

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

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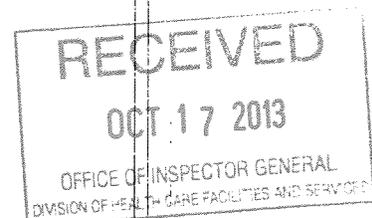
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 09/12/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
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F 431	<p>Continued From page 26</p> <p>09/12/13 at 5:10 PM, revealed the facility did not have a written policy regarding routine cleaning of medication carts.</p> <p>Observation of the medication carts on the 100 Unit, on 09/11/13 at 8:23 AM, revealed Cart #1's pill crusher was heavily soiled with black and brown sticky residue with bits of brown debris. The bottom of the bin holding the drinking cups and pill cups was soiled with brown debris. Some of the drawers were labeled with soiled tape. The inside drawers, where medications were stored, were also soiled. Cart #2 was similarly soiled with black and brown sticky residue on the pill crusher, drawers were labeled with soiled tape, and the bottom of the bin holding the drinking cups and pill cups had brown and white debris. Inhalant medication was co-mingled with nasal sprays.</p> <p>Observation of the medication carts on the Subacute I Unit, on 09/11/13 at 8:45 AM, revealed Cart #1's pill crusher was heavily soiled with black and brown sticky residue, an open container of applesauce was on the cart and the bottom of the cup bin had brown and white residue present. Cart #1 had a wrist blood pressure meter stored on the top. The face of the blood pressure cuff was soiled and smeared with a clear substance. Cart #2 had a soiled pill crusher with brown and black substances all around the edges. The bottom of the cup bin had white particles inside the bottom.</p> <p>Observation of the medication carts on the 200 Unit, on 09/11/13 at 9:03 AM, revealed Cart #1 had a Sharps container filled past the fill line, the pill crusher was soiled with a brown and black sticky substance and bits of brown debris. The</p>	F 431	<p>each respective medication cart are by 10/24/13.</p> <p>IV. The Director of Nursing or the Assistant Director of Nursing will inspect each medication cart, initially, to validate cleanliness and organization by 10/24/13. The Director of Nursing or the Assistant Director of Nursing will inspect 2 carts each weekly for four weeks, 2 carts each month for three months and quarterly, thereafter.</p> <p>On 10/18/2013 the facility's Quality Assurance Committee will meet to review the alleged deficient practice and the plan to ensure the method of cleaning, proper sanitizing and overall cleanliness is maintained in an orderly fashion each respective medication cart. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to review the validation tools, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate care plans are current and consistent with Resident assessments.</p> <p>V. Compliance Date: October 25, 2013</p>		



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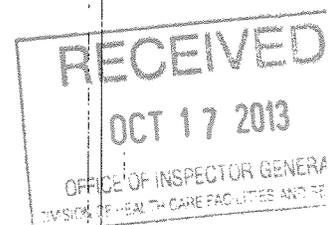
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F 431	<p>Continued From page 27</p> <p>bottom of the cup bin had brown and white particles. Cart #2 had labels adhered with soiled tape and the water pitcher on the cart had tape residue on the top which was blackened and had a sticky surface. The bottom of the cup bin had brown particles.</p> <p>Observation of the medication carts on the Subacute II Unit, on 09/11/13 at 2:26 PM, revealed Cart #1 had a pill crusher that was heavily soiled with brown and black sticky residue and white particles. The drawer holding bottles of liquid medication had large drips of red and white dried to the bottom of the drawer. There were gnat-like insects buzzing around the cart. The outside of the cart was soiled with drips as was the Sharps container attached to the side of the cart. The insides of the medication drawers were also soiled with debris and brown particles. Cart #2 had a soiled pill crusher with sticky brown and black residue present. The outside of the cart was soiled with dried drips.</p> <p>Interview with Licensed Practical Nurse (LPN) #2, on 09/11/13 at 8:45 AM, revealed all the nurses using the medication cart were responsible for cleaning the carts. He stated he wiped down the outside of the 100 Unit cart at the end of his shift daily. He stated the pill crusher and the inside of the cart was not clean.</p> <p>Interview with the 200 Unit Manager, on 09/11/13 at 10:50 AM, revealed the nurses were responsible to clean the medication carts; however, she was not aware of who was responsible to ensure the medication carts were cleaned.</p> <p>Interview with LPN #1, on 09/11/13 at 10:42 AM,</p>	F 431			



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F 431	Continued From page 28 revealed the medication carts on Subacute II were not clean on the inside and the pill crusher and Sharps containers were soiled. She stated the night shift nurses were responsible to clean the medication carts; however, there was no policy or cleaning schedule located. Interview with the Unit Manager for Subacute I, on 09/11/13 at 11:10 AM, revealed there was no cleaning schedule or policy that designated the responsibility for cleaning the medication carts. He stated the medication carts were not clean. Interview with the Director of Nursing, on 09/12/13 at 5:10 PM, revealed there was no schedule or policy for cleaning the medication carts; however, the night shift nurses were responsible. She stated the medication carts were not reviewed for cleanliness; however, the carts should be clean and sanitary.	F 431			
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.	F 441	F 441 INFECTION CONTROL: COMMUNICABLE DISEASES It is the practice of Hurstbourne Care Centre to maintain an Infection Control Program to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. I. Resident #24 no longer resides in the facility. Resident #1's face mask was cleaned and sanitized to prevent the spread of infection by the Assistant Director of Nursing on 9/26/2013. The Resident face mask is stored in a plastic bag when not in use. Resident F's gloves, briefs and tube feeding supplies were discarded by the Assistant Director of Nursing on 9/26/2013. were discarded, the air conditioning unit was cleaned and the clean supplies are stored in a sanitary manner. II. All Residents have the potential to be affected by this alleged deficient practice regarding compliance with isolation guidelines. Facility Residents		



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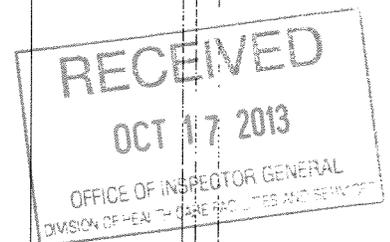
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F 441	Continued From page 29 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit 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 hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and facility policy, it was determined the facility failed to follow isolation guidelines for one (1) of twenty-four (24) sampled residents (Resident #24) with positive Clostridium Difficile cultures. In addition, the facility failed to ensure medical equipment used for two (2) of twenty-four (24) sampled residents and seven (7) unsampled residents' care (Resident #1 and Unsampled Resident F) was stored in a sanitary manner. The findings include: Review of the facility's policy for Contact Precautions, undated, revealed residents with	F 441	were reviewed to ensure respiratory equipment is stored in a bag when not in use by the Unit Managers by 10/24/2013. Any discrepancies noted were immediately addressed upon identification by the Director of Nursing and/or the Assistant Director of Nursing at that time. III. All staff will be re-educated by the, Director of Nursing/Assistant Director of Nursing/Nurse Manager to ensure the facility maintains infection control practices which provide a safe, sanitary and comfortable environment to help prevent the development and transmission of disease and infection with additional emphasis on communicating potential risks identified to their supervisor for intervention by 10/24/2013. The systemic change includes Administrative development of a Quality Assurance Room Round Sheet, developed on 10/05/2013, to identify any potential infection control concerns to include isolation precautions, reparatory equipment storage when not in use. The QA Round Sheets to be utilized by the Interdisciplinary Team, effective 10/18/13. IV. QI monitoring will be conducted by the Interdisciplinary Team	



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F 441	<p>Continued From page 30</p> <p>Clostridium Difficile (C. diff) would be placed in contact precautions. No policy was provided for storage of resident medical equipment.</p> <p>Review of the clinical record for Resident #24, revealed the facility admitted the resident with diagnoses of Congestive Heart Failure, C. diff and Hypertension. The facility completed an Admission Minimum Data Set (MDS) assessment, on 06/21/13, which revealed the resident required limited assistance with daily living tasks. The admission orders from the physician included an antibiotic to be given for two (2) months for C. diff.</p> <p>Review of the laboratory test results for C. diff, on 07/01/13, revealed the resident had positive results for C. diff antigens and toxins with communicability of disease as high if diarrhea was present. The laboratory test results for C. diff, on 07/20/13, revealed the C. diff antigen was positive and assumed the resident's disease was communicable until toxin production was determined. The final report was received on 07/23/13 which indicated the toxin production by the C. diff was negative.</p> <p>Review of the nursing notes, for 07/11/13, revealed the resident continued with loose stools and was incontinent of bowel at that time. The resident continued to feel bad.</p> <p>Review of the nursing notes, for 07/13/13, revealed the resident still had loose stools.</p> <p>Review of the nursing notes, for 07/17/13, revealed the resident continued with diarrhea.</p> <p>Interview with Certified Nurse Aide (CNA) #4, on</p>	F 441	<p>members on facility resident rooms 3/week for 4 weeks, then 2/week for 3 months and quarterly thereafter. Any performance improvement issues will be elevated up to the Nursing Home Administrator/Director of Clinical Services for immediate intervention. On 10/18/13, the facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction and plan to monitor ongoing compliance.</p> <p>V. Compliance Date: October 25, 2013.</p>		



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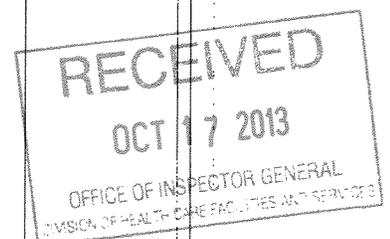
F 441	<p>Continued From page 31</p> <p>09/12/13 at 10:00 AM, revealed Resident #24 had loose stools for several weeks after admission and was incontinent of bowel at times. She stated the resident was in isolation; however, the resident did leave the room and walk up and down the hallway many times while in isolation. She stated the resident wore a brief. She stated she was not sure what type of isolation the resident required, but everyone knew to wash their hands and wear gloves to prevent the spread of the germs. She stated she had been trained on isolation.</p> <p>Interview with the Subacute I Unit Manager, on 09/12/13 at 10:10 AM, stated Resident #24 was in contact precautions for C. diff. He stated the resident was continent and the C. diff was contained. He stated he had been trained on contact precautions.</p> <p>Interview with the Director of Nursing, on 09/12/13 at 5:10 PM, revealed residents in contact precautions for C.diff should not be out and about the facility until their symptoms were resolved. She stated the infection could be spread by residents to others.</p> <p>Observation of Resident #1, on 09/10/13 at 12:25 PM, and on 09/11/13 at 8:05 AM, revealed the resident's face mask used for administration of inhalant medications was stored on top of the mini-neb machine uncovered.</p> <p>Interview with LPN #1, on 09/11/13 at 10:42 AM, revealed the face mask for mini-neb treatments should be covered when not in use to prevent it from becoming contaminated with debris. She stated she had been trained in infection control.</p>	F 441		
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F 441	Continued From page 32 Observation of Unsampled Resident F, on 09/11/13 at 8:25 AM, revealed the resident's supply of clean gloves, clean briefs and clean tube feeding supplies were stored on top of a soiled room air conditioning unit which was turned on. Interview with CNA #3, on 09/11/13 at 2:08 PM, revealed the nursing supplies should not be stored on top of the air conditioning unit. She stated the unit had brown dried substances and brown particles on top of the unit and germs could be coming out of the air unit. She stated she had been trained in infection control.	F 441		
F 514 SS=C	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 interview, record review and facility policy titled Legal Signature, it was determined the facility failed to maintain an accurate Medication Administration Record (MAR) and	F 514	F 514 CLINICAL RECORDS It is the practice of Hurstbourne Care Centre to ensure each Resident's clinical records is in accordance with acceptable professional standards and practices that are complete, accurately documented and readily accessible and systematically organized. I. No negative outcomes resulted from the facilities failure to include a Master Signature Sheet in the Residents Medical Record. All Residents have the potential to be impacted by the alleged deficient practice. II. On 9/26/13 the systemic change includes the Director of Nursing's development implementation of a Master Signature Sheet to include reference date, employee printed name, signature and initials. The Director of Nursing, Assistant Director or the Unit Managers ensured the Master Signature Sheets are present in the MAR & TAR books during the October MAR & TAR changeover on 9/30/13. On 9/26/13, all licensed nurses were reeducated regarding the Master Signature Sheets and	



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F 514	<p>Continued From page 33</p> <p>Treatment Administration Record (TAR) for one hundred twenty-one (121) of the one hundred twenty-one (121) residents in the facility with signatures and coinciding initials to provide an accurate medical record.</p> <p>The findings include:</p> <p>Review of the facility's policy titled Legal Signature, Revised 01/04/13, revealed in order to provide a legal reference of those individuals documenting in the medical record, nursing personnel are required to provide a record of their signature and coinciding initials.</p> <p>Record review of the MAR and TAR records on all units revealed a signature sheet with coinciding initials was not present with the records.</p> <p>Record review of the Master Signature Log with noted signatures and matching initials provided by Medical Records, undated, revealed in the space designated for the initials which would coincide with the signature, of the thirty-nine (39) individuals that had signed, initials were missing on thirteen (13) of the names, with a title in place of the initials. Without the reference date, it was not known if current employees were listed.</p> <p>Record review of a Master Signature Sheet provided by Medical Records, with the first signature dated 12/21/12 and the last one dated 9/11/13, revealed a form with four (4) columns. A column each for the printed name, the written name, initials and the date. The form was incomplete. Names were not all printed and titles were in place of initials. Seventy-seven (77) was the total of names listed and only twenty-eight</p>	F 514	<p>their respective placement in the MAR & TAR books.</p> <p>III. On 9/30/13, the Director of Nursing, Assistant Director of Nursing or Nursing Designee conducted an initial 100% audit of the MAR & TAR books to validate accuracy and placement of the Master Signature Logs, validating the Master Signature Sheets were in the MAR & TAR books. The Unit Managers will review 8 MAR & TAR Books weekly for 4 weeks, monthly for 3 months and quarterly thereafter to ensure the Master Signature Logs are in the MAR & TAR books, effective 10/24/13.</p> <p>The facility's Quality Assurance Committee will meet on 10/18/2013 to review the alleged deficient practice; plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members.</p> <p>IV. Compliance Date: October 25, 2013.</p>		

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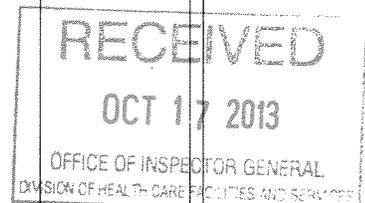
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F 514	<p>Continued From page 34</p> <p>(28) signed their initials, others had listed the abbreviation for their title instead of their initials.</p> <p>Interview, on 09/12/13 at 10:15 AM, with Medical Records revealed the person signing the MAR or TAR was supposed to put an initial in the designated box. She revealed it was the responsibility of the Unit Manager to check to make sure the staff were signing the log. She stated each new nurse signed the log, however, the log provided revealed abbreviations for titles, not initials, were documented. She stated the purpose of the log was to make sure staff signatures and initials were a matter of record. She stated she had never been responsible to make sure the log was kept and accurate.</p> <p>Interview, on 09/12/13 at 5:10 PM, with the Director of Nursing (DON) revealed the Unit Managers were responsible for the Signature Log Sheet. She stated the sheets were not current.</p> <p>Interview, on 09/12/13 at 5:16 PM, with the 100 Unit Manager revealed she was not aware she was responsible for the signature log. She revealed there were no sign in logs for the MAR and TAR on the 100 unit. The 100 Unit Manager stated it was important to maintain a signature log so you would know who had signed for a treatment or medication.</p>	F 514			

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F 514	<p>Continued From page 34</p> <p>(28) signed their initials, others had listed the abbreviation for their title instead of their initials.</p> <p>Interview, on 09/12/13 at 10:15 AM, with Medical Records revealed the person signing the MAR or TAR was supposed to put an initial in the designated box. She revealed it was the responsibility of the Unit Manager to check to make sure the staff were signing the log. She stated each new nurse signed the log, however, the log provided revealed abbreviations for titles, not initials, were documented. She stated the purpose of the log was to make sure staff signatures and initials were a matter of record. She stated she had never been responsible to make sure the log was kept and accurate.</p> <p>Interview, on 09/12/13 at 5:10 PM, with the Director of Nursing (DON) revealed the Unit Managers were responsible for the Signature Log Sheet. She stated the sheets were not current.</p> <p>Interview, on 09/12/13 at 5:16 PM, with the 100 Unit Manager revealed she was not aware she was responsible for the signature log. She revealed there were no sign in logs for the MAR and TAR on the 100 unit. The 100 Unit Manager stated it was important to maintain a signature log so you would know who had signed for a treatment or medication.</p>	F 514			



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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2013
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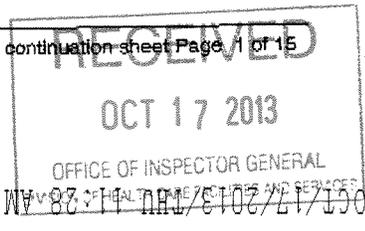
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK	STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1991, original building and 1995, sub-acute addition.</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: S/NF DP</p> <p>TYPE OF STRUCTURE: One (1) story, Type III Unprotected.</p> <p>SMOKE COMPARTMENTS: Five (5) 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 standard Life Safety Code survey was conducted on 09/10/13. Hurstbourne Care Center at Stony Brook was found not to be in compliance with the Requirements for Participation in Medicare and Medicaid.</p> <p>The findings that follow demonstrate noncompliance with Title 42, Code of Federal Regulations, 483.70(a) et seq. (Life Safety from Fire)</p>	K 000	<p>This plan of correction is to serve as Hurstbourne Care Centre's credible allegation of compliance.</p> <p>Submission of this plan of correction does not constitute an admission by Hurstbourne Care Centre's or its management company that the allegations contained in the survey report is a true and accurate portrayal of the provision of nursing care and other services in this facility. Nor does this submission constitute an agreement or admission of the survey allegations.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X8) DATE 10/17/13
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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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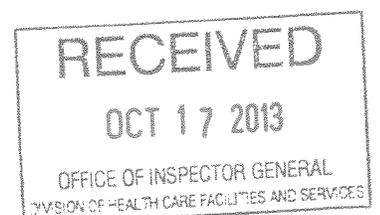
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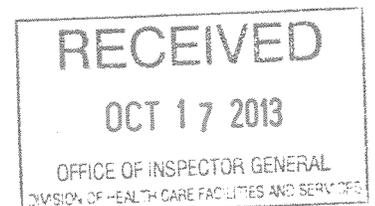
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K 000	Continued From page 1	K 000		
K 029 SS=D	<p>Deficiencies were cited with the highest deficiency identified at F level. CFR: 42 CFR 483.70(a)</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to meet the requirements for Protection of Hazards, in accordance with NFPA standards. The deficiency had the potential to affect two (2) of five (5) smoke compartments, approximately sixty (60) residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and twenty-one (121) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 09/10/13 at 9:58 AM, with the Operations Manager revealed the door to the</p>	K 029	<p>K 029</p> <p>It is the practice of Hurstbourne Care Centre to ensure doors are self closing and non-rated or field applied protective plates that do not exceed 48 inches from the bottom of the door are installed and properly utilized.</p> <ol style="list-style-type: none"> I. On Thursday, September 26, 2013, self-closing devices were installed on the Activities Storage Room door and the Medical Records Room on the Sub Acute Unit 1. II. All Residents have the potential to be effected by the alleged deficient practice. III. The Maintenance Director was educated by the Regional Operations Director on September 24, 2013, regarding the requirement to ensure that all doors are self closing and non-rated or field applied protective plates that do not exceed 48 inches from the bottom of the door are installed and properly utilized. Any audit was completed on all spaces larger than 50 Square feet, boiler rooms, bulk laundry rooms, paint shops, soiled linen rooms and trash collection rooms. The systematic change includes the validation of proper functioning of all doors self closing devices. IV. The Self Closing Door Audit was reviewed and validated by the Nursing Home Administrator on 	



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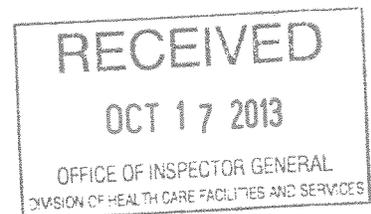
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K 029	<p>Continued From page 2</p> <p>Activities Storage Room, located within the 200 Unit, did not have a self-closing device installed on the door.</p> <p>Interview, on 09/10/13 at 9:58 AM, with the Operations Manager revealed he was not aware of the door to the Activities Storage Room not being equipped with a self-closing device.</p> <p>Observation, on 09/10/13 at 1:12 PM, with the Operations Manager revealed the door to the Medical Records Room, located within the Sub Acute 1 Unit, did not have a self-closing device installed on the door.</p> <p>Interview, on 09/10/13 at 1:12 PM, with the Operations Manager revealed he was not aware of the door to the Medical Records Room not being equipped with a self-closing device.</p> <p>Reference: NFPA 101 (2000 Edition). 19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms</p>	K 029	<p>September 27, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure the installation of 2 self closing door device were installed and subsequent audit tool. All self closing doors will be audited to ensure proper functioning, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate compliance.</p> <p>V. Compliance Date: October 21, 2013</p>	



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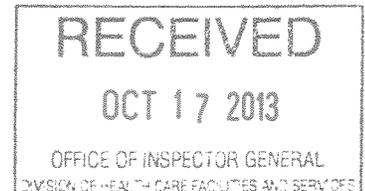
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K 029	Continued From page 3 (2) Central/bulk laundries larger than 100 ft2 (9.3 m2) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft2 (4.6 m2), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door. NFPA 101 LIFE SAFETY CODE STANDARD	K 029	K 045 It is the practice of Hurstbourne Care Centre to ensure that all illuminations of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness.	
K 045 SS=F	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. (This does not refer to emergency lighting in accordance with section 7.8.) 19.2.8 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure exits were equipped with emergency lighting in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, all residents, staff and visitors. The facility has one-hundred and thirty-two (132)	K 045	I. On September 19, 2013 2-300 watt bulb lights were installed in all 12 exit light fixtures. II. All Residents have the potential to be effected by the alleged deficient practice. III. The Maintenance Director was educated by the Regional Operations Director on September 24, 2013, regarding the requirement to ensure that all illuminations of egress, including exit discharge, is arranged so that failure of any single lighting fixture (bulb) will not leave the area in darkness. The systematic change includes the installation of the 2-300 watt bulb lights were installed in all 12 exit light fixtures being added to the facility's preventive maintenance program. IV. The Exit Door Light Audit completed on September 27, 2013. The Exit Door Light Audit was validated by the Nursing Home Administrator on September 27, 2013.	



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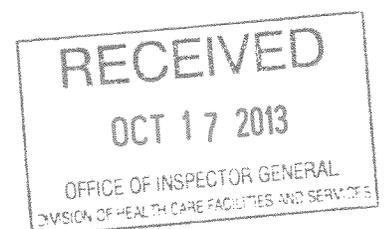
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K 045	<p>Continued From page 4</p> <p>certified beds and the census was one-hundred and twenty-one (121) on the day of the survey. The facility failed to provide the required illumination outside an exit for discharge.</p> <p>The findings include:</p> <p>Observations, on 09/10/13 between 9:42 AM and 1:49 PM, with the Operations Manager revealed all of the exterior egress light fixtures, did not have exterior egress lighting to provide the required illumination level for each exit discharge. The exits were equipped with a light fixture with only one bulb.</p> <p>Interview, on 09/10/13 between 9:42 AM, with the Operations Manager revealed he was not aware of the requirement for exterior light fixtures for egress to have two (2) bulbs.</p> <p>Reference NFPA 101 (2000 edition)</p> <p>19.2.8 Illumination of Means of Egress.</p> <p>Means of egress shall be illuminated in accordance with Section 7.8.</p> <p>7.8 ILLUMINATION OF MEANS OF EGRESS 7.8.1 General. 7.8.1.1* Illumination of means of egress shall be provided in accordance with Section 7.8 for every building and structure where required in Chapters 11 through 42. For the purposes of this requirement, exit access shall include only designated stairs,</p>	K 045	<p>The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure the installation of 2-300 watt bulb lights were installed in all 12 exit light fixtures and subsequent Exit Door Light Audit. All exit door lights will be audited to ensure proper functioning, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate compliance.</p> <p>✓ Compliance Date: October 21, 2013</p>	



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K 045	<p>Continued From page 5</p> <p>aisles, corridors, ramps, escalators, and passageways leading to an exit. For the purposes of this requirement, exit discharge shall include only designated stairs, aisles, corridors, ramps, escalators, walkways, and exit passageways leading to a public way.</p> <p>7.8.1.2 Illumination of means of egress shall be continuous during the time that the conditions of occupancy require that the means of egress be available for use. Artificial lighting shall be employed at such locations and for such periods of time as required to maintain the illumination to the minimum criteria values herein specified. Exception: Automatic, motion sensor-type lighting switches shall be permitted within the means of egress, provided that the switch controllers are equipped for fail-safe operation, the illumination timers are set for a minimum 15-minute duration, and the motion sensor is activated by any occupant movement in the area served by the lighting units.</p> <p>7.8.1.3* The floors and other walking surfaces within an exit and within the portions of the exit access and exit discharge designated in 7.8.1.1 shall be illuminated to values of at least 1 ft-candle (10 lux) measured at the floor. Exception No. 1: In assembly occupancies, the illumination of the floors of exit access shall be at least 0.2 ft-candle (2 lux) during periods of performances or projections involving directed light. Exception No. 2*: This requirement shall not apply where operations or processes require low lighting levels.</p> <p>7.8.1.4* Required illumination shall be arranged so that the failure of any single lighting unit does not</p>	K 045		



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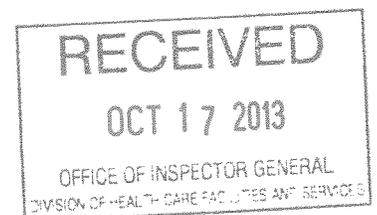
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K 045 K 054 SS=E	<p>Continued From page 6 result in an illumination level of less than 0.2 ft-candle (2 lux) in any designated area.</p> <p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure smoke detectors were installed in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the five (5) 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-one (121) on the day of the survey.</p> <p>The findings include:</p> <p>Observations, on 09/10/13 between at 9:16 AM and 12:32 PM, with the Operations Manager revealed the individual battery-powered smoke detectors installed in the Resident 's Rooms had been located on a side wall, approximately three (3) feet down from the finished ceiling.</p> <p>Interviews, on 09/10/13 between 9:16 AM and 12:32 PM, with the Operations Manager, revealed he was unaware of the battery-powered smoke detectors being installed outside of the</p>	K 045 K 054	<p>K 054 It is the practice of Hurstbourne Care Centre to ensure that smoke detectors are installed in accordance with the NFPA standards.</p> <p>I. All of the battery powered smoke detectors were removed on September 20, 2013 by the Operations Manager.</p> <p>II. All of the Residents have the potential to be effected by the alleged deficient practice.</p> <p>VI. The Maintenance Director was educated by the Regional Operations Director on September 20, 2013, regarding the requirement to ensure that all smoke detectors are installed in accordance with the NFPA standards. The systematic change includes the removal of all battery operated smoke detectors and the additions of ensuring battery operated smoke detectors are not installed in the facility to the preventive maintenance program.</p> <p>III. The Smoke Detector Audit will be completed by October 4, 2013 to ensure all battery operated smoke detectors have been removed. The Smoke Detector Audit will be validated by the Nursing Home Administrator on October 4, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social</p>	15

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K 054	Continued From page 7 acceptable range of four (4) to twelve (12) inches down from the finished ceiling. Reference: NFPA 72 (1999 Edition) 5.7.3.2* Spot-Type Smoke Detectors. 5.7.3.2.1* Spot-type smoke detectors shall be located on the ceiling not less than 100 mm (4 in.) from a sidewall to the near edge or, if on a sidewall, between 100 mm and 300 mm (4 in. and 12 in.) down from the ceiling to the top of the detector.	K 054	Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure that all smoke detectors are installed in accordance with the NFPA standards.	
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview it was determined the facility failed to maintain the sprinkler system in accordance with NFPA standards. The deficiency had the potential to affect three (3) of the five (5) smoke compartments, approximately seventy-five (75) residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and twenty-one (121) on the day of the survey. The facility failed to ensure items were not stored within eighteen (18) inches from any sprinkler heads and sprinkler head spray patterns were not obstructed..	K 062	and subsequent Smoke Detector Audit. A Smoke Detector Audit will be completed, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate compliance to ensure no battery powered smoke detectors are installed. IV. Compliance Date: October 21, 2013	



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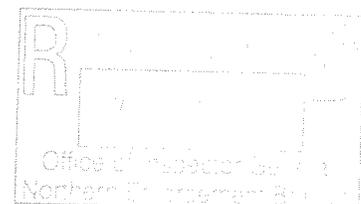
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
K 062	<p>Continued From page 8</p> <p>The findings include:</p> <p>Observation, on 09/10/13 at 8:57 AM, with the Operations Manager revealed items were stored within eighteen (18) inches of the sprinkler head in the storage closet located within the Activities Room.</p> <p>Interview, on 09/10/13 at 8:57 AM, with the Operations Manager revealed he was not aware of items being stored within eighteen (18) inches of the sprinkler head in the storage closet located within the Activities Room.</p> <p>Observations, on 09/10/13 between 12:48 PM and 1:15 PM, with the Operations Manager revealed the sprinkler head in the Riser Room, located within the Sub-acute 1 Unit and the sprinkler head in the Director of Nursing (DON) Office, had its spray patterns obstructed by surface mounted fluorescent light fixtures. The light fixtures were positioned less than four (4) inches from the sprinkler heads and extended further down from the ceiling than the sprinkler head diffusers did.</p> <p>Interviews, on 09/10/13 between 12:48 PM and 1:15 PM, with the Operations Manager revealed he was unaware the light fixtures had obstructed the spray patterns of the sprinkler heads located in the Riser Room and the DON Office.</p> <p>Reference:</p>	K 062	<p>K 062</p> <p>It is the practice of Hurstbourne Care Centre to ensure the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested, periodically.</p> <ol style="list-style-type: none"> I. All items were removed from the Activities Storage Room to ensure at least an 18 inch clearance from the sprinkler head. The fluorescent light fixtures were moved greater than 4 inches from the sprinkler heads in the Riser Room on Sub Acute Unit 1 and the Director of Nursing's Office by the Operations Director on September 20, 2013. II. All Residents have the potential to be effected by the alleged deficient practice. III. The Maintenance Director was educated by the Regional Operations Director on September 20, 2013, regarding the requirement to ensure the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested, periodically. The systematic change includes the addition of rounds to ensure there are no hindrances to the proper functioning of the sprinkler heads to the facility's preventive maintenance program. IV. The Nursing Home Administrator validated on October 4, 2013 all items were removed from the



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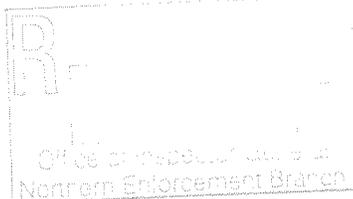
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, 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) COMPLETE DATE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE and tested, periodically. The systematic change includes the addition of rounds to ensure there are no hindrances to the proper functioning of the sprinkler heads to the facility's preventive maintenance program.	(X5) COMPLETION DATE
K 062	Continued From page 9 NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2. Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head. NFPA 25 (1998 Edition) 2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected. NFPA 101 (2000 Edition) 4.6.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition.	K 062	IV. The Nursing Home Administrator validated on October 4, 2013 all items were removed from the Activities Storage Room to ensure at least an 11 inch clearance from the sprinkler head The fluorescent light fixtures do not hang down lower than the diffusers in the Riser Room on Sub Acute Unit 1 and the Director of Nursing's Office by the Operations Director as of September 20, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected to be at least an 18 inch clearance from a sprinkler head and a items are at least 4 inches from the sprinkler heads and do not extend further down than the diffusers. An Audit will be completed, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate compliance to ensure that all items are at least an 18 inch clearance from a sprinkler head and all items are at least 4 inches from the sprinkler head and do not extend further down than the diffusers.	
K 069 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		



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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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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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K 062	Continued From page 9 NFPA 13 (1999 Edition) 5-5.5.2* Obstructions to Sprinkler Discharge Pattern Development. 5-5.5.2.1 Continuous or noncontiguous obstructions less Than or equal to 18 in. (457 mm) below the sprinkler deflector That prevent the pattern from fully developing Shall comply with 5-5.5.2. Table 5-6.5.1.2. Positioning of sprinklers to avoid obstructions to discharge requires at least one foot clearance between sprinkler heads and obstructions to spray patterns that are level with or taller than the sprinkler head. NFPA 25 (1998 Edition)	K 062	IV. The Nursing Home Administrator validated on October 4, 2013 all items were removed from the Activities Storage Room to ensure at least an 18 inch clearance from the sprinkler head The fluorescent light fixtures do not hang down lower than the diffusers in the Riser Room on Sub Acute Unit 1 and the Director of Nursing's Office by the Operations Director as of September 20, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will mee to ensure the automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected to be at least an 18 inch clearance from a sprinkler head and a items are at least 4 inches from the sprinkler heads and do not extend further down than the diffusers. An Audit will be completed, weekly, for four weeks, monthly for three months and quarterly, thereafter to validate compliance to ensure that all items are at least an 18 inch clearance from a sprinkler head and all items are at least 4 inches from the sprinkler head; and do not extend further down than diffusers.	
K 069 SS=D	2-2.1.1. Sprinklers shall be inspected from the floor level annually. Sprinklers shall be free of corrosion, foreign materials, paint, and physical damage and shall be installed in the proper orientation (e.g., upright, pendant, or sidewall). Any sprinkler shall be replaced that is painted, corroded, damaged, loaded, or in the improper orientation. 2-2.1.2*. Unacceptable obstructions to spray patterns shall be corrected. NFPA 101 (2000 Edition) 4.8.12.1. Every required sprinkler system shall be continuously maintained in proper operating condition. NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance	K 069		

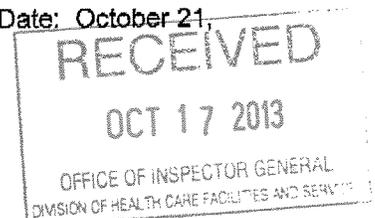


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NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY 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
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K 069 SS=D		K 069		

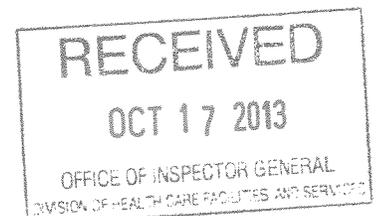
V. Compliance Date: October 21, 2013



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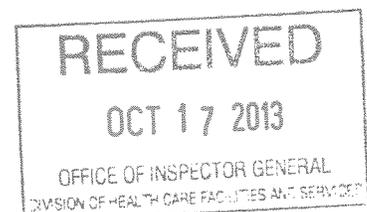
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185289	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 09/10/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, 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 069	Continued From page 10 with 9.2.3. 19.3.2.6, NF PA 96 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the kitchen hood and exhaust system was being maintained in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) 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-one (121) on the day of the survey. The findings include: Observation, on 09/10/13 at 10:33 AM, with the Operations Manager revealed the hood and ducts over the commercial cooking equipment was being cleaned every six (6) months as required; however the exhaust fan located on the exterior wall had not been cleaned when the system had last been serviced. Interview, on 09/10/13 at 10:33 AM, with the Operations Manager revealed he was not aware of the exhaust system exterior fan not being cleaned during the previous, six (6) month scheduled cleaning. Reference: NFPA 101 (2000 edition) 9.2.3 Commercial Cooking Equipment. Commercial cooking equipment shall be in	K 069	K 069 It is the practice of Hurstbourne Care Centre to ensure that the kitchen hood and exhaust system are maintained in accordance with NFPA standards. I. The exhaust hood was cleaned on September 20, 2013 by an outside contractor. II. All of the Residents have the potential to be effected by the alleged deficient practice. III. The Maintenance Director was educated by the Regional Operations Director on September 20, 2013, regarding the requirement to ensure the kitchen hood and exhaust system are maintained in accordance with NFPA standards. The systematic change includes the addition of rounds to ensure that the kitchen hood and exhaust system are maintained in accordance with NFPA standards. IV. The Nursing Home Administrator validated the exhaust hood was cleaned on September 20, 2013 by an outside contractor on September 20, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the	



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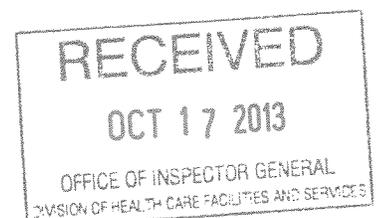
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NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BROOK			STREET ADDRESS, CITY, STATE, ZIP CODE 2200 STONY BROOK DR LOUISVILLE, KY 40220		
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K 069	Continued From page 11 accordance with NFPA 98, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.	K 069	Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure that the kitchen hood and exhaust system are maintained in accordance with NFPA standards. An exhaust hood and exhaust system will be completed, monthly, for six months and semi-annually, thereafter, to ensure that the kitchen hood and exhaust system are maintained in accordance with NFPA standards. V. Compliance Date: October 21, 2013		
K 072 SS=D	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 in accordance with NFPA standards. The deficiency had the potential to affect one (1) of five (5) smoke compartments, approximately thirty (30) residents, staff and visitors. The facility has one-hundred and thirty-two (132) certified beds and the census was one-hundred and twenty-one (121) on the day of the survey. The facility failed to ensure means of egress was free of all obstructions or impediments. The findings include: Observation, on 09/10/13 at 10:41 AM, with the Operations Manager revealed two (2) beds and two (2) bedside tables were located within the egress path for exiting the Sub Acute 2 Unit.	K 072			



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K 072	Continued From page 12 Interview, on 09/10/13 at 10:41 AM, with the Operations Manager revealed he was aware of the beds and bedside tables being stored within the required path of egress and had instructed the Housekeeping Staff to relocate them. Reference: NFPA 101 (2000 Edition) 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. K 147 SS=F NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure electrical wiring was maintained in accordance with NFPA standards. The deficiency had the potential to affect each of the five (5) smoke compartments, residents, staff, and visitors. The facility has certified for one- hundred and thirty-two (132) certified beds and the census was one-hundred and twenty-one (121) on the day of the survey. The findings include:	K 072	III. The Maintenance Director was educated by the Regional Operations Director on September 20, 2013, regarding the all means of egress are continuously maintained free of obstruction or impediments to full instant use in the case if fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from or visibility of exits. The systematic change includes Quality Assurance Rounds to ensure that all means of egress are continuously maintained free of obstruction or impediments to full instant use in the case if fire or other emergency. No furnishings, decorations, or other objects obstruct exits, access to, egress from or visibility of exits. IV. The Nursing Home Administrator completed a facility tour to ensure all objects were removed from points of egress on September 20, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of	



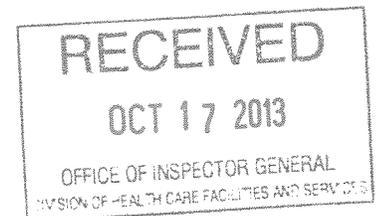
Office of Inspector General

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 100645	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 09/12/2013
NAME OF PROVIDER OR SUPPLIER HURSTBOURNE CARE CENTRE AT STONY BR			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) COMPLETE DATE	
	Continued From page 2 K147 page 13a		V. correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure that all objects were removed from points of egress. The Quality Assurance Team will meet to ensure no objects are interfering with points of egress, weekly, for four weeks, monthly for three months and quarterly, thereafter. Compliance Date: October 21, 2013		

STATE FORM

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

PRINTED: 09/16/2013
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 09/10/2013
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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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(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
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K 147	<p>Continued From page 13</p> <p>Observations, on 09/10/13 between 9:08 AM and 1:49 PM, with the Operations Manager revealed:</p> <ol style="list-style-type: none"> In the MDS Office, a refrigerator and a microwave oven were plugged into a power strip. In the Beauty Shop, a motorized chair was plugged into a power strip. In the Staff Lounge, a refrigerator and two (2) microwave ovens were plugged into a power strip. In Resident Room 218, medical equipment was plugged into a power strip. In Resident Room 204, medical equipment was plugged into a power strip. In Resident Room 35, medical equipment was plugged into a power strip. In Resident Room 21, medical equipment was plugged into a power strip. In Resident Room 20, a television was plugged into an extension cord. In Resident Room 33, a refrigerator was plugged into a power strip. In Resident Room 116, the resident bed was plugged into a power strip. In Resident Room 115, medical equipment was plugged into a power strip. In Resident Room 108, a refrigerator was plugged into a power strip. In Resident Room 103, medical equipment was plugged into a power strip. <p>Interviews, on 09/10/13 between 9:08 AM and 1:49 PM, with the Operations Manager revealed he was not aware of the misuse of power strips.</p> <p>Reference: NFPA 99 (1999 edition)</p>	K 147	<p>K 147</p> <p>It is the practice of Hurstbourne Care Centre to ensure that electrical wiring and equipment is in accordance with NFPA 70.</p> <ol style="list-style-type: none"> The power strips were removed in MDS Office, the Beauty Shop, Staff Lounge and Resident Rooms #218, 204, 35, 21, 20, 33, 116, 115, 108, and 103 will be removed by the Operations Manager or the Operations Assistant by October 4, 2013. All of the Residents have the potential to be effected by the alleged deficient practice. The Maintenance Director was educated by the Regional Operations Director on September 20, 2013, regarding the regulation prohibiting the use of power strips. The systematic change includes Residents and/or Responsible Parties will be advised of the prohibition of power strips utilization. Staff was educated not to utilize power strips by the Nursing Home Administrator on September 26, 2013. The Nursing Home Administrator will complete a tour to ensure the power strips were removed from MDS Office, the Beauty Shop, Staff Lounge and Resident Rooms #218, 204, 35, 21, 20, 33, 116, 115, 108, and 103 by October 11, 2013. The facility's Quality Assurance Committee consists of the Nursing Home Administrator, Director of Nursing, Assistant Director of Nursing, Activities Director, Social Services Director, Business Office Manager, Dietary Manager, Housekeeping Manager, Maintenance Director and the 	
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DIVISION OF HEALTH CARE FACILITIES AND SERVICES

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

PRINTED: 09/16/2013
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 09/10/2013
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 147	<p>Continued From page 14</p> <p>3-3.2.1.2 D Minimum Number of Receptacles. The number of receptacles shall be determined by the intended use of the patient care area. There shall be sufficient receptacles located so as to avoid the need for extension cords or multiple outlet adapters.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>9.1.2 Electric. Electrical wiring and equipment shall be in accordance with NFPA 70, National Electrical Code, unless existing installations, which shall be permitted to be continued in service, subject to approval by the authority having jurisdiction.</p> <p>Reference: NFPA 70 (1999 Edition)</p> <p>400-8 (Extensions Cords) Uses Not Permitted. Unless specifically permitted in 400.7, flexible cords and cables shall not be used for the following: (1) As a substitute for the fixed wiring of a structure (2) Where run through holes in walls, structural ceilings, suspended ceilings, dropped ceilings, or floors (3) Where run through doorways, windows, or similar openings (4) Where attached to building surfaces</p>	K 147	<p>Medical Director. The facility's Quality Assurance Committee met to review the alleged deficient practice and subsequent plan of correction. The plan of correction and plan to monitor ongoing compliance was accepted by all Quality Assurance Team Members. The Quality Assurance Team will meet to ensure the power strips were removed from MDS Office, the Beauty Shop, Staff Lounge and Resident Rooms #218, 204, 35, 21, 20, 33, 116, 115, 108, and 103. The Quality Assurance Team will meet to ensure power strips are not utilized, weekly, for four weeks, monthly for three months and quarterly, thereafter.</p> <p>V. Compliance Date: October 21, 2013</p>	

