/21/2011
NAME OF PROVIDER OR SUPPLIER BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
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K 029	Continued From page 7 shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in 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 ft ² (9.3 m ²) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft ² (4.6 m ²), 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 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029		
K 038 SS=D	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1	K 038		



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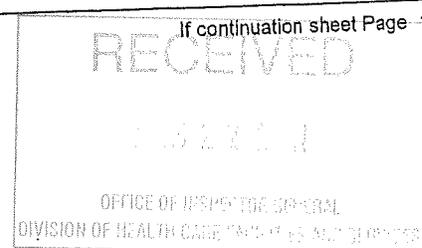
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K 038	<p>Continued From page 8</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exit access and exit doors were maintained to be clearly recognizable as a means of egress, per NFPA standards. The deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff and visitors. The facility is licensed for ninety-six (96) beds and the census was eighty-seven (87) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 07/21/11 at 1:30 PM, with the Assistant Maintenance Director revealed mini-blinds mounted on the exit door located in the main Dining Room.</p> <p>Interview, on 07/21/11 at 1:35 PM, with the Assistant Maintenance Director revealed he was unaware mini-blinds were prohibited to be mounted on exit doors and removed them immediately.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>7.5.2.2 Exit access and exit doors shall be designed and arranged to be clearly recognizable. Hangings or draperies shall not be placed over</p>	K 038	<p>It is the facilities policy to be in compliance with this regulation.</p> <ol style="list-style-type: none"> 1) The blinds to the exit door in the main dining room have been removed from the door. 2) All other doors have been assessed to ensure they are clearly recognizable and readily accessible exits at all times. 3) Maintenance has been re-educated on the Life Safety Codes as they pertain to clearly recognizable exits in the event of an evacuation. Maintenance has been re-educated by the Administrator on 8/19/11. Reviewed QI Tool to be used to check doors that they are easily identified as exits or route to exit in the case of an emergency evacuation. Maintenance will record any doors detected having an obstruction to an exit or a door that is not clearly marked as an exit. If detected the obstruction will be removed. The QI Tool will be taken to the RM/QI meeting for review. 4) The findings of the QI Tool will be reviewed in the monthly RM/QI meeting. The findings will be reviewed in the RM/QI process monthly x3 months, quarterly x3 months, then annually to ensure that exit doors are clearly recognizable as an exit door. 	08/20/2011



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K 038	Continued From page 9	K 038		
K 130 SS=E	NFPA 101 MISCELLANEOUS OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain doors within a required means of egress. This deficiency had the potential to affect eight (8) of eight (8) smoke compartments, residents, staff, and visitors. The facility is licensed for ninety-six (96) beds, with a census of eighty-seven (87) on the day of the survey. The findings include: Observation, on 07/21/11 between 8:30 AM and 10:30 AM, with the Maintenance Assistant revealed unapproved locks (slide bolt type) were installed on the egress side of the bathroom door in resident rooms C7, C8, B7, B10, B9 and B13. Interview, on 07/21/11 at 8:30 AM, with the Maintenance Assistant revealed he was aware of the locks installed on the door, but not aware they were prohibited and had them removed by maintenance personnel. NFPA 101 (2000 Edition) 19.2.2.2.4 Doors within a required means of egress shall not	K 130	It is the facilities policy to be in compliance with this regulation. 1) The bolt locks have been removed on doors in C7, C8, B7, B10, B 9 and B13. 2) All doors have been checked for bolt locks and removed. 3) Maintenance has been re-educated in the comprehensiveness of the Life Safety Codes pertaining to the inspections of doors to not be equipped with a latch that requires a tool or key from the egress side. Maintenance will RM/QI monitor doors monthly bases to ensure doors are readily accessible exits at all times. 4) The Administrator will RM/QI the monitoring tool monthly. The findings will be reviewed in the Quality Assurance process 1 X a month for three months, quarterly for 3 months then annually to ensure doors are readily accessible exits at all times.	08/20/2011



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K 130	Continued From page 10 be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130		

