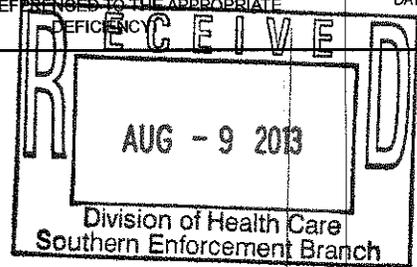


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

2nd SOD

PRINTED: 08/02/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743	
(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	F 000		
F 253 SS=E	<p>483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility policy, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observation during the environmental tour on 06/27/13 revealed the doors to the second floor shower room door, whirlpool room, and the LB shower room had worn and jagged edges. Six geri-chairs and one wheelchair on the LB Unit had torn/ripped edges on the armrests and headrests and were available for resident use. Two rooms on the LB Unit (rooms 27 and 28) had cracked tile under the air conditioner units and were in need of replacing. In addition, medication carts on the second floor and on the Shepherds Cove Unit were observed to have pill debris/powder in the drawers and in need of cleaning.</p> <p>The findings include: Review of the Wheel Chair Cleaning and Maintenance policy (02/04/13) revealed</p>	F 253	<p>F 253 HOUSEKEEPING & MAINTENANCE SERVICES</p> <p>(1.) The following corrective actions were completed for deficiencies related to maintenance and housekeeping services maintaining a sanitary, orderly, and comfortable interior:</p> <ul style="list-style-type: none"> > Door Covers were replaced on 06/27/13, for 2nd floor shower room door, whirlpool room door, and LB shower room door; > (6) Geri-Chairs identified with broken integrity of covers were immediately removed on 06/27/13, from resident available use; > The wheelchair identified with ripped covering on armrest was permanently removed 06/27/13, from service; > Cracked tiles for rooms 27 and 28 were replaced on 06/29/13, and > Medication carts for 2nd floor and Shepherd's Cove units were cleaned on 06/27/13. <p>(2.) In order to ensure that maintenance and housekeeping services maintain a sanitary, orderly, and comfortable interior on an ongoing basis the following steps were taken:</p> <ul style="list-style-type: none"> > Building interior was re-audited on 07/1/13, utilizing the revised facility 	



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

TITLE

(X6) DATE

Kathleen H. Young

ADMINISTRATOR

8/8/13

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 253	<p>Continued From page 1</p> <p>maintenance staff would clean wheelchairs monthly and "as needed." In addition, according to the policy, during the process of checking the wheelchairs monthly, maintenance staff would also check the wheelchairs for any safety concerns.</p> <p>Review of the Facility Interior policy (02/11/09) revealed maintenance staff would be responsible for ensuring facility doors were free of sharp edges and vinyl door protectors were intact.</p> <p>Review of the Resident and Staff Chair and Seating Equipment Safety policy (01/21/13) revealed geri-chairs will be audited monthly to check for rough areas which could cause skin tears.</p> <p>Review of the Environmental Rounds House Keeping/Maintenance policy (10/01/09) revealed maintenance would be provided to all areas of the building, grounds, and equipment, and included broken floor tiles.</p> <p>Review of the Storage of Medications policy (June 2012) revealed that drugs were to be stored in an orderly manner in cabinets, drawers, or carts.</p> <p>Interview with the Director of Nursing on 06/27/13, at 7:00 PM revealed nurses were to keep medication carts clean and free of pill debris.</p> <p>1. Observation during the environmental tour on 06/27/13 revealed the doors on the second floor shower room and whirlpool room, and the shower room door on the LB Unit, were rough and jagged. Six geri-chairs and one wheelchair with</p>	F 253	<p>Interior Safe Passage and Boundaries audit form.</p> <ul style="list-style-type: none"> ➤ Resident Geri Chairs were re-audited on <u>07/02/13</u>, utilizing the Resident Geri-Chair audit form. (5) new Geri Chairs were purchased on <u>07/08/13</u>, and put into service on <u>07/11/13</u> to replace (5) of the 6 Geri chairs found to be deficient. (See attached invoice) (1) of the 6 Geri chairs found to be deficient was repaired. ➤ Wheelchairs were re-audited on <u>06/28/13</u>, utilizing the Wheelchair Maintenance Audit Tool. ➤ All Medication Carts were re-audited on <u>06/28/13</u>, utilizing the Storage of Drugs and Medication Carts Audit for safe storage and cleanliness including any visible pill debris. (Supporting documentation of all audits attached.) ➤ Inservices were conducted on <u>07/17/13</u>, for Maintenance and Housekeeping Staff on the following: <ul style="list-style-type: none"> • Revised Facility Interior Safe Passage and Boundaries Policy and Audit form; • Revised Resident and Staff Chair and Seating Equipment Safety Policy and Audit form; and • Revised Wheelchair Cleaning and Maintenance Policy and Audit form. 		

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F 253	<p>Continued From page 2</p> <p>torn/ripped areas to the headrests, armrests, and seat cushions were observed on the LB Unit and were in need of repair. Resident rooms 27 and 28 on the LB Unit had tiles that were cracked and broken and in need of replacing under the air conditioner units.</p> <p>2. Observation of the Team 1 medication cart on the second floor on 06/27/13, at 2:15 PM revealed pill debris and powder in the bottom of the drawers.</p> <p>3. Observation conducted on 06/27/13, at 2:30 PM of the medication cart on the Shepherds Cove Unit revealed pill debris and powder debris in the drawers of the medication cart.</p> <p>Interview with the second floor Unit Manager on 06/27/13, at 2:15 PM revealed staff was to clean the medication carts once per week and "as needed."</p> <p>Interview on 06/27/13, at 2:30 PM with the Charge Nurse for Shepherds Cove revealed medication carts should be cleaned during the night shift and when spills occur.</p> <p>Interview with the Environmental Services Director (ESD) and the Director of Maintenance (DOM) on 06/27/13, at 4:45 PM revealed the rough doors, broken tiles, and the ripped/torn geri-chairs and wheelchairs had not been reported as being in need of repair. The ESD and DOM stated the staff should fill out maintenance request forms for any item that was in need of repairs. The ESD and DOM said they made rounds on a monthly basis to assess for any areas in need of preventative maintenance/repairs and cleaning. According to</p>	F 253	<p>➤ Inservices were conducted on 07/17/13, for Nursing Staff on the following:</p> <ul style="list-style-type: none"> • Revised Storage of Drugs and Medication Carts Policy and Audit. <p>(3.) Quality Improvement measures implemented to ensure that Housekeeping and Maintenance services maintain a sanitary, orderly, and comfortable interior to include door coverings, Geri chairs, wheelchairs, flooring, and medication carts include:</p> <ul style="list-style-type: none"> ➤ Utilizing the Geri Chair Equipment Management / Preventative Maintenance Audit form, housekeeping staff will audit Geri chairs monthly to ensure Geri chairs are in good working condition free of holes and rough areas. Areas of non-compliance will be corrected immediately by taking the Geri chair out of resident service and following the Reporting and Handling of Damaged and Malfunctioning Equipment Policy. The results of the Geri Chair Audit will be turned in to the Environmental Services Director monthly. ➤ Utilizing the Wheelchair Audit tool, Maintenance staff will audit wheelchairs monthly to ensure backs, seats, and arm rests, are free of tears, splits, and cracks. Areas of non-compliance will be corrected immediately by taking the wheelchair out of resident service and following the Reporting and Handling of Damaged and Malfunctioning Equipment policy. Results of the 		

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F 253	Continued From page 3 the ESD and DOM, the last assessment/cleaning of the facility was performed on 06/20/13 and the ripped and torn wheelchair and geri-chair headrests and armrests must have "been missed." Interview with the Director of Nursing (DON) on 06/27/13, at 7:00 PM revealed the medication carts should be kept free of pill debris and powders. According to the DON, the nurses were to ensure the medication carts were cleaned on a weekly and "as needed" basis, and stated any pill debris/powder should be cleaned from medication cart drawers after medication administration. The DON stated the pharmacy checked medication carts, including for cleanliness, on a monthly basis and had not reported any problems.	F 253	<ul style="list-style-type: none"> ➤ Wheelchair audit will be submitted to the Maintenance Director monthly. ➤ Utilizing the Interior of Facility Audit tool, Maintenance staff will audit monthly to ensure doors are free of sharp edges and vinyl door protectors are intact; and floors are free of cracked, chipped, or missing tiles. Areas of non-compliance will be corrected immediately. The Interior of Facility Audit will be submitted to the Maintenance Director monthly. ➤ Utilizing the Storage of Drugs and Medication Cart Audit, the Charge Nurse will audit Medication Carts weekly to ensure that all Medication Carts on each nursing unit are clean and free of debris. Areas of non-compliance will be corrected immediately. Results of the Storage of Drugs and Medication Cart audit will be submitted to the Director of Nursing weekly. (Copies of audits attached) 		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and facility policy review, it was determined the facility failed to have an effective system to ensure necessary	F 309	<p>(4.) Monitoring the compliance of measures taken to ensure that Maintenance and Housekeeping services maintain a sanitary, orderly, and comfortable interior are sustained include:</p> <ul style="list-style-type: none"> ➤ Utilizing the Compliance Monitoring form for Geri Chair Equipment the Environmental Services Director will conduct compliance monitoring monthly on the results of the Geri Chair Equipment Management / Preventative Maintenance Audit. The Environmental Services 		

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F 309	<p>Continued From page 4</p> <p>services were provided to attain or maintain the highest practicable well-being in accordance with the resident's comprehensive assessment and plan of care for one of twenty-four sampled residents (Resident #15). A review of the Resident Census and Conditions Report, completed by the facility on 06/25/13, revealed Resident #15 was the only resident in the facility who required dialysis services. A review of documentation revealed Resident #15 received dialysis services three times a week as ordered by the physician; however, there was no evidence communication was provided consistently between the dialysis center and the facility.</p> <p>The findings include:</p> <p>A review of the facility's policy regarding communication between the facility and the dialysis center (dated 07/20/12) revealed a method of communication between the facility and the dialysis center would be established to accurately communicate between the two facilities and ensure continuity of care. The policy revealed the facility nurse would communicate to the dialysis center any special needs of the resident and would arrange for the resident's transportation. The policy further revealed the resident's medications and meals would be coordinated between the dialysis center and the facility. In addition, the policy noted the facility would send applicable information (any unusual events or condition of the resident) to the dialysis center.</p> <p>Review of the medical record for Resident #15 revealed the facility admitted the resident on 05/31/13 with a diagnosis of End Stage Renal Disease and the resident was to receive</p>	F 309	<p>Director will submit compliance monitoring results to the QAPI committee <u>monthly</u>. Negative results will be identified and resolved through the interdisciplinary approach of the committee.</p> <ul style="list-style-type: none"> ➤ Utilizing the Compliance Monitoring form for the Wheelchair Audit the Maintenance Director will conduct compliance monitoring <u>monthly</u> on the results of the Wheelchair Audit. The Maintenance Director will submit compliance monitoring results of the Wheelchair Audit to the QAPI Committee <u>monthly</u>. Negative results will be identified and resolved through the interdisciplinary approach of the committee. ➤ Utilizing the Compliance Monitoring form for the Facility Interior Audit the Maintenance Director will conduct compliance monitoring <u>monthly</u> on the results of the Facility Interior Audit. The Maintenance Director will submit compliance monitoring results of the Facility Interior Audit to the QAPI Committee <u>monthly</u>. Negative results will be identified and resolved through the interdisciplinary approach of the committee. ➤ Utilizing the Compliance Monitoring form for the Medication Cart Cleaning Audit the Director of Nursing will conduct compliance monitoring <u>weekly</u> of the results of the Medication Cart Cleaning Audit. Areas of non-compliance will be 		

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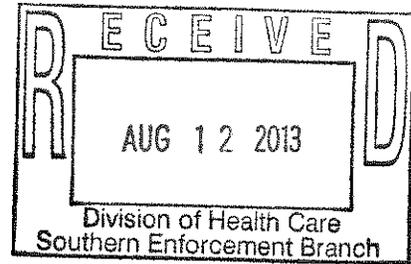
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F 309	<p>Continued From page 5</p> <p>hemodialysis treatments three times per week (Tuesday, Thursday, and Saturday). Review of the admission comprehensive assessment dated 06/06/13 revealed Resident #15 required dialysis services. A review of the comprehensive care plan revealed the facility addressed the diagnosis of ESRD and developed a care plan for dialysis care. Interventions included monitoring the resident pre-dialysis for signs/symptoms of fluid overload, monitoring the shunt site post-dialysis for bleeding or oozing, and monitoring the resident's vital signs.</p> <p>A review of the nurse's notes dated 05/31/13 through 06/27/13 revealed Resident #15 was transported to the dialysis center three times a week as ordered. According to the nurse's notes, the facility staff nurse documented each time the resident left the facility to go to the dialysis center. After the resident returned to the facility, the facility staff nurse documented an assessment of the resident's vital signs (blood pressure, pulse, respirations, and temperature) and an assessment of the resident's "shunt" (intravenous access) site. The nurse's note revealed Resident #15 had received dialysis on 06/06/13 and had returned to the facility at 4:00 PM. Continued review of documentation revealed the dialysis nurse contacted the facility on 06/06/13, at 1:00 PM to advise the facility nurse to remove the pressure dressing from Resident #15's dialysis shunt site "12-24 hours" after dialysis if no further bleeding was identified. However, further review of the nurse's notes revealed no additional communication between the facility and the dialysis center related to the resident's pre/post weights, medications required during dialysis, the amount of fluid required to be removed during dialysis and no coordination of the resident's</p>	F 309	<p>corrected immediately and the Primary Charge Nurse will initiate a QAPI study. The results of the study will be submitted by the Director of Nursing to the QAPI committee monthly. Negative results will be identified and resolved through the interdisciplinary approach of the committee.</p> <p>CORRECTIVE ACTION TAG# F 253 COMPLETED ON</p> <p>F 309 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING</p> <p>(1.) Corrective action to provide the necessary care and services to attain and maintain the highest practicable well-being related to dialysis service for resident #15 include:</p> <ul style="list-style-type: none"> ➤ Resident #15 was discharged to home on 06/25/13, per physician order (see attached order). <p>(2.) In order to ensure other residents receive 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, and to identify other residents having the potential to be affected by the same deficient practice the following was completed:</p> <ul style="list-style-type: none"> ➤ On 07/01/13, the administrator contacted the Dialysis Center Manager to request that a copy of the Dialysis Run sheet be sent with each resident receiving dialysis back to the facility. (See copy of fax) 	07/31/13	

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F 309	Continued From page 6 meals/snacks during dialysis. Interview conducted with Registered Nurse (RN) #1 on 06/27/13, at 2:55 PM revealed the facility did not communicate with the dialysis center staff each time the resident was sent for dialysis. RN #1 stated the dialysis center would tell the facility nurse which medications would be given by the dialysis center. RN #1 stated there was no communication between the dialysis center and the facility unless an "abnormal" incident occurred while the resident was at the dialysis center. Interview with Unit Coordinator (UC) #1 on 06/27/13, at 3:10 PM confirmed there was no communication between the facility and the dialysis center unless an abnormal incident occurred for the resident. An interview was conducted with a nurse at the dialysis center, RN #4, on 06/27/13, at 5:40 PM. RN #4 stated there was no communication between the facility and the dialysis center unless the resident had problems during dialysis. RN #4 stated there was no communication between the facility and dialysis center after each time the resident received dialysis services. Interview conducted with the Director of Nurses (DON) on 06/27/13, at 5:55 PM confirmed there was no routine communication between the facility and the dialysis center. The DON stated the two entities did communicate whenever a problem occurred for the resident during the dialysis treatment.	F 309	<ul style="list-style-type: none"> ➤ The Dialysis Policy was revised on 07/15/13 to include the Dialysis Run Sheet generated by the dialysis center to communicate to the facility pre and post weights, medications, and other related dialysis information; and, whenever the residents care plan is completed by the RAI office, a copy of the care plan and all subsequent care plans will be sent to the dialysis center for review. ➤ Inservices were conducted for nursing staff on 07/17/13 to include: <ul style="list-style-type: none"> • Dialysis Communication Policy and tag F 309. (Copies of inservice and policies attached) ➤ On 8/05/13, all residents who have an end of life diagnosis, are receiving end of life care, hospice services, palliative care or comfort measures were identified by the Charge Nurse on each unit. (See attached MEMO and listing of residents). On 08/06/13 the RAI Coordinator audited the identified residents' medical records and comprehensive care plans to ensure care and services are being provided to attain or maintain the highest practicable physical, mental and psychosocial well-being. (See attached Quality of Care / End of Life Audit). ➤ On 08/08/13, the Director of Nursing conducted an in-service for all nurses on the following: <ul style="list-style-type: none"> • Advance Care Planning Policy and Procedure 		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER	F 315			



F309

**F 309
PROVIDE CARE/SERVICES FOR
HIGHEST WELL BEING
(ADDENDUM TO PREVIOUSLY
SUBMITTED POC FOR 2nd SOD)**

ADDENDUM TO CRITERIA 2

- **The facility has a system in place whereby resident care and services are monitored for accurate and complete assessments; care plans reflective of residents goals and preferences based on the resident assessment; and evaluation of the interventions to ensure appropriateness. The following are policies and procedures associated with the Quality of Care process:**
 - **Assessment and Care Plan Policy**
 - **Assessment and Care Plan Procedure**
 - **Notification of a Change In the Resident's Condition**
 - **RAI Policy Audit – Resident Assessment, Significant Change, & Care Plan**
 - **CNA Reporting Changes in Condition and Interruption to Direct Care to Licensed Nursing Staff**
 - **Pain Control / Analgesic Medication Administration**
 - **Recognition and Assessment of Pain in Older Adults**
 - **Comprehensive Pain Assessment Form**
 - **Pain Control QI Data Sheet**
- (COPIES OF POLICIES & AUDITS ATTACHED)**

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ADDENDUM TO CRITERIA 3

- Utilizing the **RAI –Audit form** the **RAI Coordinator** will monitor all female and male residents for new admission assessments, all significant change in status assessments and quarterly and annual assessments to ensure that the necessary care and services are being provided to residents to attain or maintain the highest practicable physical, mental & psychosocial well-being. Areas of non-compliance or inconsistencies will be addressed and corrected immediately. **The RAI Coordinator will submit RAI – Audit results to the Director of Nursing monthly.**
(Copy of Audit Attached)

ADDENDUM TO CRITERIA 4

- Monitoring the compliance of the RAI Audit process to ensure necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being are being provided based on the findings of the comprehensive assessment and plan of care includes:
 - The **Director of Nursing** will conduct compliance monitoring on the results of the RAI Audit **monthly**. If problem trends are identified a corrective action plan will be developed which may include in-service education and revision of

F309

policies and procedures within the Quality of Care Process. Compliance monitoring results will be reported on the **Compliance Monitoring RAI Policy Audit form** and submitted to the **QAPI Committee monthly**. The **RAI Policy Audit** and designated sample size will remain as a permanent part of our **QAPI continuous monitoring process**. Negative results will be corrected through the interdisciplinary approach of the committee.

**CORRECTIVE ACTION TAG# F 309
COMPLETED ON**

08/11/13

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F 315	<p>Continued From page 7</p> <p>Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, interview, and facility policy, it was determined the facility failed to provide appropriate treatment and services to prevent urinary tract infections for one resident (Resident #6) in the selected sample of twenty-four residents. Observations during the provision of indwelling urinary catheter care for Resident #6 revealed facility staff failed to cleanse the resident's perineum/catheter tubing in accordance with facility policy and/or standards of practice in an effort to prevent infections. Facility staff failed to perform appropriate hand washing techniques and to secure the catheter positioning during incontinence and Foley catheter care.</p> <p>The findings include:</p> <p>A review of the facility's policy titled "Giving Catheter Care" (no date), revealed staff would perform hand washing and put on gloves prior to beginning catheter care. The policy review revealed perineal care would be provided by cleansing the perineal area with soap and water using a clean section of the washcloth when cleaning the inner/outer labia. The policy further</p>	F 315	<ul style="list-style-type: none"> • Advance Directive Policy • Revised Comfort Measures • Comfort Measures Form • End of Life Care Policy and Audit Tool • (Copies of in-service, policies, and audits attached) <p>(3.) Quality Improvement measures implemented to ensure residents receive the necessary care and services to maintain the highest practicable physical, mental, and psychosocial well-being include the following:</p> <ul style="list-style-type: none"> ➤ Utilizing the Communication with Dialysis Center Audit, the Primary Charge Nurse will conduct an audit on the 15th and 30th of each month. The Primary Charge Nurse will submit the results of the Dialysis Audit to the Director of Nursing bi-monthly. The Director of Nursing will evaluate and analyze the audit data. If areas of non-compliance are identified, the Director of Nursing will collaborate with the dialysis center to resolve any issues that may impact the resident's plan of care. ➤ The RAI Coordinator will utilize the Quality of Care – End of Life Audit Tool to determine if the interdisciplinary team provided care and services to residents at or approaching the end of life as directed by their advance directive. The RAI Coordinator will audit monthly 100% of all residents who have an end of life diagnosis, are receiving hospice services, are 		

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F 315	<p>Continued From page 8</p> <p>noted catheter care would be provided by cleaning the catheter with a clean cloth, soap, and water. The policy indicated when staff cleaned the catheter tubing, the tubing would be held near the urethral meatus while cleaning down the catheter (away from the resident's urethral meatus) approximately four inches to prevent pulling on the catheter. The catheter tubing was then to be rinsed with a clean washcloth again while holding the catheter at the meatus.</p> <p>Observation on 06/27/13, at 3:40 PM revealed Certified Nurse Aide (CNA) #3 filled a basin with water and soap. CNA #3 cleansed Resident #6's right and left labia as well as the inner labia by wiping in a downward motion; however, the nurse aide failed to use a clean section of the washcloth when cleaning each area of the inner/outer labia. The CNA was then observed to clean the catheter tubing downward approximately four inches, using the same washcloth, soap, and water, and failed to hold the catheter at the urethral meatus to prevent pulling on the catheter. CNA #3 then washed her hands, changed gloves, changed the water in the basin, and rinsed the catheter with the same washcloth by wiping down the tube approximately four to five inches. The CNA was then observed to empty and put the basin in the resident's closet area without changing her gloves or washing her hands. In addition, following the perineal/catheter care, the CNA picked up the resident's drinking cup and placed the cup back on the resident's overbed table while wearing the soiled gloves.</p> <p>An interview on 06/27/13, at 3:40 PM with CNA #3 revealed the CNA had been trained to provide perineal care and catheter care by cleaning each</p>	F 315	<p>receiving end of life care or comfort measures. (See attached audit policy and audit form). The purpose of the audit is to determine if residents at or approaching the end of life have appropriate care and services to optimize comfort and relieve suffering. Areas of non-compliance will be immediately corrected. The RAI Coordinator will submit the results of the Quality of Care – End of Life audit to the DON and QAPI Committee monthly.</p> <p>(4.) Monitoring the compliance of measures implemented to ensure residents receive the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being includes:</p> <ul style="list-style-type: none"> ➤ The Director of Nursing will conduct bi-monthly compliance monitoring on the data results of the Communication with Dialysis Center Audit. Compliance monitoring results will be reported on the Compliance Monitoring Communication with Dialysis Center Audit form and submitted to the QAPI Committee monthly. Negative results will be identified and resolved through the interdisciplinary approach of the committee. ➤ The Director of Nursing will conduct monthly compliance monitoring on the data results of the Quality of Care – End of Life Audit. Compliance Monitoring results will be reported on the 		

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F 315	Continued From page 9 perineal area with a different section of the washcloth and to hold the catheter near the meatus when cleaning/rinsing to prevent pulling on the catheter. CNA #3 stated she had also been trained to perform hand washing after completing perineal and catheter care. CNA #3 stated she believed she had changed sections of the washcloth when cleaning the resident's inner/outer labia. In addition, CNA #3 stated she should have held the catheter tubing near the meatus when cleaning/rinsing the tubing. CNA #3 further stated she was nervous and failed to perform hand washing and glove changes appropriately.	F 315	Compliance Monitoring Quality of Care – End of Life Audit form and submitted to the QAPI Committee monthly. ➤ The Quality of care – End of Life audit will remain as a routine monthly audit within our QAPI program. Negative results will be identified and resolved through the interdisciplinary approach of the committee and may include in-service education and revision of the policies and procedures related to quality of care, end of life, advance directives, and palliative care program.		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Interview with the Director of Nursing (DON) on 06/27/13, at 5:55 PM revealed staff had been trained to wash their hands and perform glove changes when providing perineal and catheter care. The DON stated staff had also been trained to hold the catheter tubing at the meatus when cleansing/rinsing the tubing. Based on the comprehensive assessment of a resident, the facility must ensure that – (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident 's clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration,	F 322	CORRECTIVE ACTION TAG# F 309 COMPLETED ON F 315 NO CATHETER, PREVENT UTI, RESTORE BLADDER (1.) Corrective action for Resident #6 to provide appropriate treatment and services to prevent urinary tract infections include: ➤ On 06/27/13, at 6:00p.m. , appropriate catheter care was repeated by the Charge Nurse . (See attached copy of Clinical Flow Record Documentation) (2.) In order to ensure other residents receive appropriate treatment and service to prevent urinary tract infections regarding catheter care the following was completed: ➤ Effective 06/28/13 , CNA's and CMA's will no longer perform foley	08/09/13	

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F 322	<p>Continued From page 10</p> <p>metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, the facility failed to ensure appropriate treatment and services were provided for one of twenty-four sampled and five unsampled residents (Resident A). Resident A was observed to receive medications through a gastrostomy tube (G-tube). However, observations revealed facility staff failed to appropriately verify placement of Resident A's gastrostomy tube prior to administering medications to the resident.</p> <p>The findings include:</p> <p>A review of the Enteral Feeding policy (no date) revealed verification of the gastrostomy tube (G-tube) placement would be determined by the insertion of a small amount of air into the tube prior to the administration of the feeding and/or medication administration.</p> <p>Review of the medical record revealed the facility readmitted Resident A on 11/21/12, with diagnoses including History of Aspiration Pneumonia, Seizures, Anoxic Brain Injury, Persistent Vegetative State, and Encephalopathy. Review of the June 2013 physician's orders revealed Resident A's medications and nutritional</p>	F 322	<p>catheter care. This treatment and service will be performed by the Floor Nurse. (See attached copy of MEMO)</p> <ul style="list-style-type: none"> ➤ On <u>06/28/13</u>, the floor nurse collected data utilizing the Plan of Correction Catheter tool to determine which residents need catheter care. (See attached supporting documentation) ➤ Inservices were conducted for nursing staff on, <u>07/08/13, 07/10/13, and 07/11/13</u> on the following: <ul style="list-style-type: none"> • Infection Control – Hand Hygiene / Glove Use (Copies of policies and inservice materials attached) ➤ Inservices were conducted for nursing staff on, <u>07/17/13</u> on the following: <ul style="list-style-type: none"> • Urinary Catheter Care and Audit (Copies of policies and inservice materials attached) <p>(3.) Quality Improvement measures implemented to ensure appropriate catheter care is given to prevent urinary tract infections include the following:</p> <ul style="list-style-type: none"> ➤ The Primary Charge Nurse will conduct <u>monthly</u> audits of urinary catheter care utilizing the Urinary Catheter Care Audit form. Areas of non-compliance will be corrected immediately at the time of audit. The Primary Charge Nurse will submit the results of the Urinary Catheter Care Audit to the Director of Nursing <u>monthly</u>. 	

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F 322	<p>Continued From page 11 needs were to be administered by gastrostomy tube administration.</p> <p>Observations conducted during medication administration pass on 06/26/13, at 9:35 AM revealed Registered Nurse (RN) #1 administered medications to Resident A through a G-tube. The RN was observed to inject 30 milliliters of water into the resident's G-tube while listening to the resident's stomach with a stethoscope. RN #1 then aspirated the resident's stomach contents to verify placement of the G-tube before administering the medications to the resident. However, the RN failed to insert air into the G-tube to verify placement prior to the administration of the water and medications as required by facility policy.</p> <p>Interview with RN #1 on 06/26/13, at 1:30 PM revealed he was required to verify G-tube placement prior to administering medications through the tube. RN #1 stated he had been trained to inject "a little air and a little water" into the G-tube and listen with the stethoscope to verify the tube was appropriately placed prior to administering medications.</p> <p>Interview with the Director of Nurses (DON) on 06/26/13, at 2:00 PM revealed facility nurses, including RN #1, had been trained to verify G-tube placement prior to administering medications to residents by injecting air and listening to the abdominal sounds with a stethoscope. The DON stated RN #1 should not have injected water into the G-tube to verify placement in case the tube had become dislodged and was not positioned properly in the resident's stomach. The DON acknowledged the RN should have checked placement of the</p>	F 322	<p>(4.) Monitoring the compliance of appropriate catheter care to prevent urinary tract infections includes the following:</p> <ul style="list-style-type: none"> ➤ The Primary Charge Nurse will utilize the Urinary Catheter Care audit form to conduct <u>monthly</u> Urinary Catheter Care audits on <u>100% of all nurses, all shifts, and all units</u> inclusive of <u>100% of all residents with indwelling urinary catheters.</u> (See Audit)(i.e., If the LB unit has a total of 10 nurses, and 4 residents who have indwelling catheters, residents will incur several audits to ensure all 10 nurses are audited for catheter care compliance within the month. For nurses who are working on units where there are no residents with indwelling catheters, the nurse will be scheduled for a catheter care compliance audit on another floor.) ➤ Utilizing the Compliance Monitoring Urinary Catheter Care form, the Director of Nursing will analyze the data of the Urinary Catheter Care audit and submit the results monthly to the QAPI committee. ➤ The Urinary Catheter Care Audit will remain on the action list of the facility QAPI program until 100% compliance is achieved with Urinary Catheter Care for two consecutive quarters. ➤ Negative results will be identified and resolved through the interdisciplinary approach of the committee, and may include revision 	

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F 322 F 371 SS=D	Continued From page 12 G-tube by injecting air into the tube. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to ensure foods were stored, prepared, and served under sanitary conditions. During the initial tour of the facility kitchen on 06/25/13, at 9:40 AM there were no paper towels available at the dish room hand sink for employees to dry their hands. In addition, the trashcan near the kitchen hand sink did not have a hands-free mechanism that allowed staff to dispose of the used paper towels without directly touching the trashcans after they had sanitized their hands. Continued observations during the final sanitation audit conducted on 06/27/13, at 2:45 PM revealed six clean dish racks had been placed in soiled water that was standing on the floor. The findings include: The Dietary Manager stated on 06/27/13, at 2:40 PM that the facility did not have a policy on hand towel replacement, foot-operated trashcan use,	F 322 F 371	of policies and procedures and in-service education. CORRECTIVE ACTION TAG# F 315 COMPLETED ON F 322 NG TREATMENT/SERVICES -- RESTORE EATING SKILLS (1.) Corrective action for Resident A to receive appropriate treatment and services regarding the placement of G-tube include: > Once the deficient practice was communicated to the Director of Nursing, at 2:30p.m. on 06/26/13, the Primary Charge Nurse inserted 30 cc of air into Resident A's tube to determine appropriate placement of G-tube. (See attached documentation) (2.) The facility completed the following to identify other residents that could have the potential to be affected by appropriate placement of G-tube during medication administration: > On 06/28/13 - 07/05/13, all nurses reviewed the G-tube placement procedure and signed an Acknowledgement Statement stating that they acknowledge that they have been informed that when checking the placement of a gastrostomy tube they are to instill no more than 30cc of air into the feeding lumen of the G-tube. Also the instillation of any other substance other than air is not permitted under facility policy. (Copies of	08/09/13

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F 371	Continued From page 13 and dish rack storage. A sanitation tour of the kitchen was conducted on 06/25/13, at 9:40 AM and revealed there were no paper towels available in the paper towel dispenser at the dish room hand sink for employees to dry their hands. Also, observations revealed the trashcan near the kitchen hand sink did not have a hands-free mechanism to open the lid to the can that allowed staff to dispose of the used paper towels without directly touching the trashcans after they had sanitized their hands. In addition, during the final sanitation audit conducted on 06/27/13, at 2:40 PM six clean dish racks from the dishwasher were observed to be directly on the floor in standing, soiled water. An interview was conducted on 06/25/13, at 9:40 AM with the facility's Dietary Manager (DM). According to the DM, dietary staff had contacted housekeeping staff to bring a new roll of towels but the towels had not arrived at the time of the observation. Also, according to the DM, a foot-operated trashcan had been kept at the kitchen hand sink but had been inadvertently placed at another station and not been returned.	F 371	Acknowledgement Statement attached) <ul style="list-style-type: none"> ➤ Inservices were conducted for all nurses on 07/17/13 for the following: <ul style="list-style-type: none"> • Removal and Insertion of Standard Balloon Gastrostomy Tube • Tube Placement Verification and audit of G-tube placement • Medication Administration Policy (Inservices materials attached) ➤ The Nurse Educator and Infection Prevention Nurse conducted clinical check off for all nurses on the procedure for verifying the appropriate placement of G-tubes from 7/10/13 to 07/17/13. (Copies of Clinical Check Offs' attached) <p>(3.) Quality Improvement measures implemented to ensure nurses verify appropriate placement of G-tubes prior to medication administration include:</p> <ul style="list-style-type: none"> ➤ The Charge Nurse will conduct a <u>monthly</u> audit of G-tube Medication Administration to include verifying the appropriate placement of G-tube utilizing the QAPI Audit G-tube Medication Administration tool. Areas of non-compliance will be corrected immediately during the audit. Results of the QAPI Audit G-Tube Medication Administration will be submitted to the Director of Nursing <u>monthly</u>. 		
F 441 SS=F	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	F 441			

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F 441	<p>Continued From page 14</p> <p>Program under which it -</p> <p>(1) Investigates, controls, and prevents infections in the facility;</p> <p>(2) Decides what procedures, such as isolation, should be applied to an individual resident; and</p> <p>(3) Maintains a record of incidents and corrective actions related to infections.</p> <p>(b) Preventing Spread of Infection</p> <p>(1) When the Infection Control Program 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</p> <p>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:</p> <p>Based on observation, interview, record review, and facility policy review, the facility failed to maintain an Infection Control Program designed to prevent the development and transmission of disease and infection for four of twenty-four sampled residents (Residents #1, #12, #7, and #8). Facility staff failed to perform appropriate hand washing procedures when providing wound</p>	F 441	<p>(4.) Monitoring the compliance of appropriate G-tube verification during Medication Administration includes the following:</p> <ul style="list-style-type: none"> ➤ In addition to the annual clinical competency check off, utilizing the G-Tube Medication Administration Audit form the Primary Charge Nurse will conduct monthly G-Tube Medication Administration audits on 100% of all nurses on all shifts and all units inclusive of all residents who have G-Tubes. (See Audit) (i.e., If the 2nd floor unit has a total of 8 nurses, and 3 residents with G-tubes, residents will incur several audits to ensure all 8 nurses are audited for G-tube medication administration compliance within the month. For nurses who are working on units where there are no residents with G-tubes, the nurse will be scheduled for a G-tube medication administration audit on another floor.) ➤ The Director of Nursing will analyze the results of the QAPI Audit for G-tube Medication Administration and document the findings on the Compliance Monitoring G-tube Medication Administration form. The Director of Nursing will submit the compliance monitoring results to the QAPI committee monthly. ➤ The G-Tube Medication Administration audit will remain on the action list of the facility QAPI program until 100% compliance is achieved with proper 	

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F 441	<p>Continued From page 15</p> <p>care for Resident #1, when administering intravenous medications (IV) to Resident #12, and when conducting a skin assessment for Resident #8. Facility staff failed to maintain clean technique when providing wound care for Resident #7. In addition, observation of the lunch meal revealed staff failed to perform hand washing and glove changes appropriately when serving the meal to the twelve residents eating in the Dining Room, including unsampled Resident C, Resident D, and Resident E.</p> <p>The findings include:</p> <p>A review of the Infection Control/Hand washing policy (no date) revealed hand washing was considered one of the best ways to prevent the spread of infection and illness. The policy revealed hand washing procedures should be performed after removing gloves or other personal protective equipment; before and after handling peripheral vascular catheters and other invasive procedures; upon and after coming in contact with a resident's intact skin; and after handling soiled or used dressings, linens bedpans, catheters, and urinals.</p> <p>A review of the Dressing Changes policy (March 2013) revealed supplies should be opened on a clean field. Hand washing or the use of hand sanitizer should be performed after each glove change. Gloves should be removed, hands washed, and new gloves applied after removal of old dressings, after cleaning wounds, and after applying ointments. According to the policy, staff was to use a "no-touch" technique to clean wounds, "Do not directly touch any item that will come in contact with the wound."</p>	F 441	<p>G-Tube medication administration for two consecutive quarters.</p> <p>➤ Negative results will be identified and resolved through the interdisciplinary approach of the committee, and may include revision of policies and procedures and inservice education.</p> <p>CORRECTIVE ACTION TAG# F 322 COMPLETED ON</p> <p>F 371 FOOD PROCURE, STORE/PREPARE/SERVE – SANITARY</p> <p>(1.) In order to ensure that foods are stored, prepared, and served under sanitary conditions, the following corrective action was completed:</p> <p>➤ On 06/25/13, the paper towel holder at the dish room hand sink was filled with paper towels.</p> <p>➤ On 06/25/13, the trash can near the kitchen hand sink was removed and a trash can with a hands-free mechanism was implemented.</p> <p>➤ On 06/27/13, the six dish racks were removed from the floor.</p> <p>(2.) The facility completed the following to ensure that foods are stored, prepared, and served under sanitary conditions to include safe hand washing facilities and clean dish rack storage, and identify other areas that have the potential to be affected by deficient practice:</p> <p>➤ On 07/04/13, The Dietary Manager conducted an inservice for dietary staff on the following:</p> <ul style="list-style-type: none"> • Hand Washing Facilities Policy and Audit 	08/09/13	

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F 441	<p>Continued From page 16</p> <p>A review of the Ways to Enhance the Resident's Dining Experience (March 2012) revealed, "Clean gloves are available in the dining room at all times. Staff assigned to the dining room do not have to wear gloves unless you are coming in direct contact with the resident's food. Hand sanitizer is available to all staff and should be used between trays whenever distributing the trays."</p> <p>1. Review of the medical record revealed the facility admitted Resident #8 on 08/15/11 with diagnoses that included Alzheimer's Dementia, Hypertension, Failure to Thrive, Expressive Aphasia, and Cerebrovascular Accident.</p> <p>Observation conducted during a skin assessment of Resident #8 on 06/26/13, at 10:30 AM revealed Registered Nurse (RN) #2 performed hand washing and put on gloves prior to initiating the skin assessment. RN #2 was observed to begin the skin assessment by checking the resident's lower extremities and feet for any skin breakdown. RN #2 then proceeded to remove the resident's incontinence brief and examined/touched the resident's perineal area while wearing the same gloves used to examine the resident's feet. RN #2 was observed to reapply the resident's brief and proceeded with the skin assessment. The RN was observed to touch the resident's breasts and upper extremities as well as checking the resident's oral cavity by opening the resident's mouth without performing hand washing or a glove change after touching the resident's feet/perineal area.</p> <p>Interview conducted with RN #2 on 06/26/13, at 11:10 AM revealed the RN had been trained to perform hand washing and glove changes when</p>	F 441	<ul style="list-style-type: none"> • Cleaning Dishes/Dish Machine and Handling of Dish Racks Policy and Audit. (Copies of Policies and Audits attached) ➤ A utility cart was purchased for clean dish rack storage. (Copy of invoice attached) ➤ On 08/07/13, The Dietary Manager conducted an inservice for dietary staff on the following: <ul style="list-style-type: none"> • Revised Food Storage, Preparation and Distribution under Sanitary Conditions Policy; and • New Dietary Sanitation Audit Tool (Copies of Policy, Audit and Inservice attached) ➤ On 08/06/13, The Dietary Manager conducted a sanitation audit of the kitchen. (Audit results attached). <p>(3.) Quality Improvement measures implemented to ensure that foods are stored, prepared and served under sanitary conditions to include safe hand washing facilities and clean dish rack storage include:</p> <ul style="list-style-type: none"> ➤ Utilizing the Hand Washing Facilities Audit form, Dietary Staff will audit every two days hand washing facility areas. Areas of non-compliance will be corrected immediately. Results of the Hand Washing Facilities Audit will be turned into the Dietary Manager monthly. (See attached Audit) ➤ Utilizing the Dish Washing Area Audit form, the Dietary Staff will audit daily the dishwashing area for appropriate storage of clean dish 	

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F 441	Continued From page 17 coming in direct contact with a resident's skin. RN #2 stated she should have washed her hands and changed gloves after touching the resident's feet/perineal area and before proceeding to complete the skin assessment. Interview conducted with the Director of Nursing (DON) on 06/27/13, at 5:55 PM revealed staff had been trained to perform hand washing techniques and glove changes when conducting a skin assessment. The DON stated the nurse should have washed her hands and changed gloves after removing Resident #8's incontinence brief and prior to touching the resident's perineal area with her gloved hands. 2. Observation of the noon meal in the main dining room on 06/25/13 revealed the Director of Billing put on gloves in preparation to deliver meal trays to residents. The Director of Billing was observed to deliver a meal tray to Resident C at 12:16 PM, to Resident D at 12:18 PM, and to Resident E at 12:20 PM. The Director of Billing placed the food trays in front of Residents C, D, and E, removed the covering over the residents' food trays, and opened the residents' drinks while wearing the same gloves. The Director of Billing failed to wash/sanitize her hands between each resident contact. An interview conducted with the Director of Billing on 06/25/13, at 12:30 PM revealed she had attended hand washing in-services at the facility and thought she was only required to change her gloves and wash/sanitize her hands between residents if she touched drink cans. An interview conducted with the Director of Nursing (DON) on 06/27/13, at 5:55 PM revealed	F 441	racks. Areas of non-compliance will be corrected immediately. Results of the Dishwashing Area Audit will be turned into the Dietary Manager monthly . (See attached Audit) ➤ Utilizing the Dietary Sanitation Audit tool , the Dietary Manager will audit at a minimum of at least monthly Sanitation and Food Storage, Preparation, and Distribution of food. Areas of non-compliance will be corrected immediately. The Dietary Manager will turn the results of the Dietary Sanitation Audit into the QAPI committee monthly . (See attached audit) (4.) Monitoring the compliance of measures implemented to ensure that foods are stored, prepared, and served under sanitary conditions to include safe hand washing facilities and clean dish rack storage include: ➤ Utilizing the Compliance Monitoring Hand Washing Facilities Audit form , the Dietary Manager will document the findings of the Hand Washing Facilities Audit . Compliance monitoring results will be submitted to the QAPI committee monthly . Negative results will be identified and resolved through the interdisciplinary approach of the committee and may include revision of policies and in-service education. The Hand Washing Facilities Audit will remain as an action item in our QAPI program until 100% compliance is achieved for two consecutive quarters .	

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F 441	<p>Continued From page 18</p> <p>staff was not required to wear gloves to deliver food trays to residents, but was required to wash/sanitize their hands between residents. The DON stated the facility monitored hand washing as part of the Quality Assurance program, and there had not been any concerns identified related to hand washing or glove changes.</p> <p>3. Observation on 06/25/13, at 4:00 PM of medication administration for Resident #12 revealed Licensed Practical Nurse (LPN) #3 performed hand washing and applied gloves prior to flushing the intravenous access cannula in Resident #12's right hand with 7 milliliters of normal saline. The LPN was then observed to remove the syringe from the intravenous cannula, dispose of the syringe in the sharps container, discard her gloves, and leave the room to obtain another syringe of normal saline flush. However, the nurse failed to wash/sanitize her hands after removing her gloves and prior to leaving the resident's room.</p> <p>An interview conducted with LPN #3 on 06/27/13, at 4:00 PM revealed the LPN was required to wash/sanitize her hands after disposing of her gloves. The LPN stated she had attended in-services on hand washing but had been nervous during the observation and failed to wash her hands as required.</p> <p>An interview conducted with the DON on 06/27/13, at 5:55 PM revealed staff was required to wash/sanitize their hands anytime during medication pass when they leave the room to obtain additional supplies. The DON stated staff was required to complete an annual assessment on hand washing and stated the facility also</p>	F 441	<ul style="list-style-type: none"> ➤ Utilizing the Compliance Monitoring Dish Washing Area Audit form, the Dietary Manager will document the findings of the Dish Washing Area Audit. Compliance monitoring results will be submitted to the QAPI committee monthly. Negative results will be identified and resolved through the interdisciplinary approach of the committee and may include revision of policies and in-service education. The Dish Washing Area Audit will remain as an action item in our QAPI program until 100% compliance is achieved for two consecutive months. ➤ Utilizing the Compliance Monitoring Dietary Sanitation Audit Form, The Dietary Manager will conduct monthly compliance monitoring of the Dietary Sanitation Audit, documenting the corrective action taken, who will complete the corrective action, and follow-up and time frame for completion. Compliance monitoring results will be submitted to the QAPI Committee monthly. The Dietary Sanitation Audit will be a permanent routine monthly audit within our QAPI program. ➤ Negative outcomes will be identified and resolved through the interdisciplinary approach of the committee, which may include revision of dietary sanitation policies, equipment/supply changes, in-service education with specific emphasis on areas found 	

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F 441	Continued From page 19 monitored hand washing during medication administration as part of the Quality Assurance program and had not identified any concerns with hand washing.	F 441	not in compliance, and strengthening kitchen preventative maintenance program. CORRECTIVE ACTION TAG# F 371 COMPLETED ON	08/09/13
	<p>4. Observation during wound care provided to Resident #1 on 06/25/13, at 4:15 PM revealed Licensed Practical Nurse (LPN) #2 placed a clean wound cover dressing directly on the bed with Resident #1 prior to placing the wound cover dressing on the wound to the resident's coccyx area. In addition, LPN #2 placed a jar of "magic butt cream" directly in the bed with Resident #1 prior to applying the cream to Resident #1's coccyx area.</p> <p>Interview with LPN #2 on 06/25/13, at 4:35 PM revealed medications/ointments should not be placed on the bed with residents.</p> <p>5. Observation during a wound treatment for Resident #7 on 06/26/13, at 10:10 AM revealed RN #5 failed to remove gloves and wash hands after cleaning the wound to the resident's coccyx region and applying ointment. RN #5 failed to remove soiled gloves before opening a new roll of pre-cut tape, opening a tube of ointment, applying the ointment to the wound bed, and packing the wound with "Aquacel" (foam dressing). RN #5 then covered the wound with a sponge dressing and taped the dressing into place. RN #5 then recapped the tube of ointment and placed the ointment and the roll of pre-cut tape into his/her shirt pocket to be returned to the medication room.</p> <p>Interview with RN #5 on 06/26/13, at 10:20 AM revealed gloves should be removed after cleaning wounds and hands should be washed/sanitized</p>		<p>F 441 INFECTION CONTROL, PREVENT SPREAD, LINENS</p> <p>(1.) The following corrective actions were accomplished for resident's #1, #12, #7, and #8 to 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 include:</p> <ul style="list-style-type: none"> ➤ While we could not re-do the wound care for resident's #1, and #7, or re-do the IV administration for resident #12, or re-do the skin assessment for resident #8, the staff (RN#2, LPN#3, LPN#2, and RN#5), who provided care to these residents during the deficient practice were provided a one-on-one discussion on 06/27/13, by the Director of Nursing of proper hand and glove hygiene as it relates to wound care, IV administration, and skin assessment. (Copies of discussion documentation attached) ➤ Meal trays had already been delivered to resident's C, D, and E, however on 06/28/13, the Director of Nursing conducted one-on-one discussion with the Billing Director, SW#1, SW#2, and 	

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F 441	Continued From page 20 and new gloves applied prior to the application of creams/ointments and dressings. Interview conducted with the Director of Nursing (DON) on 06/27/13, at 5:55 PM revealed staff had been trained to perform hand washing techniques and glove changes when conducting a skin assessment. The DON stated the nurse should have washed her hands and changed gloves after removing Resident #8's incontinence brief and prior to touching the resident's perineal area with her gloved hands.	F 441	Information Technologist regarding proper hand hygiene and glove use for meal tray delivery service. (Copies of discussion documentation attached)	
F 514	6. Observation of the noon meal on 06/25/13, at 12:05 PM revealed 13 trays were delivered to the dining room. Twelve residents were served their meals in the dining room by facility staff, including Social Worker (SW) #1, SW #2, and the Information Technologist. Further observation revealed SW #1, SW #2, and the Information Technologist failed to change gloves and wash/sanitize their hands between residents as required. Interview with SW #1 and SW #2 on 06/27/13, at 5:45 PM revealed they had received training by the facility on serving meals and "thought" gloves had to be only worn and changed when touching resident drinks. SW #1 and SW #2 also stated gloves should be changed between residents and hands washed/sanitized after each glove change. Interview with the Information Technologist on 06/27/13, at 9:30 AM revealed gloves were always worn to serve residents and he was not aware gloves needed to be changed between residents when serving the meal.	F 514	(2.) In order to ensure proper infection control practices are in place related to proper hand hygiene as it relates to wound care, IV administration, skin assessment, and concierge meal tray service, and to identify other residents having the potential to be affected by the same deficient practices the facility implemented the following: <ul style="list-style-type: none"> ➤ On <u>07/08/13, 07/10/13, and 07/11/13</u>, in-services were provided to all nursing staff to include the following updates and revisions to the Infection Control Program; <ul style="list-style-type: none"> • Hand Hygiene / Glove Use / Dietary Trays (Inservice documentation attached) ➤ Clinical Check Off for all nurses for Wound Care Aseptic Technique completed by the Nurse Educator on 07/10/13 – 07/16/13. (Check off documentation attached) ➤ Inservice was conducted on <u>07/15/13</u> by the Infection Prevention Nurse to include: <ul style="list-style-type: none"> • Hand Hygiene and glove use for Meal Tray Delivery and Concierge Program for ancillary staff. • Copies of revised policies, audits, and inservice materials attached 	

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F 514 SS=D	<p>Continued From page 21</p> <p>RECORDS-COMPLETE/ACCURATE/ACCESSIBLE</p> <p>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.</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 observation, interview, record review, and facility policy review, it was determined the facility failed to ensure clinical information on clinical records/documents was accurate for two of twenty-four sampled residents (Resident #9 and Resident #18). A review of a physician's order dated 11/12/12 revealed Resident #9 was to have a safety belt on when the resident while up in a wheelchair. However, a review of the 60-day physician's orders dated 05/24/13, which were preprinted by the pharmacy, revealed the order for the safety belt had been omitted from the preprinted physician's orders. A review of physician's orders dated 05/01/13 revealed Resident #18 was to have Claritin (antihistamine) once a day "as needed" and then to discontinue the medication after 30 days. A review of the 60-day physician's orders dated 06/01/13 for Resident #18, which were preprinted by the pharmacy, revealed the facility failed to ensure</p>	F 514	<p>➤ Inservice was conducted on <u>07/17/13</u>, by the Director of Nursing for all nurses on the facility plan of correction to include:</p> <ul style="list-style-type: none"> • Revised Dressing Change Policy and Wound Care (Standard Aseptic Technique) QAPI audit; • Revised Head to Toe Assessment Policy and Head to Toe Assessment QAPI Audit; and • Considerations with Gloves Policy Preventing the Spread of Infection (Hand Hygiene) policy to include invasive medical devices such as IV's. • Revised Dining Concierge Program and Audit • Copy of inservice materials attached <p>➤ On <u>August 08, 2013</u> the Director of Nursing conducted in-services for all nurses on the following policies and procedures contained within our Infection Control Program. The program's primary purpose is to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of disease and infections.</p> <ul style="list-style-type: none"> • Surveillance Policy and Revised audit(s) • Culturing for Microbiological Analysis 		

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F 514	Continued From page 22 the Claritin had been discontinued for the resident as requested by the physician. The findings include: A review of the facility policy titled, "MARS and Physician's Orders," dated February 2013, revealed the pharmacy staff would obtain the physician's orders, including medication orders, from each resident's medical record and provide the facility a printed copy of the physician's orders five days prior to the effective date of the orders. According to the policy, upon receipt of the printed orders from the pharmacy, the Charge Nurse on each unit would be responsible to assign staff to review the printed physician's orders and validate the physician's orders with the orders in the resident's medical record for accuracy. The validation of the physician's orders would be performed by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) at the end of the month when the pharmacy provided the orders for the next month. The nurse assigned to validate the accuracy of the physician's orders would sign his/her name to the physician's orders, and leave a carbon copy of the validated physician's orders, with any corrections, so the pharmacy could make any changes in the database to ensure the correct and accurate printing of future physician's orders. 1. A review of the medical record for Resident #9 revealed the facility admitted the resident on 10/10/12. The resident's diagnoses at the time of admission included Alzheimer's Dementia, Parkinson's, Depression, and Insomnia. A review of the most recent quarterly Minimum Data Set (MDS) assessment dated 04/07/13, revealed the resident had a Brief Interview for Mental Status	F 514	<ul style="list-style-type: none"> • Environmental Sampling – Cultures • Visitor Control • Infection Control Admission Surveillance • Healthcare Associated Infection Summary • Antibiotic Utilization • Positive Cultures Report • Baseline Immunization Report • Handling Clean and Dirty Linens • Tracking and Reporting Employee Illness/Infections • Preventing the Spread of Infection – Transmission Precautions (Isolation) • Copies of In-service and Policies and Audits Attached <p>(3.) Quality Improvement measures implemented to 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 to include proper hand hygiene and glove use as it relates to wound care, IV medication administration, skin assessment, and meal tray delivery service include:</p> <ul style="list-style-type: none"> ➤ The Primary Charge Nurse will conduct <u>quarterly</u> Wound Care Audits utilizing the QAPI Wound Care Audit form. The Primary Charge Nurse will perform a direct observation of dressing changes. Areas of non-compliance will be 		

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F 514	<p>Continued From page 23</p> <p>(BIMS) score of 11 and his/her cognition was moderately impaired.</p> <p>A review of a physician's order for Resident #9 dated 11/12/12, revealed facility staff was to utilize a safety belt for the resident when the resident was up in a wheelchair due to the resident's impaired decision-making, poor judgment, and lack of safety awareness related to the resident's diagnosis of Parkinson's. A review of the current 60-day preprinted orders dated 05/24/13, for Resident #9 revealed the order for the safety belt had been omitted from the order sheet. No verbal or telephone physician's orders were observed on the resident's medical record to discontinue the order for the safety belt.</p> <p>Observation of Resident #9 on 06/25/13, at 3:00 PM revealed the resident was sitting up in a wheelchair in the dayroom watching television. A safety belt was observed to be positioned around the resident's waist and the resident was observed seated in a wheelchair.</p> <p>An interview conducted with LPN #4 on 06/27/13, at 10:20 AM, revealed she had validated the physician's orders in Resident #9's medical record with the copy of the physician's orders provided by the pharmacy dated 05/24/13. The LPN stated she was required to fax a copy of the validated orders to the pharmacy after she reviewed the orders for accuracy. The LPN stated the safety belt should have been placed on the 60-day orders; however, she stated she had overlooked the order.</p> <p>An interview conducted with Charge Nurse #3 for the 200 Unit on 06/27/13, at 4:05 PM revealed she had assigned staff to validate preprinted</p>	F 514	<p>corrected immediately during the audit. The results of the QAPI Wound Care Audit will be submitted to the Director of Nursing quarterly.</p> <p>➤ The Primary Charge Nurse will conduct quarterly Head-to-Toe Assessment audits utilizing the QAPI Head-To-Toe Assessments Audit form. The Primary Charge Nurse will perform a direct observation of the head-to-toe assessment. Areas of non-compliance will be corrected immediately during the audit. The results of the QAPI Head-To-Toe Assessment audit will be submitted to the Director of Nursing quarterly.</p> <p>➤ The Primary Charge Nurse will conduct quarterly IV medication administration audits utilizing the QAPI IV Medication Administration Audit form. The Primary Charge Nurse will perform a direct observation of IV medication administration. Areas of non-compliance will be corrected immediately during the audit. The results of the QAPI IV Medication Administration audit will be submitted to the Director of Nursing quarterly.</p> <p>➤ The Infection Prevention Nurse will conduct surveillance monitoring monthly on infection control for the first floor dining room utilizing the QAPI First Floor Dining Room Concierge Audit tool. Areas of non-compliance will be corrected immediately during the audit. The</p>		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185003	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743		
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F 514	<p>Continued From page 24</p> <p>physician's orders. The Charge Nurse stated the physician's order for the safety belt restraint for Resident #9 had been an oversight and should have been on the 60-day physician's order sheet printed and provided by the pharmacy. According to the Charge Nurse, after the nurse validated the physician's orders, the orders were to be placed on the resident's chart to be signed by the physician. The Charge Nurse stated the facility did not have a process in place to monitor physician's orders to ensure the printed orders provided by the pharmacy were in accordance with the physician's orders in the resident's medical record.</p> <p>An interview conducted with Pharmacist (RPh) #1 on 06/27/13, at 3:05 PM revealed he had stopped adding physician's orders for restraints to the preprinted physician's orders "a couple of years ago." The RPh stated the pharmacy only placed the resident's diagnoses, laboratory orders, and diet orders on the preprinted 60-day orders. The RPh stated Nursing was responsible for writing on the physician's orders for any restraint orders.</p> <p>An interview conducted with the Director of Nursing (DON) on 06/27/13, at 3:10 PM revealed restraint orders for residents were not placed on the preprinted physician's orders. The DON stated the orders for restraints were usually obtained from a physician and written by facility staff on a "telephone order" slip. According to the DON, staff did not rewrite the orders for restraints each month unless the order was changed or discontinued. The DON stated he was not aware orders for restraints should be on the current physician's "60-day" orders.</p> <p>2. A review of the medical record for Resident</p>	F 514	<p>results of the QAPI First Floor Dining Room Concierge Audit will be submitted to the Director of Nursing monthly.</p> <p>➤ The Infection Prevention Nurse will conduct weekly surveillance audits on each nursing unit to include all shifts. Utilizing the QAPI Infection Control Compliance audit the Infection Prevention Nurse will document the findings. Areas of non-compliance will be corrected immediately during the audit and reported to the Director of Nursing. It is our intent that our surveillance practices will serve to prevent and detect infectious disease among our residents. The data collection will be at the facility level, not at the individual resident level. The facility has a systematic approach to infection, therefore resident level data will be routinely collected and analyzed. Through our surveillance practices, we will detect areas of weakness, and non-compliance and this surveillance will be utilized to continuously improve the quality of our standards and practices related to infection control and resident care. The Infection Prevention Nurse will submit the results of the QAPI Infection Control surveillance audits monthly to the QAPI Nursing committee. The Infection Prevention Nurse will also report quarterly on the Antibiotic Utilization Report, The Healthcare Associated Summary, The</p>		

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F 514	<p>Continued From page 25</p> <p>#18 revealed the facility admitted the resident on 02/05/13. The resident's diagnoses at the time of admission included Allergic Rhinitis, Alzheimer's, Dementia, Anxiety, and Hypertension. A review of physician's orders dated 05/01/13 revealed Resident #18 was to have 10 mg of Claritin by mouth once a day "as needed," and then discontinue after 30 days.</p> <p>A review of Resident #18's preprinted physician's orders for the month of June 2013 revealed the physician's order for Claritin had been added to the preprinted orders even though the medication should have been discontinued on 05/30/13 as requested by the physician. The pre-printed orders had been received on 05/24/13 and reviewed on 05/28/13 by Registered Nurse (RN) #1.</p> <p>An interview conducted with RN #1 on 06/27/13, at 2:43 PM revealed he had validated the physician's orders in Resident #18's medical record with the copy of the physician's orders provided by the pharmacy dated 05/24/13. RN #1 said that he had signed off on the pre-printed orders on 05/28/13. The RN stated, "I should have wrote discontinue after 05/30/13 on the physician's orders [for the Claritin]. It was just an oversight."</p> <p>An interview conducted with Unit Coordinator on 06/27/13, at 2:33 PM revealed it was the responsibility of the facility's nursing staff to check for accuracy of all physician's orders after the pharmacy printed them. In addition, the Unit Coordinator stated nursing staff was responsible to sign and date the preprinted physician's orders after they verified the orders were accurate.</p>	F 514	<p>Readmission Antibiotic Surveillance, and The Admission Antibiotic Surveillance to the facility QAPI Committee. (See Attached Audits)</p> <p>(4.) Monitoring the compliance of measures implemented in the Infection Control Program to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection to include wound care, IV medication administration, skin assessments, and hand hygiene and glove use for meal tray delivery service includes:</p> <ul style="list-style-type: none"> ➤ The Director of Nursing will analyze results of the QAPI Wound Care Audit to determine if there is a problem with staff compliance and document the results on the Compliance Monitoring QAPI Wound Care Form. The Director of Nursing will submit the results of the Compliance Monitoring QAPI Wound Care audit to the QAPI Committee quarterly. Negative results will be identified and resolved through the interdisciplinary approach of the committee. ➤ The Director of Nursing will analyze the results of the QAPI Head-To-Toe Assessment Audit to determine if there is a problem with staff compliance and document the results on the Compliance Monitoring QAPI Head-To-Toe Assessment form. The Director of Nursing will submit the results of the Compliance Monitoring QAPI Head-To-Toe Assessment audit to 		

- F441** the **QAPI Committee quarterly**. Negative results will be identified and resolved through the interdisciplinary approach of the committee.
- The **Director of Nursing** will analyze the results of the **QAPI IV Medication Administration audit** to determine if there is a problem with staff compliance and document the results on the **Compliance Monitoring QAPI IV Medication Administration form**. The **Director of Nursing** will submit the results of the **Compliance Monitoring QAPI IV Medication Administration audit** to the **QAPI Committee quarterly**. Negative results will be identified and resolved through the interdisciplinary approach of the committee.
 - The **Director of Nursing** will analyze the results of the **QAPI First Floor Dining Room Concierge Audit** to determine if there is a problem with staff compliance and will document the results on the **Compliance Monitoring QAPI First Floor Dining Room Concierge form**. The **Director of Nursing** will submit the results of the **Compliance Monitoring QAPI First Floor Dining Room Concierge audit** to the **QAPI Committee monthly**. Negative results will be identified and resolved through the interdisciplinary approach of the committee.
 - The **Director of Nursing** will analyze the results of surveillance

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audits and report to the Nursing QAPI Committee monthly evidence of infection and infectious disease as well as trends and other statistical information that will help to guide and direct our direct care initiatives. **This data will be used to plan control activities and educational programs and to provide early identification of outbreaks.** If problems are identified during the monitoring process, the Director of Nursing will take **immediate action necessary to ensure that residents have a safe, sanitary, and comfortable environment to help prevent the spread of infectious disease.** Problem areas will also be identified and resolved through the interdisciplinary approach of the QAPI Committee process, which may include increased monitoring of compliance with infection control program and in-service education with specific emphasis on problem trends. **Surveillance audits** will be done weekly and remain as a **continuous component of our Infection Control Program.**

**CORRECTIVE ACTION TAG# F 441
COMPLETED ON**

08/09/13

**F 514
RES RECORDS –
COMPLETE/ACCURATE/ACCESSIBLE**

(1.) In order to ensure that clinical information on the clinical records/documents are accurate,

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corrective actions accomplished for those residents found to have been affected by the deficient practice include:

- On 06/27/13, the physician order for the safety belt while up in wheelchair for resident #9 was written on the physician orders for this resident. Also, on 06/27/13, the pharmacy made the correction to the pre-printed physician order for resident #9 to include W/C with soft seat belt. (Copies of physician orders attached)
- On 06/27/13, the nurse documented on the pre-printed physician order for resident #18 that Claritin (Loratadine) was discontinued. Also, on 06/27/13 the pharmacy made the correction on the pre-printed physician order for resident #18 discontinuing the Claritin order. (See attached copy of pre-printed physician orders attached)

(2.) In order to ensure that clinical information on the clinical records/documents are accurate and to identify other residents having the potential to be affected by the same deficient practice the facility accomplished the following:

- On 06/28/13 – 07/01/13 The Primary Charge Nurse for each nursing unit performed the following audits:
 - **Restraint Orders Audit** to check the restraint orders to make sure the order appears on the pre-printed physician orders; and

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- **Validation of Medication on MAR and a Current Physician's Order audit** to validate that each medication listed on the MAR appears on the pre-printed physician orders. (Copies of completed audits attached)
- On 07/17/13, inservices were conducted by the **Director of Nursing for all nurses and pharmacy staff** on the following:
 - **Revised Mars and Physician Orders (End of Month Change Over Process) Policy; and**
 - **QAPI Physician Orders/Medication Administration Record audit**(Inservice documentation attached)
- On 08/08/13, the **Director of Nursing** conducted an in-service for **all nurses and medical records staff** on the following:
 - **Revised Clinical Record Policy**
 - **Revised Clinical Record Audit**
 - **Case Management; and**
 - **Case Management Audit Form**
 - **(See attached Policies and Audit Forms)**

(3.) Quality Improvement measures implemented to monitor resident clinical records for accuracy include:

If continuation Page 30 of 34

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- The **Pharmacist** will conduct a **QAPI audit monthly** utilizing the **QAPI Physician Orders/Medication Administration Record audit form**. Areas of non-compliance will be corrected immediately. The **Pharmacist** will submit the results of the **QAPI Physician Orders/Medication Administration Record audit** to the **Clinical Pharmacist monthly**. The results of the audit will be discussed at the **multi-disciplinary clinical meetings held Monday through Friday** to resolve any immediate problems.
- The **Clinical Records Clerk** will conduct an **audit monthly** on **resident clinical records utilizing the Clinical Record Audit form**. The **Clinical Records Clerk** will **audit all new admission clinical records within the admission month**. Thereafter the remaining resident clinical records will be audited by a sample of 10% on each unit monthly. Each month a new 10% sample of resident clinical records will be selected. Areas of non-compliance will be referred immediately to the **Director of Nursing**. The **Director of Nursing** will develop an action plan for correction of the Clinical Record. The **Clinical Records Clerk** will **submit the Clinical Record Audit results to the Director of Nursing monthly**.
- Utilizing the **Case Management Audit form** the **Staff Nurse** will

If continuation Page 31 of 34

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conduct Case Management Audits on resident clinical records quarterly to ensure that the care documented and assessed, accurately reflects the needs and condition of the resident. The Primary Charge Nurse will oversee the Case Management on their unit. The Primary Charge Nurse will document any problem trends and report them to the Director of Nursing. Variances in care or omissions of care will be resolved immediately. The Primary Charge Nurse will submit the results of the Case Management Audit to the Director of Nursing quarterly.

(4.) Monitoring the compliance of measures implemented to ensure accuracy of resident clinical records includes:

- The Clinical Pharmacist will conduct compliance monitoring monthly and analyze the results of the QAPI Physician Orders/Medication Administration Record audit and document the findings on the Compliance Monitoring QAPI Physician Orders/Medication Administration Record audit form. The Clinical Pharmacist will present the compliance monitoring results of the QAPI Physician Orders/Medication Administration Record audits to the facility wide QAPI Committee quarterly. Negative results will be identified and resolved through the

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interdisciplinary approach of the committee.

- The **Director of Nursing** will conduct compliance monitoring **monthly** and analyze the results of the **Clinical Record Audit** and document the findings on the **Compliance Monitoring Clinical Record Audit form**. The **Director of Nursing** will develop any **corrective action plans required** and submit the **clinical record compliance report to the QAPI Committee**. The **Clinical Record Audit will be a permanent routine monthly audit within our QAPI program**. Negative outcomes will be discussed and resolved through the interdisciplinary approach of the committee, which may include increased monitoring of clinical records and in-service education.
- The **Director of Nursing** will conduct **quarterly** compliance monitoring and analyze the results of the **Case Management Audit** and document the findings on the **Compliance Monitoring Case Management Audit form**. The **Director of Nursing** will develop any **corrective action plans required** and submit the **case management compliance report to the QAPI committee**.
- The **Case Management Audit** will be a **permanent routine quarterly audit within the nursing QAPI program**. Negative outcomes will be discussed and resolved through the interdisciplinary approach of the

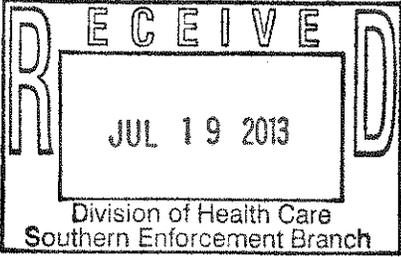
F514 committee, which may include increased monitoring of clinical records and in-service education with specific emphasis on problem trends.

**CORRECTIVE ACTION TAG# F 514
COMPLETED ON**

08/09/13

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NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743	
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K 000	INITIAL COMMENTS CFR: 42 CFR 483.70(a) BUILDING: 01 PLAN APPROVAL: 1965 SURVEY UNDER: 2000 Existing FACILITY TYPE: SNF/NF TYPE OF STRUCTURE: Two story, Type 11 (000) SMOKE COMPARTMENTS: 9 FIRE ALARM: Complete automatic fire alarm system SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system. GENERATOR: Type II diesel generator A life safety code survey was initiated and concluded on 06/27/13. The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70 (a) et seq (Life Safety from Fire). The facility was found not to be in substantial compliance with the Requirements for Participation for Medicare and Medicaid. Deficiencies were cited with the highest deficiency identified at "F" level.	K 000	 <p>K 027 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>(1.) In order to ensure that cross-corridor fire doors are able to resist the passage of fire and smoke for the LB Barrier Doors the following was completed:</p> <ul style="list-style-type: none"> ➤ The LB Barrier Doors closure was adjusted on 06/27/13, to ensure that fire barrier doors close all the way. (See attached Memo) <p>(2.) The following was completed to ensure other residents having the potential to be affected by NFPA requirements for complete closure of fire barrier doors are protected:</p> <ul style="list-style-type: none"> ➤ On 06/28/13, the Maintenance Director audited all fire compartment fire barrier doors to ensure proper closure. (See attached audit) ➤ On 07/17/13, the Administrator conducted an inservice for all maintenance staff on the following: <ul style="list-style-type: none"> • K 027 – Door openings in Smoke Barriers; 	
K 027 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least	K 027		

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

Kathleen Young

TITLE

Administrator

(X6) DATE

7/18/13

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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K 027	<p>Continued From page 1</p> <p>1¼-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure that cross-corridor fire doors were able to resist the passage of fire and smoke. This deficient practice affected two of nine smoke compartments, staff, and approximately sixty residents. The facility has the capacity for 160 beds with a census of 153 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 06/27/13, at 1:30 PM with the Director of Maintenance (DOM), a set of cross-corridor fire/smoke barrier doors for the LB area were observed not to close all the way when tested. One of the doors was being held open approximately three inches by air movement in the facility. These doors must close all the way to help prevent fire/smoke from reaching other parts of the building in a fire situation. An interview with the DOM on 06/27/13, at 1:30 PM revealed he was not aware the door was being held open by air movement.</p> <p>The findings were revealed to the Administrator</p>	K 027	<ul style="list-style-type: none"> • Revised Fire and Smoke Barrier Doors Policy; and • Revised Fire Compartment Door Inspection audit (Inservice documentation attached) <p>(3.) Quality Improvement measures implemented to ensure that cross-corridor fire doors are able to resist the passage of fire and smoke include:</p> <ul style="list-style-type: none"> ➤ The Maintenance Staff Peron will conduct monthly audits of fire and smoke barrier compartment doors utilizing the Fire Door Inspection audit form. Areas of non-compliance will be corrected immediately, and the Maintenance Director will be contacted immediately. The Maintenance Staff Person will submit the results of the Fire Door Inspection Audit to the Maintenance Director monthly. <p>(4.) Monitoring the compliance of measures taken to ensure that cross-corridor fire doors are able to resist the passage of fire and smoke include:</p> <ul style="list-style-type: none"> ➤ The Maintenance Director will conduct compliance monitoring monthly and analyze the results of the Fire Door Inspection Audit and document the findings on the Compliance Monitoring Fire Door Inspection audit form. The Maintenance Director will submit the results of the Compliance Monitoring Fire Door Inspection audit to the QAPI committee 	

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K 027	Continued From page 2 upon exit. Reference: NFPA 80 (1999 Edition). 15-1.4 Repairs. Repairs shall be made and defects that could interfere with operation shall be corrected immediately. 15-2.1.1* Hardware shall be examined frequently and any parts found to be inoperative shall be replaced immediately. 15-2.4.1 Self-closing devices shall be kept in proper working condition at all times.	K 027	monthly. Negative results will be identified and resolved through the interdisciplinary approach of the committee. CORRECTIVE ACTION TAG #K027 COMPLETED ON K 062 NFPA 101 LIFE SAFETY CODE STANDARD (1.) In order to ensure that the facility maintain the fire sprinkler system by NFPA standards, the following action was taken immediately to correct deficient practice related to fire department connection on the exterior of the facility: ➤ On 06/27/13, the Maintenance Director replaced the missing cap on the fire department connection. (2.) The following was completed to ensure other residents having the potential to be affected by missing caps from the fire department connections are protected: ➤ On 07/17/13, the Administrator conducted an inservice on the following: <ul style="list-style-type: none"> • K062 – NFPA Automatic Sprinkler System; • Facility Grounds Policy; • and • Exterior of Facility Audit (Inservice documentation attached) 	07/31/13
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 observation and interview, the facility failed to maintain the fire sprinkler system by NFPA standards. This deficient practice affected nine of nine smoke compartments, staff, and all the residents. The facility has the capacity for 160 beds with a census of 153 on the day of the survey. The findings include:	K 062		

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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
K 062	Continued From page 3 During the Life Safety Code survey on 06/27/13, at 11:50 AM with the Director of Maintenance (DOM), one of two covers was observed to be missing from the fire department connection on the exterior of the facility. These covers help ensure foreign material does not get into the facility's fire sprinkler system. An interview with the DOM on 06/27/13, at 11:50 AM revealed he was not aware the cover was missing. The DOM stated he has had problems in the past with someone removing the covers. The findings were revealed to the Administrator upon exit. Reference: NFPA 25 (1998 Edition). 9-7.1 Fire department connections shall be inspected quarterly. The inspection shall verify the following: (a) The fire department connections are visible and accessible. (b) Couplings or swivels are not damaged and rotate smoothly. (c) Plugs or caps are in place and undamaged. (d) Gaskets are in place and in good condition. (e) Identification signs are in place. (f) The check valve is not leaking. (g) The automatic drain valve is in place and operating properly.	K 062	(3.) Quality Improvement measures implemented to ensure that the facility maintains the fire sprinkler system by NFPA standards to include fire department connection caps include: ➤ The Maintenance Staff Peron will utilize the Exterior of Facility audit to conduct monthly audits of the facility grounds to include fire department connection caps. Areas of non-compliance will be corrected immediately. The Maintenance Staff Person will submit the results of the Exterior of Facility audit to the Maintenance Director monthly . (4.) Monitoring the compliance of measures taken to ensure that the facility meets NFPA standards to include fire department connection caps include: ➤ The Maintenance Director will conduct compliance monitoring and analyze the results of the Exterior of Facility audit monthly documenting the findings on the Compliance Monitoring Exterior of Facility audit form . The Maintenance Director will submit the results of compliance monitoring of the Exterior of Facility audit to the QAPI committee monthly . Negative results will be identified and resolved through the interdisciplinary approach of the committee.	
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions: (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids,	K 066	CORRECTIVE ACTION TAG #K062 COMPLETED ON	07/31/13

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: 185003	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 06/27/2013
NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743	
(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 066	<p>Continued From page 4</p> <p>combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the smoking area according to NFPA standards. This deficient practice would affect one of nine smoke compartments, staff, and approximately twenty-two residents. The facility has the capacity for 160 beds with a census of 153 on the day of the survey.</p> <p>The findings include:</p> <p>During the Life Safety Code tour on 06/27/13, at 10:35 AM with the Director of Maintenance (DOM), a smoking area located in the Shepherds Cove area of the facility was observed not to have a metal self-closing container to empty cigarette</p>	K 066	<p>K 066 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>(1) Corrective action accomplished for the residents found to have been affected by failure to have a metal self-closing container to empty cigarette ashtrays as required by Life Safety Code Standards for smoking includes:</p> <ul style="list-style-type: none"> ➤ On <u>06/27/13</u>, the Environmental Services Director placed a metal self-closing container to empty cigarette ashtrays on the Shepherd's Cove smoking area. <p>(2.) The following was completed to ensure other residents having the potential to be affected by missing metal self-closing containers to empty cigarette ashtrays are protected:</p> <ul style="list-style-type: none"> ➤ On <u>07/17/13</u>, the Administrator conducted an inservice on the following: <ul style="list-style-type: none"> • K066 – NFPA Life Safety Code Standard - Smoking; • Smoking and Ashtray Policy; and • Smoking Area Audit (Inservice documentation attached) <p>(3.) The Quality Improvement measures implemented to ensure that the facility meets NFPA standards to include smoking and metal self-closing containers include:</p> <ul style="list-style-type: none"> ➤ The Housekeeping Staff Person will utilize the Smoking Area Audit form to conduct <u>monthly</u> audits of the facility smoking areas. Areas of 	

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NAME OF PROVIDER OR SUPPLIER LAUREL HEIGHTS HOME FOR THE ELDERLY			STREET ADDRESS, CITY, STATE, ZIP CODE 208 WEST TWELFTH STREET LONDON, KY 40743		
(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 066	Continued From page 5 ashtrays into as required. An interview with the DOM on 06/27/13, at 10:35 AM revealed there had been a container there in the past. He was not aware how long the container had been missing. The findings were revealed to the Administrator upon exit.	K 066	non-compliance will be corrected immediately. The Housekeeping Staff Person will submit the results of the Smoking Area Audit to the Environmental Services Director <u>monthly</u> . (4.) Monitoring the compliance of measures taken to ensure that the facility meets NFPA standards to include smoking and metal self-closing containers include: <ul style="list-style-type: none"> ➤ The Environmental Services Director will conduct compliance monitoring and analyze the results of the Smoking Area Audit <u>monthly</u> documenting the findings on the Compliance Monitoring Smoking Area Audit form. The Environmental Services Director will submit the results of compliance monitoring of the Smoking Area audit to the QAPI committee <u>monthly</u>. Negative results will be identified and resolved through the interdisciplinary approach of the committee. <p>CORRECTIVE ACTION TAG #K066 COMPLETED ON</p>	07/31/13	