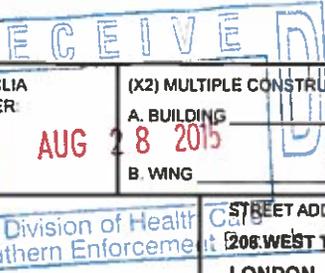


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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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 08/06/2015
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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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F 000	INITIAL COMMENTS	F 000		
F 323 SS=E	<p>A standard health survey was conducted on 08/04-06/15. Deficient practice was identified with the highest scope and severity at "E" level.</p> <p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review it was determined the facility failed to ensure that the resident environment was as free from accident hazards as possible for three (3) unsampled residents (Residents A, B, and C) of sixty (60) residents on the LB Unit of the facility. Observation on 08/04/15 of the LB nursing unit revealed a crash cart was observed to be sitting in the hall beside the ice machine and observed to be unlocked. The crash cart contained items that posed accident hazards to wandering residents (needles and blood collection system).</p> <p>The findings include: Review of facility policy titled "Emergency Crash Cart," dated 10/02/98, revealed the crash cart would be locked at all times and kept at the nursing unit unless it was removed for an</p>	F 323	<p>F 323 483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>(1.) The following corrective actions were completed for those residents found to have been affected by the deficiency related to the security of the crash cart:</p> <ul style="list-style-type: none"> > On <u>08/04/15</u> when the Surveyor found the crash cart on the LB Unit unlocked, the Director of Nursing (DON) immediately instructed the Primary Charge Nurses (PCN) on all floors to audit all crash carts to ensure their lock integrity and to ensure that all residents were free from accidental hazards. The crash cart on the LB Unit was checked to see if there was any items missing. There were no missing items and the crash cart was immediately secured with the standard break away lock utilized by the facility. (See Attached Crash Cart Audit) <p>(2.) The following actions were taken to identify other residents having the potential to be affected by the same deficient practice.</p> <ul style="list-style-type: none"> > On <u>08/05/15</u> the Wandering Notebooks on each nursing unit were reviewed by the PCN's validating the residents listed in the Wandering Notebook were accurate. Results indicated a total of four residents excluding the three residents on the LB Unit which would bring the total number of wandering residents to seven potential residents to have been affected by the same deficient practice. 	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathy K. Young TITLE: Administrator (X6) DATE: 8/28/15

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 323	<p>Continued From page 1</p> <p>emergency situation. The policy stated the Charge Nurse was responsible for verifying the crash cart was locked and documenting it on the crash cart log.</p> <p>Observation on 08/04/15 at 5:15 PM, of the LB nursing unit, revealed a crash cart sitting in the hall beside the ice machine, unlocked. The crash cart contained three 23 gauge 1-inch needles, one 18 gauge 1-inch needle, one blood collection system (containing needles to collect blood), two 24 gauge angio-catheters (a hollow, flexible tube to allow fluids to be given intravenously) with needles, two 22 gauge angio-catheters with needles, and two 20 gauge angio-catheters with needles.</p> <p>A list of wandering residents was obtained from the Director of Nursing (DON) on 08/04/15 that identified three (3) residents to be at risk for wandering who could have had access to the unlocked crash cart on the LB Unit. Resident A, Resident B, and Resident C were identified to be a wandering risk.</p> <p>Interview with Registered Nurse (RN) #4 on 08/04/15 at 5:22 PM revealed she had been responsible for ensuring the crash cart was locked and at the nursing station. The RN stated she had checked the crash cart earlier in her shift and had not identified the crash cart was open nor was she aware the crash cart was not in the appropriate area.</p> <p>Interview with facility DON on 08/04/15 at 5:23 PM revealed he checked the crash cart at approximately 1:00 PM, and the crash cart was in the appropriate place and was locked. The DON stated he randomly checked crash carts every</p>	F 323	<p>(3.) In order to ensure that compliance is maintained with security of crash carts, the following measures and systemic changes have been made:</p> <ul style="list-style-type: none"> ➤ From 08/04/15 through 08/24/15 a daily audit was conducted by the Primary Charge Nurse (PCN) to ensure the unit based staff nurses were following policy by checking the crash cart lock each shift and recording each time they checked the cart by signing the signature log. (See Attached Audit and Signature Log) ➤ On 08/25/15 a new policy on crash carts was issued and the Charge Nurses on all shifts were educated on the new crash cart policy at our weekly Charge Nurse meeting. (See Attached Crash Cart Policy and Inservice Records) ➤ On 08/24/15 the crash carts were moved to ensure each crash cart on all units are located behind a locked door. Therefore, the crash carts will be subject to a double lock, the lock to the room where the crash cart is located and the breakaway lock which secures the integrity of the cart. (See Attached New Locations List For Each Crash Cart) ➤ On 08/24/15 a new crash cart checklist was implemented. The new checklist requires two nurses signatures (the offgoing nurse and the ongoing nurse) indicating the time the crash cart was checked, that the breakaway lock was intact, and 		

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F 323	Continued From page 2 day to ensure they were locked and had not identified a concern with crash carts not being in the appropriate area, or the crash carts being unlocked.	F 323	the contents of the crash cart were secure. (See attached copy of new crash cart checklist)	
F 371 SS=E	483.35(j) 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	F 371	<p>➤ The PCN will conduct a weekly audit for two consecutive weeks and monthly thereafter utilizing the QAPI Crash Cart Audit Form. (See attached Copy of QAPI Crash Cart Audit Form). Negative results will be immediately corrected. Results of the QAPI Crash Cart Audit will be submitted to the DON. The PCN will continue to conduct the QAPI Crash Cart Audit monthly for a three month period. When the PCN has reached a 100% compliance for a three month period, the QAPI Crash Cart Audit will be discontinued.</p> <p>(4.) Monitoring the performance of measures taken to ensure the continued security of the crash cart is compliant include:</p> <p>➤ Utilizing the Compliance Monitoring form for Crash Cart Security the Director of Nursing will conduct compliance monitoring <u>monthly</u> on the results of the Crash Cart Security Audit. The Director of Nursing 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>	
	<p>This REQUIREMENT is not met as evidenced by: Based on observation, interviews, record review, and review of facility policies, it was determined the facility failed to store, prepare, distribute, and serve food under sanitary conditions for one hundred thirty-five (135) of one hundred forty-two (142) residents of the facility who received nutrition from the kitchen. Observations in the kitchen on 08/04/15 and 08/05/15 revealed the following: foods in dry storage that did not include dates when the product arrived according to the policy, opened foods that did not include the date that the food was opened, raw eggs stored in a reach-in refrigerator above cooked foods and ready-to-eat foods, and Dietary Aides touching the inside portion of the plates, bowls, and saucers with bare skin while serving food. Observations further revealed three (3) dietary</p>		<p>CORRECTIVE ACTION TAG# F 323 COMPLETED ON</p>	08/28/15

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F 371	<p>Continued From page 3</p> <p>staff members not wearing hairnets when walking through the kitchen past the serving line and the cooking line, and one employee not wearing a hairnet properly at the end of the serving line.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Food Storage," dated 2009, revealed the policy stated food should be dated as it is placed on the shelves, and date marking to indicate the date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded would be visible on all high-risk foods. The policy further stated cooked foods must be stored above raw foods to prevent contamination. The policy stated that meat, fish, and poultry should be stored on lower shelves, while fruits, vegetables, juices, and breads should be stored on upper shelves.</p> <p>Review of the facility's policy, "General Food Preparation and Handling," dated 2009, revealed silverware was stored in such a manner to encourage contact with handles only. The facility policy stated staff should handle utensils, cups, glasses, and dishes in such a way as to avoid touching surfaces that food or drink would come in contact with. Further review of the policy revealed staff was to use tongs or other serving utensils to serve breads or other items. The policy directed staff to never touch food directly with bare hands.</p> <p>Review of the facility's policy, "Dietary Personal Requirements," no date, revealed hairnets would be worn at all times while in the kitchen.</p> <p>1. Observations on 08/04/15 at 9:08 AM during the initial tour of the kitchen revealed the</p>	F 371	<p>F 371 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(1.) Corrective action for those residents found to have been affected by the deficient practice include:</p> <ul style="list-style-type: none"> ➤ Labeling was completed 08/04/15 for food in dry storage area including the arrival date and date the food was opened; ➤ Raw eggs were stored in the bottom shelf on 08/04/15 per policy; ➤ Dietary Aide #1 put on gloves to transfer bowls and plates containing food items 08/05/15; ➤ Dietary Aides #2, #3, and Cook #1 donned their hairnets 08/05/15 upon instruction; and ➤ Dietary aide #1 with improper fitting hairnet was given a hat to help her hairnet to fit properly 08/05/15. <p>(2.) The facility has completed the following to identify other residents having the potential to be affected by proper labeling of dry storage foods, proper glove use and handling of food, food storage, and proper hairnet attire:</p> <ul style="list-style-type: none"> ➤ The Infection Prevention Coordinator completed a QAPI audit 08/24/15 on proper storage of food and the distribution and serving of food under sanitary conditions (copy of audit attached); ➤ Dietary policies and procedures were revised with an emphasis on glove use for the handling of bowls and plates containing food items, labeling of foods to include arrival date and 	

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F 371	<p>Continued From page 4</p> <p>following: a tray of opened raw eggs in the shell sitting on the top shelf in a reach-in cooler with no date on them. The eggs were on a shelf above cheese, what appeared to be hot dog chili, and a package of opened bologna.</p> <p>Interview with the Dietary Manager on 08/05/15 at 3:56 PM revealed that the eggs should not have been on the upper shelf in the reach-in cooler, they should have been in the walk-in cooler, and all foods should have a date on them.</p> <p>2. Observations on 08/04/15 at 9:10 AM during the initial tour of the kitchen revealed the following: a bin with an opened bag of food thickener in it with no label or date on it and nine (9) boxes of oatmeal cakes in the dry stock room with no dates.</p> <p>Interview with the Dietary Manager on 08/05/15 at 3:56 PM revealed that all food items should have a label and a date on them.</p> <p>3. Observations on 08/05/15 at 10:40 AM revealed Dietary Aide #1 touched the inside portion of bowls and plates while serving rolls, salads, and pie. The Dietary Aide served 47 trays before putting on gloves.</p> <p>Interview with Dietary Aide #1 on 08/05/15 at 12:15 PM revealed she was not aware she was touching the bowls or pie plates in the food contact areas.</p> <p>Interview with the Dietary Manager on 08/05/15 at 3:56 PM revealed the Dietary Aide should not have been touching the inside area of the bowls and pie plates with her bare hand.</p>	F 371	<p>when opened, food storage of raw eggs, and dietary staff use of hairnets when entering the kitchen:</p> <ul style="list-style-type: none"> • General Food Preparation and Handling • Food Storage • Use of Plastic Gloves • Dietary Personnel Attire Requirements <p>(Revised Policies Attached)</p> <p>➤ Inservices were conducted on 08/26/15 by the Assistant Dietary Manager on revised policies and the new QAPI Dietary Department Audit. (Inservice Materials Attached)</p> <p>(3.) The facility has implemented the following QAPI measures to ensure that food is labeled and stored and distributed under sanitary conditions:</p> <ul style="list-style-type: none"> ➤ The Infection Prevention Coordinator will conduct bi-weekly QAPI audits utilizing the QAPI Dietary Department Audit Form (see attached). The Infection Prevention Coordinator will conduct bi-weekly Dietary QAPI audits until 100% compliance is achieved for two consecutive months at which time the Infection Prevention Coordinator will conduct ongoing monthly Dietary QAPI audits. ➤ Results of the QAPI Dietary Department audit will be submitted to the Dietary Manager. Negative outcomes will be immediately corrected. 	

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F 371	<p>Continued From page 5</p> <p>4. Observation on 08/05/15 at 11:53 AM revealed Dietary Aide #2, Dietary Aide #3, and Cook #1 entered the kitchen and walked past the serving line and the cooking line to the back of the kitchen without wearing a hairnet. In addition, Dietary Aide #1, who was working on the end of the serving line, was observed to be wearing her hairnet pulled to the back of her head and not covering her hair while serving 47 trays before covering all of her hair.</p> <p>Interview with Dietary Aide #1 on 08/05/15 at 12:15 PM revealed she had a hard time keeping her hairnet in place.</p> <p>Interview with Dietary Aide #2 on 08/05/15 at 12:06 PM revealed she was supposed to put on a hairnet when entering the kitchen, but forgot to.</p> <p>Interview with Dietary Aide #3 on 08/05/15 at 12:06 PM revealed he was supposed to wear a hairnet when in the kitchen.</p> <p>Interview with Cook #1 on 08/05/15 at 3:29 PM revealed staff was supposed to put on a hairnet before entering the kitchen.</p> <p>Interview with the Dietary Manager on 08/05/15 at 3:56 PM revealed kitchen staff should have hairnets on while in the kitchen.</p> <p>Interview with the Registered Dietitian on 08/05/15 at 4:10 PM revealed that all the foods should have been dated, the eggs should not have been on the upper shelves in the reach-in cooler, staff should not have been touching the bowls and pie plates in the food contact areas with bare skin, and all staff should wear hairnets covering all their hair at all times in the kitchen.</p>	F 371	<p>(4.) Compliance monitoring of the performance of the Dietary Department process and procedure related to labeling of food properly and distribution of food under sanitary conditions include the following:</p> <ul style="list-style-type: none"> ➤ Utilizing the Compliance Monitoring Dietary Department QAPI form (attached), the Dietary Manager will analyze and document the results of the Dietary Department QAPI 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 inservice education. The QAPI Dietary Department Audit will be a permanent routine monthly audit within our QAPI program. <p>CORRECTIVE ACTION TAG# F 371 COMPLETED ON</p> <p>F 412 483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>(1.) Corrective action for those residents found to have been affected by the deficient practice include:</p> <ul style="list-style-type: none"> ➤ Dental service appointments for residents #2, #6, and #13 were scheduled to be seen by the dentist on 08/27/15. Residents #1, #3, #8, #10, #14, and #18 refused dental 	08/28/15	

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F 412 SS=E	<p>483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS</p> <p>The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy, the facility failed to provide dental services for nine (9) of twenty-four (24) sampled residents (Residents #1, #2, #3, #6, #8, #10, #13, #14, and #18) to meet the needs of the residents. There was no evidence that Residents #1, #2, #3, #6, #8, #10, #13, #14, and #18 received an exam by a dentist on an annual basis.</p> <p>The findings include:</p> <p>Review of the facility's policy entitled "Dental Services," (dated May 2015) revealed the nursing staff will conduct an Oral Cavity Assessment at the time of admission and annually thereafter. The policy further revealed during the oral assessment, any problems or concerns identified would be referred to the resident's Primary Care Physician.</p> <p>1. Review of the medical record revealed the</p>	F 412	<p>services. (Copies of refusal statements attached)</p> <p>(2.) The facility has completed the following to identify other residents requiring annual dental services:</p> <ul style="list-style-type: none"> ➤ Dental Services Audits were completed by the PCN's for all residents on 08/08/15, 08/13/15, and 08/17/15 to determine resident's annual dental service needs. (Dental Service Audits attached) ➤ The Dental Service Program Policy was revised on 08/24/15. (Revised Dental Service Program Policy Attached) ➤ The Dentist who is a medical staff member of this facility will conduct annual dental evaluations for all residents in need of dental services. The Dentist will come to the facility monthly and as needed in emergency situations. (See Attached Staff Application) ➤ Appointments for residents who are in need of annual dental services will be scheduled by the PCN with their dentist or the facility dentist. ➤ The DON conducted inservices 08/25/15 – 08/26/15 to review the Revised Dental Services Program Policy and the Dental Services Audit. (See attached Inservice Records) <p>(3.) Measures implemented to ensure all residents receive annual and appropriate dental services from the dentist include:</p> <ul style="list-style-type: none"> ➤ Upon admission to Laurel Heights the admitting nurse will obtain a 	

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F 412	<p>Continued From page 7</p> <p>facility admitted Resident #2 on 10/10/12 with diagnoses that included Parkinson's Disease, Dementia, Alzheimer's Disease, Hypertension, and Anemia. Review of the annual Minimum Data Set (MDS) Assessment dated 08/30/14 revealed the facility assessed Resident #2 to have no concerns in the dental section of the MDS. Further review of the medical record revealed no evidence that Resident #2 had received an annual dental examination by a dentist.</p> <p>Observation of Resident #2 on 08/04/15 at 2:05 PM revealed Resident #2 had a clean mouth and clean dentures.</p> <p>2. Review of the medical record revealed the facility admitted Resident #6 on 10/09/13 with diagnoses that included Diabetes, Hypertension, Dementia, Alzheimer's Disease, and Debility. Review of the annual MDS dated 09/30/14 revealed the facility assessed Resident #6 to have no natural teeth or tooth fragments. Further review of the medical record revealed no evidence that Resident #6 had received an annual dental examination by a dentist.</p> <p>3. Review of the medical record for Resident #3 revealed the facility admitted the resident on 08/25/14 with diagnoses that included End Stage Chronic Obstructive Pulmonary Disease, Cachexia, and Depression. Further review of the medical record revealed no evidence Resident #3 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change Minimum Data Set (MDS) assessment dated 09/08/15, revealed Resident #3 had been assessed by the facility to</p>	F 412	<p>dental history and complete section #9 of the Nursing Admission History and Assessment. The admitting nurse in conjunction with the resident and/or family member will determine if there are any urgent dental interventions needed. If the resident being admitted has not seen a dentist within one year prior to admission a dental appointment will be offered and/or a refusal statement will be signed.</p> <p>➤ The nursing Administrative Assistant will maintain a Dental Service Database detailing the residents' dentist and annual dental service appointment needs. The Nursing Administrative Assistant will provide a Monthly Dental Appointment report to the PCN and Social Service Staff. The Monthly Dental Appointment Report indicates the names of the residents who last saw a dentist in the month listed or have been admitted to the facility for a one year time frame and are due a dental appointment. The PCN will ensure that the resident appointment is scheduled.</p> <p>➤ The PCN will conduct a monthly audit utilizing the Dental Service Audit form to ensure residents requiring annual dental services have a dentist appointment scheduled. (Dental Service Audit Form Attached) The PCN will submit the results of the audit to the DON monthly. Deficient results will be corrected immediately. The QAPI Dental Service Audit will remain</p>		

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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 08/06/2015
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 412	<p>Continued From page 8</p> <p>be cognitively intact with a Brief Interview for Mental Status (BIMS) score of 15. The MDS also revealed the resident had been assessed to have no teeth.</p> <p>Observation of Resident #3's oral cavity on 08/04/15 at 3:05 PM revealed Resident #3 was observed to be edentulous and did not wear dentures.</p> <p>Interview conducted with Resident #3 on 08/04/15, at 3:05 PM, revealed the resident had not been to the dentist since prior to coming to the facility. Resident #3 stated the facility had not asked him/her about seeing the dentist since admission to the facility.</p> <p>4. Review of the medical record for Resident #8 revealed the facility admitted the resident to the facility on 09/12/07 with diagnoses that included Dementia and Diabetes Mellitus. Further review of the medical record revealed no evidence Resident #8 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change MDS assessment dated 12/08/14, revealed the resident had been assessed to have a BIMS score of 15 and therefore to be cognitively intact. Further review of the MDS revealed the resident was edentulous.</p> <p>Interview with Resident #8 on 08/05/15, at 3:45 PM, revealed the resident had not received an oral evaluation by a dentist since being admitted to the facility.</p> <p>5. Review of the medical record for Resident #10</p>	F 412	<p>an action item in our QAPI program indefinitely.</p> <p>(4.) Monitoring the performance of the facility providing annual Dental Services to our residents performed by the Dentist include:</p> <ul style="list-style-type: none"> ➤ Utilizing the Compliance Monitoring Dental Service form (attached), the DON will analyze the results of the Dental Service Audit monthly. The DON will develop an action plan if required and submit the compliance monitoring report to the QAPI committee monthly. Negative outcomes will be discussed and resolved through the interdisciplinary approach of the committee, which may include increased monitoring and staff education. <p>CORRECTIVE ACTION TAG# F 412 COMPLETED ON</p>	08/28/15	

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

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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	
F 412	<p>Continued From page 9</p> <p>revealed the facility admitted the resident on 07/12/12 with diagnoses that included Dementia and Diabetes Mellitus. Further review of the medical record revealed no evidence Resident #10 had received an oral evaluation by a dentist since August 2013.</p> <p>Review of an annual MDS assessment dated 08/30/14, revealed the resident had been assessed to have a BIMS score of 12 and therefore to be moderately cognitively impaired. Further review of the MDS revealed the resident had been assessed to have missing teeth.</p> <p>Observation of Resident #10's oral cavity during a skin assessment on 08/05/15, at 3:15 PM, revealed the resident was observed to have two lower teeth and no upper teeth.</p> <p>6. Review of the medical record for Resident #13 revealed the facility admitted the resident on 04/29/14 with diagnoses that included Blindness and Weight Loss. Further review of the medical record revealed no evidence Resident #13 had received an oral evaluation by a dentist since the resident was admitted to the facility.</p> <p>Review of a significant change MDS assessment dated 03/30/15, revealed the resident had been assessed to have a BIMS score of 15 and therefore to be cognitively intact. Further review of the MDS revealed the resident had no dental problems.</p> <p>Observation during a skin assessment on 08/04/15, at 10:30 AM, revealed the resident was observed to have all of his/her lower teeth and to be wearing upper dentures.</p>	F 412			

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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	
F 412	<p>Continued From page 10</p> <p>Interview with Resident #13 on 08/05/15, at 11:15 AM, revealed he/she had not seen a dentist since his/her admission to the facility.</p> <p>7. Review of the medical record for Resident #14 revealed the facility admitted the resident on 02/02/06 with diagnoses that included Dementia and Hypertension. Further review of the medical record revealed no evidence Resident #14 had received an oral evaluation by a dentist since admission.</p> <p>Review of an annual MDS assessment dated 09/09/14, revealed the resident had been assessed to have a BIMS score of 15 and therefore to be cognitively intact. Further review of the MDS revealed the resident had been assessed to have no natural teeth.</p> <p>Observation during a skin assessment on 08/04/15, at 2:20 PM, revealed Resident #14 was observed to have no natural teeth and had no dentures.</p> <p>Interview conducted with Resident #14 on 08/04/15, at 3:50 PM, revealed he/she had not been evaluated by a dentist since he/she was admitted to the facility.</p> <p>8. Review of the medical record for Resident #18 revealed the facility admitted the resident on 07/19/13 with diagnoses that included Dementia and Asthma. Further review of the medical record revealed no evidence Resident #18 had received an oral evaluation by a dentist since admission.</p> <p>Review of an annual MDS assessment dated 06/21/15, revealed the resident had been</p>	F 412			

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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 08/06/2015
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 412	<p>Continued From page 11</p> <p>assessed to have a BIMS score of 15 and therefore to be cognitively intact. Further review of the MDS revealed the resident had been assessed to have his/her own natural teeth.</p> <p>Interview conducted with Resident #18 on 08/06/15, at 2:00 PM, revealed the resident had not been to the dentist since his/her admission to the facility.</p> <p>9. Review of Resident #1's medical record revealed the facility admitted Resident #1 on 06/12/14 with diagnoses that included Hyperlipidemia, Hypertension, Osteoporosis, Vitamin D Deficiency, and Chronic Diastolic Heart Failure. Further review of Resident #1's medical record revealed no evidence or documentation of Resident #1 receiving an oral evaluation performed by a dentist. Review of the annual MDS dated 05/26/15 revealed the facility assessed Resident #1 to have no natural teeth or tooth fragments.</p> <p>Observation of Resident #1 on 08/04/15 at 1:49 PM revealed Resident #1 to have a clean mouth and clean dentures.</p> <p>Interview with Registered Nurse (RN) #2 on 08/05/15 at 3:45 PM revealed the facility did not provide the residents with annual dental consultations by a dentist. She further revealed residents were seen by a dentist when a problem or complaint was identified.</p> <p>Interview with the Social Services staff on 08/06/15 at 3:15 PM revealed if a problem was identified with a resident a nurse filled out a referral form, the family was notified, and the facility would honor their preference/choice of</p>	F 412			

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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 08/06/2015
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 412	Continued From page 12 dentist. If the family did not have a preferred dentist, then the facility would arrange for the resident to see a dentist. He further stated that a dentist did not see residents annually for a dental exam. Interview with the Administrator on 08/06/15 at 3:25 PM revealed she had been trying to get a dentist on staff. The Administrator stated that residents were being seen by a dentist on an "as needed basis" or when a problem or complaint by a resident was identified.	F 412			

DEPARTMENT OF HEALTH AND HUMAN 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 08/04/2015
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	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1965</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: Two story, Type 11 (000)</p> <p>SMOKE COMPARTMENTS: 9</p> <p>FIRE ALARM: Complete automatic fire alarm system</p> <p>SPRINKLER SYSTEM: Complete automatic (wet) sprinkler system.</p> <p>GENERATOR: Type II diesel generator</p> <p>A life safety code survey was initiated and concluded on 08/04/15 for compliance with Title 42, Code of Federal Regulations, §483.70(a) and found Laurel Heights to be in compliance with NFPA 101 Life Safety Code, 2000 Edition.</p> <p>No deficiencies were identified during this survey.</p>	K 000		
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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.