

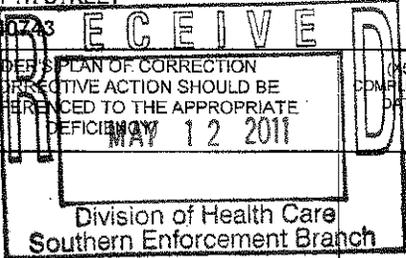
DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/28/2011  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>185003</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  C <b>04/14/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL HEIGHTS HOME FOR THE ELDERLY</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>208 WEST TWELFTH STREET LONDON, KY 40323</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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F 000	INITIAL COMMENTS  A standard health survey was conducted on April 12-14, 2011. Deficient practice was identified with the highest scope and severity at "D" level.  An abbreviated standard survey (KY16242) was also conducted at this time. The allegation was unsubstantiated with no regulatory violation identified.	F 000		
F 281 SS=D	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, and record review, the facility failed to provide services that meet professional standards of quality. The facility failed to follow the physician's orders for tube feeding for one of twenty-four residents. Resident #12 had a physician's order for tube feeding to be administered at forty-five cubic centimeters per hour; however, the tube feeding was observed to be infusing at thirty-five cubic centimeters per hour.  The findings include:  Observation of resident #12 on April 12, 2011, during the initial tour at 10:25 a.m., and again at 2:55 p.m., 4:03 p.m., and 5:20 p.m., revealed the resident's Jevity 1.2 calorie tube feeding was infusing at 35 cubic centimeters (cc) per hour. Observation of the label on the Jevity 1.2 calorie bottle revealed the tube feeding was supposed to be infusing at 45 cc per hour.	F 281	<b>F281 SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</b>  (1.) Resident #12 was assessed immediately on <b>04/12/11 at 5:40PM</b> and the G-Tube feeding rate was <b>adjusted from 35cc/hr to 45cc/hr</b> as ordered. (See attached nurse's notes)  (2.) To ensure all residents G-Tube feeding rate matched the order from the physician a <b>house wide audit was completed on 04/12/11 at 7:00PM</b> . The audit revealed that <b>all G-Tube feeding rates were correct</b> as ordered by the physician. (See attached audit)  (3.) Quality Improvement measures implemented to ensure residents receive their G-Tube feeding at the rate ordered by the physician include:  ➤ <b>A revision to the G-Tube Feeding Policy to require that the G-Tube feeding rates be verified at each shift change</b> by the off-going and on-coming nurse during the bedside shift exchange report. <b>The verified rate will be recorded by the on-coming nurse on the resident's MAR.</b> All nurses were educated on <b>this policy change on 05/03/11.</b>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Kathy K. Brown</i>	TITLE <i>Administrator</i>	(X6) DATE <i>5/12/11</i>
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Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 281	Continued From page 1  A review of resident #12's physician's orders dated March 25, 2011 through July 31, 2011, revealed the resident had an order for Jevity 1.2 at 45 cc per hour with a 35 cc per hour water flush via the resident's G-tube (feeding tube).  A review of resident #12's April 2011 G-tube Medication Administration Record (MAR) revealed staff had initialed the document every shift, including the 7 a.m. to 3 p.m. shift on April 12, 2011, that resident #12's tube feeding was infusing at 45 cc per hour.  On April 12, 2011, at 5:30 p.m., an interview conducted with the nurse assigned to provide care for resident #12 revealed the nurse confused the tube feeding rate with the water flush rate and had mistakenly decreased the resident's tube feeding rate to 35 cc per hour earlier on April 12, 2011. The nurse stated the resident's tube feeding should have been infusing at 45 cc per hour.  A review of resident #12's G-tube fluid intake for April 12, 2011, revealed the resident's 24-hour formula (feeding) total was 1,045 cc, 35 cc less than the 1,080 cc ordered by the resident's physician.	F 281	(See attached revised policy and education attendance list)  (4.) Monitoring the compliance of the revised G-Tube Feeding Policy will include: <ul style="list-style-type: none"> <li>➤ The <b>Unit Based Primary Charge Nurse</b> will conduct a <b>weekly audit</b> of the <b>residents MAR's</b> who are receiving G-Tube Feedings and <b>validate that the feeding rate has been checked</b> at each shift change. (See attached audit tool)</li> <li>➤ <b>Areas of non-compliance will be corrected immediately.</b></li> <li>➤ The <b>weekly G-Tube audit</b> will be sent to the <b>Director of Nursing each week</b> and reviewed.</li> <li>➤ The Director of Nursing will submit assessment results of the weekly G-Tube Audit to the Quality Improvement committee monthly. Negative results will be identified and resolved through the interdisciplinary approach of the committee.</li> <li>➤ Compliance monitoring will be done <b>monthly until an acceptable standard of care is met.</b></li> </ul>		
F 364 SS=D	483.35(d)(1)-(2) NUTRITIVE VALUE/APPEAR, PALATABLE/PREFER TEMP  Each resident receives and the facility provides food prepared by methods that conserve nutritive value, flavor, and appearance; and food that is palatable, attractive, and at the proper temperature.	F 364	<b>CORRECTIVE ACTION TAG #F281 COMPLETED ON</b>	<b>05/04/11</b>	

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NAME OF PROVIDER OR SUPPLIER  <b>LAUREL HEIGHTS HOME FOR THE ELDERLY</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>208 WEST TWELFTH STREET LONDON, KY 40743</b>		
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F 364	<p>Continued From page 2</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, it was determined the facility failed to provide foods that were palatable and at a preferable temperature during the lunch and evening meal on April 12, 2011.</p> <p>The findings include:</p> <p>Observation of the noon meal service on April 12, 2011, revealed a food cart was delivered from the kitchen in a closed, unheated cart to the second floor of the facility at 11:25 a.m. The last tray was removed from the food cart at 12:12 p.m., 47 minutes after the food cart was delivered to the floor. A food palatability test was conducted of the food items from the last tray. The food palatability test revealed the lasagna tasted cold, the butterscotch pudding cool but not cold, and the bread stick tasted hard and chewy.</p> <p>Observation of the evening meal service on April 12, 2011, revealed the food cart was delivered from the kitchen in a closed unheated cart, to the second floor of the facility at 5:16 p.m. The last tray was removed from the food cart at 6:02 p.m., 46 minutes after the food cart was delivered to the floor. A food palatability test was conducted of the food items from the last tray. The food palatability test revealed the ground chicken livers tasted cold, the mashed potatoes tasted cold, the broccoli Normandy tasted cold, and the chocolate milk tasted room temperature.</p> <p>An interview was conducted on April 12, 2011, at 6:15 p.m., with the State Registered Nursing Assistant (SRNA) assigned to provide care for the residents on the second floor. The SRNA stated</p>	F 364	<p><b>F364</b> <b>Nutritive Value/Appear, Palatable/Prefer Temp</b></p> <p>(1.) On <b>04/12/11</b> the CNA ordered a <b>replacement meal</b> from dietary for the residents affected at the noon and evening meals.</p> <p>(2.) To ensure that each resident receives food that is palatable and at a preferable temperature, the facility has completed the following:</p> <ul style="list-style-type: none"> <li>➤ On <b>05/03/11</b>, test tray audits were conducted to determine appropriate tray distribution time. (See attached Food and Nutrition Services Test Tray Evaluation Audit)</li> <li>➤ A policy was developed for <b>Meal Service Guidelines</b> delineating the process for resident meal delivery. Meals will be delivered to residents by the nursing staff <b>within 25 minutes of arrival</b> on the unit. (See attached policy)</li> <li>➤ <b>Assignment of two additional staff members</b> from the restorative therapy department to assist with meals on the <b>2<sup>nd</sup> Floor Unit</b>.</li> <li>➤ An <b>additional meal tray delivery time</b> was added for <b>2<sup>nd</sup> Floor</b> resident meals</li> </ul>		

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F 364	Continued From page 3 he/she had never been told how long a tray should be allowed to sit on the food cart before it needed to be replaced due to the food items not being palatable. The SRNA further revealed it normally takes staff approximately 45 minutes every day to deliver trays on the second floor for both the noon and supper meals.  An interview conducted with the Dietary Manager (DM) on April 14, 2011, at 11:00 a.m., revealed the facility did not have a specific policy/procedure related to meal service. However, the DM stated food trays should be distributed within 25 minutes after the food cart has been delivered to the floor.	F 364	allowing time for meal assistance. ➤ <b>Education for Dietary and Nursing staff</b> was conducted on <b>05/05/11</b> on the Meal Service Guidelines.		
F 431 SS=D	<b>483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b>  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.	F 431	(3.) Quality Improvement measures implemented to ensure resident meals are palatable and temperature appropriate include: ➤ Utilizing the <b>Food Cart Delivery Log daily</b> , Dietary Staff will document the time the trays leave the kitchen and nursing staff will log the time the cart arrives on the unit. ➤ The <b>Dietary Manager</b> will conduct <b>compliance monitoring three times weekly</b> using the <b>Food and Nutrition Services Test Tray Evaluation Tool</b> to ensure that resident meals are palatable and temperature appropriate. ➤ <b>Nursing staff</b> delivering trays will refer to the time arrived on the unit as their reference point, any resident meal not delivered to the resident <b>within 25 minutes of arrival time</b> will be discarded and a <b>replacement meal</b> will be requested from the dietary department.		

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F 431	<p>Continued From page 4</p> <p>The facility must provide separately locked, 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 and interview the facility failed to assure that out of date biologicals were not available for resident use. In the L-B medication room there was a box of Hemocult specimen folders that were out of date and available for resident use.</p> <p>The findings include:</p> <p>Observation on April 14, 2011, of the L-B medication storage room revealed a box of Hemocult specimen cards available for resident use that had an expiration date of March 2011.</p> <p>An interview with the Registered Nurse Unit Manager (RNUM) on April 14, 2011, at 10:25 a.m., revealed the staff utilized the Hemocult specimen cards as ordered by the physician. The RNUM was unaware the Hemocult specimen cards were out of date.</p> <p>An interview with the Director of Nursing (DON) on April 14, 2011, at 10:40 a.m., revealed the nursing staff was responsible to check dates on</p>	F 431	<p>(4.) Monitoring the compliance of delivering palatable and temperature appropriate food will include:</p> <ul style="list-style-type: none"> <li>➤ The <b>Dietary Manager</b> will monitor test tray evaluations <b>utilizing the Summary of Tray Assessments Form.</b> (See Attached Form)</li> <li>➤ <b>Areas of non-compliance will be immediately corrected.</b></li> <li>➤ The <b>Dietary Manager</b> will submit assessment results of compliance monitoring of test tray evaluations to the Quality Improvement Committee <b>monthly.</b></li> <li>➤ Negative results will be identified and resolved through the interdisciplinary approach of the committee.</li> <li>➤ Compliance Monitoring will be done <b>monthly until an acceptable standard of care is met.</b></li> </ul> <p><i>consults)</i></p> <p><b>CORRECTIVE ACTION TAG #F364 COMPLETED ON</b> <i>SM</i></p> <p><b>F431 DRUG RECORDS, LABEL/STORE DRUGS &amp; BIOLOGICALS</b></p> <p>(1.) No residents were impacted by the box of expired hemocult test cards. On <b>04/14/11 at approximately 7PM</b> rounds were made on each nursing unit to ensure that no hemocult</p>	<b>05/09/11</b>	

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F 431	Continued From page 5 everything in the medication room with the exception of medications. The DON also stated the pharmacist was responsible to check medications and the Hemocult specimen cards were supposed to be kept in the DON's office.	F 431	<p>test cards remained on the nursing units. <b>No hemocult cards were found on any other unit. The expired box of hemocult cards that was found during survey was discarded by the Director of Nursing on 04/14/11.</b></p> <p>(2.) In an effort to identify if there was any potential for residents to be affected by the expired hemocult test cards <b>a review of each chart was conducted by the primary charge nurse on 04/15/11.</b> The review revealed that <b>no Hemocult tests had been performed from 03/31/11 through 04/14/11.</b> (See attached chart audit)</p> <p>(3.) Quality Improvement measures implemented to ensure that the deficient practice will not recur include the following:</p> <ul style="list-style-type: none"> <li>➤ The Hemocult policy was revised to include: <ol style="list-style-type: none"> <li>1. Procurement of the hemocult test card from the nursing office 24/7.</li> <li>2. Recording the expiration date of the test card on the test record.</li> <li>3. <b>The Nursing Office will maintain a supply of the test cards and audit each month for the expiration date.</b></li> <li>4. Staff Members were educated on this policy change on 05/03/11.</li> </ol> </li> </ul> <p>(See attached for continuation of Plan of Correction)</p>		

(See attached revised policy, nursing office log, test record, and education attendance list)

(4.) Monitoring the compliance of the hemocult test cards policy will include:

- **The Primary Charge Nurse will conduct a weekly audit of the lab test to identify all hemocult tests that have been performed. Each test that has been performed will be checked to insure that the hemocult card expiration date is recorded on the test record. This audit will be submitted to the Director of Nursing weekly for review.**
- **Areas of non-compliance will be immediately corrected.**
- **The Director of Nursing will maintain hemocult test cards in the nursing office and will maintain a log of monthly expiration checks and document re-ordering stock. (See attached audit tool)**
- **Compliance monitoring will be done monthly until an acceptable standard of care is met.**

**CORRECTIVE ACTION TAG  
#F431COMPLETED ON**

**05/03/11**

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K 000	<p>INITIAL COMMENTS</p> <p>TYPE OF STRUCTURE: 1967 Two-story unprotected frame Type 11(000) with a complete automatic sprinkler system throughout.</p> <p>A life safety code survey was initiated and concluded on April 14, 2011, for compliance with Title 42, Code of Federal Regulations, §483.70 and found Laurel Heights to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000			
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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