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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

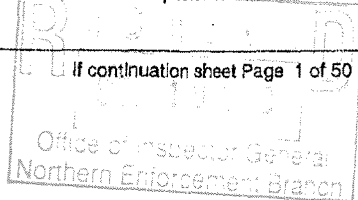
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	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 AMENDED SOD 08/29/13 A standard/abbreviated survey was initiated on 07/30/13 and concluded on 08/01/13 with deficiencies cited at the highest scope and severity of a "G". A Life Safety Code survey was conducted on 8/01/13 with deficiencies cited at the highest scope and severity of a "F". The facility had no opportunity to correct the deficiencies and remedies will be recommended for imposition. KY20437, investigated during the standard survey was substantiated with G level deficiencies cited.	F 000		
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers	F 156	**Resident #15, #16, and #17 was given a letter to notify them of non-covered days by the social worker. The facility will be posting a frame indicating information of who the ombudsman, Executive Director, number of contact state agencies, and Director of Nursing will be completed by 8/30/2013.** **Current resident population receiving Medicare services were reviewed by the interdisciplinary team consisting of nursing, social services, Director of Nursing, Admission Director, and Executive Director to determine time frame of when resident will be issued notice of non-coverage Reviewed Completed September 9, 2013.**	9/13/13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: X [signature] TITLE: Executive Director (X6) DATE: X 9/16/13

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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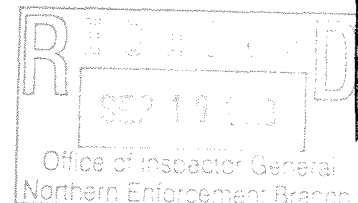
F 156	Continued From page 1 and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification	F 156	**The social services director was re-educated by the Executive Director on August 06, 2013 on issuance of correct Medicare notice of Non-Coverage. Social Services Director will QI monitor residents receiving Medicare coverage to determine when non coverage days will end weekly x 1 month, then monthly x2 months then quarterly x 3 to ensure the appropriate documentation is given to the resident.** **Findings of QI monitoring will be brought to review to the QAPI(Quality Assurance Performance Improvement) consisting of the Executive Director (ED), Director of Clinical Services (DCS), Assistant Director of Nursing (ADON), Nurse Supervisors, Social Service Director (SS), Activities Director (AD), Maintenance Director, Dietary Manager, and Medical Director (MD) meeting monthly x 3 then quarterly x 3.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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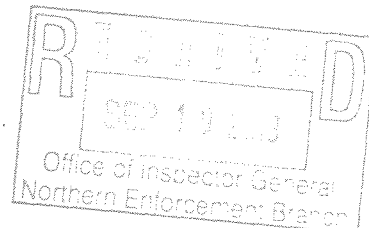
F 156	Continued From page 2 agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This REQUIREMENT is not met as evidenced by: Based on observation, interview and review of the facility's policy Advance Beneficiary Notice of Non Coverage (ABN), it was determined the facility failed to issue correct Medicare notices of non-coverage for three (3) of three (3) resident records reviewed out of a total sample of seventeen (17)sampled residents (Residents #15, #16, and #17). Effective dates of non-coverage were not included in the notices. The findings include: Review of the facility's policy regarding Advance Beneficiary Notice of Non-coverage (ABN) (Form CMS-R-131), dated 03/08, revealed if Medicare doesn't pay for ____(fill in the blank) below, you may have to pay. Medicare does not pay for everything, even some care that you or your	F 156		



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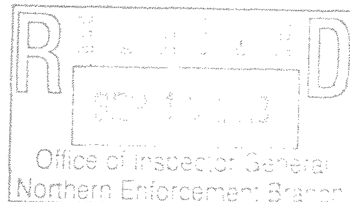
F 156	Continued From page 3 health care provider have good reason to think you need. We expect Medicare may not pay for the ___(fill in the blank) below, with reason Medicare may not pay, and estimated cost, with options to bill Medicare or not to bill. 1. Review of Resident #15's Advance Beneficiary Notice of Non-Coverage (ABN), on 08/01/13, revealed the resident was issued a notice of non-coverage, on 04/20/13; however, there was no date noted when the Medicare benefits would terminate. 2. Review of Resident #16's Advance Beneficiary Notice of Non-Coverage (ABN), revealed a notice of 05/15/13; however, the notice did not list the effective date of non-coverage on the form. 3. Review of Resident #17's record revealed an ABN was issued on 06/03/13; however, there was no written documentation given to the family or Power of Attorney (POA) for the effective date of non-coverage. Interview with Social Services Director, on 08/01/13 at 9:00 AM, revealed she had been responsible for issuing the notices since February 2013, when she started to work. The Social Services Director revealed she did not put effective dates on the notice, but tried to telephone the responsible party. The Director stated she kept a log in her office when she knew residents were coming off Medicare, but did not include the date on the letter. She further stated she was not trained on doing the notices, but just started doing what the last person did before her. Interview with the Administrator, on 08/01/13 at 10:00 AM, revealed there was no specific policy	F 156		



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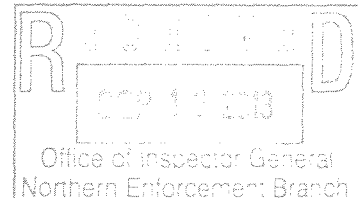
F 156	Continued From page 4 for demand billing; however, effective dates of non-coverage should have been put on the notice to the family.	F 156		
F 203 SS=D	483.12(a)(4)-(6) NOTICE REQUIREMENTS BEFORE TRANSFER/DISCHARGE Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except as specified in paragraph (a)(5)(ii) and (a)(8) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or	F 203	**Resident #5 will be having a care plan meeting with all disciplines (Medical Director, Nurse Practitioner, Ombudsman, Social Worker, Executive Director, and Director of Nursing) to discuss the policy and being non-compliant. Resident and staff safety is important for all. This will be completed by September 12, 2013.** **The Interdisciplinary Team consisting of Director Clinical Services, Social Services, Activity Director and Dietary Manager reviewed on September 13, 2013 with current residents to ensure that anyone with outstanding discharge notice had the appropriate documentation and guideline had been followed per facility policy and procedure. No residents in current population identified following review.** **The Executive Director re-educated the Social Services Director, Director of Clinical Services, Medical Director, and Nurse Practitioner on the facility policy and procedure for discharge notices on September 12, 2013. The interdisciplinary Team (consisting of Director Clinical Services, Social Services Director, Activity Director and Dietary Manager) will QI monitor monthly all residents prior to issuing discharge notices to ensure documentation and guidelines are followed by regulation and policy.**	9-13-13

Terry Willis Jr Executive Director 9/9/13- Corrected



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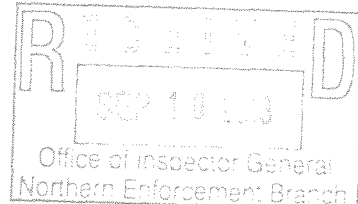
F 203	Continued From page 5 discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies, it was determined the facility failed to ensure the written notice of discharge included a valid reason for transfer or discharge for one (1) of seventeen (17) sampled residents (Resident #5). A Notice of Discharge was submitted to Resident #5 with a description of the resident's behavior while in the facility; however, there was no documented evidence the Notice of Discharge specified a valid reason for discharge. The findings include: Review of the facility's Transfer and Discharge, Involuntary Policy, revised 01/01/09, revealed all residents regardless of payment source, were transferred or discharged from the facility for the following situations:	F 203	**Finding will be brought to the QAPI (Quality Assurance Performance Improvement) consisting of Executive Director, Director Clinical Services, Assistant Director of Nursing, Nurse Supervisor, Social Services Director, Activity Director, Maintenance Director, and Dietary Manager meeting monthly for review and development of action plan to ensure written notice of discharges includes a valid reason for transfer discharge of resident from facility. This will be managed through the QI monitoring process.**	9-13-13

Terry Willis Jr. Executive Director 9/9/13 - Corrected



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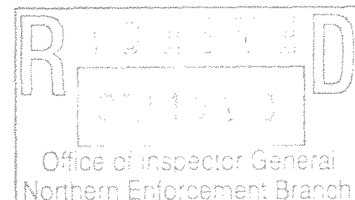
F 203	Continued From page 6 1. The resident's needs could not be met in the facility; therefore discharge is necessary for the welfare of the resident. 2. The resident was no longer in need of the services of the facility. 3. The safety of the residents or individuals within the facility were endangered. 4. The health of individuals within the facility would otherwise be endangered. 5. The resident, after reasonable and appropriate notice, had failed to pay for services rendered. 6. The resident had failed, after reasonable and appropriate notice, to pay for or to have already paid, under Medicaid or Medicare requirements. 7. The facility ceases to operate. Further review, revealed in the events of 1,2, and 4, a physician must document in the medical record the reasons for transfer/discharge. The written notice must be in a language and fashion that the resident and family members will understand and must contain: 1. The reason for discharge, 2. The effective date of discharge, 3. A statement that the resident had the right to appeal the action to the state, 4. The name, address, and telephone number of the State Long Term Ombudsman. Review of Resident #5's medical record revealed diagnoses which included Impulse Control Disorder and Delusional Disorder, Diabetes Mellitus, Congestive Heart Failure, Chronic Obstructive Pulmonary Disease, and End Stage Renal Disease with Dialysis. Review of the Annual Minimum Data Set (MDS) Assessment dated 06/14/13, revealed the facility assessed the	F 203		



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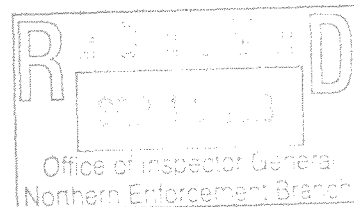
F 203	Continued From page 7 resident as having a Brief Interview for Mental Status (BIMS) score of fifteen (15) indicating no cognitive impairment. Review of the Comprehensive Plan of Care, dated 06/17/13, revealed the resident was verbally abusive, yelled and cursed at staff, had an explosive temper, re-directed poorly, and had a history of obtaining medications from the physicians in the community and hiding them in his/her room or on his/her person. Review of a Progress Note, dated 06/28/13 at 6:00 PM, written by a Licensed Practical Nurse (LPN) revealed after the resident returned from dialysis he/she started yelling for his/her medications. The nurse administered medications and then was interrupted prior to completing his/her accucheck due to a pharmacy delivery and an x-ray technician. The resident started yelling at the nurse and after wheeling self up the hallway, came back and knocked a vase off a table and proceeded back up the hallway. Review of the Progress Note, dated 07/04/13, (not timed) completed by the Social Service Director (SSD) revealed she had contacted the Ombudsman to discuss the facility's intention to issue a thirty (30) day notice of discharge to Resident #5 related to explosive behavior towards others, the seeking outside medications, and the verbal abuse toward staff. Further review revealed she also discussed the incident, on 06/28/13, related to the resident throwing a vase after becoming upset with staff in the nursing station area. Review of the subsequent Progress Note, dated 07/04/13, (untimed) completed by the SSD,	F 203		



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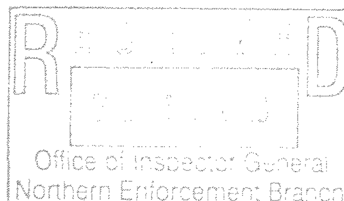
F 203	Continued From page 8 revealed the SSD, the Administrator and the Director of Nursing (DON) met with Resident #5 to explain the purpose of his/her thirty (30) day notice, explained the resources for alternate housing placement, read the Discharge Notice to him/her and advised of his/her right to appeal. Further review revealed it was explained due to protecting the safety of other residents and himself the discharge would be implemented; however, he/she had the right to appeal. Review of the Discharge Notice, issued 07/04/13, revealed the effective date of discharge was 08/04/13, and the facility name and address to which the resident would be discharged. The Notice also contained a statement indicating the resident had the right to appeal the action to the state with the name, address, and telephone number of the State Long Term Ombudsman. Further review of the Discharge Notice revealed the resident had been non-compliant with facility policies regarding receiving medication from outside sources and had been involved with extreme verbal abuse and disruptive behavior. However, there was no statement in the Notice indicating the safety of the residents or individuals within the facility were endangered. A review of the Order of Summary Reversal, dated 07/19/13, and signed by the Administrative Law Judge, revealed the Discharge Notice was deficient as it did not specify a valid reason for discharge and did not state a valid legal justification for discharge. Further review revealed the Discharge Notice contained a simple description of resident behavior but did not specify the specific regulation and legal justification for the decision.	F 203		



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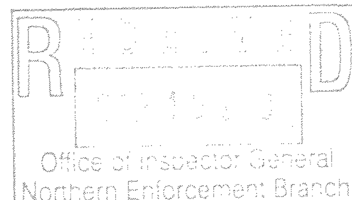
F 203	Continued From page 9 Interview, on 07/31/13 at 10:30 AM, with the Attending Physician/Medical Director, revealed Resident #5 posed a risk to others related to safety violations; however, he was unaware of any physical abuse by the resident. He stated he only documented in the medical record the incidents that occurred with the resident and not necessarily that the resident was a danger to others. Interview, on 08/01/13 at 10:00 AM, with the Interim Administrator revealed he had reviewed Resident #5's medical record and felt the resident was a danger to others after he/she threw a vase during an outburst. Further interview revealed the Discharge Notice was not upheld due to the verblage as it did not state the resident was a danger to self or others. Interview, on 08/01/13 at 4:50 PM, with the DON and the SSD revealed the resident had just been verbally abusive up until the time he/she recently threw a vase after getting angry because the nurse could not attend to him/her right away because of a pharmacy delivery. The SSD revealed she and the Interim Administrator had written the Discharge Notice and the appeal was upheld due to the verblage. She stated there should have been a statement in the Notice indicating the safety of the residents or individuals within the facility were endangered.	F 203		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in	F 241	**Resident #10 was interviewed by Social Services Director on August 31, 2013 as determined to have suffered no harm.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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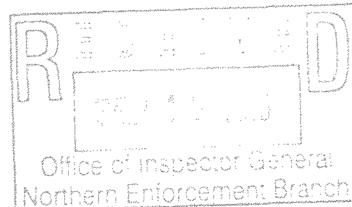
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 10 full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of facility's policy, it was determined the facility failed to promote care for residents in a manner that maintains or enhances each residents dignity and respect for one (1) of seventeen (17) sampled residents (Resident #10). The staff failed to close the door during incontinence care for Resident #10 even though there was no privacy curtain. The findings include: Review of the facility's Privacy Policy, revised 09/01/12, revealed it was the policy of the company to give all residents privacy, and residents' privacy would always be respected. Observation, on 07/30/13 at 3:25 PM, revealed Resident #10's door was open, and the resident could not be seen from the hallway because of a wall by the door. The surveyor entered the room after knocking and not receiving an answer, and noted the resident was receiving incontinence care with the door open. There was no privacy curtain noted. Interview, on 07/30/12 at 3:30 PM, with Registered Nurse (RN) #1 who was assigned to the resident, revealed there was no privacy curtains in Resident #10's room because it was a private room. She stated Certified Nursing Assistant (CNA) #2 should have ensured the door was shut during incontinence care. Interview with Certified Nursing Assistant (CNA)	F 241	**The Executive Director, Director of Clinical Services and nurse manager completed a facility tour by August 30, 2013 to ensure all residents have curtains and all other means to provide privacy.** **The Executive Director and Assistant Director of nursing re-educated all staff including contract services August 8, 2013 through August 12, 2013 on resident rights and privacy with an emphasis on knocking on doors and pulling of curtains. The Executive Director, Director Clinical Service and/or nurse manager will conduct random QI monitoring weekly x 4 weeks then monthly x 2 then quarterly x 3 to ensure residents privacy and dignity are maintained. A competency on provision of privacy and dignity on all new hires as well as provision of information regarding facility policy addressing residents' right and privacy.** **Findings of the QI monitoring will be brought to the QAPI (Quality Improvement Performance Improvement) meeting consisting of Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Nurse Supervisors, Social Services Director, Activity Director, Maintenance Director and Dietary Director monthly x 3 then quarterly x 3. Based on review of findings, an action plan will be developed to ensure the facility promotes care for residents in a manner that maintains or enhances each resident's dignity and respect through the QI monitoring process.**	9/13/13

Tony Willis Jr Executive Director 9/9/13 - Corrected



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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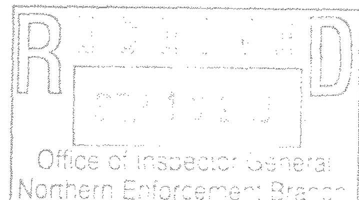
F 241	Continued From page 11 #2, on 08/01/30 at 5:15 PM, revealed she was walking by Resident #10's room and noted he/she had a bowel movement in the bed and did not have a brief on. She stated she immediately started performing incontinence care, but should have ensured the door was closed. Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON) revealed the residents door should be closed for any kind of care including incontinence care.	F 241		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the facility's policies, it was determined the facility failed to ensure resident's needs were accommodated for three (3) of seventeen (17) sampled residents and one (1) of two (2) unsampled residents (Resident #2, #9, #11 and unsampled Resident A). Resident #9 and Unsampled Resident A did not receive linens to cover their mattresses while lying down on the bed. Resident #11 was not provided a sippy cup with handles and a plate guard, and the call light was not in reach for Resident #2.	F 246	**Resident #2 was immediately provided with a call light. Resident no longer resides at the facility.** **Resident #9's had linen was provided on August 1, 2013 and housekeeping is delivering linen three times per shift (6am, 10am and 2pm) as of August 23, 2013.** **Resident #11 was given a Sippy cup and plate guard as of August 01, 2013. The facility provided a larger print meal ticket to identify adaptive equipment for both kitchen and nursing staff. The facility purchased additional Sippy cups and adaptive equipment for all Residents on August 5, 2013. The facility provided a larger print meal ticket to identify adaptive equipment for both kitchen and nursing staff on August 5, 2013.** **An audit was conducted on August 13, 2013 by the Registered Dieticians to identify proper meal**	9-13-13

Terry Willett Jr Executive Director 9/9/13 - Corrected



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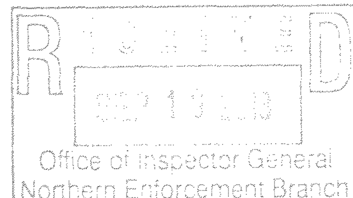
F 246	Continued From page 12 The findings include: 1. Interview with the Environmental Services Supervisor, on 07/30/13 at 1:00 PM, revealed the facility did not have a policy related to linens. However, the Supervisor stated staff was required to stock clean linens for resident use three times daily at 8:00 AM, 10:30 AM and 2:30 PM. Observations, on 07/30/13 at 12:10 PM, revealed Unsampled Resident A was lying on a bare mattress, with no linens on the resident's bed. Continued observations at 12:40 PM revealed Unsampled Resident A continued to be on a mattress with no linens. Observations of Resident #9, also at 12:40 PM, revealed the resident was also lying on a bare mattress with no linens. Observations, on 07/30/13 at 12:50 PM, of the two (2) storage areas for facility linens, located by each nursing station, revealed clean sheets were not available for resident use. Observations of the laundry area (located in the facility basement), on 07/30/13 at 12:55 PM, revealed there were clean linens available, yet staff had failed to stock the resident care areas as required. Interviews were unable to be conducted with Unsampled Resident A and Resident #9 on 07/30/13 related to cognitive impairment. Interview with Certified Nurse Aide (CNA) #3, on 07/30/13 at 12:40 PM, revealed she was unable to provide the residents with clean linen, because there was no linens available on the unit for	F 246	**tickets and therapy assessment for adaptive equipment on identified residents. Facility installed additional cabinets to provide storage of linen for all shifts which was completed by August 15, 2013.** **Re-education was provided by Executive Director August 8, 2013 through August 12, 2013 on importance of provision of linen to residents and the additional locations of linen to nursing staff. Nursing Staff re-educated by Director of Clinical Services and/or Assistant Director Clinical services on September 6, 2013 of provision of call lights and importance of ensuring resident has the adaptive equipment provided to them during meal services.** **The Executive Director and/or Housekeeping Supervisor will QI monitor Linen storage weekly x 4 weeks then monthly. Any identified need for additional linen will be ordered at that time. Nursing Management consisting of Director of Clinical Services, assistant Director Clinical Services, House Supervisors will QI monitor call light placement every shift x 4 weeks and any negative findings will be addressed immediately then daily thereafter to ensure placement. Nursing Management same as above will QI monitor placement of adaptive equipment on resident's meal tray each meal x 4 weeks the n3x week x 2 months then weekly ongoing. Any missed equipment will be addressed immediately with Dietary Department.**	9/13/13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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CENTERS FOR MEDICARE & MEDICAID SERVICES

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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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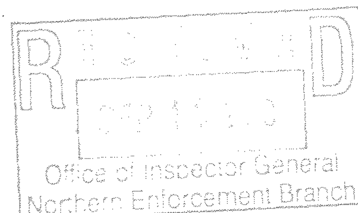
F 246	Continued From page 13 resident use. The CNA further stated there was not enough clean linens available for resident use on most days. Interview with Licensed Practical Nurse (LPN) #9, on 07/30/13 at 12:45 PM, revealed linens were a constant problem. She continued to state adequate amounts of clean linen were never stocked to provide clean linens to facility residents. Interview with CNA #4, at 4:00 PM on 07/30/13, confirmed an inadequate supply of clean linens was a very big problem in the facility. The CNA further stated the problem had been ongoing, yet was unable to remember exact time frames. The CNA stated however, the clean linen shortage had gotten worse the past few months. She stated the concern had been reported to nursing staff, yet no changes had taken place. Interview with the Environmental Services Supervisor, at 1:00 PM on 07/30/13, revealed the resident care areas should have been stocked with linens at 8:00 AM and 10:30 AM on 07/30/13. The Supervisor stated he was unsure why facility staff had not stocked the care areas. However, he stated concerns had been identified related to enough clean linens being available on the units for resident use. The Supervisor stated he had discussed the concern with the current Administrator related to insufficient storage areas in the resident care areas for linen a couple of weeks ago, but was unable to remember exact date. However, the Supervisor stated no actions had been taken to correct the problem. 2. Interview with the Dietary Manager, on 07/31/13 at 12:55 PM, revealed there was no	F 246	**Findings by Director of Clinical Services will be brought to the QAPI(Quality Assurance Performance Improvement) consisting of Executive Director, Director Clinical Services, Assistant Director of Clinical Services, Nursing Supervisors, Social Services Director, Activity Director, Maintenance Director and Dietary Manager meeting monthly for review and development of action plan to ensure residents needs are accommodated.**	9-13-13

Terry Willett Jr Executive Director 9/9/13 - Corrected



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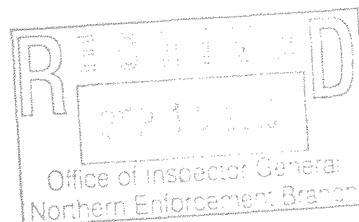
F 246	Continued From page 14 facility policy related to assistive devices being provided to facility resident's during meal times. However, she stated residents who require sippy cups or plate guards were to be provided these items from dietary when meals were prepared. Observations conducted, on 07/31/13 at 12:20 PM, during the lunch meal service, revealed Resident #11 attempted to feed his/herself and had difficulty obtaining food and fluids from the resident's plate. The resident's food was observed on the resident's plate, tray, and overbed table. Continued observations revealed the resident's fluids had been spilled onto the resident's food, and liquids were observed leaking onto the resident, and onto the floor. Review of the resident's tray card revealed the resident's fluids should have been served in sippy cups with handles, and a plate guard should have been provided. Interview with CNA #8, on 07/31/13 at 12:30 PM, revealed she had provided Resident #11 with tray set up. The CNA stated she identified the resident's plate guard and sippy cups had not been provided, and should have notified dietary. Interview with LPN #10, at 12:40 PM on 07/31/13, revealed the CNA should have ensured Resident #11 had a plate guard and sippy cups before she served the resident's tray. Interview with the Assistant Dietary Manager, on 07/31/13 at 12:50 PM, revealed she had prepared Resident #11's meal tray during the lunch meal on 07/31/13. The Assistant Dietary Manager stated she should have put the resident's plate guard and served the resident's fluids in sippy	F 246		



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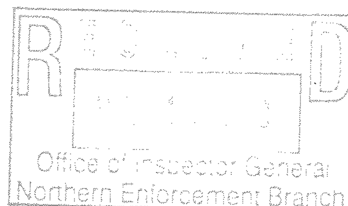
F 246	Continued From page 15 cups. She continued to state she was unable to provide a "real" reason why she had not provided the needed assistive devices to the resident. An interview with the Dietary Manager, on 07/31/13 at 12:55 PM, revealed Resident #11's plate guard and sippy cups should have been provided when the resident's tray was prepared by dietary staff on 07/31/13. 3. Review of the clinical record for Resident #2 revealed an admission date of 07/20/12 and diagnoses of CVA, Chronic Renal Failure, Diabetes, Hyperlipidemia, Aphasia, Anxiety State, Depressive disorder, Vascular dementia, and Failure to Thrive. There was no evidence the facility assessed the resident's functional ability in the use of a call light. Observations, on 07/30/13, during the initial tour of the building from 10:00 AM to 12:00 noon revealed Resident #2 was laying in a low bed with a falls mat at the side of the bed. The bed was positioned with one side of the bed against the wall, and his/her call light was not in reach. In the afternoon at 1:00 PM and 2:10 PM, Resident #2 was observed without his call light in reach. On 08/01/13 at 08:55 AM, interview with LPN #3, the charge nurse for the E wing, where Resident #2 lived, revealed he/she never used the call light; he/she just lets it fall on the floor and yells for help. LPN #3 stated Occupational Therapy did not assess for alternative call lights. Interview, on 08/01/13 at 09:30 AM, with the Rehabilitation Manager revealed the resident's nursing staff had to notify the Occupational/Physical Therapy Department if	F 246		



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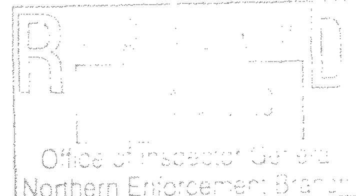
F 246	Continued From page 16 there was a problem and make a referral for the therapist to evaluate the resident's motor skill ability. The nursing staff may also request a soft touch call light from maintenance for any resident.	F 246		
F 279 SS=G	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview, record review and a review of the facility's policy, it was determined the facility failed to ensure a comprehensive care plan was developed for one (1) of seventeen (17) sampled residents (Resident #12) to reflect the required assistance needed for bed mobility as assessed on the resident's Minimum Data Set	F 279	**A comprehensive care plan was developed for resident #12 related to falls and extensive assistance of two to help with transferring as of August 7, 2013.** **On, July 30, 2013 an audit was completed by Regional Director of Clinical Services and Regional MDS on current residents' charts, and any noted inconsistencies were corrected by the DCS/ADCS/Nurse Managers. Currently the MDS Director is verifying the Kardex to the most current MDS assessment. As of August 23, 2013 MDS nurse is comparing and updated nursing Kardex with the ADL tracking and MDS.** **Licensed staff re-educated on importance of accuracy of the Kardex to the current MDS by the Director of Clinical Services on August 23, 2013. A 72 hour meeting post admission will be held by the IDT (Nursing-Activities-Social Services-Dietary Manger to initiate comprehensive care plan to identify areas of concerns-strengths and weakness to assist in the development of initial care plan. The comprehensive care plan is developed in collaboration with the IDT on before the 21st day post admission.**	9/13/13

FORM CMS-2567(02-99) Previous Versions Obsolete   Event ID: 7Q7711   Facility ID: 100197   If continuation sheet Page 17 of 50

Tony Willis Jr   Executive Director   9/9/13 - Corrected



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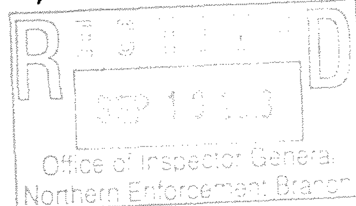
F 279	Continued From page 17 Assessment (MDS). The facility had identified Resident #12 required extensive assistance of two (2) people with bed mobility. However, the resident's care plan did not indicate any level of assistance. In addition, the Nurse Tech Information Kardex, to be utilized by staff as a resource to provide care to residents, stated Resident #12 was a one (1) person assist for bed mobility versus two (2) persons. On 04/25/13, Certified Nursing Assistant (CNA) #1 independently provided incontinent care to Resident #12. When she turned the resident, the resident rolled out of the bed and sustained an Acute Distal Ulnar Fracture. The findings include: Review of the facility's Care Plan Policy, revised 09/11, revealed an Interdisciplinary Plan of Care would be established for every resident and updated in accordance with state and federal regulatory requirements and on an as needed basis. Review of the facility's policy titled Nurse Tech Information Kardex, revised 09/01/11, revealed Nurse Techs (CNAs) would utilize the Kardex as a resource when care was provided to the residents. Review of Resident #12's medical record revealed the resident was readmitted to the facility on 08/02/12 with diagnoses of Osteoporosis, Muscle Disorders, Rheumatoid Arthritis, and Chronic Pain. Review of the Quarterly MDS, dated 02/25/13, revealed the facility assessed Resident #12 as requiring extensive assistance of two (2) persons with bed mobility and toileting.	F 279	Any Revisions to the comprehensive care plan completed during the daily operations meeting in by the interdisciplinary Team. The Regional Case Mix coordination provided education on September 6, 2013 on Facility policy and procedure related to comprehensive care plan. A random 10% sampling will be QI monitoring by the Regional Case Mix Coordinator monthly to ensure the comprehensive care plan is reviewed and revise as indicated. The MDS Coordinator will query 10% nursing staff on the identification of care plan revisions per RAI Guidelines monthly to ensure staff is aware of how to make revisions to comp care plan. Any negative findings will be addressed immediately. Findings will be brought to the QAPI (Quality Assurance Performance Improvement) consisting of Executive Director, Director of Clinical Services, Assistant Clinical Services, Social Services, Activity Director, Maintenance Director and Dietary Manager meeting monthly for review. Based on review of findings, an action plan will be developed to ensure comprehensive care plans are developed following assessment.	9-13-13

Terry Willett Executive Director 9/9/13 - Corrected



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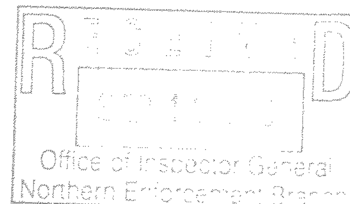
F 279	Continued From page 18 Review of Resident #12's comprehensive care plan, dated 12/04/12, revealed a problem listed as at risk for falls/injury with a goal that the resident would not sustain any significant injuries related to falls. The care plan revealed the resident required assistance with turning and repositioning; however, the care plan failed to indicate extensive assistance of two (2) persons. Review of the Nurse Tech Information Kardex for Resident #12 indicated the resident was a one person assist for bed mobility and incontinent care, not a two (2) person assist as assessed by the facility. Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON) revealed she had completed the information provided on the Nurse Tech Information Kardex for Resident #12, which directed staff to assist the resident with one (1) staff member for bed mobility and incontinent care. However, she stated she obtained the information from the chart in various places and had not reviewed the resident's MDS assessment which identified Resident #12 as a two (2) assist. Review of the SBAR Communication Form for Resident #12 revealed the resident experienced a fall out of bed on 04/25/13. Interview, on 08/01/13 at 11:30 AM, with CNA #1 revealed she had provided incontinent care to the resident on 04/25/13, and turned Resident #12 when the resident "tipped" out of bed, which resulted in injury. The CNA stated at the time of the fall, the resident required one (1) staff member assistance with bed mobility and incontinent care. However, the CNA stated she	F 279		



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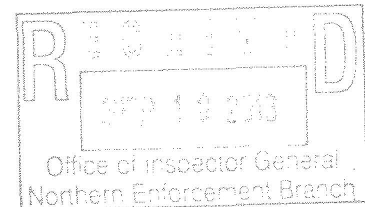
F 279	Continued From page 19 was informed of the level of staff assistance Resident #12 required by another CNA and had not reviewed Resident #12's Nurse Tech Information Kardex. Interview with CNA #6, on 08/01/13 at 2:00 PM, revealed she was told by the CNA who trained her that the resident required assistance of one (1) staff member with incontinent care and when being turned and repositioned. Per interview, she had not reviewed Resident #12's Kardex. Interview, on 08/01/13 at 1:00 PM, with Licensed Practical Nurse (LPN) #1, revealed she had assessed Resident #12 after the fall occurred, on 04/25/13. The LPN stated she had been assigned to care for Resident #12 frequently; however, the LPN was not sure what level of assistance the resident required for incontinent care or bed mobility. Further interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON) revealed staff know what to do for the residents because they look at the Kardex. She acknowledged Resident #12's information was inaccurate on the Kardex and she should have reviewed the resident's MDS information related to the level of assistance required. The DON continued to state if there had been two staff members, it would have prevented the resident from falling out of bed and sustaining a fracture. Interview with the Regional Case Mix Consultant, on 08/01/13 at 6:30 PM, revealed resident care plans and Nurse Tech Information Kardexs, were required to be developed, reviewed and revised with information obtained through the MDS assessment. The Consultant stated care plans	F 279		



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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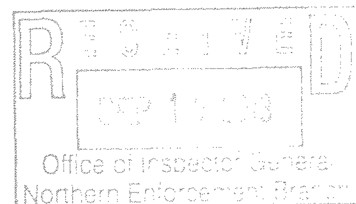
F 279	Continued From page 20 and Nurse Tech Information Kardex, should be updated when incidents or significant changes in the resident's condition occurred. She stated information on the residents care plans/kardexs, should be specific to the resident's needs, and the number of staff required to provide care should be included and accurate based on the MDS assessment. However, interviews with CNA #1 and CNA #6 revealed they did not refer to Resident #12's Nurse Tech Information Kardex to obtain information on how care was to be provided to the resident. The MDS Coordinator who had completed Resident #12's assessment and comprehensive plan of care was no longer employed at the facility.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed	F 280	**Resident # 10 care plan was updated on August 13, 2013.** **The DCS/Nurse Manager in-service was provided to all staff on August 8, 2013 through August 12, 2013 regarding fall policy, procedure, and SBAR Nursing Aides were in-service on Kardex of how to review and go over Resident care throughout the shift.**	9-13-13

Terry Willett Jr Executive Director 9/9/13 Corrected



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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

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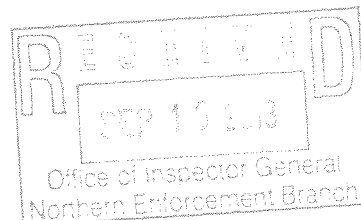
F 280	Continued From page 21 and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on interview, record review and a review of the facility's policy, it was determined the facility failed to ensure a resident's comprehensive care plan was reviewed and revised for one (1) of seventeen (17) sampled residents (Resident #10). Resident #10 experienced a fall on 02/13/13. A review of the resident's care plan revealed no evidence the care plan was updated after the fall occurred. The findings include: Review of the facility's policy titled Care Plan, dated 09/01/11, revealed all staff should be familiar with each resident's Care Plan. The policy stated the care plans would be updated in accordance with state and federal regulatory requirements and on an as needed basis. Review of Resident #10's clinical record revealed diagnoses of End Stage Renal Disease with Dialysis, and Peripheral Neuropathy. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/07/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of eight (8), denoting cognitive impairment. Further review revealed the facility assessed the resident as requiring extensive assistance of one (1) person for bed mobility, limited assistance of two (2) persons for transfers, as ambulation did not occur and as	F 280	**Any and all omissions and revisions to the comprehensive care plan will be addressed at time of daily operations meeting audit. Additionally interdisciplinary Team consisting of Nursing-Dietary-Activities-and Social Services will be completed as indicated.** **Results of daily operations meeting audits will be brought to the QAPI (Quality Assurance Performance Improvement) consisting of Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Director, Activity Director, Maintenance Director and Dietary Manager meeting monthly for review and development of action plan to ensure revisions are made to the comprehensive care plan to accurately reflect resident care.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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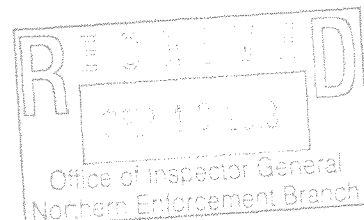
F 280	Continued From page 22 having no falls since admission, reentry, or prior assessment. Review of the Comprehensive Plan of Care revealed a problem, with a date of 02/16/13, which stated the resident was at risk for injury related to falls, tried to roll out of bed, and was restless at times. The approaches included providing needed devices for locomotion, transfer, wheelchair, walker, assist with transfers, and 1/2 side rails as ordered. Review of a Nursing Progress Note, dated 07/02/13 at 3:00 AM, revealed Resident #10 was awake, yelling and rolled out of bed to get his/her girlfriend's attention. Further review revealed the resident had no complaint of pain or discomfort, and just wanted to get in bed with his/her girlfriend. Further review of the record revealed no documented evidence the Care Plan was updated to indicate the resident actually sustained a fall, on 07/02/13, or was updated with interventions to prevent further falls. Interview, on 08/01/13 at 5:30 PM, with LPN #2 revealed she had assessed Resident #10 after the fall and no injury was noted. Continued interview revealed the nurse assessing the resident after a fall was responsible for updating the care plan immediately to indicate a fall had occurred with new interventions to prevent further falls, and she had failed to update the care plan. Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON) revealed the nurse assessing the resident after a fall was to complete the SBAR (Situation, Background,	F 280		



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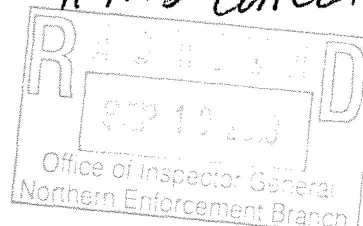
F 280	Continued From page 23 Assessment, Request), the Fall Investigation, the Root Cause Analysis Form, and immediately revise the care plan with interventions to prevent further falls; however, this was not done by the nurse who assessed this resident after the fall, on 07/02/13. Continued interview revealed the fall was also to be documented on the 24 Hour Report which she reviewed daily. The DON stated she checked the 24 Hour Report for the date of the fall and the fall was not documented. She indicated the day after a fall, she and the MDS nurse were to check the Care Plans to ensure they were updated. However, there was no follow up in updating the care plan after this resident's fall on 07/02/13 because she was not aware the resident had fallen.	F 280		
F 283 SS=B	483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy Interdisciplinary Discharge Summary, it was determined the facility failed to complete discharge summaries for two (2) of three (3) discharged residents (#16, #17). Contents of the summary did not contain documented information from all disciplines, and	F 283	**Resident # 16 will be reconciled by Nursing, Dietary, and Medical Director during the QAPI meeting.** **Resident #17 will be reconciled by Dietary, Activities, Rehab and the Medical Director during the QAPI meeting scheduled for 9-13-13.** **The Executive Director will re-educate on 9-10-13 of the process of discharging residents in the Daily Operational morning meeting. Re-education will occur by the Executive Director on 9-13-13 during the QAPI meeting.** **Charts of discharged residents will be brought to the Daily Operational morning meeting by the Director of Clinical Services and will then be reviewed and signed by each department manager as appropriate. The chart will then be given to**	9-13-13

Tony Willis Jr Executive Director 9/9/13 - Corrected



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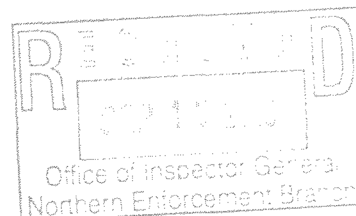
F 283	Continued From page 24 physician diagnoses and signatures were not present. The findings include: Review of the facility policy Interdisciplinary Discharge Summary, revised 09/01/11, revealed all residents discharged from the facility would have an Interdisciplinary Discharge Summary completed as part of the Medical Record. Social Services would initiate the Interdisciplinary Discharge Summary. The following departments would give a final summary regarding the resident's stay on the summary form: Social Services; Nursing Services; Dietary Services; Activities; and Rehab Services. The physician would give a discharge diagnosis and sign the form. 1. Review of Resident #16's clinical record revealed the resident was discharged home, on 05/14/13. Review of the resident's Interdisciplinary Discharge Summary revealed no evidence that Nursing Services, or the Dietary Services sections had been completed, as they remained blank. In addition, there was no physician documentation of the resident's stay, nor was there a physician's signature on the summary. 2. Review of Resident #17's clinical record revealed the resident was discharged home, on 06/04/13. Review of the Discharge Summary for Resident #17 revealed no evidence that Dietary Services, Activities, or Rehab Services had completed their designated sections. In addition, the physician's section for Discharge Diagnosis was blank, and there was no physician's signature for completion of the discharge	F 283	**MDS for the discharge assessment to be completed. MDS will then give the chart to medical records for QA review. Medical records will report to the Executive Director to identify issues and discuss with appropriate department managers of any documentation that has not been completed. This will be an ongoing process implemented for this facility. Medical Director will be notified monthly of all discharges by the Executive Director through the QAPI process.**	9-13-13

Tony Wilkes Jr Executive Director 9/9/13 corrected



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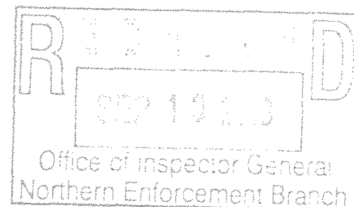
F 283	Continued From page 25 summary. Interview with the Social Services Director, on 08/01/13, at 11:30 AM, revealed she was responsible for initiating the discharge summaries when residents are discharged. The Director stated each department for nursing, dietary, activities, social services, and rehab are responsible for completing their section of the discharge summary. Interview with the Director of Nursing (DON), on 08/01/13 at 12:00 PM, revealed discharge summaries for the Nursing Services are completed by nurses on the floor, whomever discharges the resident. The DON stated the physician should also be signing the summaries after they are completed. Each department should be completing their individual section. Further interview revealed Social Services should be monitoring the Discharge Summaries, and stated she had initiated Resident's #16 and #17's discharge summaries.	F 283		
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:	F 309	**Resident #14 physician notified of medication error and new order to D/C KCL obtained as well as BMP to be drawn August 3, 2013.** **1. Pharmacy recommendations for July and August were reviewed by nursing management to identify recommendations to re-evaluate medication usage and any lab ordered.** **2. Any un-addressed recommendations lab orders were called to residents' physician for any orders as indicated.** **3. Family or responsible party notified as indicated.**	9/13/13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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F 309	Continued From page 26 Based on observation, interview, record review and policy review it was determined the facility failed to ensure one (1) of seventeen (17) residents (Resident#14) had physician orders transcribed appropriately. The facility continued to administer Potassium Chloride to Resident #14 after a physician's order to discontinue the medication since the resident was not on any potassium depleting medications. The findings include: Review of the facility's Physician Orders Policy and Procedure, (created 01/04/13), revealed a clinical nurse shall transcribe and review all physician orders in order to affect their implementation. The order must be transcribed to all appropriate areas (Medication Administration Record, Treatment Administration Record, etc.). The nurse shall sign off the orders upon completion or verification of transcription. Review of the clinical record for Resident #14 revealed the facility admitted the resident on 03/23/13 with diagnoses of Syncope and Collapse, Atrial Fibrillation, Diastolic and Systolic Heart Failure, Pneumonia, Severe Protein Calorie Malnutrition, Anemia, Chronic Obstructive Pulmonary Disease, and Hypertension. Review of the July 2013, Physician orders revealed an order for Potassium Chloride (KCL) 10 milli-equivalent (MEQ) capsule, give 2 capsules (20 MEQ) orally once a day. Review of the Pharmacy Consultation Report recommendation, dated 05/10/13, revealed a recommendation for staff to re-evaluate continued need for low-dose potassium supplementation, perhaps discontinuing its use	F 309	**4. Care plans reviewed and revised as indicated by the IDT** **1. Licensed staff re-educated by the Director of Clinical Services on notification of pharmacy recommendations to the resident's physician.** **2. Licensed staff re-educated by the Director of Clinical Services on timely and appropriate transcription of new physicians orders to the MAR/TAR.** **3. New physician orders will be brought to the daily operations meeting for QA monitoring review by the IDT to ensure orders have been transcribed accurately to the MAR/TAR, labs orders are transcribed accurately.** **4. Any negative findings will be addressed immediately** 5. **1. Findings of the Daily operations QA monitoring by the IDT will be brought monthly to the QAPI for review and development of action plan to ensure physician's orders are transcribed accurately.** 3. The House Supervisor educated by the Vice President Clinical Services on management of pharmacy Recommendations following discussion c̄ resident's primary physician on 9/11/2013.	9-13-13

Terry Willis Jr Executive Director 9/9/13-Corrected
Terry Willis Jr Executive Director 9/10/13-Corrected

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... HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 08/29/2013
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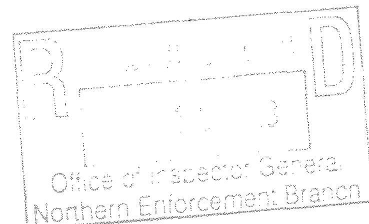
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7Q7711 Facility ID: 100197 If continuation sheet Page 27 of 50

Terry Willett Jr Executive Director 9/9/13 - Corrected


Office of Inspector General
Northern Enforcement Branch

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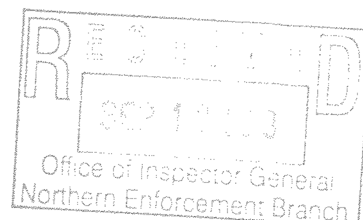
F 309	Continued From page 27 and rechecking a potassium concentration in two weeks due to the resident not being on any potassium depleting medications. Further review of the consult report revealed it was recommended that there be a risk versus benefit indicating that it continues to be a valid therapeutic intervention for this individual for a diagnosis of Hypokalemia. The facility interdisciplinary team should ensure ongoing monitoring for effectiveness and potential adverse consequences. On 07/02/13 the physician (Medical Director) accepted the recommendation and ordered to discontinue the KCL then obtain a Basal Metabolic Panel (BMP) labs in one month. The order was noted and signed by Licensed Practical Nurse (LPN) #1, on 07/03/13 at 2:04 PM. Observation of Resident #14 during Medication Pass task of the survey, on 07/31/13 at 8:13 AM, revealed Potassium 10 MEQ was administered by LPN #1. Reconciliation of the Medication Pass revealed KCL 10 MEQ capsule, give 2 capsules (20 MEQ) orally once a day was discontinued on 07/03/13. However, this order remained on Resident #14's Medication Administration Record and the resident continued to receive the medication until LPN #1 notified the physician via telephone on 07/31/13 to inform him of the error. Review of Resident#14's MAR revealed that he/she received KCL 10 MEQ two (2) capsules (20 MEQ) for a total of 28 days without an MD order. Interview with LPN #1, on 07/31/13 at 11:40 AM, revealed she remembered taking the order off and passing it on to the 2nd shift to complete the transcription. She stated she did not follow-up and take the medication and lab order off	F 309		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F 309

Continued From page 28

correctly and the resident continued to receive the medication.

Interview, on 08/01/13 at 5:35 PM, with the Director of Nursing revealed that it was her expectation that all MD orders be taken off correctly.

F 323 SS=G

483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on interview; record review and review of the facility's policy, it was determined the facility failed to ensure resident's received adequate supervision and assistive devices to prevent accidents for three (3) of seventeen (17) sampled resident's (Resident's #12, #10 and #3). The facility staff failed to provide adequate supervision with bed mobility and repositioning which resulted in the Resident #12 rolling out of bed and sustaining an Acute Distal Ulnar Fracture.

In addition, the facility failed to to complete a thorough investigation and root cause analysis following falls sustained by Residents #10 and #3.

The findings include:

Provider's Plan of Correction — F 309 / F 323

Resident #3 care plan and Kardex was updated as of August 5, 2013.

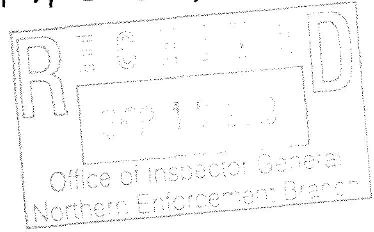
Resident #10 care plan has been updated along with the Kardex August 13, 2013.

Resident #12 care plan related to falls and extensive assistance of two to help with transferring was updated as of August 7, 2013.

Current resident population has had a falls assessment completed by the Director of Clinical Service, House Supervisor by September 6, 2013. These assessments have been reviewed by the Interdisciplinary Team for accuracy and re-assessed as indicated. Appropriate safety measures and interventions will be updated/developed by the interdisciplinary team on the care plan by September 13, 2013. Current resident population have had their Kardex and current MDS reviewed and revised by Director of Clinical Services and House Supervisors by September 13, 2013 to ensure the mobility status coding on MDS is accurately placed on resident's Kardex. Residents identified to be at high risk for falls have had a star placed on their door plate, MAR/TAR and resident equipment.

Completion date: 9-13-13

Terry Willis Jr Executive Director 9/9/13 Corrected



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING ______ B. WING ______	08/01/2013

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F 323	Continued From page 29	F 323		

Review of the facility's policy and procedure regarding Procedure for Incidents, effective 01/23/13, revealed the following must be completed prior to completing an incident report: assess the resident; complete the SBAR (Situation, Background, Assessment, Request) placing the original in the chart and sending a copy to the Director of Nursing (DON); call the on call supervisor and the on call would notify the DON; complete a Root Cause Analysis Form and send a copy to the DON; complete the appropriate investigation (Fall, Bruise, Skin Tear or Behavior) and send to the DON; update the Care Plan; call the Physician; and if sending the resident out, complete the QI (Quality Improvement) Tool.

A review of the facility policy titled Nurse Tech Information Kardex, with revised date of 09/01/11, revealed Nurse Tech's would utilize the Kardex as a resource when care was provided to the residents.

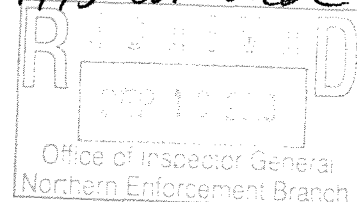
1. Review of the medical record for Resident #12 revealed the facility readmitted the resident on 08/02/12 with diagnoses of Muscle Disorders, Rheumatoid Arthritis, Chronic Pain and Osteoporosis. Review of the Quarterly MDS, dated 02/25/13, revealed the facility staff had assessed Resident #12 as extensive assistance of two (2) persons with bed mobility and toileting.

Review of Resident #12's comprehensive care plan, dated 12/04/12 and reviewed on 03/04/13, revealed a problem listed as at risk for falls/injury with a goal that the resident would not sustain any significant injuries related to falls. The care plan revealed the resident required assistance with turning and repositioning; however, the care plan

Licensed Nursing staff haven re-educated as of September 13, 2013 by the Director of Clinical Services and/or House supervisor on the importance of the development, implementation, and documentation of new interventions on the residents comprehensive care plan and transcription to residents Kardex.
Staffing patterns have been reviewed by the Executive Director and Director of Clinical Services on August 5, 2013 to ensure there is staffing to provide adequate supervision for residents.
Nursing Staff re-educated by the Director of Clinical Services on September 6, 2013 on the nursing Kardex for each individual resident.
Nursing staff will complete pre and post testing of development, implementation, and documentation of new interventions on the resident's comprehensive care plan and to include resident Kardex September 13, 2013.
To evaluate the competency of licensed nursing staff in the revision of the care plans and Kardex post fall, the Director of clinical Services will be notified by the nurse following the fall to assist the licensed staff in identifying appropriate interventions to reduce further risk of falls. On going the resident's falls care plan and Kardex will be QI monitored by the members of the Daily Operations meeting which is comprised of the Executive Director, Director of Clinical Services, Assistant Director of Nursing, RN MDS Coordinator, Activities Director Dietary manager, and Social Services post incident during the daily operations meeting the next business day following incident. Any variances will result in

9-13-13

Tony Willis Jr Executive Director 9/9/13-Corrected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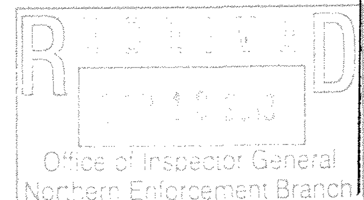
F 323	Continued From page 30 failed to indicate extensive assistance of two (2) persons. In addition, Review of Resident #12's Nurse Tech Information Kardex, not dated, revealed the resident required assistance of one (1) staff member for bed mobility and incontinent care not two (2) person assist as assessed by the facility. Review of the SBAR Communication Form for Resident #12 revealed the resident experienced a fall out of bed on 04/25/13. Further review of the fall incident documentation revealed the Root Cause Analysis form or a complete investigation related to the fall had not been completed. Interview with Certified Nursing Assistant CNA #1, on 08/01/13 at 11:30 AM, revealed she had independently provided incontinent care and turned the resident when the resident "tipped" out of bed on 04/25/13. The CNA stated the resident required assistance of one (1) staff member with bed mobility at the time of the fall and had obtained this information from another CNA. However, CNA #1 was unable to recall which CNA provided her training. Per interview, CNA #1 did not refer to Resident #12's Kardex to obtain care information. Interview with CNA #6, on 08/01/13 at 2:00 PM, who has also provided care to Resident #12, revealed Resident #12 required assistance of one (1) staff member when incontinent care was provided and when being turned and repositioned. She further stated this was reported to her by another CNA and she had not reviewed Resident #12's Kardex. Interview with Licensed Practical Nurse (LPN) #1, on 08/01/13 at 1:00 PM, revealed she had	F 323	**correction of the care plan and Kardex. Re-education will be provided as identified.** **The Director of Clinical Services will bring the findings to the QAPI meeting monthly to evaluate the effectiveness of staff re-alignment for supervision, the effectiveness of the review of resident's comprehensive falls care plan post fall and accuracy of Kardex. The findings will be reviewed with development of action plan if indicated to ensure residents fall care plan and Kardex is reviewed and revised post fall.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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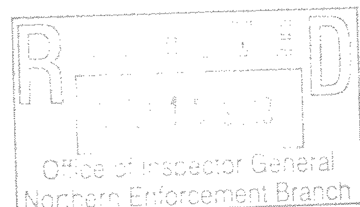
F 323	Continued From page 31 assessed Resident #12 after the fall occurred on 04/25/13. The LPN stated the resident complained of generalized pain, had a few abrasions and a physician's order was obtained to transfer the resident to the hospital for further evaluation. The LPN stated she was frequently assigned to care for Resident #12; however, she was not sure what level of assistance the resident required for bed mobility. The LPN stated she was responsible to conduct the root cause analysis of an incident when it occurred on her shift. The LPN indicated she was unsure if she had completed the root cause analysis for the resident's fall on 04/25/13 and stated she couldn't recall if she had identified a causative factor for the fall or not. Review of Resident #12's fall investigation revealed the root cause analysis had not been completed. Interview with the Director of Nursing (DON), on 08/01/13 at 10:45 AM, revealed she had completed the information provided on the Nurse Tech Information Kardex for Resident #12; however, she had not reviewed the resident's MDS assessment and was not aware the resident was a two (2) person assist for bed mobility. The DON further stated she had investigated Resident #12's fall on 04/25/13; however, she had not identified Resident #12 required the assistance of two (2) staff members with bed mobility and incontinent care and that adequate supervision was not provided. Review of Resident #12's fall investigation a thorough investigation had not been completed. 2. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 01/04/13 with diagnoses of Acute/Chronic Systolic Heart Failure, Respiratory Failure, Chronic	F 323		



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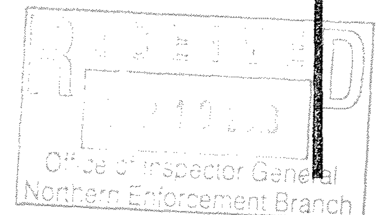
F 323	Continued From page 32	F 323		

Obstructive Pulmonary Disease, Cardiomyopathy, Hypertension, and Hypoglycemia. Review of the 06/24/13 Quarterly Assessment revealed the resident had received two injuries from falls since the 01/11/13 Admission Assessment, one with minor injury on 03/25/13 and one with major injury on 06/15/13. In addition, review of the admission assessment revealed the resident was coded as requiring minimal assist with bed mobility. The resident was assessed with a BIMS score of 9.

Observation of Resident #3, on 07/30/13 at 12:40 PM, revealed the resident was lying in his/her bed with his/her eyes closed. Observation, on 07/31/13 at 2:00 PM, revealed the resident was sitting up on the side of the bed watching TV. Interview with the resident revealed he/she did not like to go out of the room very much, and had a fall last month from having low blood sugar; however, stated he/she felt much better now.

Review of the Fall Investigation, dated 03/25/13, revealed the resident fell at 12:00 AM, with interventions post fall for vital signs, accuchecks, and neuro checks. The Fall Committee Review/Recommendations were to assist the resident to lie down after meals; however, there was no evidence a root cause analysis had been documented on the Root Cause Analysis Form to reflect why the resident had fallen.

In addition, Resident #3 sustained a second fall on 06/15/13, which was placed on the SBAR Communication Form and Progress Note. Review of the SBAR form under the section Situation revealed the fall was due to a drop in blood sugar; however, there was no documentation on the form as to what the blood sugar reading was at the time of the fall.



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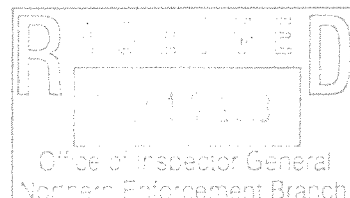
F 323	Continued From page 33 Review of the Quality Improvement Tool, dated 06/16/13, revealed the resident was found on the floor with a cut to the bridge of the nose and mid forehead. Review of the Quality Improvement Tool revealed the resident's blood sugar was 58, and was given Glucogel, with a post Blood Sugar reading of 157. The resident was sent to the hospital for evaluation and treatment. However, review of the Root Cause Analysis for Fall's Form, revealed the 06/15/13 fall had not been evaluated for the root cause, and most of the form was noted to be blank. Interview with LPN #6, on 08/01/13 at 10:00 AM, revealed Resident #3's fall, on 06/15/13, was due to low blood sugar, and stated all falls must have an incident report and SBAR completed with root cause analysis form completed. The LPN stated there had been a lot of turnover with staff, especially administrative staff over the past few months, and the paperwork may not always be completed. 3. Review of Resident #10's medical record revealed diagnoses of End Stage Renal Disease with Dialysis, Alcoholic Cirrhosis of the Liver and Peripheral Neuropathy. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/07/13, revealed the facility assessed the resident as having a Brief Interview of Mental Status (BIMS) of eight (8) indicating cognitive impairment. Further review revealed the facility assessed the resident as requiring the extensive assistance of one (1) staff for bed mobility, limited assistance of two (2) staff for transfers, as ambulation did not occur and as having no falls since admission, reentry, or prior assessment.	F 323		



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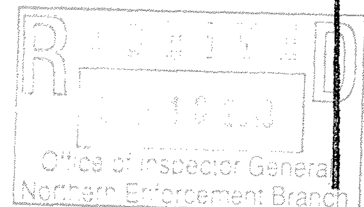
F 323	Continued From page 34 Review of the Comprehensive Plan of Care with an onset date of 02/16/13 revealed the resident was at risk for injury related to falls, tried to roll out of bed, and was restless at times. The interventions included providing needed devices for locomotion, transfer, wheelchair, walker, assist with transfers, and 1/2 side rails as ordered. Review of a Skilled Nursing Progress Note, dated 07/02/13 at 3:00 AM, revealed the resident was awake, yelling and rolled out of bed to get his/her girlfriends attention. No complaint of pain or discomfort, resident just wanted to get in bed with the girlfriend. Vital Signs were documented as Blood Pressure 126/78, Respirations 18, pulse 88. Oxygen saturation 99 percent on room air. The resident was incontinent of bowel/bladder and required assist of two (2) with transfers, and assist of one (1) with Activities of Daily Living (ADL's). The nurse would continue to monitor. The Note was signed by Licensed Practical Nurse (LPN) #2. Further review of the record revealed no evidence the physician was notified of the fall and no evidence a SBAR was completed, that the Supervisor was notified, the Root Cause Analysis Form was completed, or that the Investigation was completed. Further review revealed there was no evidence the Care Plan was revised as per the procedure or that the facility procedure for incidents was followed. Interview, on 08/01/13 at 5:30 PM, with LPN #2 revealed she had assessed Resident #10 after the fall and there did not appear to be any injury. She stated she checked for range of motion of extremities as well as obtained vital signs.	F 323		



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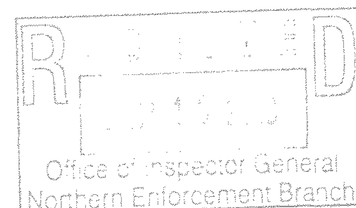
F 323	Continued From page 35 Continued Interview revealed there was a binder at the desk which contained the forms needed to complete after a fall including the SBAR, Incident Report, and Root Cause Analysis. She stated it was up to the nurse to decide which forms to complete depending on the severity of the fall. She further stated a fall was also to be transcribed to the Twenty-four (24) Hour Report. Continued interview revealed she could not remember if she had completed these forms after the fall or transcribed the information related to the fall on to the 24 Hour Report. Further interview revealed she did not remember calling the on-call supervisor or notifying the physician of the fall. She stated the girlfriend was on an air mattress on the floor beside the bed when the resident rolled out on top of the girlfriend. Further interview revealed she should have updated the care plan after the fall to indicate a fall had occurred with interventions to prevent further falls. Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON), revealed she had worked at the facility since November 2012, in different roles and had been in the DON position since 04/13. She stated she was unaware of Resident #10 sustaining a fall. She further stated, after a fall, the nurse was to complete the SBAR which included information regarding notification to the physician and family, complete a Fall Investigation which indicated which part of the body was injured, complete a Root Cause Analysis Form, to determine the reason for the fall, then update the care plan. Continued interview revealed the initial revision of the care plan was to be completed by the nurse who assessed the resident after a fall. She stated the fall was also to be noted on the 24 Hour Report.	F 323		



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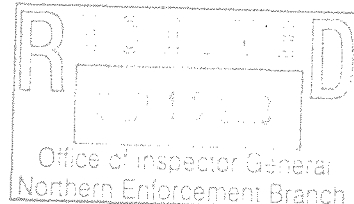
F 323	Continued From page 36 Further interview, revealed the day after a fall she and the MDS nurse were to check the Care Plans to ensure they were updated. The DON stated she had delegated the Unit Manager to update the kardex. The DON stated, there was a morning meeting Monday through Friday in which incidents such as falls was discussed. She stated, an Interdisciplinary Team Meeting (IDT) was held each Tuesday which consisted of the DON, Social Services, Activities, and Dietary and they checked to see if the interventions were working that were placed after the fall. Interview with the DON also revealed there had been several administrative staff members who were no longer there, and they had identified several system problems, one of them being falls. The DON stated this had been identified as a concern in the last QA meeting, where it was identified that several nurses were not thoroughly completing all the forms required by policy after a fall.	F 323		
F 328 SS=D	483.25(k) TREATMENT/CARE FOR SPECIAL NEEDS The facility must ensure that residents receive proper treatment and care for the following special services: Injections; Parenteral and enteral fluids; Colostomy, ureterostomy, or ileostomy care; Tracheostomy care; Tracheal suctioning; Respiratory care; Foot care; and Prostheses. This REQUIREMENT is not met as evidenced by:	F 328	**Corrective action for the storage of respiratory supplies for residents in rooms D4, E2, and D7 have been placed in bags and label with resident's name as of August 17, 2013** **Rooms of all residents utilizing respiratory equipment were audited by Director Clinical Services and all licensed nurses to ensure equipment is clean, mini nebulizers covered and accessory equipment stored in plastic bags and oxygen tubing stored in plastic bag if not in use by resident completed by September 13, 2013.**	9-13-13

Terry Wills Jr Executive Director 9/9/13 Corrected



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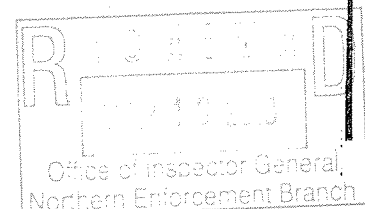
F 328	Continued From page 37 Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure respiratory equipment was clean and stored appropriately in a manner to prevent the spread of infection for one unsampled resident (Unsampled Resident B). The staff failed to ensure Unsampled Resident B's nasal cannula and oxygen tubing was not touching the floor and appropriate equipment to store the cannula was provided. In addition, the facility failed to properly store and cover mini-nebs in three rooms D4, E2, and D7. The findings include: Interview on 08/01/13 at 11:00 AM with the Director of Nursing (DON), revealed there was no specific policy related to storage of oxygen tubing when not in use. She stated the oxygen tubing was to be placed in a plastic bag when not in use and the oxygen tubing and bags for oxygen tubing storage were changed out every week. Observation on initial tour on, 07/30/13 at 11:10 AM, revealed Unsampled Resident B's nasal cannula and oxygen tubing were in the floor and the oxygen was turned off. Interview, on 07/30/13 at 11:10 AM, with Licensed Practical Nurse (LPN) #6 revealed the oxygen nasal cannula and tubing was not to be in the floor, but was to be stored in a plastic bag when not in use. Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON), revealed she further stated the oxygen nasal cannula and tubing should not have been on the floor because it would be an infection control issue.	F 328	**Licensed Nurse will check residents utilizing respiratory equipment every shift. Equipment check will be placed on the TAR (Treatment Administration Record) and initialed by Nurse upon completion each shift. TAR's will be QI monitored by House Supervisor Daily 5 x weeks x 4 weeks then weekly ongoing. Any negative findings will be addressed immediately with re-education provided.** **Director of Clinical Services will bring findings to the Quality Performance Improvement consisting of Executive Director, Director of Clinical Services, House Supervisor, Social Services, Activity Director, Maintenance Director, Dietary Manager and Medical Director meeting monthly** **for review and development of action plan to ensure respiratory equipment is cleaned and stored appropriately.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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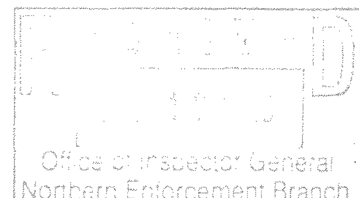
NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

(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 328	Continued From page 38 Review of the facility's policy and procedure for the ultrasonic nebulizer, created 01/05/12, revealed the Ultrasonic nebulizer was used to provide high-density aerosol and or medications to the respiratory tract to promote expectoration. The nurse should follow Infection control procedures, as appropriate. When the nurse is discontinuing the therapy - disconnect and disassemble device. Accessory equipment shall be rinsed with tap water and dried. Observations during the initial tour of the facility on 07/30/13 between 10:00 AM to 12:00 PM, in room D4 revealed one mini-nebulizer was observed to be open to the air, connected to accessory equipment and not covered; in room E2 one mini-nebulizer was observed to be open to the air, connected to accessory equipment and not covered; and in room D7, one mini-nebulizer was observed to be open to the air, connected to accessory equipment, and not covered. Interview, on 08/01/13 during the tour with LPN #8, revealed all of the mini-nebulizers should be appropriately stored in a plastic bag following the resident's ordered mini-nebulizer treatments. Interview, on 08/01/13 at 11:55 AM, with the Director of Nursing revealed it was her expectation that all of the nursing staff who administer mini-nebulizer treatments should cover and properly store the mini-nebulizer equipment following the mini-nebulizer treatment for each resident.	F 328		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		



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F 431	Continued From page 39	F 431		

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 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, interview, and record review it was determined the facility failed to

Corrective action was immediate removal of expired applesauce and yogurt products from all medication rooms. A thermometer was placed in the medication room refrigerator and the temperature of the refrigerator was logged for the date of August 1, 2013.

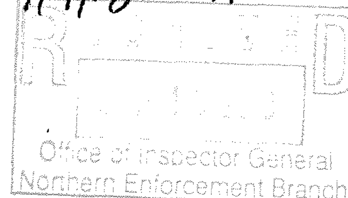
The Executive Director and Director of Nursing conducted an in-service August 8, 2013 through August 12, 2013 for all nursing staff on policy and procedure of Maintenance of carts and medication rooms.

House Supervisor will QI monitor 5 x weekly, x 4 weeks and then monthly ongoing medication room refrigerators to ensure thermometer are placed and temperatures logged 5 x weeks x 4 weeks then monthly ongoing. House supervisor will QI monitor resident designated refrigerators at each nurses station to ensure there are no outdated foods/drinks and the refrigerator are cleaned. Any noted area of concern will be addressed immediately and reported to Director of Clinical Services and/or Assistant Director of Nursing. QI monitoring tools will be reviewed during the Daily operations meeting to further discuss and address any identified issues and/or continued educational needs of the staff.

Director of Clinical Services will bring findings to the QAPI consisting of Executive Director , Assistant Director of Clinical Services, Director of Clinical Services, House Supervisor, Social Services, Dietary Manager, Activity Director, Medical Director, and Maintenance Director meeting monthly for review and development of action plan to ensure the proper storage of drugs and biologicals medication room refrigerators and resident designated refrigerators on units.

9-13-13

Tony Willis Jr Executive Director 9/9/13 - Corrected



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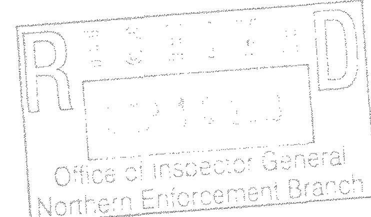
F 431	Continued From page 40 ensure the proper storage of drugs and biologicals for two medications rooms. The facility staff failed to remove an applesauce, which had a green substance and identified as mold by the staff, with a date of 06/14/13 and one 8-oz container of yogurt with an expiration date of 01/2013. In addition, Hall B's refrigerator did not have a thermometer. The findings include: Review of the facility's Omnicare Long Term Care Facility Pharmacy Services and Procedures Manual, Policy Title 5.3 Storage and Expiration of Medications, Biological, Syringes, and Needles, revised 01/01/13., Section 3.6, revealed the facility should ensure that food was not to be stored in the refrigerator, freezer, or general storage areas where medications and biological are stored. Observation of the medication room on the B wing on 08/01/13 at 8:45 AM, revealed there was no thermometer in the medication refrigerator. There was a log of thermometer temperatures on the front of the refrigerator, but no temperature was recorded for 08/01/13. Observation of the medication room on the E hall on 08/01/13 at 08:55 AM, revealed on the second shelf of the refrigerator a container of applesauce dated 06/14/13, with a green substance on the top of the applesauce. A container of Yogurt with an expiration date of 01/13 was also present on the second shelf of the medication refrigerator. Interview, on 08/01/13 at 9:15 AM, with LPN #8 revealed the 3rd shift house supervisor was responsible for checking all of the thermometers	F 431		



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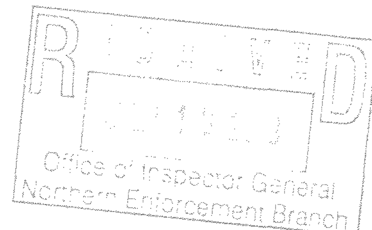
F 431	Continued From page 41 and recording the temperatures on the log sheet. LPN #8 stated she had received in morning report that the thermometer was missing in the refrigerator on the B Wing and that a replacement had been ordered. Interview, on 08/01/13 at 11:55 AM, with the Director of Nursing revealed it was the responsibility of the Night Shift Nursing Supervisor to check and record the medication refrigerator temperatures and to clean out the medication refrigerators. She stated that it was her expectation that the Night Shift Nursing Supervisor check and record the medication refrigerator temperature, find a replacement thermometer as soon as possible, and clean out the medication refrigerators in a timely manner.	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	F 441	**Resident #14 remains in contact isolation** **CNA #3 re-educated by House Supervisor on September 13, 2013 on infection control procedures with emphasis on personal protective equipment and when to use the equipment.** **DCS/Nurse Manager conducted a review of current facility residents to ensure that residents with diagnoses of infectious disease have infection control procedures in place per facility policy and procedure on August 8, 2013 through August 12, 2013.** **House Supervisor and/or Assistant Director of Nursing will randomly QI monitoring 10% direct, care staff when providing care to residents requiring isolation due to their diagnosis, daily x 4 weeks then monthly x 2 months then quarterly. QI monitoring will consist of observation and**	9-13-13

Terry Willett   Executive Director   9/9/13 - corrected



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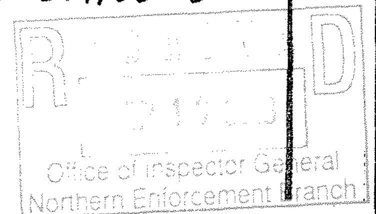
F 441	Continued From page 42 determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct 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 record review it was determined the facility failed to follow proper infection control procedures for one (1) of the seventeen (17) sampled residents. Facility staff were observed to provide care with no protective gown on for Resident #14 who had Vancomycin Resistant Enterococci (VRE) in the urine and C-Difficile colitis. The findings include: Review of the clinical record for Resident #14 revealed the facility admitted the resident on 03/23/13 with diagnoses of Syncope and Collapse, Diastolic and Systolic Heart Failure, Pneumonia, Severe Protein Calorie Malnutrition, Anemia, Hypertension, and Chronic Obstructive Pulmonary Disease. C-difficile toxin was positive	F 441	**interview. Any noted area of concern will be addressed immediately through re-education.** **Director of Clinical Services will bring findings monthly to the QAPI consisting of Executive Director, Director Clinical Services, Assistant Director Clinical Services, Activity Director, Social Services, Medical Director, and Maintenance Director meeting for review and development of action plan (including re-education) as indicated to ensure proper infection control procedures are followed.**	9-13-13

Terry Willett Executive Director 9/9/13 - Corrected



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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

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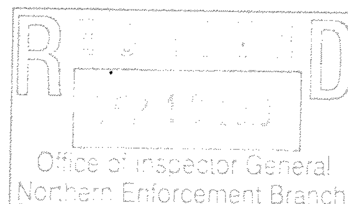
F 441	Continued From page 43 In stool specimen - reported 07/28/13, and VRE was reported in a urine culture on 07/28/13 and the resident was placed in contact isolation. Observations, on 08/01/13 at 9:15 AM, revealed CNA #3 provided care to Resident #14 and changed the bed sheets without wearing a gown to protect her uniform. Interview with CNA #3, on 08/01/13 at 9:20 AM, revealed she thought it was alright to just wear gloves when she was changing Resident #14's bed sheets. Interview with LPN #8, the Charge Nurse and House Supervisor for day shift,on 08/01/13 at 11:00 AM, revealed CNA #3 should have been wearing both a gown and gloves when providing care to Resident #14. Interview with the Director of Nursing, on 08/01/13 at 11:25 PM, revealed she was responsible for Staff Development and Infection Control for the facility. The Director of Nursing stated that all of the nursing and facility personnel were in-serviced during orientation regarding universal precautions and infection control policies.	F 441		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIB LE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.	F 514	**Resident #10 physician's orders were written for Dialysis three times a week and PRN as of August 2, 2013 by Medical Director Signature.** **All active medical records have been reviewed by the Medical Records clerk, and the Medical Lab to validate that only the correct medical record is in the chart. Review was complete on August 8, 2013.**	9-13-13

FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 7Q7711 Facility ID: 100197 If continuation sheet Page 44 of 50

Terry Willis Jr Executive Director 9/9/13-Corrected



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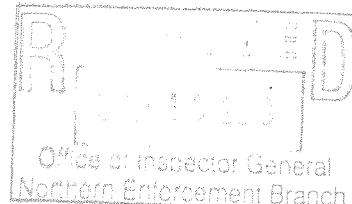
F 514	Continued From page 44 The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview, record review and review of facility policy it was determined the facility failed to ensure clinical records were maintained on each resident in accordance with accepted professional standards and practices that are completed and accurately documented for one (1) of seventeen (17) sampled residents (Resident #10). The staff failed to ensure Resident #10 had a physician order for the dialysis treatments received three (3) times a week. The findings include: Review of the facility's Medical Records Policy, reviewed 01/09/12, revealed a separate clinical record shall be maintained for each resident admitted to the facility. All physicians, nursing staff, and other health care professionals involved in the resident's care would be responsible for making prompt, appropriate entries in the record. Further review revealed current Physician's Orders were obtained from the attending physician on admission, and the orders were to include; recommendation for admission, medications, treatments, diets and general activity level. Further review revealed if applicable the Physician's Orders were to include; laboratory services, radiographic services, other	F 514	**Director of Clinical Services, Assistant Director of Clinical Services, and/or house Supervisor will QI monitor dialysis residents physicians orders monthly to ensure the order is on the current physician order sheet, along with the days of the week the dialysis is conducted. Any negative findings will be addressed immediately with re-education. The Director of Clinical Services, Assistant Director of Clinical Services and/or House Supervisor will QI monitor monthly the residents discontinued medications to ensure it is removed from cart, destroyed or returned if indicated per facility policy and was not carried over to the current physician order sheet. Any negative findings will be addressed immediately through re-education.** **Director of Clinical Services will bring findings monthly to the QAPI(Quality Assurance Performance Improvement) consisting of** **Executive Director, Director of Clinical Services, Assistant Director of Clinical Services, Social Services, Dietary Manager, Activity Director, and Medical Director meeting for review and development of action plan to include re-education as indicated to ensure residents receiving dialysis have a current physicians order which includes the days of week the dialysis is performed.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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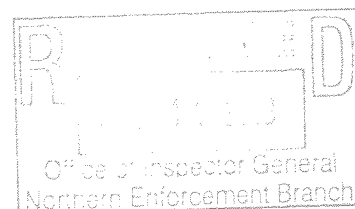
F 514	Continued From page 45 diagnostic and therapeutic services, physical restraints, chemical restraints, specialized rehabilitation assessments and treatments, self administration of medication, and therapeutic work orders if applicable. Review of Resident #10's medical record revealed the facility admitted the resident on 02/08/13, with a re-admission date of 07/26/13, and diagnoses of Chronic Kidney Disease, and End Stage Renal Disease with Dialysis. Review of the Quarterly Minimum Data Set (MDS) Assessment, dated 05/07/13, revealed the facility assessed the resident as having a Brief Interview for Mental Status (BIMS) of eight (8) indicating cognitive impairment. Review of the Comprehensive Plan of Care, dated 05/29/13, revealed Resident #10 had the potential for fluid volume deficit and fluid volume excess related to End Stage Renal Disease with Dialysis. The interventions included dialysis as ordered, with access of the dialysis catheter per dialysis center only. Review of a Progress Note, dated 07/26/13 at 5:00 PM, completed by Registered Nurse (RN) #1, revealed the resident was re-admitted to the facility from the hospital. Further review revealed a tunneled dialysis catheter was noted to the resident's right upper chest. The Note did not specify if the resident was to receive dialysis. Review of the Physician's Orders, dated 07/26/13, (the date of re-admission) revealed no orders for dialysis. Review of the Hospital Discharge Summary, dated 07/26/13, revealed the resident was	F 514		



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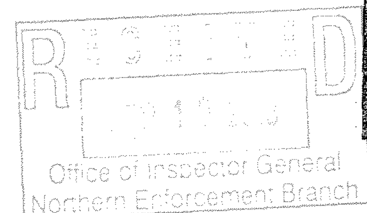
F 514	Continued From page 46 admitted to the hospital, on 07/10/13, and discharged back to the facility, on 07/26/13. Further review revealed the resident was admitted to the hospital for transplant surgery; however, surgery was not performed due to fever. The Discharge Summary did not specify the resident was to receive dialysis upon discharge. Interview, on 07/30/13 at 2:40 PM, with Licensed Practical Nurse (LPN) #3, who was assigned to Resident #10, revealed the resident was transported to dialysis three (3) times a week. She stated dialysis should have been on the Admission Physician's Orders for 07/26/13. She further stated RN #1 had re-admitted the resident to the facility, on 07/26/13, and had completed the Physician's Orders. She stated she would need to call the physician to obtain orders for dialysis. Review of the Physician's Orders, written 07/30/13, revealed orders for dialysis Mondays, Wednesdays and Fridays and as needed per physician approval. Interview, on 07/30/13 at 3:20 PM, with RN #1 revealed she had re-admitted the resident to the facility, on 07/26/13, and had transcribed the orders for medications from the Hospital Discharge Summary to the Physician's Orders, dated 07/26/13. She stated she was familiar with the resident and aware the resident was to continue dialysis three (3) times a week upon return to the facility and transportation had been set up for the dialysis by another nurse; however, she did not think about writing for dialysis on the Physician's Orders because the Hospital Discharge Summary did not specify Dialysis was to be continued.	F 514		



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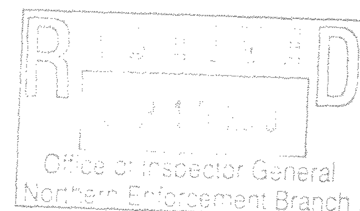
F 514	Continued From page 47 Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON), revealed the admitting nurse was to look at the medical record including the Discharge Summary, labs, treatments, follow up appointments, and review the medical record. She stated the RN #1 should have ensured Dialysis was on the re-admission Physician's Orders.	F 514		
F 520 SS=G	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced	F 520	**1. Care Plans- Kardex and MDS for residents #3, #10 and #12 by the Interdisciplinary team to ensure appropriate interventions have been documented on care plan, the Kardex addresses mobility status and amount of direct care staff assistance that is needed.** **2. A new fall risk assessment completed by licensed nurse by September 9, 2013 for residents #3, #10, and #12. The falls risk assessment was reviewed by the interdisciplinary Team on September 9, 2013 to determine residents at risk for fall and needs to be placed on the falling star program.** **1. Current Resident population had a new falls risk assessment completed by licensed nurses September 9, 2013 thru September 13, 2013. The falls risk assessment was reviewed by the interdisciplinary team on September 13, 2013 to determine resident at risk for falls and to be placed on the falling star program. Residents on the falling star program will have a star placed on their name plate, equipment, and medication administration record. Their care plan was reviewed appropriate interventions by the interdisciplinary team by September 9, 2013. The resident Kardex was reviewed for accuracy by the interdisciplinary team by September 9, 2013.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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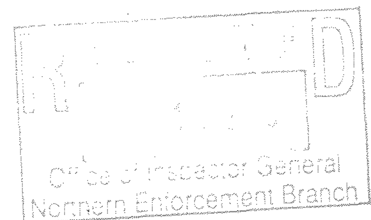
	185348	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	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 520	Continued From page 48 by: Based on interview and a review of the facility's policies, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee that developed and implemented appropriate plans of action to correct identified quality deficiencies related to falls. Administrative staff and the Regional Director of Clinical Services failed to implement action plans after audits identified deficiencies related to the fall investigative process. Based on this failure Resident #12 sustained a fall on 04/25/13 which resulted in actual harm of a fracture and hospital intervention. Refer to F323 The findings include: A review of the facility's policy regarding Performance Improvement Committee (Quality Assurance), dated 09/01/11, revealed the Performance Improvement Committee would meet monthly to review, recommend and act upon activities of the facility. The policy further stated an action team would be developed to collect and evaluate data and would implement needed action, under the direction of the Performance Improvement Committee. Interview with the Director of Nursing (DON), on 08/01/13 at 7:00 PM, revealed the facility had identified several system problems, in the last Quality Assurance (QA) meeting conducted on 06/28/13, and one of those areas was falls. She stated in the last QA meeting they had identified that several nurses were not completing all the forms needed after a fall, and many of the forms were not thoroughly completed. However, no	F 520	**2. As a result of the failure of the former Executive Director to chair monthly QA meetings the annual survey team identified deficient practices in citations in F156, F203, F241, F279,F280, F283, F309, F323, F328, F431, F441, F514, and F520.** **3. An Ad Hoc QA committee meeting was held August 2, 2013 chaired by the Executive Director areas cited upon exit was discussed with action plans initiated. The action plans were utilized until the arrival of the 2567 on August 16, 2013. The QA Committee members were re-educated by the Executive Director on August 2, 2013.** **4. The root cause analysis was conducted on September 6, 2013 by Director of Regional Clinical Services, Director of Clinical Services, and Executive Director to determine the QA committee's failure to ensure action plan development for identified deficiencies. The conclusion was the failure of the former Executive Director, Chairman of the Committee, to hold the meeting as directed in policy and procedure. As the result of the failure, identified deficient practices were not discussed by committee, action plans were not implemented following the discussion, follow-up was not initialed therefore placing the entire resident population at risk for falls.** **1. QAPI meeting is now scheduled weekly by Executive Director, Chairman of the committee. The meeting will be held weekly until the facility is determined to be in compliance, and then will move to a monthly format.**	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected



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

PRINTED: 08/29/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185348	A. BUILDING ______ B. WING ______	08/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BROWNSBORO HILLS NURSING HOME	2141 SYCAMORE AVENUE LOUISVILLE, KY 40206

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F 520	Continued From page 49 corrective plan of action had been implemented to correct the identified concerns related to falls. An interview with the Regional Director of Clinical Services, on 08/01/13 at 6:54 PM, revealed she had conducted a fall audit at the facility approximately six (6) weeks ago. She stated she identified root cause analysis had not been completed for facility residents who had experienced falls. The Regional Director stated approximately six (6) weeks ago when her audit was completed, she discussed the results with the DON and the Administrator (no longer employed at the facility) about the concerns she identified related to falls. However, there was no evidence corrective action was implemented. The Regional Director stated she developed a four point system, same as a plan of correction, related to the concerns she had identified and emailed it to the current Administrator, during the week of July 29, 2013 (unable to recall exact date). She stated she had requested this Administrator to conduct a QA meeting to discuss identified concerns. An interview with the current Administrator, on 08/01/13 at 6:00 PM, revealed she had been the facility's Administrator since 07/08/13. The Administrator acknowledged concerns related to fall investigations as being incomplete for the facility's residents. The Administrator stated she had not conducted a QA meeting since she had been Administrator; however, she held a "mini" QA meeting with the DON on 07/26/13 and had discussed fall concerns. The Administrator stated she had not implemented any action plans to correct identified concerns related to falls.		2. At any time a deficient practice is identified, an Ad Hoc QAPI will be called by the Executive Director, Chairman of Committee, to discuss deficient practice, develop and implement an action plan. QI monitor for effectiveness, and then discuss QI monthly findings at next scheduled monthly QAPI meeting. Action plan revision if indicated will be developed at this time. Action plans will include re-education of the staff associated with identified deficient practice. Competency of staff will be monitored by observation return demonstration and pre/post testing 3. All falls will be reported to Director of Clinical Services for discussion of intervention to be implemented immediately following the fall. The fall investigation report will be initiated by the nurse at the time of the fall. The Director of Clinical Services will complete the supervisor's component. The investigation report, clinical record, comprehensive care plan, root cause analysis and avoidable vs. unavoidable form will be brought to next daily operations meeting following the fall. These documents will be reviewed by the interdisciplinary team for interventions, determination of root cause analysis and determine if fall was avoidable or unavoidable. 4. During the Regional Director Clinical Services visit, any identified area of concern will be discussed with Executive Director and the Director of Clinical Services at time of exit. 5. The Executive Director will call for an Ad HOC QAPI meeting to be held next business day following exit. An action plan will be developed and implemented. A copy of the plan and attendance log will be forward to the Regional Director of Clinical Services for review and revision as indicated. 1. The Executive Director will schedule an AD Hoc QAPI meeting on September 9, 2013 to review the revised plan of correction with team members consisting of Executive Director, Director of Clinical Services, Social Services, Activity Director, Maintenance Director, MDS Coordinator, Dietary Manager, and Housekeeper Manager to ensure their knowledge of their role in the implementation of the plan of correction. 2. The Regional Director of Clinical Services will review QI monitoring tools monthly prior to the schedule QAPI meeting to assist in identifying trends requiring additional follow up. 3. The Regional Director of Clinical Services will attend the monthly QAPI meeting times three months to ensure continued compliance. 4. The Executive Director will schedule and chair the monthly QAPI meeting. Committee member will be notified a week in advance of the meeting. 5. At each monthly meeting the designated areas for QA review the following month will be assigned to the respective discipline by the Executive Director. 6. At each monthly meeting, the Executive Director will conduct discussion of status of plan of correction to ensure continued compliance.	9-13-13

Terry Willis Jr Executive Director 9/9/13 - Corrected