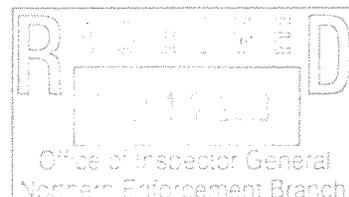


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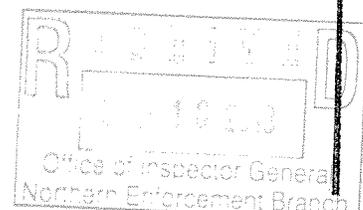
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NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 323	<p>Continued From page 33</p> <p>Review of the 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.</p> <p>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.</p> <p>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.</p>	F 323			



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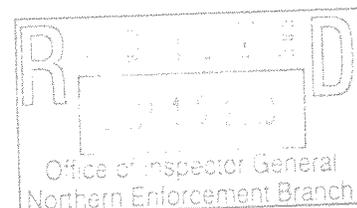
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F 323	<p>Continued From page 34</p> <p>Review of the Comprehensive Plan of Care with an onset date of 02/16/13 revealed the resident was at risk for injury related to falls, tried to roll out of bed, and was restless at times. The interventions included providing needed devices for locomotion, transfer, wheelchair, walker, assist with transfers, and 1/2 side rails as ordered.</p> <p>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 girlfriend's 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, Respiration 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.</p> <p>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.</p> <p>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.</p>	F 323		



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F 323	<p>Continued From page 35</p> <p>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.</p> <p>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.</p>	F 323			



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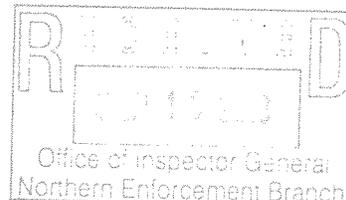
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F 323	Continued From page 36 Further interview, revealed the day after a fall she and the MDS nurse were to check the Care Plans to ensure they were updated. The DON stated she had delegated the Unit Manager to update the kardex. The DON stated, there 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	

*Tony Wells Jr*

*Executive Director*

*9/9/13 Corrected*



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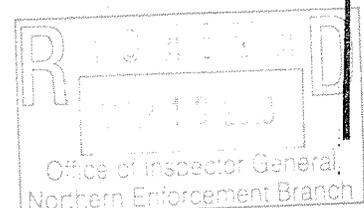
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F 328	<p>Continued From page 37</p> <p>Based on observation, interview, and review of the facility's policy, it was determined the facility failed to ensure respiratory equipment was clean and stored appropriately in a manner to prevent the spread 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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>	F 328	<p>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.</p> <p>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</p> <p>for review and development of action plan to ensure respiratory equipment is cleaned and stored appropriately.</p>	9-13-13

*Tony Willes Jr*

*Executive Director*

*9/9/13 - Corrected*



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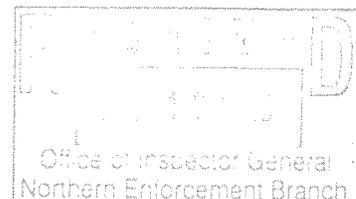
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F 328	Continued From page 38  Review of the facility's policy and procedure for the ultrasonic nebulizer, created 01/05/12, revealed the Ultrasonic nebulizer was used to provide high-density aerosol and or medications to the respiratory tract to promote 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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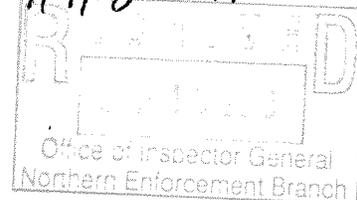
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F 431	<p>Continued From page 39</p> <p>The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.</p> <p>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.</p> <p>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.</p> <p>The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to</p>	F 431	<p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

*Tony Willes Jr*

*Executive Director*

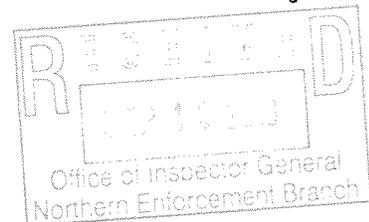
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F 431	<p>Continued From page 40</p> <p>ensure the proper storage of drugs and biologicals for two medications rooms. The facility staff failed to remove an applesauce, which had a green substance and identified as mold by the staff, with a date of 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.</p> <p>The findings include:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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</p>	F 431		



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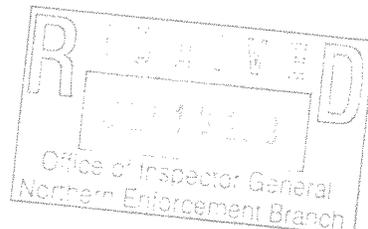
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F 431	Continued From page 41 and recording the temperatures on the log sheet. LPN #8 stated she had received in morning report that the thermometer was missing in the refrigerator on the B Wing and that a replacement had been ordered.  Interview, on 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 Willes*

*Executive Director*

*9/9/13 - corrected*



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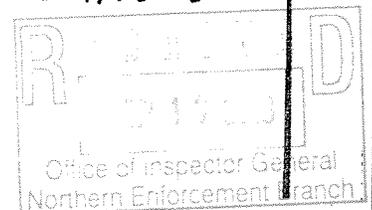
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F 441	<p>Continued From page 42</p> <p>determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.</p> <p>(2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.</p> <p>(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.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>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.</p> <p>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</p>	F 441	<p>interview. Any noted area of concern will be addressed immediately through re-education.</p> <p>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.</p>	9-13-13	

*Tony Williams*

*Executive Director*

*9/9/13-Corrected*



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2013
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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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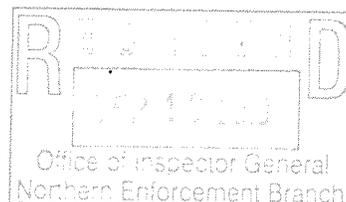
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F 441	Continued From page 43 In stool specimen - reported 07/28/13, and VRE was reported in a urine culture on 07/28/13 and the resident was placed in contact isolation.  Observations, on 08/01/13 at 9:15 AM, revealed CNA #3 provided care to Resident #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/ACCESSIBLE  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

*Terry Willis Jr*

*Executive Director*

*9/9/13 Corrected*



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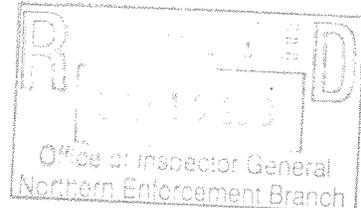
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F 514	<p>Continued From page 44</p> <p>The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.</p> <p>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.</p> <p>The findings include:</p> <p>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</p>	F 514	<p>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.</p> <p>Director of Clinical Services will bring findings monthly to the QAPI(Quality Assurance Performance Improvement) consisting of</p> <p>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.</p>	9-13-13	

*Tony Wille's Jr*

*Executive Director*

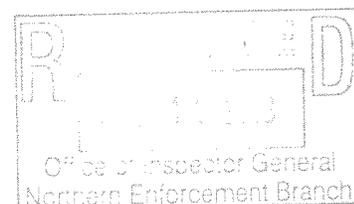
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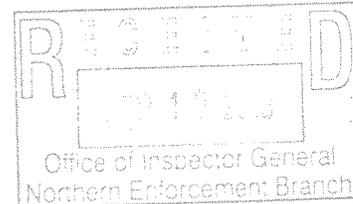
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NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
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F 514	<p>Continued From page 45</p> <p>diagnostic and therapeutic services, physical restraints, chemical restraints, specialized rehabilitation assessments and treatments, self administration of medication, and therapeutic work orders if applicable.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>Review of the Physician's Orders, dated 07/26/13, (the date of re-admission) revealed no orders for dialysis.</p> <p>Review of the Hospital Discharge Summary, dated 07/26/13, revealed the resident was</p>	F 514		



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F 514	<p>Continued From page 46</p> <p>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.</p> <p>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.</p> <p>Review of the Physician's Orders, written 07/30/13, revealed orders for dialysis Mondays, Wednesdays and Fridays and as needed per physician approval.</p> <p>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.</p>	F 514			



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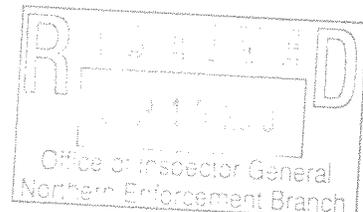
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F 514	Continued From page 47 Interview, on 08/01/13 at 11:00 AM, with the Director of Nursing (DON), revealed the admitting nurse was to look at the medical record including the Discharge Summary, labs, treatments, follow up appointments, and review 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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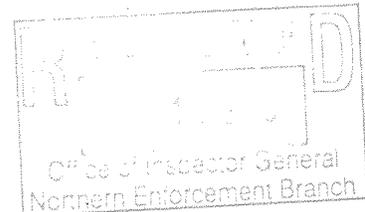
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F 520	Continued From page 48 by: Based on interview and a review of the facility's policies, it was determined the facility failed to maintain a Quality Assessment and Assurance Committee that developed and implemented appropriate plans of action to 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 initiated 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-B	

*Tony Willes Jr*

*Executive Director*

*9/9/13 - Corrected*



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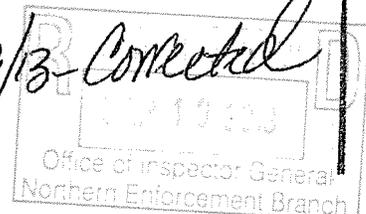
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	<p>Continued From page 49</p> <p>corrective plan of action had been implemented to correct the identified concerns related to falls.</p> <p>An interview with the Regional Director of Clinical Services, on 08/01/13 at 6:54 PM, revealed she had conducted 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.</p> <p>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.</p>			<p>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</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>3. The Regional Director of Clinical Services will attend the monthly QAPI meeting times three months to ensure continued compliance.</p> <p>4. The Executive Director will schedule and chair the monthly QAPI meeting. Committee member will be notified a week in advance of the meeting.</p> <p>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.</p> <p>6. At each monthly meeting, the Executive Director will conduct discussion of status of plan of correction to ensure continued compliance.</p>	

9-13-13

*Terry Willard Jr*

*Executive Director*

*9/9/13 - Corrected*



DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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NAME OF PROVIDER OR SUPPLIER  <b>BROWNSBORO HILLS NURSING HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2141 SYCAMORE AVENUE LOUISVILLE, KY 40206</b>		
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{F 000}	INITIAL COMMENTS  An on-site revisit was completed on 09/18-09/19/13 relating to the 08/01/13 standard survey. The facility was found to meet the regulatory requirements, based upon implementation of the acceptable POC, and in compliance on 09/13/13 as alleged.	{F 000}			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
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C

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2013
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1982, 1983, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story, Type V (111)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II 40KW generator. Fuel source is diesel.</p> <p>A standard Life Safety Code survey was conducted on 08/01/13. Brownsboro Hills Nursing Center was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000		9-13-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: *Terry Wells* TITLE: *Executive Director* DATE: *9/10/13*

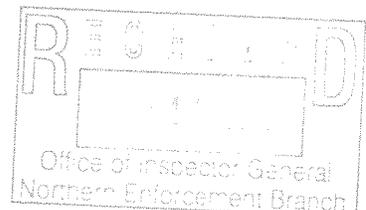
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable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

DISCLOSED  
If continuation sheet Page 1 of 14  
Office of Inspector General  
Northern Enforcement Branch

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

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K 000  K 018 SS=D	Continued From page 1 Deficiencies were cited with the highest deficiency identified at "F" level. NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3  Roller latches are prohibited by CMS regulations in all health care facilities.  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors would completely latch when closing, to prevent the passage of smoke in the event of an emergency, in accordance with NFPA standards. The deficiency had the potential to affect three (3) of eight (8) smoke compartments, approximately thirty-three (33) residents, staff, and visitors. The facility has ninety-six (96) certified beds and the	K 000  K 018	The doors C1, B4, and D4 were fixed immediately as of August 5, 2013 to ensure there are no obstructions or impediments on any resident or passage doors.  A facility wide was re-educated, by the Executive Director on 8/8/2013 through 8/12/2013, for all employees to educate them on making sure doors are secured and closed properly. <i>9-13-13</i>  Doors to residents' rooms will be QI monitored weekly by the Maintenance Director and/or Assistant Maintenance Director to ensure doors latch appropriately. This will be part of the preventive maintenance check. Any negative findings will be addressed immediately.  The Executive Director will bring the QI monitoring findings to the QAPI meeting monthly for review and development of action plan to ensure corridors doors latch completely when closing.



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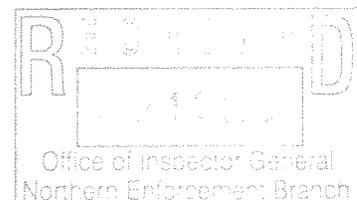
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K 018	<p>Continued From page 2</p> <p>census was eighty-five (85) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/01/13 between 10:25 AM and 11:34 AM, with the Director of Plant Operations revealed the doors to resident rooms C1, B4 and D4 would not latch when tested.</p> <p>Interviews, on 08/01/13 between 10:25 AM and 11:34 AM, with the Director of Plant Operations revealed he was unaware of the door hardware malfunctioning and not being able to latch and prevent the passage of smoke in the event of an emergency.</p> <p>19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.</p> <p>Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.</p> <p>Exception No. 2: In smoke compartments protected throughout by an approved, supervised</p>	K 018	



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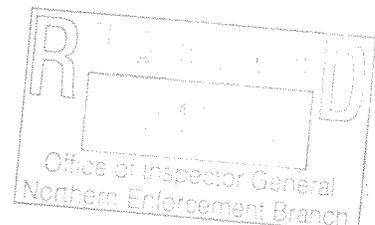
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K 018	Continued From page 3 automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.	K 018		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD  One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from	K 029		



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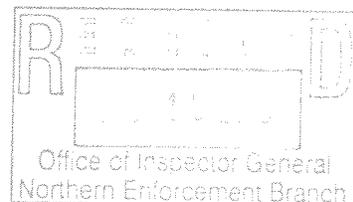
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K 029	<p>Continued From page 4</p> <p>other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments, approximately twenty (20) residents, staff and visitors. The facility has ninety-six (96) certified beds and the census was eighty-five (85) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/01/13 at 10:05 AM, with the Director of Plant Operations revealed the door to the Medical Records Room, located in the service corridor, did not have a self-closing device installed on the door.</p> <p>Interview, on 08/01/13 at 10:05 AM, with the Director of Plant Operations revealed the facility is in the process of renovation and had relocated the medical records to its current location. They had overlooked the requirement for the room, classified as a hazardous area, for the door being required to be equipped with a self-closing device.</p>	K 029	<p>1. The Medical Records has been moved to a secure area with a self closing device on the door.</p> <p>2. Maintenance Director conduct monthly QI monitoring through visualization of doors and areas requiring self closing devices. Any negative findings will be addressed immediately</p> <p>Executive Director will bring findings of the monthly QI monitoring to the QAPI meeting for review and development of action plan to ensure rooms classified as hazardous will be equipped with a self-closing device.</p> <p style="text-align: right;">9-13-13</p>



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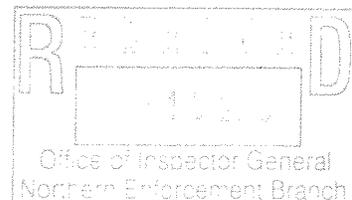
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K 029	Continued From page 5  Reference:  NFPA 101 (2000 Edition).  19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.	K 029		



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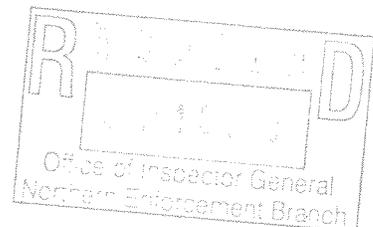
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K 050 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to ensure fire drills were conducted quarterly on each shift at random times, in accordance with NFPA standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, all residents, staff, and visitors. The facility has ninety-six (96) certified beds and the census was eighty-five (85) on the day of the survey.</p> <p>The findings include:</p> <p>Record review, on 08/01/13 at 1:45 PM, with the Director of Plant Operations revealed the facility had no documentation of fire drills being conducted during the first shift in the first quarter of 2013, during the second shift in the first quarter of 2013 and during the third shift in the second quarter of 2013.</p> <p>Interview, on 08/01/13 at 1:45 PM, with the Director of Plant Operations revealed he was not</p>	K 050	<p>All Residents have the potential to be affected by the facility to ensure fire drills are conducted quarterly on each shift at random times. On August 27, 2013 conducted on first shift and On August 29, 2013 conducted on second shift.</p> <p>1. The QI monitoring tool consists of reaction of staff members, closure of all fire doors, head count of all residents, and identification of location of fire.</p> <p>2. QI monitoring will be conducted by maintenance Director and/or Assistant Maintenance Director immediately post drill. Drills will be conducted quarterly on each shift at random times. Negative findings post drill will be brought to the monthly safety meeting and monthly QAPI.</p> <p>Findings will be brought monthly to the QAPI meeting for review and development of action plan, including re-education of staff if indicated to ensure staffs are competent to react to fire drills.</p>	9/13/13	



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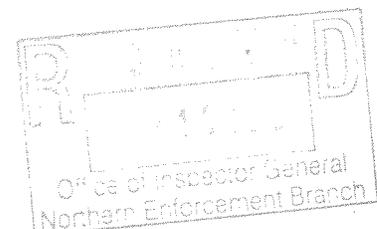
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K 050	Continued From page 7 aware of fire drills not being conducted at a minimum of one per shift per quarter at random times. He indicated he was not the Director of Plant Operations and not in charge of conducting fire drills, at the time they were not being conducted.  Reference: NFPA Standard NFPA 101 19.7.1.2. Fire drills shall be conducted at least quarterly on each shift and at unexpected times under varied conditions on all shifts.	K 050		
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD  Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5  This STANDARD is not met as evidenced by: Based on record review and interview, it was determined the facility failed to have quarterly inspections conducted on the automatic sprinkler system in accordance with NFPA standards. The deficiency had the potential to each of the eight (8) smoke compartments, all residents, staff, and visitors. The facility has ninety-six (96) certified beds and the census was eighty-five (85) on the day of the survey.  The findings include:  Record review, on 08/01/13 at 2:07 PM, with the Director of Plant Operations revealed the facility	K 062	We have contacted Dalmatian Company and our system was inspected on August 17, 2013. In September the Dalmatian Company will be running quarterly inspection of the wet and dry system. After the September, our next quarterly inspection is scheduled for February 2014.  1. The Maintenance Director and Assistant Maintenance Director by the Executive Director on September 9, 2013 on importance of conducting quarterly sprinkler system according to NFPA standards. 2. Maintenance Director and Assistant Maintenance Director will ensure a quarterly inspection will be scheduled and conducted through a calendar format and reviewed at QAPI monthly. 3. Copy of work order will be given to Executive Director and Safety Committee quarterly.  Work order will be reviewed in Safety meeting and QAPI quarterly to ensure the work has been completed by contracted company.	9-13-13



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K 062	<p>Continued From page 8</p> <p>had no documentation of quarterly inspections being conducted on the automatic sprinkler system during the fourth quarter of 2012 and during the second quarter of 2013.</p> <p>Interview, on 08/01/13 at 2:07 PM with the Director of Plant Operations, revealed he was unaware of the automatic sprinkler system quarterly inspections not being conducted. He indicated he was not the Director of Plant Operations at the time when the quarterly inspections were required to be conducted.</p> <p>Reference: NFPA 25 (1998 Edition).</p> <p>2-1 General. This chapter provides the minimum requirements for the routine inspection, testing, and maintenance of sprinkler systems. Table 2-1 shall be used to determine the minimum required frequencies for inspection, testing, and maintenance.</p> <p>Exception: Valves and fire department connections shall be inspected, tested, and maintained in accordance with Chapter 9.</p> <p>Table 2-1 Summary of Sprinkler System Inspection, Testing, and Maintenance</p> <table border="1"> <thead> <tr> <th>Item</th> <th>Activity</th> <th>Frequency</th> <th>Reference</th> </tr> </thead> <tbody> <tr> <td>Gauges (dry, preaction deluge systems)</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>2-2.4.2</td> </tr> <tr> <td>Control valves</td> <td>Inspection</td> <td>Weekly/monthly</td> <td>Table 9-1</td> </tr> <tr> <td>Alarm devices</td> <td>Inspection</td> <td>Quarterly</td> <td>2-2.6</td> </tr> </tbody> </table>	Item	Activity	Frequency	Reference	Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2	Control valves	Inspection	Weekly/monthly	Table 9-1	Alarm devices	Inspection	Quarterly	2-2.6	K 062		
Item	Activity	Frequency	Reference																	
Gauges (dry, preaction deluge systems)	Inspection	Weekly/monthly	2-2.4.2																	
Control valves	Inspection	Weekly/monthly	Table 9-1																	
Alarm devices	Inspection	Quarterly	2-2.6																	





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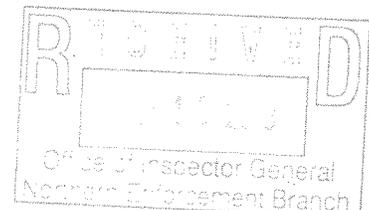
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K 130	Continued From page 10 Based on observation and interview, it was determined the facility failed to maintain kitchen doors within a required means of egress, in accordance with NFPA standards. The deficiency had the potential to affect one (1) of eight (8) smoke compartments and the staff working in the Kitchen. The facility has ninety-six (96) certified beds and the census was eighty-five (85) on the day of the survey.  The findings include:  Observation, on 08/01/13 at 10:15 AM, with the Director of Plant Operations revealed unapproved locks (two (2) slide bolt types) were installed on the egress side of the pair of doors exiting from the kitchen to the Service Corridor.  Interview, on 08/01/13 at 10:15 AM, with the Director of Plant Operations revealed he was unaware of the slide bolt locks being prohibited and agreed that slide bolt locks could be a deterrent to exiting the Kitchen in the event of an emergency. Further interview revealed the pair of doors are scheduled to be replaced with new doors and hardware, as a part of the facility's renovation.  Reference: NFPA 101 (2000 Edition)  19.2.2.2.4 Doors within a required means of egress shall not be equipped with a latch or lock that requires the use of a tool or key from the egress side.	K 130	2. Maintenance Director conduct monthly QI monitoring through visualization of doors and areas requiring self closing devices. Any negative findings will be addressed immediately  Executive Director will bring findings of the monthly QI monitoring to the QAPI meeting for review and development of action plan to ensure rooms classified as hazardous will be equipped with a self-closing device.	9/13/13
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 147		

*Corrected. Terry Willes*

*Executive Director*

*9/19/13*



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2013
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40208	
(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)
K 147	<p>Continued From page 11</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observation and Interview, it was determined the facility failed to ensure electrical wiring and devices were maintained in accordance with NFPA standards. The deficiencies had the potential to affect each of the eight (8) smoke compartments, all residents, staff, and visitors. The facility has ninety-six (96) certified beds and the census was eighty-five (85) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 08/01/13 between 10:35 AM and 12:03 PM, with the Director of Plant Operations revealed the electrical panels located in Resident Halls A, B, C, D and E were all unlocked and permitted unauthorized access to electrical circuits.</p> <p>Interviews, on 08/01/13 between 10:35 AM and 12:03 PM, with the Director of Plant Operations revealed he was not aware of the requirement that electrical panels, located in the resident corridors, were to be locked. He had been informed by the local Fire Department that their preference was for the panels to be unlocked for easy access in the event of an emergency. However, the Authority Having Jurisdiction (AHJ) maintains the panels are required to be locked to prohibit unauthorized access by residents and</p>	K 147	<p>The facility electrical panels were equipped with locks on Residents Halls A, B, C, D and E as of August 22, 2013. The Executive Director educated the Maintenance Director on August 2, 2013. The keys to the locks are located at the nurses station related to each hall's location.</p> <p>Panels will be QI monitored monthly by Maintenance Director and/or Assistant Maintenance Director to ensure panels are locked securely.</p> <p style="text-align: right;"><i>9/13/13 TW</i></p>

*Corrected Terry Willis*

*Executive Director*

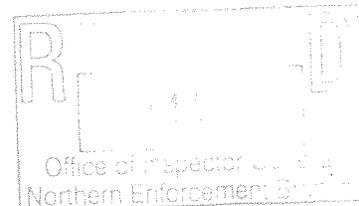
*9/9/13*



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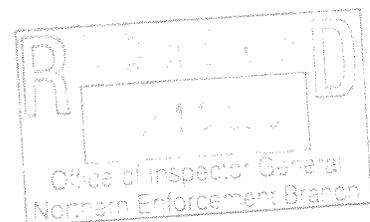
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/01/2013
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	<p>Continued From page 12 other non-qualified persons.</p> <p>Further observations, on 08/01/13 between 11:37 AM and 11:50 AM, with the Director of Plant Operations revealed medical equipment (an oxygen concentrator) was plugged into a power strip located in Resident Room D3 and a personal refrigerator was plugged into a power strip located in Resident Room A2.</p> <p>Further interviews, on 08/01/13 between 11:37 AM and 11:50 AM, with the Director of Plant Operations revealed he was aware of the requirements for the proper use of power strips. However, he was not aware of the misuse of power strips in the Resident Rooms D3 and A2.</p> <p>Reference: NFPA 70 (1999 edition) 110-26. Spaces</p> <p>About Electrical Equipment. Sufficient access and working space shall be provided and maintained about all electric equipment to permit ready and safe operation and maintenance of such equipment. Enclosures housing electrical apparatus that are controlled by lock and key shall be considered accessible to qualified persons.</p> <p>Reference: NFPA 99 (1999 edition) 3-3.2.1.2 D</p> <p>Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall</p>	K 147		



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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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 147	Continued From page 13 be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.	K 147		



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NAME OF PROVIDER OR SUPPLIER  <b>BROWNSBORO HILLS NURSING HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>2141 SYCAMORE AVENUE LOUISVILLE, KY 40206</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{K 000}	<p>INITIAL COMMENTS</p> <p>Based upon implementation of the acceptable POC, the facility was deemed to be in compliance, 09/13/13 as alleged.</p>	{K 000}		

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

TITLE

(X6) DATE

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