

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

PRINTED: 01/07/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
(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 A Recertification Survey was initiated on 12/16/14 and concluded on 12/18/14. The facility was found not meeting the minimum requirements for recertification and deficiencies were cited with the highest scope and severity of an "E".	F 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to repair/replace broken furniture and windows in four (4) of seventy-seven (77) resident rooms, (rooms 110, 111, 113, and 118). In addition, the facility failed to ensure all windows were equipped with screens for thirty (30) of one hundred-sixty five (165) windows. The findings include: Review of the facility's policy, titled Maintenance, not dated, revealed the facility would prevent and promptly identify areas and items in need of repair. The policy stated the Director of Environmental Services would perform daily rounds of the building to ensure the facility was free of hazards and in proper physical condition. All employees would report to their supervisor any areas or equipment needing repair or service. Employees would report all items needing	F 253	F253 1. The Following items that were identified..... <ul style="list-style-type: none">The dresser handle (3rd drawer) in room 113 was repaired by maintenance on 1/13/15. The chest of drawers with scratches on the top and sides in room 113 was repaired/stained by maintenance on 1/14/15.The five drawer dresser in room 118-2 (second drawer missing) was repaired by maintenance on 12/17/14.The window, windowsill, top of the air conditioner and floor near the window in room 118 was cleaned and leaves were removed by housekeeping on 12/18/14.		

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

TITLE

(X6) DATE

[Signature]
Executive Director

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DEPARTMENT OF HEALTH AND HUMAN SERVICES

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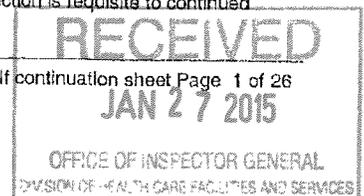
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] Executive Director *[Signature]* 1/13/15
amended

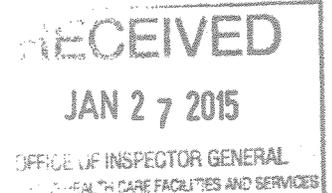
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F 253	<p>Continued From page 1</p> <p>maintenance by using the Maintenance Repair Request form located in a maintenance binder at each nurses station. In addition, the Maintenance staff would review the maintenance binder throughout the day for completed Maintenance Repair Request forms.</p> <p>Observations during the initial tour, on 12/16/14 at 11:00 AM, revealed a dresser in room 113 with its handle hanging loosely on the third drawer down. A chest of drawers in this room had scratches on the top and sides.</p> <p>Observation of room 118, on 12/17/14 at 8:05 AM, revealed the resident in bed two (2) used a 5-drawer dresser. The second drawer of the dresser was missing completely. Further observation of room 118 revealed the window was open approximately one inch with no screen in the window. The windowsill, the top of the air conditioning unit and the floor near the window contained dried leaves that the wind had blown through the screenless window.</p> <p>Observation of room 111, on 12/17/14 at 9:35 AM, revealed a three (3) drawer nightstand for bed one (1). The nightstand appeared to be designed for one handle per drawer. The handle of the middle drawer was missing completely.</p> <p>Observation of one hundred sixty-five (165) facility windows, on 12/17/14 at 11:40 AM, revealed thirty (30) did not contain a window screen. The observation further revealed a window in room 110 was broken. The window was double pane glass and the outer pane of glass was broken.</p> <p>Review of the maintenance books with the</p>	F 253	<ul style="list-style-type: none"> The (3) drawer nightstand in room 111 missing the handle in the middle drawer was repaired by maintenance on 1/13/15. The administrator submitted capital expenditure requests for replacement of 30 window screens, replacement of four windows and the French doors on 1/9/15. ABM construction is expected to complete the repairs on or before 1/31/15. (This includes the screen for room 118, window for 110 and all identified screens and windows needing repairs) <p>2. A facility tour was completed by the director of maintenance, the maintenance assistant and housekeeping supervisor on 1/9/15. The tour was completed to identify any additional maintenance and/or housekeeping concerns. The tour included a focus on furniture including drawers, furniture handles, and scratches. All items identified during the tour related to furniture, windows, screens, call lights, lights and bathrooms will be corrected by maintenance and housekeeping staff on or before 1/19/15.</p>		



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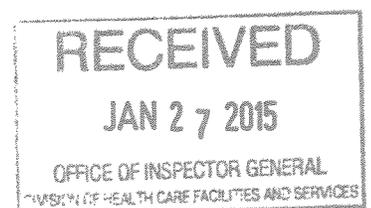
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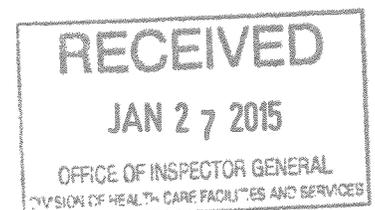
F 253	<p>Continued From page 2</p> <p>Maintenance Director, on 12/18/14 at 11:35 AM, revealed staff had not reported furniture or window maintenance issues on a Maintenance Repair Request form located in the maintenance binder.</p> <p>Interview with Housekeeper #1 on the 100 Unit, on 12/18/14 at 11:15 AM, revealed housekeepers were not responsible for reporting maintenance issues they identified in a resident room.</p> <p>Interview with Licensed Practical Nurse (LPN) #5, on 12/18/14 at 2:35 PM, revealed nursing staff could fill out a slip in the maintenance book, located at the nurses' stations, if they identified an item in a resident's room that needed maintenance.</p> <p>Interview with the Maintenance Director, on 12/18/14 at 11:25 AM, revealed the Maintenance Director completed a walk-through of the facility daily to identify any needed repairs. The Maintenance Director stated he noticed the broken window in room 110 about one week ago and he was waiting for the approval from the corporate office to repair the window. The Maintenance Director stated the facility had quotes from a vendor to make the window repairs. In addition, the Maintenance Director stated there was a maintenance book located at each nurses' station. Staff were to record any maintenance issues in that book. The Maintenance Director reviewed the maintenance book first thing each morning and again several times during the day. He would then sign off on each item in the book after making the necessary repairs. The Maintenance Director stated that staff should have reported any maintenance concerns including furniture repairs.</p>	F 253	<p>3. The Policy for completion of maintenance requests was reviewed by the administrator on 12/18/14 and found to be acceptable. The systemic intervention was re-education to licensed and unlicensed staff regarding the procedure for completing maintenance requisitions and placing the requests in the maintenance books located on each unit. This education was initiated on 1/15/14 and given by the Director of Maintenance, and administrative nursing staff (for future reference administrative nursing staff includes the director of clinical services, assistant director of clinical services, unit managers, nursing shift supervisors and corporate nursing staff.)</p> <p>In addition, on 1/8/15 the executive director implemented a "facility monthly tour quality assurance round sheet". This sheet will be completed monthly by housekeeping and maintenance staff monthly to identify any maintenance or housekeeping needs that have not been identified by staff using the work order system. The facility tour quality assurance sheet will be submitted monthly to the executive director. The executive director will be responsible for prioritizing repairs that can not be completed by the in</p>	
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F 253	Continued From page 3 Review of three (3) maintenance proposals the vendor, all dated 12/08/14, revealed the facility had received quotes on 12/08/14 for the repair of three (3) broken windows, the replacement of fifteen (15) missing window screens, and the replacement of one set of french doors. As of 12/17/14 the facility was unable to provide a purchase requisition or work order stating the repairs would begin. Previously noted observation, on 12/17/14 at 11:40 AM, indicated the facility was missing thirty (30) window screens.	F 253	house maintenance staff. Routine repairs will continue to be requested by staff that complete maintenance requests and file them in the work order books. The housekeeping and maintenance supervisors were educated on this process on 1/14/15 by the executive director.	
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's Material Safety Data Sheets (MSDS), it was determined the facility failed to ensure cleaning chemicals were secured in a locked closet for one (1) of one (1) closets on the 100 Unit. The findings include: Review of the facility's MSDS, not dated, for the floor care product Taj Mahal, revealed the	F 323	4. On 1/14/15 a Maintenance audit tool for daily repairs was created by the Clinical Ambassador and approved by the executive director. This Tool will be used to by the executive director to audit the maintenance binders to validate that work orders are completed timely and appropriately reflect the needs of the building based on administrative tours. The Executive Director will conduct Quality Improvement (QI) monitoring of regulation F253 by completing this audit tool five times a week for four weeks, weekly for 8 weeks and monthly for 3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.	



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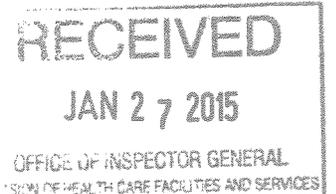
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F 323	<p>Continued From page 4 chemical could cause eye and skin irritation.</p> <p>Review of the facility's MSDS for the disinfectant Oasis 299, not dated, revealed the chemical was corrosive to the eyes and skin and that the chemical could irritate the respiratory system. Additionally, Oasis 299 could cause burns to the mouth, throat, and stomach if ingested.</p> <p>The facility did not provide a policy on the storage of chemicals.</p> <p>Observation during the environmental tour, on 12/16/14 at 1:15 PM, revealed the facility stored chemicals in an unlocked storage closet on the 100 hallway. The closet contained four (4) 2.5-gallon containers of liquid chemicals including Oasis 299 heavy-duty bathroom cleaner and disinfectant and Taj Mahal stone and resilient floor cleaner. The closet also contained paper products, three (3) bags of clothing, a wheel chair, a geri-chair, and a mop bucket with water in it and a mop.</p> <p>Interview with the Account Manager of Laundry and Housekeeping, on 12/17/14 at 2:20 PM, revealed housekeeping stored chemicals in a locked closet in the laundry room and in the Account Manager's office. The Account Manager also stated housekeeping kept chemicals on the locked housekeeping carts and in the chemical dispenser located in the locked, central, Janitor's closet. The Account Manager stated she stored the floor sealant, strippers, and disinfectants in the housekeeping supervisor's office. The Account Manager was unaware of any other location, including the unlocked closet on the 100 Unit, where staff kept cleaning chemicals.</p>	F 323	<p>(For future reference the QAPI-Quality Assurance Performance Improvement Committee consists of the Medical Director, ED, DCS, and at least 3 other staff members from housekeeping, nursing, therapy, activities, dietary, social services, business office, admissions or medical records.)</p> <p>5. The administrator is responsible for this process. Compliance Date is 02/02/15. <i>1-31-15 per C Outage by PB 2-3-15</i></p> <p>F323</p> <ol style="list-style-type: none"> The Housekeeping supervisor removed the (4) 2.5 gallon containers of liquid chemicals including Oasis 299 heavy duty bathroom cleaner and disinfectant and Taj Mahal stone and resilient floor cleaner and mop bucket from the closet on 100 hall on 12/17/14. A facility tour was completed by the housekeeping supervisor on 12/17/14 and no other concerns were identified with storage of chemicals. The policy and procedure for storage of chemicals and biologicals was reviewed by the executive director on 12/18/14 and found to be acceptable. The systemic revision included education to licensed and unlicensed staff (including housekeeping/floor tech staff) regarding the storage of chemicals and biologicals. This education included a review of the policy as 	

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F 323	Continued From page 5 Interview with Housekeeper #1, on 12/18/14 at 11:15 AM, revealed housekeeping stored chemical cleaning supplies on the locked housekeeping cart, in the Janitor's closet on the Subacute Unit 2, and in the laundry room. Interview with the Account Manager of Laundry and Housekeeping, on 12/18/14 at 1:50 PM, revealed the unlocked storage closet on the 100 Unit was not an appropriate storage closet for the chemicals Oasis 299 heavy-duty bathroom cleaner and disinfectant and the Taj Mahal stone and resilient floor cleaner. The Account Manager stated she was previously unaware the chemicals were in the storage closet. The Account Manager also stated staff should have kept this storage closet locked to prevent resident injury due to other equipment in that room. The Account Manager stated the chemicals stored in that closet were dangerous due to the possibility of a resident drinking the chemical. She stated many residents liked to walk around and could have potentially gotten into this closet, drank the chemicals and become sick.	F 323	well as information regarding the storage of housekeeping chemicals, appropriate labels and storage of chemicals in closets. The education was initiated verbally following the survey and followed by a written competency. The written competencies were initiated on 1/14/15 by the director of maintenance and administrative nursing staff.		
F 372 SS=D	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and facility policy review, it was determined the facility failed to ensure proper disposal of garbage in two (2) of three (3) dumpsters with lids closed.	F 372	4. On 1/14/15 a chemical and biologicals storage audit tool was created by the clinical ambassador and approved by the executive director. The audit includes facility rounds to validate that chemicals and biologicals are stored appropriately. The administrative team including the executive director, director of clinical services, assistant director of clinical services, unit manager(s), director of maintenance, activities, social services, medical records, dietary manager, housekeeping supervisor will conduct Quality Improvement (QI) monitoring of regulation F323 by completing the chemical and biological Audit Tool on random shifts, dates and times		



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F 372	Continued From page 6 The findings include: Review of the facility's policy, Solid Waste Management, not dated, revealed the facility had in place a contract with a trash removal company to empty the dumpsters every other day. However, the policy did not address the upkeep of the dumpsters, keeping the doors closed and not over filling. Observation of the dumpster, on 12/16/14 at 2:50 PM, revealed the facility had two (2) dumpsters at the rear of the building for garbage. The lids on both dumpsters were open. Observation of the dumpster area, on 12/17/14 at 11:45 AM, revealed the lid of one (1) dumpster lid was open. Staff had piled the garbage above the top of the dumpster. The other dumpster was relatively empty. Further observation of the grounds, on 12/16/14 at 3:00 PM, revealed the kitchen used a separate dumpster for food and kitchen waste. Interview with the Maintenance Director, on 12/18/14 at 11:25 AM, revealed staff were supposed to keep the lid of the dumpsters closed at all times. The Maintenance Director stated if staff left the lids of the dumpsters open the wind could blow the garbage out of the dumpsters and onto the grounds or animals could get into the dumpster. The Maintenance Director stated that the trash removal company emptied the dumpsters every other day. Interview with the Housekeeping and Laundry Account Manager, on 12/18/14 at 1:50 PM, revealed the housekeeping staff were responsible	F 372	five times a week for four weeks, weekly for 8 weeks and monthly for 3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required. 5. The administrator is responsible for this process. Compliance Date is 02/02/15. <i>1-31-15 per C. Ortega</i> F372 1. The Director of Maintenance and maintenance assistant closed the lids to the two dumpsters and cleaned the refuse surrounding grounds on 12/18/14. 2. No other dumpsters were identified. 3. The policy and procedure for solid waste management was reviewed by the executive director on 12/18/14 and found to be acceptable. The executive director developed an additional protocol for waste management on 1/14/15. This protocol addresses upkeep of the dumpsters, keeping doors closed, surrounding grounds clean up and filling capacity. All staff is required to dispose of refuse in an appropriate manor, however, the director of maintenance is responsible for routine observation		

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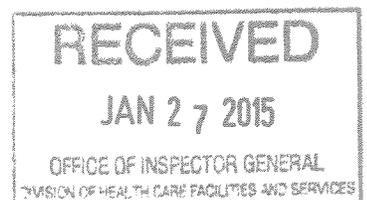
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F 372	Continued From page 7 for taking trash to the dumpsters one time per day. The Account Manager stated she had not completed an in-service with the housekeeping staff that specifically addressed closing the dumpster lids. The Account Manager stated the staff leaving the lids open on the dumpsters increased the risk of wind causing trash to litter the ground and attraction of rodents. Rodents could increase the risk for infection control problems.	F 372	of the dumpsters daily Monday through Friday. The systemic revision included education to licensed and unlicensed staff regarding the disposal of refuse, maintaining the area around the dumpsters and closing the lids. The education was initiated verbally following the survey and followed by a written competency. The written competencies were initiated on 1/14/15 by the director of maintenance and administrative nursing staff.		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	4. On 1/14/15 a disposal of refuse Quality Assurance audit tool was created by the clinical ambassador and approved by the executive director. The disposal of refuse audit tool includes auditing to validate that dumpster lids are closed; refuse is not surrounding the dumpsters and making sure dumpsters are not over filled. The executive director/ director of maintenance/ maintenance assistant and housekeeping supervisor will conduct Quality Improvement (QI) monitoring of regulation F372 by reviewing the Disposal of Refuse Audit Tool five times a week for four weeks, weekly for 8 weeks and monthly for		



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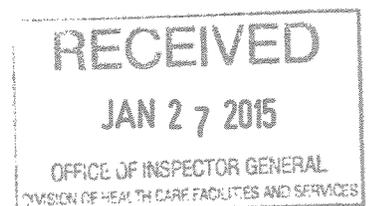
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F 431	<p>Continued From page 8</p> <p>Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and policy review, it was determined the facility failed to ensure medication and treatment carts were routinely cleaned to ensure sanitary storage in three (3) of eight (8) medication carts, and one (1) of four (4) treatment carts. In addition, the staff stored an opened pack of Marlboro cigarettes, belonging to a resident, in the top drawer of the 100 Unit medication cart, with other residents' medications. This is repeat deficiency from the 09/12/13 survey.</p> <p>The findings include:</p> <p>The facility did not provide a policy specific for cleaning the medication and treatment carts. However, review of the September 2013 Plan of Correction revealed the facility developed a cleaning schedule and would monitor two carts quarterly for cleanliness.</p> <p>Review of the facility's policy titled Storage and Expiration of Medications, Biologicals, Syringes and Needles, not dated, revealed test reagents, germicides, disinfectants, and other household substances should be stored separately from medications. In addition, poisons were to be stored separately from medications.</p>	F 431	<p>3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.</p> <p>5. The administrator is responsible for this process. Compliance Date is 02/02/15. <i>1-31-15 per C. O'Leary on 03/2-15</i></p> <p>F431</p> <ol style="list-style-type: none"> The three medication carts and one treatment cart identified were cleaned by licensed nursing staff on 12/17 and 12/18/14. The cigarettes were removed from the medication cart on 12/18/14 by the assistant director of clinical services. All medication and treatment carts have potential to be affected by this process. The protocol for cleaning medication carts and storage of medications was reviewed by the director of clinical services on 1/12/14 and revised on 1/14/14 to include a daily cleaning schedule. Licensed nursing staff is responsible for maintaining the cleanliness of medication carts every shift. The 11-7 nursing staff is responsible for documenting daily audits of the medication and treatment carts and pill crushers to ensure appropriate cleaning of the 	

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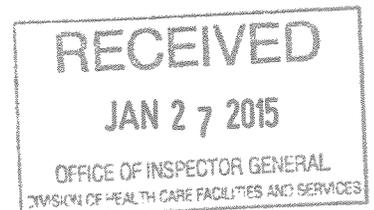
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F 431	Continued From page 9 Observation, on 12/16/14 at 8:35 AM, during initial tour of the facility, revealed two (2) medication carts on the 100 Unit had a build-up of sticky/old looking tape residue on the drawer handles. Particles of debris/crums were observed on the metal ledge of the medication cart containing medications for residents in rooms 100- 110. This same cart also had drip stains across the front of the bottom drawer where liquid medications were stored, and the pill crusher was heavily soiled with a dark brown/black substance. Observation, on 12/16/14 at 1:15 PM, revealed the medication cart, containing medications for residents in rooms 111-119, had sticky/old looking tape residue on the drawer handles and sides of the medication cart. The pill crusher on the medication cart was heavily soiled with a dark brown/black substance. Observation, on 12/17/14 at 7:50 AM, revealed the pill crusher on top of the medication cart, containing medications for residents in rooms 28-33, was also soiled. A dark brown/black substance was observed on the sides and top of the pill crusher. Observation, on 12/17/ 14 at 8:25 AM, during the medication pass, revealed the medication cart for the residents in rooms 111-119 continued to be soiled with a build up of sticky tape on the drawer handles and the pill crusher continued to appear soiled with a build up of a dark brown/black substance. Observation of the treatment cart for Rooms 28-40, on 12/17/14 at 3:09 PM, revealed a build-up of a sticky grayish tape residue on top of	F 431	carts and appropriate storage of chemicals and biologicals. The 11-7 nursing staff will be required to document daily audits including the date. The systemic revision included education to licensed nursing staff regarding the cleanliness of the medication and treatment carts, pill crusher cleanliness and appropriate storage of chemicals and biologicals on the medication and treatment carts. The education was initiated verbally following the survey and followed by a written competency. The written competencies were initiated on 1/14/15 by director of nursing and administrative nursing staff. The written competency included education regarding the revised protocol and documentation requirements when cleaning the medication/treatment carts. 4. On 1/14/15 a medication and treatment cart audit tool was created by the clinical ambassador and approved by the director of clinical services. The medication and treatment audit tool includes auditing to validate that the carts are clean, pill crushers are clean, and no cigarettes or personal items are stored in the cart and 11-7 documentation on the daily cleaning schedule. The director of clinical services, assistant director of clinical services and		



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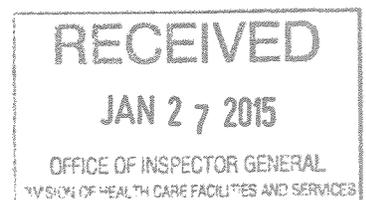
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F 431	<p>Continued From page 10 the cart with bits of yellow labels stuck to the sides and top of the cart.</p> <p>Observation, on 12/18/14 at 8:53 AM, during inspection of the medication cart containing medications for Residents in Rooms 100-110, revealed an opened pack of Marlboro cigarettes, containing four (4) cigarettes, stored in the top drawer of the medication cart with residents' eye drops and insulin. The cigarette pack was labeled with a first name, only.</p> <p>Interview, on 12/18/14 at 8:55 AM, with Registered Nurse (RN) #2 revealed the cigarettes did not belong to any residents on the 100 Unit.</p> <p>Interview with the 100 Unit Manager (UM), RN #3, on 12/18/14 at 8:56 AM, revealed the opened pack of cigarettes belonged to a resident who resided on the facility's Subacute II Unit.</p> <p>Review of the medication audits provided by the facility, revealed they did not identify the date or time of the audits for the medication and treatment carts. Cleaning of the medication and treatment carts was listed as a responsibility, but this component of the audit was consistently left blank (not initialed by staff as completed).</p> <p>Interview, on 12/18/14 at 9:20 AM, with RN #2 revealed she was not aware of a cleaning schedule for the medication and treatment carts, but stated if she spilled something on the cart while passing medications, she cleaned it up. RN #2 stated the pill crusher on her medication cart appeared soiled and that it could use a cleaning. RN #2 stated the soiled medication cart and pill crusher could pose a risk for cross contamination as nurses frequently touched the cart and</p>	F 431	<p>administrative nursing staff will conduct Quality Improvement (QI) monitoring of regulation F431 by auditing the cleanliness of the medication and treatment carts using the Medication and Treatment Audit Tool five times a week for four weeks, weekly for 8 weeks and monthly for 3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.</p> <p>5. The director of clinical services is responsible for completion of this tag. Date of compliance is 02/02/15: <i>1-31-15</i> <i>RN C. Dwyer</i> <i>by PB 2-3-15</i></p>		



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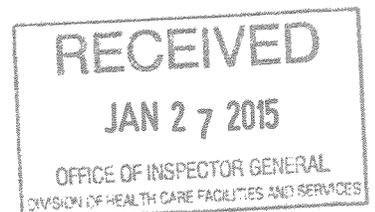
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F 431	<p>Continued From page 11 equipment while passing medications and while providing other types of resident care.</p> <p>Interview, on 12/18/14 at 9:40 AM, with RN #2 revealed after inspection of the pill crusher on the medication cart for residents in rooms 23-28, he thought the pill crusher looked disgusting. RN #2 stated using that soiled piece of equipment for preparing the residents' medications posed a risk for cross-contamination and the spread of infections.</p> <p>Interview, on 12/18/14 at 2:10 PM, with RN #3 revealed the medication and treatment carts were to be cleaned by the third shift licensed nurses on Mondays, Wednesdays, and Fridays. The nurses were to complete and sign the audit tool to verify the carts had been cleaned, and the contents had been inspected for organization and any outdated medications/supplies had been removed. Further interview with RN #3 revealed she did not routinely inspect the exterior of the carts for cleanliness, but the potential problem with dirty carts and equipment would be an increased risk for cross-contamination as nurses routinely provided medications and other types of care for multiple residents. In addition, RN #3 stated residents' personal property, such as an opened pack of cigarettes, should be locked up for safety, but they should not be intermingled with the residents' medications.</p> <p>Interview, on 12/18/14 at 2:40 PM, with the facility's Director of Nursing (DON) revealed the third shift staff was responsible for the periodic cleaning and auditing of the medication and treatment carts, but she was not sure of the exact schedule for this task. The DON stated she would try to obtain any completed audits for review. The</p>	F 431			



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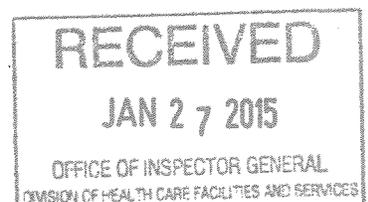
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F 431	Continued From page 12 DON stated residents' cigarettes should not be stored with the residents' medications, but should be secured in another location in the facility. The DON stated her dominating concern with unclean resident care equipment was the increased risk for cross-contamination and breaks in infection control which could adversely affect the health of the residents.	F 431	F441 1. LPN #4 was verbally in-serviced by the assistant director of clinical services regarding hand washing and infection control procedures during the survey. RN #4 was verbally in-serviced by the director of clinical services regarding hand washing and infection control procedures during the survey. Un-sampled resident A's catheter was re-secured at a level to ensure that the catheter did not touch the floor on 12/18/14 by the assistant director of clinical services. The assistant director of Nursing provided verbal education to certified nursing assistants regarding transferring a resident with a catheter and securing the catheter. Maintenance was verbally educated during annual survey by the executive director regarding infection control procedures and bringing in equipment into resident rooms. Maintenance was provided a secured cart to allow them to leave un-necessary equipment outside of resident's room on 12/18/14.		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which	F 441			



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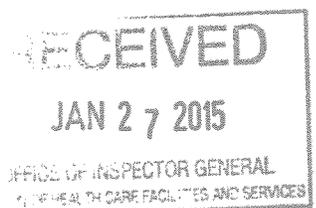
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F 441	<p>Continued From page 13 hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy review, it was determined the facility failed to ensure staff practiced infection control standards for three (3) of twenty-four (24) sampled residents, (Resident #1, #7 and #16) and two (2) unsampled residents, Unsampled Resident A and B.</p> <p>The facility failed to implement contact precautions for Resident #16 when the resident was symptomatic and awaiting laboratory results for C-Diff. The facility failed to follow contact precautions by utilizing available Personal Protective Equipment (PPE) and washing hands per policy. The facility failed to ensure staff did not store soiled linens on the floor in resident's rooms. Licensed Practical Nurse (LPN) #4 failed to wash her hands and change gloves when going from a soiled area to a clean area during a dressing change for Resident #1. Staff were observed on three occasions to leave Unsampled Resident A's bedside drainage bag attached to an indwelling catheter in direct contact with the floor. RN #4 used her bare hands to turn the water faucet off after washing her hands when passing medications to Unsampled Resident B. Further, RN #4 was noted to bring medications into the</p>	F 441	<p>Signage was posted on resident #16's door and isolation equipment was put into place by RN #2 and the 2 bags of linens were removed on 12/16/14. The nurse aide care plan for resident #16 was updated by the assistant director of clinical services to include isolation precautions. Certified nursing assistant #1 was verbally in-serviced by the assistant director of clinical services during the annual survey regarding hand washing and use of gloves. The director of clinical services provided verbal education and instruction during the survey to certified nursing assistants #3,#5,#6 and Hsk #1 regarding infection control and use of PPE.</p> <ol style="list-style-type: none"> All residents have the potential to be affected by infection control procedures. The systemic revision included education to licensed and unlicensed staff regarding the CDC guidelines for c-diff, isolation precautions, hand washing, Foley catheters, handling medical equipment, tray delivery and hand washing, and disposal procedures for soiled linens. The education was initiated verbally following the survey and followed by a written competency. The written competencies were initiated on 	



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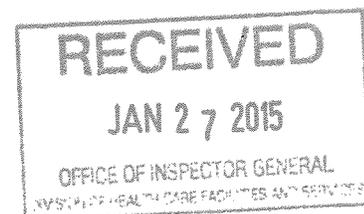
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F 441	<p>Continued From page 14</p> <p>resident's room and prepare the medications for administration without creating a clean field. In addition, the Maintenance staff took a soiled maintenance cart into rooms 112, 115, and 109.</p> <p>The findings include:</p> <p>1. Review of the facility's policy for Preventing the Spread of C-diff, not dated, revealed gown and gloves were worn when entering a resident's room especially if they were incontinent of bowel. Antimicrobial soap should be used to wash hands. Other facility policies for management of contact precautions no longer met current Center for Disease Control (CDC) guidelines.</p> <p>Review of the facility's Handwashing policy titled, Hand Washing Technique, not dated, revealed hands must be washed after contact with contaminated items or surfaces. The handwashing procedure outlined a multiple step process which included turning off the faucet handles with a paper towel once hands had been washed.</p> <p>No facility policy was provided regarding storing soiled linens on the floor in a resident's room.</p> <p>Observation of Resident #16, on 12/16/14 at 8:46 AM, revealed a small plastic cart with isolation supplies sitting in the hallway near the resident's room. There was no evidence of signage to explain the type of precautions in place or if any precautions were in place. Staff was observed entering and exiting the room without personal protective equipment (PPE). Certified Nurse Aide (CNA) #1 delivered the resident's breakfast tray and wore gloves. When she left the room, she</p>	F 441	<p>1/14/15 by director of nursing and administrative nursing staff. The written competency included education regarding the revised protocol for storage and disposal of isolation linens, trash and equipment.</p> <p>4. On 1/14/15 an Infection Control Audit Tool was created by the clinical ambassador and approved by the director of clinical services. The director of clinical services, assistant director of clinical services and administrative nursing staff will conduct Quality Improvement (QI) monitoring of regulation F441 by auditing staff compliance with appropriate infection control precautions. Each auditor will be responsible for a minimum of five observations of staff during each observation date. Audits will be completed on random shifts and days of the week. Auditors will observe isolation precautions, hand washing, catheters, meal tray delivery, handling medical equipment, and disposal of soiled linens. The audit Tools will be completed by each participant a minimum of five times a week for four weeks, weekly for 8 weeks and monthly for 3 months. Any concerns identified throughout the QI process will be immediately</p>		



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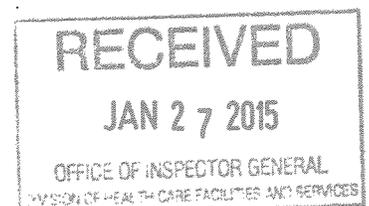
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F 441	<p>Continued From page 15</p> <p>did not wash her hands. In addition, two (2) bags of soiled linen were stored on the floor in Resident #16's room.</p> <p>Review of the clinical record for Resident #16, revealed the facility admitted the resident with diagnoses of Clostridium Difficile Colitis (C-diff) and Diabetic Foot Ulcers. The facility completed a quarterly Minimum Data Set (MDS) assessment on the resident on 10/26/14 which revealed the resident was cognitively intact, required extensive assistance with all care, and was frequently incontinent of bowel and bladder.</p> <p>Review of the laboratory findings, dated 10/01/14 and 11/07/14, revealed Resident #16 was positive for C-diff. Review of the laboratory findings from 12/15/14, revealed the resident was positive for C-diff.</p> <p>Review of the Nurse Aide Care Plan for Resident #16, revealed the resident's contact precautions were discontinued on 12/15/14.</p> <p>Interview with Registered Nurse (RN) #2, on 12/16/14 at 12:15 PM, revealed Resident #16 had a recent history of Clostridium Difficile (C-diff) and was experiencing diarrhea. She stated the physician was notified on 12/15/14 and there were new orders for an antibiotic and a stool sample was sent for testing. She stated the resident was not on isolation precautions as there were no results from the laboratory yet. She stated at the end of the interview that it was highly suspicious that Resident #16 had C-diff and she was reimplementing contact precautions for the resident.</p> <p>Observation of Resident #16, on 12/16/14 at</p>	F 441	<p>addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.</p> <p>5. The director of clinical services is responsible for completion of this tag. Date of compliance is <u>1-31-15</u> <i>per C. Ortega</i> <i>by PB 2-3-15</i></p>		



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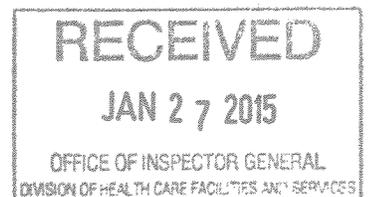
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 12/18/2014
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
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F 441	<p>Continued From page 16</p> <p>12:48 PM, revealed CNA #5 delivered the resident's lunch tray wearing gloves, but no gown. The CNA did not wash her hands with soap and water prior to leaving the resident's room. She also leaned against the bed during a conversation with the resident.</p> <p>Interview with CNA #5, on 12/17/14 at 8:21 AM, revealed she had received training in isolation precautions by the facility; however, there was a question regarding precautions and some staff used PPE and some did not. She stated she needed to use PPE since C-diff was suspected. She stated she could spread infection to herself and other residents if the stool culture returned as positive. She stated Resident #16 had diarrhea for several days and she told the nurse daily how many stools the resident had.</p> <p>Observation of Resident #16, on 12/17/14 at 8:17 AM, revealed CNA #3 and CNA #6 entered the resident's room and using the sheet, pulled the resident up in bed. Neither CNA wore PPE. CNA #3 and CNA #6 did not wash their hands prior to leaving the resident's room.</p> <p>Interview with CNA #3, on 12/17/14 at 8:21 AM, revealed she had received training on isolation precautions by the facility. She stated Resident #16 was pulled up in bed with a sheet and since the resident was not touched, there was no need for gloves or a gown. She stated she forgot she was supposed to wear PPE and wash her hands with soap and water before exiting the resident's room. She stated bacteria was spread to others when hand washing was not completed between residents. She stated linen should never be placed on the floor.</p>	F 441			



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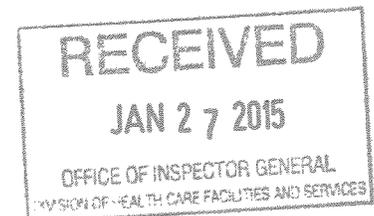
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F 441	<p>Continued From page 17</p> <p>Interview with CNA #6, on 12/17/14 at 8:33 AM, revealed she had been trained on isolation precautions by the facility, she stated she did not see the isolation cart or any isolation signage prior to entering Resident #16's room. She stated she did use some alcohol sanitizer after leaving the room to prevent the spread of infection. She stated she did not know C-diff was destroyed by soap and water.</p> <p>Interview with Housekeeper #1, on 12/17/14 at 9:43 AM, revealed she had received training on isolation precautions by the facility; however, sometimes she wore a gown when cleaning Resident #16's room and sometimes she did not. She stated she used alcohol sanitizer for hand cleaning.</p> <p>Interview with the Director of Nursing, on 12/18/14 at 1:26 PM, revealed all nurses should have knowledge of contact precautions. She stated the Unit Manager was responsible for ensuring the appropriate care was provided for all residents. She stated Resident #16 was to go outside and smoke when no other residents were present. She stated all staff were trained on handwashing and her expectation was for nursing staff to wash hands as required and as needed. She was not sure when the last handwashing inservice was completed. She stated she had been at the facility as DON for two weeks.</p> <p>3. No policy was provided regarding taking soiled maintenance equipment and supplies into residents' rooms.</p> <p>Observation of Maintenance, on 12/17/14 at 11:58 AM, revealed an old cart was used to hold equipment and small items needed to do small</p>	F 441			



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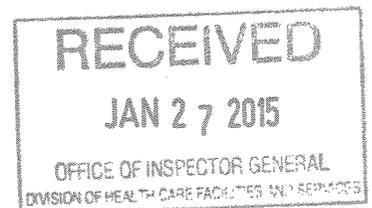
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F 441	<p>Continued From page 18</p> <p>repairs. The maintenance person took this cart into Rooms 112, 109, and 115.</p> <p>Interview with the Maintenance Director, on 12/17/14 at 11:58 AM, revealed taking the maintenance cart from one room to the next could cause the spread of infection. He stated a new lockable cart, that could stay in the hallway would be better.</p> <p>4. No policy was provided regarding using a clean field to set up medications for administration.</p> <p>The facility did not provide a policy for disinfection and cleaning of non-dedicated resident care equipment after use for individual residents.</p> <p>Observation, on 12/17/14 at 8:25 AM, revealed RN #4, carried a pill crusher and an opened container of apple sauce (dated 12/17/14), from the medication cart for residents in rooms 111-119, into to room 111-A and crushed the resident's medications at the bedside. RN #4 did not clean the resident's overbed table or create a clean field before she placed the pill crusher and apple sauce container on the over-bed table. Upon completing the resident's care, RN #4 returned the pill crusher to the medication cart and left the apple sauce container in the resident's room. She assisted the resident to the 100 Unit dining area, returned to the med cart, obtained a disinfectant wipe, and wiped off the top and sides of the pill crusher. RN #4 did not clean the bottom of the pill crusher which had made contact with the surface of the over-bed table.</p>	F 441			



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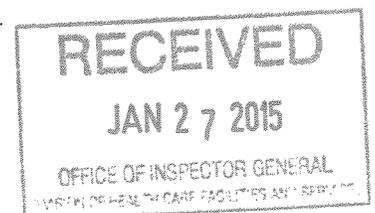
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F 441	<p>Continued From page 19</p> <p>Observation, on 12/17/14 at 11:30 AM, revealed the medication cart for resident rooms 111-119 was stationed in the storage room on the 100 Unit. An opened container of apple sauce was on the medication cart (dated with a blue marker as opened on 12/17/14). The apple sauce was on surface of the cart.</p> <p>Interview, on 12/17/14 at 11:45 AM, with RN #4 revealed once she removed the pill crusher from Room 111-1, she placed it back on the medication cart, cleaned it with a disinfectant wipe, but did not clean the bottom of the pill crusher. RN #4 stated she eventually returned the apple sauce container to the medication cart, but failed to clean the exterior of the container before placing it back on the cart. RN #4 stated the apple sauce should have been placed in the container of ice on the medication cart. RN #4 stated that placing non-dedicated resident care equipment on potentially contaminated surfaces and then not properly cleaning them after use, increased the risk for cross-contamination and the spread of infections. RN #4 stated the medication cart's surface was used to prepare medications for many residents, and it should be kept as clean as possible.</p> <p>5. Observation, on 12/17/14 at 9:55 AM, revealed RN #4 entered Resident #7's room to administer the resident's medications. RN #4 stated she did not have a blood pressure cuff, so she left the room to obtain the cuff. Upon returning to Resident #7's room, RN #4 washed her hands at the sink in the resident's restroom, but turned off the faucet handles with her bare hands.</p>	F 441			



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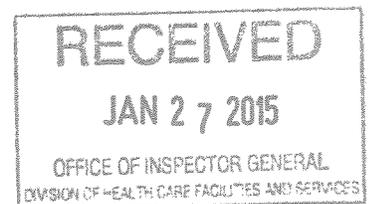
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F 441	<p>Continued From page 20</p> <p>Observation, on 12/17/14 at 10:05 AM, revealed RN #4 went into Resident #7's restroom and flushed the toilet, but did not wash or sanitize her hands after touching the toilet handle. RN #4 returned to Resident #7's bedside to administer the resident's blood pressure medication.</p> <p>Interview, on 12/17/14 at 11:45 AM, with RN #4 revealed she realized she had not turned off the faucet handles with a paper towel after she washed her hands, and that improper handwashing technique increased the risk for cross-contamination and the spread of infections to Resident #7 and to others.</p> <p>Interview, on 12/18/14 at 2:10 PM, with RN #3 Unit Manager (UM) for the 100 Unit, revealed all direct care staff should follow the facility's policy for handwashing in order to prevent the spread of infections. The UM stated staff should always use a paper towel to turn off the faucet handles, after washing their hands, as the faucet handles were considered dirty.</p> <p>6. Review of the facility's policy regarding Catheterization, not dated, revealed catheter tubing must be off the floor at all times.</p> <p>Observation of Unsampled Resident #A, on 12/17/14 at 4:48 PM, revealed the resident was in a wheelchair using their feet to propel the wheelchair forward. The bedside drainage bag attached to the indwelling catheter was in direct contact with the floor.</p> <p>Observation, on 12/18/14 at 8:26 AM, revealed Unsampled Resident A was seated in his/her wheelchair near the 100 Unit nurses' station. The resident's indwelling catheter tubing and the</p>	F 441		



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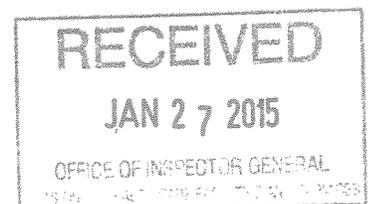
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F 441	<p>Continued From page 21</p> <p>attached urine collection bag was touching the floor.</p> <p>Interview, on 12/18/14 at 8:27 AM, with Unsampled Resident A revealed he/she did not self-transfer to his/her wheelchair, but was assisted by staff.</p> <p>Observation, on 12/18/14 at 10:32 AM, revealed Unsampled Resident A's catheter tubing and collection bag continued to touch the floor, and a scraping sound was heard as the bag was dragged across the floor when the resident self-propelled his/her wheelchair.</p> <p>Interview, on 12/18/14 at 10:33 AM, with RN #3, revealed Unsampled Resident A did not self-transfer to his/her wheelchair, but staff on the third shift had transferred him/her from the bed to the wheelchair earlier that morning. RN #3 stated it would have been that staff person's responsibility to ensure the catheter tubing and bag was secured to remain off the floor. RN #3 further stated any nursing staff member who saw a resident's catheter tubing or collection bag touching the floor should adjust the bag and tubing to ensure both parts of the drainage system remained off the floor.</p> <p>Interview, on 12/18/14 at 11:15 AM, with Certified Nursing Assistant (CNA) #6 revealed when transferring a resident to his/her wheelchair, the indwelling catheter tubing and the attached urine collection bag should always be secured to ensure the tubing and bag did not touch the floor, and this would be the responsibility of the staff person who transferred the resident to the wheelchair. CNA #6 stated it was unsanitary for the catheter's tubing and drainage bag to touch</p>	F 441			



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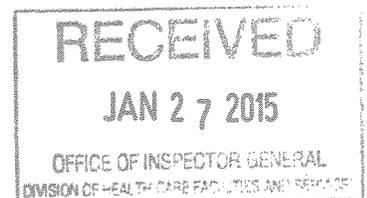
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F 441	<p>Continued From page 22</p> <p>the floor, and this could increase the resident's risk for infection.</p> <p>Interview, on 12/18/14 at 2:40 PM, with the Director of Nursing (DON), revealed residents' medications should be prepared at the medication cart and then administered to the resident in his/her room. Pill crushers should remain on the medication cart, but once used for resident care needs, any piece of non-dedicated equipment should be properly/completely disinfected before being returned to the medication cart. The DON further stated the staff was to follow the facility's step-wise process for handwashing. The DON stated the dominating concern with breaks in the facility's handwashing policy was an increased risk for the spread of infections throughout the facility.</p> <p>7. Review of the facility's Dressing Change Policy and Procedure, not dated, revealed the proper procedure included: remove soiled dressing and dispose of per Exposure Control Policy; remove gloves; wash hands; apply new disposable gloves; cleanse wound as ordered; and apply a clean dressing and secure.</p> <p>Observation by two (2) surveyors of Resident #1's skin assessment and wound dressing change, on 12/17/14 at 2:20 PM, by License Practical Nurse (LPN) #4 revealed after the soiled dressing was removed from Resident #1's left heel and disposed of, LPN #4 did not wash her hands prior to applying a new pair of disposable gloves.</p> <p>Interview with LPN #4, on 12/17/14, at 3:30 PM, revealed she stated she should have washed her hands after removing her old gloves and before</p>	F 441			



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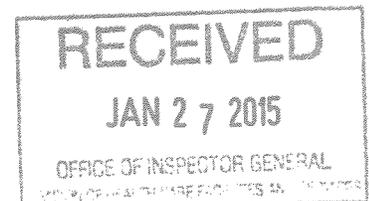
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F 441	Continued From page 23 putting on a clean pair of disposable gloves. LPN #4 stated by not washing her hands prior to donning a clean pair of disposable gloves infection could be spread. Interview with the Director of Nursing, on 12/18/14, at 1:30 PM, revealed the proper wound care procedure was to wash hands after disposing of soiled disposable gloves and before applying a new pair of disposable gloves.	F 441	F514 1. The pharmacy was notified of resident #15's allergy on 12/15/14 by the unit manager and the medication record was updated by licensed nursing staff to include the Rocephin allergy. 2. An initial medical record audit was completed by the regional nurse, medical record staff and clinical ambassador on 12/17/14 during annual survey in the facility to identify any resident with an allergy that is not reflected on the physician order sheet, medication record or clinical record any discrepancy that was identified was immediately corrected and the pharmacy was notified via fax.		
F 514 SS=D	483.75(l)(1) RES RECORDS-COMplete/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interviews and record review, it was determined the facility failed to communicate an allergy for one (1) of twenty-four (24) sampled residents, (Resident #15). The facility staff failed to document an allergy to Rocephin in the clinical record which resulted in the resident receiving the	F 514	A second audit was completed on 1/15/15 and 1/16/15 by the director of clinical services, assistant director of clinical services, unit manager and medical records to identify any resident that had allergies that were not listed on the medication record, face sheet, clinical record or physician order sheet. Any discrepancy was immediately corrected by licensed nursing staff.		



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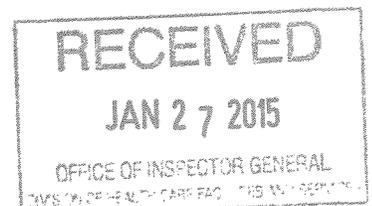
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F 514	<p>Continued From page 24 medication.</p> <p>The findings include:</p> <p>Interview with a family member of Resident #15, on 12/16/14 at 3:50 PM, revealed concerns that the resident had been given Rocephin and that the resident was allergic to Rocephin. She stated the resident had red skin rash when he/she had been given Rocephin in the past.</p> <p>Review of the Interdisciplinary Progress Notes, dated 09/03/14 at 5:30 PM, revealed documentation that the nurse had written Resident #15 had no reaction to receiving Rocephin.</p> <p>Continued review of the Interdisciplinary Progress Notes, dated 09/03/14 at 6:15 PM, revealed there was a nurses note that documented Resident #15 had a reaction to Rocephin and an order to give Benadryl was obtained from the physician. There was no description of the reaction such as a rash or itching.</p> <p>Review of the Advanced Practice Registered Nurse (APRN) assessment sheet, dated 09/25/14, revealed the resident had an allergy to Rocephin.</p> <p>Interview with the facility's physician, on 12/17/14 at 3:40 PM, revealed Resident #15 had been given Rocephin in the fall (September he thought) and the staff had told the daughter this was the antibiotic Resident #15 had been placed on. The daughter told staff the resident was allergic to Rocephin. To his knowledge Resident #15 had no reaction to having been given the Rocephin. In addition, he stated he did not feel Resident # 15</p>	F 514	<p>3. The policy and procedure for allergies was reviewed by the director of executive director on 1/15/15 and revised to include a more detailed chart audit on admission regarding allergies. The director of medical records is required to complete admission audits within 72 hours of admission. The executive director educated the medical record staff regarding the revision of the admission audit tool on 1/15/15.</p> <p>Licensed nursing staff is responsible for faxing the allergy information to the pharmacy, applying an allergy sticker to the clinical record and updating the medication administration records when a resident is admitted to the facility or a new allergy is identified.</p> <p>Verbal education regarding this process was initiated following the annual survey and written competencies were initiated on 1/15/14 by the director of clinical services and administrative nursing staff.</p>		



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F 514	<p>Continued From page 25</p> <p>was allergic to Rocephin, but because the family stated that Resident #15 was allergic, it should have been communicated to Pharmacy and added to the resident's clinical record as an allergy. He was aware Rocephin was again ordered for Resident #15 on December 15, 2014. Staff did not notify the physician of the allergy when the Rocephin was given in September. He stated the Rocephin allergy should have been communicated to him and the Pharmacy in September 2014.</p> <p>Review of the Medication Administration Record (MAR), dated 12/01/14, revealed the MAR, in the allergy area, it was documented that the resident had no allergies. Review of the Physician Order Sheet, dated 12/01/14, in the allergies area was written, no known drug allergies.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 12/18/14 at 9:35 AM, revealed Resident #15 had received intramuscular (IM) injections of Rocephin four (4) times with no reactions on 12/9/14 thru 12/12/14. In addition he stated the resident never reported shortness of breath or itching.</p> <p>Interview with the Unit Manager LPN #1, on 12/18/14 at 9:50 AM, revealed on 12/13/14 when the family member told her of the Rocephin allergy she placed the information on the twenty-four (24) hour report. On 12/16/14 Pharmacy was notified of the allergy to Rocephin after 4:05 PM. In addition, she stated the allergy should have been added in September 2014 and communicated to the Pharmacy when it was first reported.</p>	F 514	<p>4. On 1/15/15 an Allergy Audit Tool was created by the clinical ambassador and approved by the executive director. The director of clinical services, executive director, assistant director of clinical services and administrative nursing staff will conduct Quality Improvement (QI) monitoring of regulation F514 by auditing staff compliance with allergy documentation on the medication records, documentation in the clinical record, physician orders sheet and pharmacy notification. Each auditor will be responsible for a minimum of five clinical record audits five times a week for four weeks, weekly for 8 weeks and monthly for 3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.</p> <p>5. The administrator is responsible for this process. Compliance Date is 02/02/15: <i>1-31-15</i> <i>rn C Ortega</i> <i>by PB 2-3-15</i></p>		



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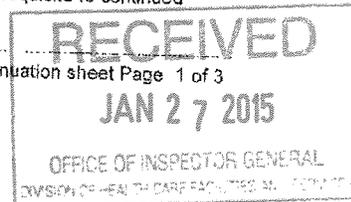
PRINTED: 12/19/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 12/16/2014
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991, original building and 1995, sub-acute addition.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Nine (9) smoke compartments.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors, upgraded in 1995.</p> <p>SPRINKLER SYSTEM: Complete automatic (dry) sprinkler system, hydraulically designed.</p> <p>GENERATOR: Type II, 100 KW, fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey, utilizing the 2786S Short Form, was conducted on 12/16/14. The facility was found not in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>K072</p> <ol style="list-style-type: none"> The director of maintenance removed the orange tape, weight chair, recliner and wheel chair from the 100 hall exit access on 12/16/14. The director of maintenance completed a facility tour on 12/16/14 and no other egress concerns were identified. All staff are required to maintain clear exit door egress. The systemic change required staff education. The executive director educated the director of maintenance and assistant maintenance staff regarding the requirement for K072 on 12/16/14. <p>Verbal education regarding this process was initiated following the annual survey and written competencies were initiated on 1/16/14 by the director maintenance, director of clinical services and administrative nursing staff.</p> <ol style="list-style-type: none"> On 1/16/15 an Exit Door Egress Obstruction Audit Tool was created by the clinical ambassador and approved by the executive director. The executive director, director of maintenance and maintenance assistant will conduct Quality Improvement (QI) monitoring of 	

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

[Signature] Executive Director 01/16/15

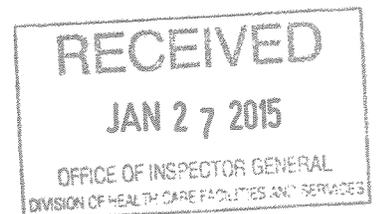
Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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K 000	Continued From page 1	K 000	regulation K072 by monitoring exit doors to ensure that doors are not blocked by wheel chairs or equipment. Each auditor will be responsible for a minimum of five tours a week for four weeks, weekly tours for 8 weeks and tours monthly for 3 months. Any concerns identified throughout the QI process will be immediately addressed to ensure compliance is sustained. The results of these audits will be submitted to the QAPI Committee monthly. The QAPI Committee will determine if additional education or auditing is required.		
K 072 SS=E	Deficiencies were cited with the highest deficiency identified at an E level. CFR: 42 CFR 483.70(a) NFPA 101 LIFE SAFETY CODE STANDARD Means of egress are continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from, or visibility of exits. 7.1.10 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to maintain exit access corridors in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect two (2) of nine (9) smoke compartments, residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and twenty-four (124) on the day of the survey. The facility failed to ensure the means of egress were free of all obstructions or impediments to exiting the building in the event of an emergency. The findings include: 1. Observation, on 12/16/14 at 9:07 AM, with the Plant Operations Director, revealed the 100 Hall exit access corridor had a weight chair, a recliner and a wheel chair stored on one side of the	K 072			



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K 072	<p>Continued From page 2</p> <p>corridor with a storage area marked on the floor with orange tape.</p> <p>Interview, on 12/16/14 at 9:09 AM, with the Plant Operations Director, revealed he was aware the items were stored in the corridor and the floor marked with orange tape to designate a storage space. He had been misinformed that storage was permissible as long as it was on one side of the corridor only.</p> <p>Observation, on 12/16/14 at 9:23 AM, with the Plant Operations Director revealed the Oxygen Corridor had a bariatric bed, a shower bed, a wheel chair, and a mobile scale stored on one side of the corridor.</p> <p>Interview, on 12/16/14 at 9:25 AM, with the Plant Operations Director revealed he was not aware of the items being stored in the Oxygen Corridor, how long they had been stored there or who had placed them there.</p> <p>The census of one-hundred and twenty-four (124) was verified by the Administrator on 12/16/14. The findings were acknowledged by the Administrator and verified by the Plant Operations Director at the exit interview on 12/16/14.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>Means of Egress Reliability 7.1.10.1 Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency.</p>	K 072		

