

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

PRINTED: 08/28/2014  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  08/14/2014
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS  A Recertification Survey was initiated on 08/12/14 and concluded on 08/14/14 with deficiencies cited at the highest scope and severity of an "E".  An Abbreviated Survey was initiated on 08/12/14 and concluded on 08/14/14 to investigate KY22085 in conjunction with the survey. The Division of Health Care unsubstantiated the allegation with no deficiencies cited.	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=D	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 and interview, it was determined the facility failed to ensure the medication rooms were clean for three (3) of three (3) medication rooms, Hall ABC, E and F medications rooms were found with dirty carpet, floors, walls, dust, and dirty sinks.  The findings include:  The facility did not provide a policy on cleaning medication rooms.  Observation of the ABC Hall Medication room, on 08/14/14 at 10:57 AM, revealed white and dark spots in the carpet and dust covered the counter tops.	F 253	<b>F 253 Housekeeping &amp; Maintenance Services</b>  1. ABC Hall Medication room was cleaned/sanitized by housekeeping on 8/17/14 to remove the white and dark spots in the carpet and dust from the counter tops. E hall Medication Room was cleaned/sanitized by housekeeping on 8/17/14 to remove the dirty plate in the sink, clean/sanitize the sink and the entire surface and the floors were cleaned to remove the dirt and debris. The chipped wall in the plaster were repaired and repainted by maintenance on 9/2/14. The F Hall Medication Room was cleaned/sanitized by housekeeping on 8/17/14.  2. All Residents have the potential to be affected by the alleged deficient practice, therefore all medication rooms were cleaned by housekeeping on 8/17/14.  3. The systemic change includes reeducation of the Housekeeping & Maintenance Director on 9/4/14 regarding the requirement to check the Medication Rooms daily to ensure they are cleaned/sanitized and free from maintenance concerns. The reeducation was completed by the Administrator. The Housekeeping &	Completion Date: 9/10/14

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

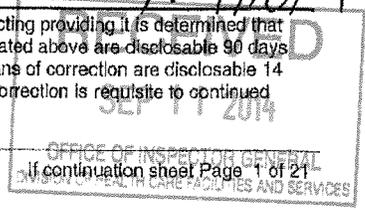
*Tracey Cavalleri*

TITLE  
X NHA

(X6) DATE

X 9/10/14

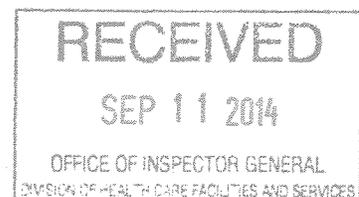
Any deficiency statement ending with an asterisk (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 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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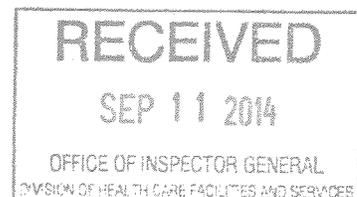
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F 253	<p>Continued From page 1</p> <p>Observation of E Hall Medication room, on 08/14/14 at 10:30 AM, revealed a dirty plate in the sink, white film covering the sink across the entire surface of the sink. The floors had dark debris and dirt. The walls had chipped plaster.</p> <p>Observation of F Hall Medication room, on 08/14/14 at 2:00 PM, revealed the sink was covered with white spots and the floor had dark debris.</p> <p>Interview with the E Hall Licensed Practical Nurse (LPN) #2, on 08/14/14 at 10:55 AM, revealed she thought the medication room was dirty. LPN #2 stated she had never asked the housekeeping staff to clean the medication room. LPN #2 stated housekeeping had not asked her to open up the medication room for cleaning. LPN #2 stated she thought the medication room was not cleaned by housekeeping because the medication room was always locked.</p> <p>Interview with the Director of Nursing (DON), on 08/14/14 at 4:33 PM, revealed she had heard the medication rooms were dirty that day. The DON stated LPN #2 told her the medication room was dirty. The DON stated the housekeeping staff should be checking the medication rooms daily with the nurses present. The DON stated it was housekeeping's responsibility and it was disgusting that housekeeping was not cleaning the medication rooms.</p> <p>Interview with Housekeeper #1, on 08/14/14 at 11:13 AM, revealed she had worked at the facility for four (4) months and she had never been assigned to clean a medication room. She revealed she had never seen any of her housekeeping co-workers go into the medication rooms to clean. The Housekeeper also stated</p>	F 253	<p>Maintenance Staff were reeducated on 9/10/14 regarding the requirement to check the Medication Rooms daily to ensure they are cleaned/sanitized and free from maintenance concerns.</p> <p>4. On 09/05/14, a Medication Room Audit Tool was created by the Clinical Ambassador. The Medication Room Audit Tool will be completed by the Housekeeping Supervisor and a licensed nurse daily to validate the medication rooms are checked daily to ensure cleanliness and free from maintenance issues. Any maintenance or cleaning concerns will be immediately addressed to ensure Medication Rooms are sanitary and orderly. The Administrator/Director of Nursing (DON) will conduct Quality Improvement (QI) monitoring of regulation F253 by reviewing Medication Room Audit Tool three 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><i>(For future reference the QAPI-Quality Assurance Performance Improvement Committee consists of the Medical Director, Administrator, Director of Nursing (DON), and at least 3 other staff members from housekeeping, nursing, therapy, activities, dietary, business office, admissions or medical records.)</i></p> <p>5. The Administrator is responsible for this process. Compliance Date 09/13/14</p>		



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F 253	Continued From page 2 she had seen the nurses take the trash out of the medication rooms.  Interview with the Housekeeping Director, on 08/14/14 at 11:20 AM, revealed he had been the Housekeeping Director for four (4) months and he and his staff followed the cleaning schedules of the former Housekeeping Director. He stated he went over those schedules with his boss and the medication rooms were not included in the cleaning schedules. The Housekeeping Director stated he was involved in meetings with the Director of Nursing and he had never been asked about cleaning the medication rooms.	F 253	<b>F 280 Right to Participate Planning Care-Revise Care Plan</b>	<i>Completed Date: 9/12/14</i>
F 280 SS=D	<b>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</b>  The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.  A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.	F 280	1. Responsible Party for Resident #3 was sent a care plan meeting request letter on 9/3/14 by the Social Services Director. Responsible Party for Resident #2 was sent a care plan meeting request letter on 9/3/14 by the Social Services Director. Responsible Party for Resident #13 was sent a care plan meeting request letter on 9/3/14 by the Social Services Director. Responsible Party for Resident #4 was sent a care plan meeting request letter on 9/3/14 by the Social Services Director. 2. All Residents have the potential to be affected by the alleged deficient practice therefore care plan invitations were sent out to all residents and/or responsible parties by the Minimum Data Set (MDS) Coordinator and/or Social Services Director on or before 9/8/14. 3. The systemic change includes reeducation of the Care Plan Team (Participants in attendance were Business Office Manager, Administrator, Dietary Manager, Admissions Director, Social Services Director, Activities Director, Therapy Director, Assistant Director of Nursing (ADON) and Medical Records) regarding the requirement to engage the Resident and/or Responsible Party's invitation to participate in planning care and treatment. The care plan conference may include but is not limited to face to face meeting, teleconference, written communication or one to one discussions. This education was completed by the MDS Coordinator on 8/20/14 and included care plan meeting schedules and time frames and a discussion regarding revised	



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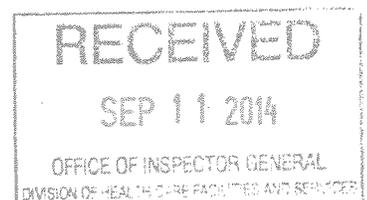
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F 280	Continued From page 3  This REQUIREMENT is not met as evidenced by: Based on interview and record review, it was determined the facility failed to offer resident families the opportunity to participate in Interdisciplinary Discipline Team Meetings (IDT) for three (3) of nineteen (19) sampled residents, (Resident #, #4, and #13). The facility failed to notify family members of upcoming careplan meetings.  The findings include:  The facility did not provided a policy related to Interdisciplinary Discipline Team (IDT) Meetings. However review of the Interdisciplinary Team Care Plan letter, revealed the facility encouraged the residents and families to attend and participate in the ongoing care plan conferences and that it would be an excellent time to update any discharge plans, advance directives and related wishes.  1. Review of the clinical record for Resident #3 revealed the facility admitted the resident on 11/24/10 with diagnoses of Alzheimer's Disease, Anemia, Muscle Disorder, Anxiety, and Dysphagia with a Gastrostomy tube for nutrition. The facility completed a quarterly Minimum Data Set (MDS) assessment on 06/08/14, which revealed the resident had severe cognitive impairment. The clinical Care Conference Record revealed one (1) quarterly meeting for the year, dated 01/02/14. In addition the documentation for family or responsible party attendance and or notifications prior to meetings were not recorded.	F 280	tracking of this process. (The DON approved this education.) Effective 9/5/14, the MDS Director will provide a monthly schedule identifying the date set for each long term care Residents quarterly review. Effective 9/5/14, the Social Services Director will contact each respective Resident and/or Responsible Party to schedule care plan meetings. The MDS Coordinator will maintain a binder that has the care plan meeting and conference schedules. 4. The Administrator/ Director of Nursing will conduct Quality Improvement (QI) monitoring of regulation F 280 by reviewing the monthly MDS Schedule and the Care Plan Notification Letters three times a week for four weeks, weekly for 8 weeks and monthly for 3 months to ensure compliance. 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 auditing or education is required. 5. The DON is responsible for this process. Compliance Date 09/13/14		

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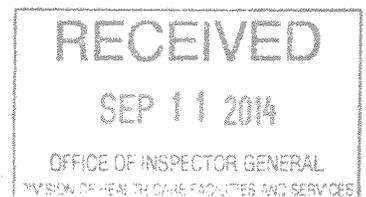
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F 280	<p>Continued From page 4</p> <p>Interview by phone with Responsible Party (RP) #2, on 08/13/14 at 8:28 PM, revealed the last IDT meeting he/she was invited to was early spring. RP #2 further stated he/she had not received any phone calls or letters regarding any facility scheduled IDT meetings in several months.</p> <p>2. Review of the clinical record for Resident #13 revealed the facility admitted the resident on 11/13/13 with diagnoses of Senile Dementia, Chronic Pain, Congested Heart Failure, Depression, Chronic Kidney Disease, and Hypertension. The facility completed a quarterly Minimum Data Set (MDS) assessment on 05/21/14, which revealed the resident had cognitive impairment. The Clinical Care Conference Record revealed two (2) IDT meetings for the year, dated 02/18/14 and 02/25/14. In addition, the documentation for family or responsible party attendance and or notifications prior to meetings were not recorded.</p> <p>3. Review of the clinical record for Resident #4 revealed the facility admitted the resident on 05/01/13 with diagnoses of Obstructive Hydrocephalus, Cerebral Palsy, Intellectual Disability, Epilepsy, and Visual Loss. The facility completed a quarterly Minimum Data Set (MDS) assessment on 07/18/14, which revealed the resident had severe cognitive impairment.</p> <p>An interview conducted with Resident #4's family/responsible party, on 08/12/14 at 3:15 PM, revealed his/her last facility care plan conference notification was January, 2014.</p> <p>Interview with the MDS Registered Nurse (RN), on 08/14/14 at 5:48 PM, revealed when resident</p>	F 280			



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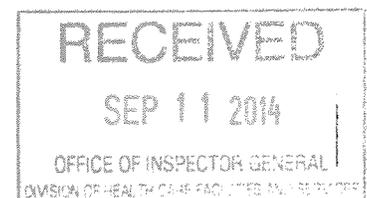
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F 280	Continued From page 5 MDS assessments were completed based on the Assessment Reference Dates; each resident would be placed on the calendar list for scheduling of the IDT meetings, usually on Tuesdays or Thursdays. She further stated Resident #3 should have had a total of three IDT meetings for this year and she was unable to confirm if the letters were sent.  Interview with the Social Services Director (SSD), on 08/14/14 at 4:39 PM, revealed she was responsible for inviting facility residents and their responsible party or family. She was surprised to hear Resident #3 had not had an IDT meeting since January of 2014. The SSD stated she was supplied with a calendar list of residents that were due an IDT meeting based on the Residents Assessment Reference Dates from the MDS department. In addition she was not able to locate Resident #3's name on her June, July, or August calendar list and would consider Resident #3 to be a priority for scheduling a IDT meeting. The SSD stated she did not retain a copy of the care plan notification letters in the resident's clinical record. The SSD was unable to provide documentation that the resident's family/responsible party had been notified of the scheduled care plan conference.  Interview with the Director of Nursing, on 08/14/14 at 5:25 PM, revealed it was a concern that residents, responsible parties and family were not invited to IDT meetings. She further stated the IDT meetings were important to keep families in the loop concerning healthcare needs, changes, and concerns.	F 280		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431	<b>F 431 Drug Records, Label/Store Drugs &amp; Biologicals</b> 1. On 8/14/14, the DON discarded the two staple removal kits and 6 IV solutions from the ABC Hall Medication Room. On 8/14/14, the DON discarded 13 Transport Specimen Containers, 1 Safety-lock Collection Set, 3 vacutainers and 1 Derma Rite from the F Hall Medication Room. On 8/14/14, the DON discarded the expired medication from the B Hall Medication Cart. On 8/14/14 the DON removed the expired medication from the E Hall Medication Cart. 2. All Residents have the potential to be affected by the alleged deficient practice. All Medication Rooms and Medication Carts were inspected by the DON/Nurse Manager to ensure expired drugs and biologicals are not stored in the Medication Rooms and/or Medication Carts on 9/5/14. 3. The systemic change includes re-education of all licensed nurses by the Clinical Ambassador and Administrative Nursing Staff regarding the requirement to audit their assigned Medication Rooms & Medication Carts to ensure no expired drugs or biologicals are used during care. The re-education was started on 8/26/14 and will be	Completion Date: 9/13/14



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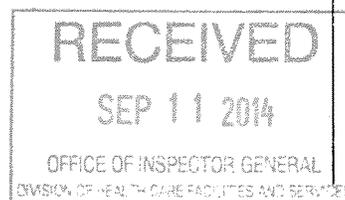
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F 431	Continued From page 6  The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; 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 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.  This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review and review of the Storage and Expiration of	F 431	completed by 9/13/14. A new protocol was created by the DON and Clinical Ambassador to validate that expired medications and supplies are removed from the medication rooms timely. The new protocol includes weekly documentation by licensed nursing staff to ensure that medication carts and supply rooms are checked routinely to validate disposal of expired supplies and/or medications. The date for this documentation to be initiated is 9/8/14 and weekly thereafter. (The DON will provide oversight of this process). 4. The DON and Administrative Nursing staff will conduct Quality Improvement (QI) monitoring of regulation F 431 by reviewing the Medication Room Audit Tool to validate the Medication Rooms and Medication Carts do not contain expired drugs and biologicals. Any expired drugs and biologicals identified will be immediately discarded with subsequent reeducation to the licensed nurses. Cleaning or maintenance concerns will be immediately addressed to ensure Medication Rooms and Medication Carts are free of expired drugs and biologicals. The DON and Administrative Nursing staff will conduct Quality Improvement (QI) monitoring of regulation F 431 by reviewing the Medication Room Audit Tool weekly for 12 weeks and monthly for 3 months. The results of these audits will be submitted to the QAPI Committee monthly. Any concerns identified throughout the QAPI process will be immediately addressed to ensure compliance is sustained. The QAPI Committee will determine if additional education or auditing is required. 5. The DON is responsible for this process. Compliance Date 9/13/14	



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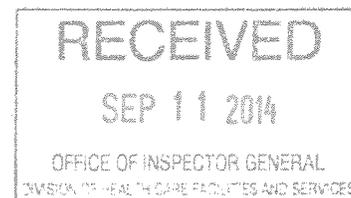
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F 431	<p>Continued From page 7</p> <p>Medications, Biologicals, Syringes and Needles Policy, it was determined the facility failed to ensure expired drugs and biologicals were removed from two (2) of three (3) medication rooms, (F Hall and ABC Hall Medication rooms). In addition, the facility failed to ensure expired medications were removed from two (2) of five (5) medication carts, (medication cart B and E), that remained stored and available for use by staff.</p> <p>The findings include:</p> <p>Review of the facility's Storage and Expiration of Medications, Biologicals, Syringes and Needles Policy, revised 01/01/13, revealed the facility would ensure the medications and biologicals had not been retained longer than recommended by the manufacturer or supplier guidelines.</p> <p>1. Observation of the ABC Hall Medication room, on 08/14/14 at 10:57 AM, revealed two (2) skin staple remover kits that expired on October 2013, three (3) intravenous (IV) solutions that expired on 08/06/14 and three (3) IV solutions that expired 08/10/14 remained available for use by staff.</p> <p>2. Observation of the F Hall Medication room, on 08/14/14 at 2:00 PM, revealed thirteen (13) orange top Collection and Transport Bacteria Specimen Containers had expired in February 2014, one (1) BD Vacutainer Safety-lock Blood Collection Set had expired in May 2014, three (3) yellow top Vacutainers had expired in July 2014 and one (1) Derma Rite had expired in December 2009 remained available for staff use.</p> <p>Interview with Licensed Practical Nurse (LPN) #4, on 08/14/14 at 2:00 PM, revealed the nursing</p>	F 431		



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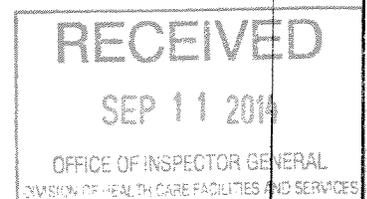
STATEMENT OF DEFICIENCIES ID PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2014
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 431	<p>Continued From page 8</p> <p>staff did not draw blood; however, nurses were responsible to collect urine specimens and stool specimens. LPN #4 stated she was not responsible for checking the lab supplies and was not sure who was responsible.</p> <p>Interview with the Director of Nursing (DON), on 08/14/14 at 4:33 PM, revealed nurses did not draw labs in the facility. The DON stated Med Lab drew the labs; however, there was a stock of vacutainers for later use, if they needed to draw a lab, they would have vacutainers on hand. If an expired Vacutainer was utilized on a resident, the test could be altered or the blood could hemolyze. The DON stated it was night shift's responsibility to monitor the medication rooms. However, the DON could not produce evidence the night shift nurses were checking the medication rooms and medication carts for expired medicines.</p> <p>3. Observation of the B Hall Medication Cart, on 08/14/14 at 11:20 AM, revealed twenty-eight (28) tablets of Tylenol 325 mg, had expired in July 2014, three (3) tablets of Lorazepam, had expired in August 2014 and two (2) tablets of Baclofen 10 mg had expired on 07/15/14.</p> <p>4. Observation of the E Hall Medication Cart, on 08/14/14 at 10:30 AM, revealed nine (9) tablets of Meclizine 12.5 mg had expired in July 2014, ten (10) tablets of Meclizine 12.5 mg had expired on 06/30/14 and eleven (11) tablets of Acetaminophen 325 mg had expired in July 2014.</p> <p>Interview with LPN #2, on 08/14/14 at 10:55 AM, revealed nurses were responsible for checking the medication carts when they were giving medications. LPN #2 stated the Nursing</p>	F 431			



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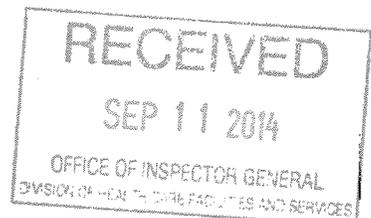
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F 431	<p>Continued From page 9</p> <p>Supervisors were responsible for medication cart audits. LPN #2 stated if a resident were to receive an expired medication, it could make the resident feel sick, have nausea and vomiting or not work effectivity.</p> <p>Interview with LPN #1, on 08/14/14 at 11:35 AM, revealed he checked medications for expiration dates when giving medications. LPN #1 stated Omnicare (Pharmacy Services) checked the medication carts; however, was not sure how often Omnicare came to check the carts. LPN #1 stated if a resident were to ingest an expired medication it could cause an adverse reaction.</p> <p>Interview with the Director of Nursing (DON), on 08/14/14 at 11:05 AM, revealed the nurses were responsible for checking the refrigerators, medication rooms and medication carts for expired medications and biologicals. The DON stated the night shift should check the medications and check off that it was completed nightly.</p> <p>Interview with the Pharmacy Consultant, on 08/14/14 at 4:00 PM, revealed the pharmacy staff came to the facility once a month and the staff did not do a complete audit, just a Quality Assurance (QA) audit. The QA audits then went to the DON. The Pharmacy Consultant stated on 07/14/14, the pharmacy staff were at the facility and had found expired medications in the medication carts. The medication rooms were ok.</p> <p>Record review of the Quality Improvement: Consultant Pharmacist Summary, for period of 05/01/14, revealed the facility needed improvement for out-of-date medications being</p>	F 431			



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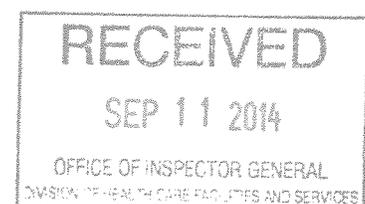
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F 431	Continued From page 10 available for administration.  Record review of the Quality Improvement: Consultant Pharmacist Summary, for the period of 07/01/14 through 07/31/14, revealed isolated issues were observed with out-of-date medications being available for administration.  Interview with the DON, on 08/14/14 at 11:05 AM, revealed the DON was ultimately responsible to ensure staff were doing what they were suppose to do. The DON stated their was no system for monitoring expired medications and biologicals and that she was not aware there were expired medications and biologicals. The DON stated if a resident were to take an expired medication, the medication may not have the same desired affect. Further interview, with the Director of Nursing (DON), on 08/14/14 at 4:33 PM, revealed she went to see which medications were expired and removed those medications. The DON then informed her Assistant Director of Nursing and Unit Managers about the need to monitor for expired medications. The DON stated when the Pharmacy Consultant found the expired medications, she did not give the team a time frame or a time when to monitor for expired medication. The DON stated she should have made a time frame for staff to monitor and remove expired drugs and biologicals.	F 431		
F 441 SS=E	<b>483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS</b>  The facility must establish and maintain an <u>Infection Control Program</u> designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	<b>F 441</b> <b>Infection Control, Prevent Spread, Linens</b> 1. LPN's #2, 6 and 9 received immediate verbal education regarding hand washing and infection control precautions which was provided by the administrative nursing staff during the survey process. The MDS Coordinator and Social Services Director completed training on infection control and hand washing on 8/26/14 given by the Clinical Ambassador which included a post test on infection control. (Note LPN's #2, #6, #9 and CNA #2 all completed formal education with a post test regarding infection control and hand washing. This education was initiated on 8/26/14 by the Clinical Ambassador and all identified team members were educated prior to 9/5/14 with a post test. 2. All residents residing in the facility have the potential to be affected by the alleged deficient practice related to hand washing therefore hand	<i>Completion Date 9/13/14</i>



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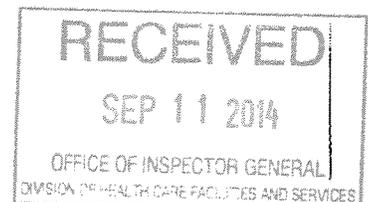
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F 441	Continued From page 11  (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, 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 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 observations, interview and review of the facility's policy Standard Precautions, it was determined the facility failed to ensure staff washed their hands after resident contact for six (6) of seven (7) staff (Licensed Practical Nurse	F 441	washing education was initiated by the clinical ambassador and administrative nursing staff for all staff on 8/26/14 and will be completed by 9/13/14. The education included a hand washing return demonstration,  3. The systemic change includes re-education of staff by the Clinical Ambassador and Administrative Nurses regarding the hand washing requirements for all staff to wash their hands after each direct contact, for which hand washing is accepted professional practice; and re-education of staff on isolation procedures to help prevent the development and transmission of disease and infection. The education was initiated on 8/26/14 and will be completed by 9/13/14. The education includes a post test as well as hand washing demonstrations.  4. On 09/07/14, a Hand Washing & Standard Precaution Validation Tool was created by the Clinical Ambassador. The Hand Washing & Standard Precaution Validation Tool will be completed by the DON/ADON/Nurse Manager to validate staff are washing hands after each direct contact for which hand washing is accepted professional practice and isolation procedures to help prevent the development and transmission of disease and infection. Any concerns identified will be immediately addressed with subsequent reeducation regarding the area of concern to prevent the development and transmission of disease and infection. The validation tool will be completed three times a week for four weeks, weekly for 8 weeks and monthly for 3 months. 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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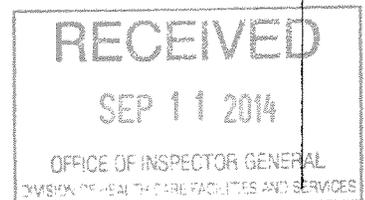
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F 441	Continued From page 12 #2, #6, and #9) who failed to perform hand washing or hand hygiene during medication administration. Two (2) additional facility staff (Minimum Data Set Nurse, and Social Services Director) washed their hands or provide hand hygiene after performing resident care, and Certified Nursing Assistant #2 failed to wear gloves while touching the resident's equipment in an isolation room.  The findings include:  Review of the facility's policy regarding Standard Precautions, revised 09/01/11, revealed facility staff were to wash their hands after touching body fluids and contaminated items whether or not gloves were worn. The staff was to wash their hands immediately after gloves were removed, between resident contact, and when otherwise indicated to avoid transfer of microorganisms to other residents or environments. The staff was to wash their hands between tasks and procedures on the resident when contaminated with body fluids to prevent cross-contamination of different body sites.  Review of the facility's Nursing Education provided to facility nursing staff on 04/15/14, 04/17/14, and 04/23/14 revealed education was provided on Infection control and Breaking the Chain with a focus on types of infection and how to prevent the spread of infections including hand washing details.  1. Observation of a medication administration, on 08/13/14 at 7:51 AM, with License Practical Nurse (LPN) #2 revealed she unlocked the medication cart with her keys kept in her uniform	F 441	The DON is responsible for this process. Compliance Date 09/13/14		



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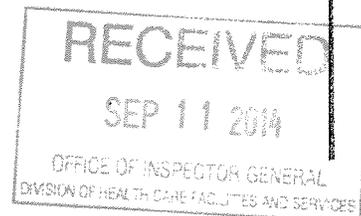
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F 441	Continued From page 13 pocket, she prepared Resident #6's medications and placed them in a medicine cup, locked the cart then entered and exited Resident #6's room without performing hand washing. LPN #2 returned to the medication cart to prepare medications for Unsampled Resident C. The LPN #2 entered Unsampled Resident C's room at 8:07 AM without washing her hands, and touched the resident's lower lip with her bare hand during the administration of the medication. LPN #2 exited Unsampled Resident C's room without washing her hands. LPN #2 without washing her hands, unlocked the medication cart and prepared Resident #10's medications at 8:15 AM, locked her medication cart then entered the room, she checked the resident's blood pressure and heart rate, administered the medication then exited the resident's room without performing hand washing.  Interview with LPN #2, on 08/14/14 at 2:35 PM, revealed the facility policy was to perform hand washing before and after resident care or contact with resident objects. LPN #2 stated she was aware she had not washed her hands or used hand sanitizer during medication administration on 08/13/14 for three (3) facility residents and she should have performed hand washing. She further stated the facility had provided training on infection control and completed her orientation which included a skills check off for infection control. LPN #2 stated the risk of spreading infections could cause sickness or possible death.	F 441		
	2. Observation of the medication administration, on 08/13/14 at 8:41 AM, with LPN #9 revealed she unlocked the medication cart with her keys kept in her uniform pocket. She prepared			



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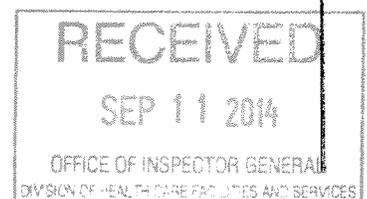
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F 441	<p>Continued From page 14</p> <p>Unsampled Resident A's medication and placed them in a medicine cup. One tablet fell to the floor and the LPN picked up the tablet with her bare hand, and then disposed of the medication. The LPN, without hand washing, replaced the dropped tablet from the medication cart, locked the medication cart, entered the resident's room, and administered the medications to the resident.</p> <p>Interview with LPN #9 by phone, on 08/14/14 at 3:48 PM, revealed she had picked up a dropped medication from the dirty floor, disposed of the dropped medication, and proceeded to dispense another tablet from the locked medication cart to replace the dropped pill, without performing any hand hygiene. She further stated she should have cleaned her hands before going into Unsampled Resident A's room and administered the medication. LPN #9 stated she was trained on infection control during orientation and recently attended an in-service on infection control that included hand washing. She stated the lack of hand hygiene could transfer bacteria which could cause residents to get sick due to a weak immune system.</p> <p>3. Observation of the medication administration, on 08/13/14 at 9:00 AM, with LPN #6 revealed she unlocked the medication cart with her keys kept in her uniform pocket, she then prepared Unsampled Resident B's medication and placed them in a medicine cup. LPN #6 entered the resident's room without hand washing, placed gloves on her hands to break a medication tablet, and then administered the resident's medication. LPN #6 removed her gloves while in the resident room then exited without washing her hands. LPN #6 was observed during medication administration, on 08/14/14 at 2:07 PM to 2:25</p>	F 441			



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F 441	<p>Continued From page 15</p> <p>PM; she entered Resident #8's room without washing her hands to assist the resident with a transfer to the bed then exited the room without performing hand washing. In addition, LPN #6 was observed during a skin assessment, on 08/08/14 at 2:25 PM, enter Resident #3's room without hand washing, put on gloves and performed a skin assessment starting at the residents feet, examined and touched the genital area, then continued with the assessment of the upper half of the residents body, touching the face, ears and head without changing her gloves or performing hand washing. LPN #6 removed her gloves and exited the room without any hand washing.</p> <p>Interview with LPN #6, on 08/14/14 at 2:45 PM, revealed she did not wash her hands after she exited Unsampld Resident #B's room nor did she wash her hands before or after assisting Resident #8 get into the bed. The nurse stated it was the facility's policy to perform hand washing in between each resident and when entering and exiting resident rooms. She further stated she was aware of a cross contamination risk to all residents and visitors in the building. LPN #6 stated she had been trained during orientation on infection control and had attended an in-service as well which included hand washing. A phone call made to LPN #6, on 08/14/14 at 4:21 PM, revealed contact could not be made to discuss hand hygiene during a skin assessment.</p> <p>Interview with the Unit Manager, on 08/14/14 at 4:24 PM, revealed her duties included monitoring, resource, and supervision of the floor nurses. She stated no surveillance had been done by her on infection control issues. The Unit Manager added the facility nurses when performing skin</p>	F 441		



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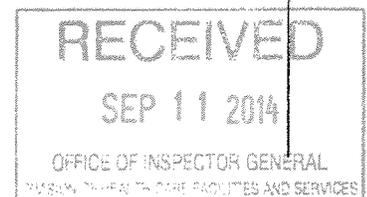
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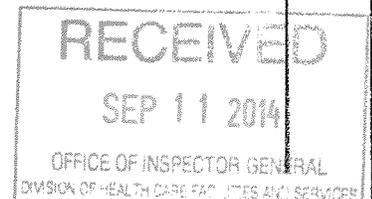
F 441	<p>Continued From page 16</p> <p>assessments should not go from a dirty area to a clean area because doing so could cause the spread of infections. The Unit Manager further stated she was not aware facility staff were not performing hand hygiene with resident care and all staff had been trained on infection control.</p> <p>Interview with Director of Nursing (DON), on 08/14/14 at 5:11 PM, revealed facility staff should be performing hand washing when entering and exiting resident's rooms, and in-between resident contact if the residents happen to be in the same room. She further stated no surveillance was currently being done at this time. The DON stated resident skin assessments performed by the facility nurse that started from the toes to the head was not the correct procedure. She further stated skin assessments should be performed from head to toe and clean to dirty areas, and she stated that was basic nursing practice.</p> <p>4. Observation, on 08/20/14 at 8:45 AM, of Resident #11's door entrance to the room revealed a contact precaution sign posted to the upper left side of the door facing and a rolling cart containing Personal Protective Equipment (PPE) sitting to the left of the door.</p> <p>Observation, on 08/14/14 at 8:48 AM, revealed Certified Nursing Assistant (CNA) #2 passing breakfast trays on the D Hall. CNA #2 entered Resident #11's room without Personal Protective Equipment (PPE), sat the breakfast tray on the over bed table and moved the over bed table to the opposite side of the resident's bed with her bare hands. The CNA then exited the resident's room and pulled the door closed without washing or sanitizing her hands. The CNA then</p>	F 441		
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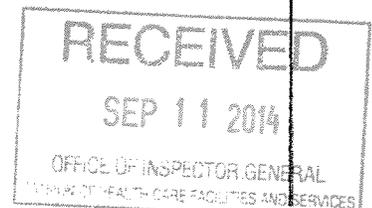
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F 441	<p>Continued From page 17</p> <p>proceeded to the breakfast cart, that contained additional resident breakfast trays, and pushed the cart to the door of the next room. CNA #2 was observed opening the door to the breakfast cart, then closing the door and using the hand sanitizer on the corridor wall.</p> <p>Review of the clinical record for Resident #11 revealed the resident was admitted to the facility on 08/08/14 with diagnoses of Chronic Respiratory Failure with Chronic Tracheostomy, Chronic Obstructive Pulmonary Disease, Diabetes mellitus, and Chronic Kidney Disease. Further review of the clinical record revealed a physician's order, dated 08/10/14, for contact isolation precautions related to a diagnosis of Methicillin Resistant Staph Aureus (MRSA) of the sputum.</p> <p>Interview with CNA #2, on 08/12/14 at 8:50 AM, revealed he/she did not work on the D Hall on a regular basis. The CNA stated he/she did not notice the contact precaution sign on the door facing, or the personal protective equipment (PPE) cart sitting outside the door, of Resident #11's room. CNA #2 revealed she had been trained by the facility regarding hand washing and sanitizing when entering and exiting a resident's room. The CNA further revealed she should have washed her hands prior to exiting the resident's room. CNA #2 stated there was the potential of passing germs to other residents in the facility.</p> <p>5. Observation, on 8/14/14 at 10:45 AM, revealed Resident #14 was sitting in her wheelchair in her room with the wheelchair alarm sounding. The Minimum Data Set (MDS) Coordinator was observed entering the resident's room and resetting/silencing the wheelchair alarm with her</p>	F 441			



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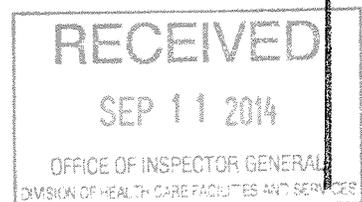
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  08/14/2014
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206		
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F 441	<p>Continued From page 18</p> <p>bare hands. She then exited the resident's room without using hand sanitizer or washing her hands. She proceeded to push the B Hall ice cart down the hall and in to the kitchen.</p> <p>Interview with the MDS Coordinator, on 8/14/14 at 10:50 AM, revealed she had forgotten to wash or sanitize her hands after exiting Resident #14's room. She stated she had been trained on standard precautions, including the use of gloves and hand washing. She revealed she had cross-contaminated the ice cart which could result in the spread of germs or infections to other residents.</p> <p>6. Observation, on 8/14/14 at 11:10 AM, revealed the Social Services Director (SSD) having a discussion with Resident #12 who was lying in bed. The SSD readjusted the resident's bed linens on two (2) occasions while in the room. She was then observed exiting the resident's room without washing her hands or using hand sanitizer.</p> <p>Interview, on 8/14/14 at 10:20 AM, with the Director of Nursing (DON) revealed all staff had been trained on standard precautions and handwashing. The DON further stated there had not been any staff handwashing check-offs or audits since March, 2014. The DON could not provide documentation of any handwashing audits that had been performed. The DON stated she recently provided an in-service on 04/15/14, 04/17/14, and 04/23/14 regarding Infection Control which included hand washing. LPN #2, #6, #9 attended the inservice; however, the MDS nurse, CNA #2 and Social Services did not attend. She further stated no surveillance was currently being done at this time.</p>	F 441			



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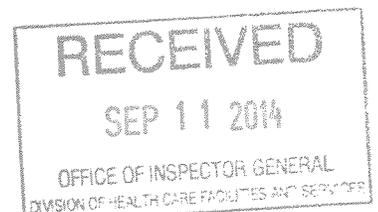
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F 497 SS=C	<p>483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE</p> <p>The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview and review of the facility's education records, it was determined the facility failed to ensure the Certified Nursing Assistants received the required twelve (12) hours of continued education for fifteen (15) of fifteen (15) records reviewed.</p> <p>The findings include: The facility did not provide a policy regarding CNA 12 hour continued education.</p> <p>Review of the in-service education record for fifteen (15) CNAs revealed each CNA had an education sheet in a binder which listed in-service programs they had attended, but there was no documented evidence of the length of time for each in-service attended.</p>	F 497	<p><b>F 497 Nurse Aide Perform Review-12 Hr/Yr In-service</b></p> <p>1. The DON and ADON initiated a 100% audit of all certified nursing staff's education to determine the status of nurse aide continuing education hours. The audit was initiated immediately following survey to identify educational needs and logging needs for education hours that have been provided to certified nursing staff. This audit was completed from 8-15-14 thru 8-21-14.</p> <p>2. All certified nurse aides were identified as having a potential to be affected by this process. The DON and/or ADON will validate that additional education is provided to certified nursing staff and will complete logging by 9/13/14 to ensure that certified nursing staff have appropriate educational hours.</p> <p>3. The systemic change includes education on the regulation F497 to the Administrator, DON, ADON and Human Resources Director by the Clinical Ambassador by 9/10/2014. The education includes information regarding tracking hours of education based on anniversary dates of certified nursing staff as well as education on appropriate methods for tracking hours of education.</p> <p>The facility DON, ADON and or Unit Manager will provide regular in-service training sufficient to ensure the continuing competence of the nurse aides for at least 12 hours per year. The DON/ADON will ensure the nurse aides receive 12 hours of continued education with the record to include employee name, course, the number of hours, and the date of completion.</p>	<p><i>completion date: 9/13/14</i></p>	



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F 497	Continued From page 20 Interview with CNA #5, on 08/14/14 at 4:47 PM, revealed she had attended eight (8) trainings so far this year. She stated awareness of the requirement for twelve (12) hours of education and stated she could not work if she did not have the twelve (12) hours.  Interview with CNA #6, on 08/14/14 at 4:55 PM, revealed she thought she had twelve (12) to fourteen (14) trainings this year; however, could not validate how many.  Interview with the Assistant Director of Nursing (ADON)/Assistant Director of Clinical Records (ADCR), on 08/14/14 at 4:23 PM, revealed she was unable to validate the time frames for each of the in-service programs listed. She stated she had a big cardboard box full of in-service training's that she had not sorted through and recorded hours yet. Therefore, it was impossible to state the current CNA staff had attended twelve (12) hours of in-service education. She stated that she should had documented on the education log for each CNA in order to validate and track the CNA attendances in the required twelve (12) hours of yearly in-service education.	F 497	Systemic change- An annual calendar was created by the DON and ADON on 9/9/14. The calendar outlines at least one hour of education every month. The DON and ADON will be responsible for tracking educational hours monthly to determine staff compliance with in-service attendance.  4. The Administrator/DON will conduct Quality Improvement (QI) monitoring of regulation F 497 by identifying Nurse Aide start dates and validating all 12 hours of education have been completed prior to their anniversary date. QI monitoring will be completed three times a week for four weeks, weekly for 8 weeks and monthly for 3 months using a sample size of five. Any concerns identified throughout the QAPI 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. 3. The DON is responsible for this process. 5. Compliance Date 9/13/14		



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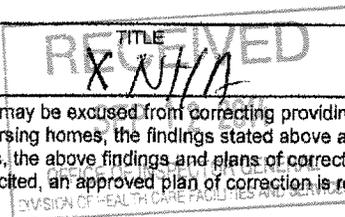
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C	STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206
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K 000	<p>INITIAL COMMENTS</p> <p>CFR: 42 CFR 483.70(a)</p> <p>BUILDING: 01</p> <p>PLAN APPROVAL: 1962, 1983, 1992</p> <p>SURVEY UNDER: 2000 Existing</p> <p>FACILITY TYPE: SNF/NF</p> <p>TYPE OF STRUCTURE: One (1) story with a partial basement, Type III (200)</p> <p>SMOKE COMPARTMENTS: Eight (8) smoke compartments on the ground floor where residents reside; a partial basement occupied by Staff only.</p> <p>FIRE ALARM: Complete fire alarm system with heat and smoke detectors</p> <p>SPRINKLER SYSTEM: Complete automatic dry sprinkler system.</p> <p>GENERATOR: Type II 40KW generator. Fuel source is diesel.</p> <p>A Recertification Life Safety Code Survey was conducted on 08/12/14. 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		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*X Tracy Walker*



(X6) DATE

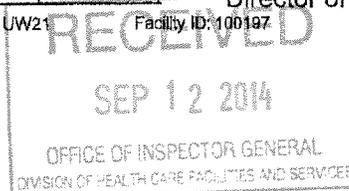
*8/10/14*

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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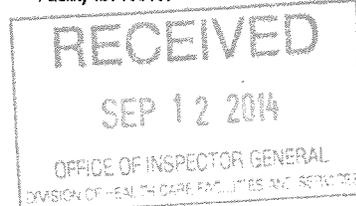
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K 000	Continued From page 1	K 000	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider with the statement of deficiencies. The plan of correction is prepared and/or executed because it is required by provision of Federal and State regulations.	
K 018 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure corridor doors where provided from the Staff Break Room to the exit access service corridor, to prevent the passage of smoke in the event of an emergency, in accordance with National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect one (1) of eight (8)</p>	K 018	<p><b>NFPS 101 Life Safety Code Standard</b></p> <ol style="list-style-type: none"> <li>Two 20 minute solid-bonded core wood corridor doors capable of resisting fire will be installed in Staff Break Room to prevent the passage of smoke in the event of emergency by 9/12/14.</li> <li>All Residents have the potential to be affected by the alleged deficient practice removed doors. Two 20 minute solid-bonded core wood corridor doors capable of resisting fire will be installed in Staff Break Room to prevent the passage of smoke in the event of emergency by 9/12/14. The Maintenance Director and the Administrator utilized the facility layout design to validate all required Resident areas have fire rated doors to prevent the passage of smoke.</li> <li>The systemic change includes re-education of the Administrator &amp; Maintenance Director on 8/28/14 regarding the requirement 20 minute solid-bonded core wood corridor doors to resist fire in Staff Break Room to prevent the passage of smoke in the event of emergency by the Regional Director of Plant Operations.</li> </ol>	<p><i>Completion Date 9/18/14 R</i></p>



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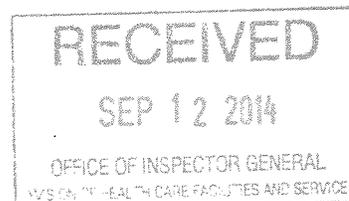
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K 018	<p>Continued From page 2</p> <p>smoke compartments, and the facility's staff. The facility has ninety-six (96) certified beds and the census was ninety-two (92) on the day of the survey.</p> <p>The findings include:</p> <p>Observation, on 08/12/14 at 9:37 AM, with the Director of Plant Operations revealed two (2) corridors doors located in the staff break room, containing staff lockers, had been removed and left open to the exit access service corridor as a convenience for staff using the break room.</p> <p>Interview, on 08/12/14 at 9:39 AM, with the Director of Plant Operations revealed he was not aware the staff break room could not be open to the service exit access corridor used by staff only and stated the break room would not be able to resist the passage of smoke in the event of an emergency and allow smoke to enter the exit access corridor used as a means of egress. Since the break room contained employee lockers potentially storing combustible materials, the room was catogorized as a hazardous area.</p> <p>The census of ninety-two (92) was verified by the Administrator, on 08/12/14. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 08/12/14.</p> <p>Reference: NFPA 101 (2000 Edition)</p> <p>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</p>	K 018	<p>4. The Maintenance Director developed a Fire Door Audit Tool to validate placement of the 20-minute doors are in place. The QAPI (Quality Assurance/Performance Improvement) Committee has approved the plan of correction to replace the 20-minute fire doors in the Staff Break Room and Fire Door Audit Tool. The Administrator and Maintenance Director will validate the doors remain in place, weekly for four weeks and monthly for six months.</p> <p>5. Compliance Date: 9/13/14</p>



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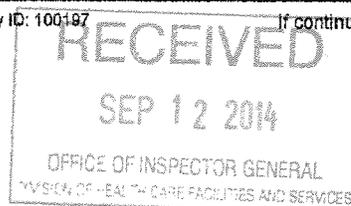
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K 018	Continued From page 3 with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 ft <sup>2</sup> (9.3 m <sup>2</sup> ) (3) Paint shops (4) Repair shops (5) Soiled linen rooms (6) Trash collection rooms (7) Rooms or spaces larger than 50 ft <sup>2</sup> (4.6 m <sup>2</sup> ), including repair shops, used for storage of combustible supplies and equipment in quantities deemed hazardous by the authority having jurisdiction (8) Laboratories employing flammable or combustible materials in quantities less than those that would be considered a severe hazard. Exception: Doors in rated enclosures shall be permitted to have nonrated, factory or field-applied protective plates extending not more than 48 in. (122 cm) above the bottom of the door.  19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80,	K 018			



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K 018	Continued From page 4 Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with 19.3.5.2. Exception No. 1: Doors to toilet rooms, bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials. Exception No. 2: Existing roller latches demonstrated to keep the door closed against a force of 5 lbf (22 N) shall be permitted to be kept in service.  19.3.6.3.3*	K 018			

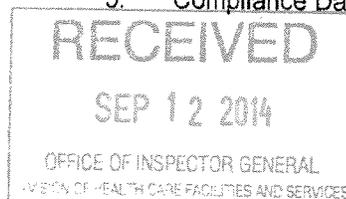


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NAME OF PROVIDER OR SUPPLIER  <b>BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2141 SYCAMORE AVENUE LOUISVILLE, KY 40206</b>	
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K 018  K 029 SS=E	Continued From page 5 Hold-open devices that release when the door is pushed or pulled shall be permitted. <b>NFPA 101 LIFE SAFETY CODE STANDARD</b> 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  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 National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect each of the eight (8) smoke compartments, residents, staff and visitors. The facility has ninety-six (96) certified beds and the census was ninety-two (92) on the day of the survey.  The findings include:  Observation, on 08/12/14 at 8:57 AM, with the Director of Plant Operations revealed the storage room located in the service corridor had full height, and four (4) inch wide opening on each	K 018  K 029	<b>K 029</b> <b>NFPS 101 Life Safety Code Standard</b> 1. A one hour fire rated door will be installed by the Maintenance Director before 9/13/14. Both of the 4 inch wide openings in the storage area and the two unsealed holes were repaired by the Maintenance Director on 8/28/14. 2. All Residents have the potential to be affected by the alleged deficient practice. A one hour fire rated door will be installed in the boiler room, by the Maintenance Director by 9/12/14. Both of the 4 inch wide openings in the storage area and the two unsealed holes were repaired by the Maintenance Director on 8/28/14. 3. The systemic change includes re-education of the Administrator & Maintenance Director on 8/28/14 regarding the requirement to have smoke resistant partitions and fire rated doors in areas separated from other spaces to prevent the passage of smoke in the event of emergency by the Regional Director of Plant Operations. 4. The Maintenance Director will continue to review Quality Assurance (QA) Rounds and Maintenance Request Forms to identify any walls that may require patching to ensure smoke resistance. The QAPI Committee has approved the plan of correction to replace the Boiler room door and patch the holes on the storage space and Fire Door Audit Tool. The Administrator and Maintenance Director will validate the door remains in place and the Resident rooms and other space are free from holes, weekly for four weeks and monthly for six months.	<i>Completion Date: 9/13/14</i> <i>rc</i>

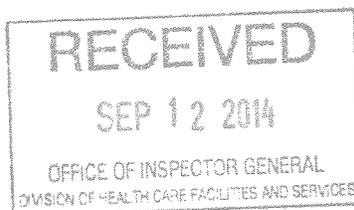
5. Compliance Date: 9/13/14



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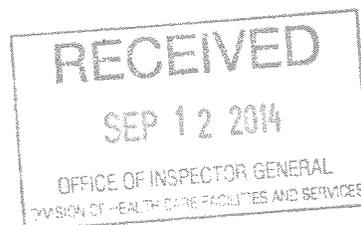
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  185348	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  08/12/2014
NAME OF PROVIDER OR SUPPLIER  BROWNSBORO HILLS HEALTH CARE AND REHABILITATION C			STREET ADDRESS, CITY, STATE, ZIP CODE 2141 SYCAMORE AVENUE LOUISVILLE, KY 40206	
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K 029	<p>Continued From page 6</p> <p>side of the room where a partition had been removed. The drywall had not been patched and sealed and was not capable of resisting the passage of smoke in the event of an emergency. In addition, there were two (2) unsealed holes in the wall where the sprinkler pipes penetrated the walls.</p> <p>Interview, on 08/12/14 at 8:59 AM, with the Director of Plant Operations revealed he was not aware the room was not smoke tight and stated the room was not capable of resisting the passage of smoke in the event of an emergency.</p> <p>Observation, on 08/12/14 at 9:16 AM, with the Director of Plant Operations revealed the door to the boiler room, located in a partial basement below the building service area, had an unrated wood door and was not equipped with a self-closing device.</p> <p>Interview, on 08/12/14 at 9:18 AM, with the Director of Plant Operations revealed he was not aware the door to the boiler room was required to be fire-rated and equipped with a self-closing device as it was accessible only from the exterior of the building.</p> <p>The census of ninety-two (92) was verified by the Administrator on 08/12/14. The findings were acknowledged by the Administrator and verified by the Director of Plant Engineering at the exit interview on 08/12/14.</p> <p>Reference: NFPA 101 (2000 Edition).</p> <p>19.3.2 Protection from Hazards. 19.3.2.1 Hazardous Areas. Any hazardous areas shall be safeguarded by a fire barrier having a</p>	K 029		



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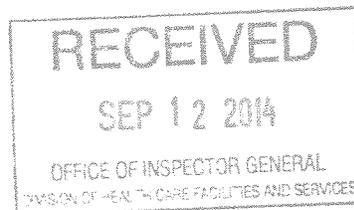
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K 029	Continued From page 7 1-hour fire resistance rating or shall be provided with an automatic extinguishing system in accordance with 8.4.1. The automatic extinguishing shall be permitted to be in accordance with 19.3.5.4. Where the sprinkler option is used, the areas shall be separated from other spaces by smoke-resisting partitions and doors. The doors shall be self-closing or automatic-closing. Hazardous areas shall include, but shall not be restricted to, the following: (1) Boiler and fuel-fired heater rooms (2) Central/bulk laundries larger than 100 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 quintiles deemed hazardous by the authority having jurisdiction.  19.3.6.3.1* Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4-in. (4.4-cm) thick, solid-bonded core wood or of construction that resists fire for not less than 20 minutes and shall be constructed to resist the passage of smoke. Compliance with NFPA 80, Standard for Fire Doors and Fire Windows, shall not be required. Clearance between the bottom of the door and the floor covering not exceeding 1 in. (2.5 cm) shall be permitted for corridor doors.  Exception No. 1: Doors to toilet rooms,	K 029			



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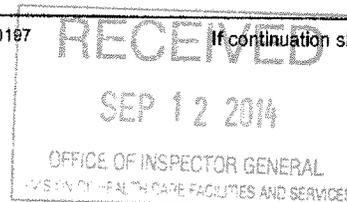
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K 029	Continued From page 8 bathrooms, shower rooms, sink closets, and similar auxiliary spaces that do not contain flammable or combustible materials.  Exception No. 2: In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, the door construction requirements of 19.3.6.3.1 shall not be mandatory, but the doors shall be constructed to resist the passage of smoke. 19.3.6.3.2* Doors shall be provided with a means suitable for keeping the door closed that is acceptable to the authority having jurisdiction. The device used shall be capable of keeping the door fully closed if a force of 5 lbf (22 N) is applied at the latch edge of the door. Roller latches shall be prohibited on corridor doors in buildings not fully protected by an approved automatic sprinkler system in accordance with  19.3.6.3.3* Hold-open devices that release when the door is pushed or pulled shall be permitted.  A. 19.3.6.3.3 Doors should not be blocked open by furniture, door stops, chocks, tie-backs, drop-down or plunger-type devices, or other devices that necessitate manual unlatching or releasing action to close. Examples of hold-open devices that release when the door is pushed or pulled are friction catches or magnetic catches. NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no	K 029		
K 066 SS=D		K 066	<p><b>K 066</b> <b>NFPS 101 Life Safety Code Standard</b></p> <ol style="list-style-type: none"> <li>On 8/14/14, a fire extinguisher was placed outside for the employee smoking area by the Maintenance Director.</li> <li>All Residents have the potential to be affected by the alleged deficient practice. On 8/14/14, a fire extinguisher was placed outside for the employee smoking area by the Maintenance Director. Additionally, the Maintenance Director validated the Resident designated smoking area continues to have an easily accessible fire extinguisher.</li> <li>The systemic change includes re-</li> </ol>	<p><i>Completion Date</i> 9/18/14</p>



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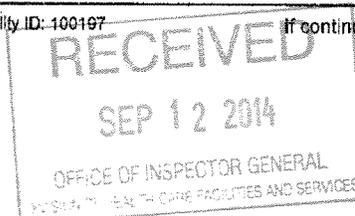
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K 066	Continued From page 9 less than the following provisions:  (1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.  (2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.  (3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.  (4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4  This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the designated outdoor smoking area for employees was properly equipped for safe smoking, in accordance with the National Fire Protection Association (NFPA) standards. The deficiency had the potential to affect employees using their designated smoking area. The facility has ninety-six (96) certified beds and the census was ninety-two (92) on the day of the survey.  The findings include:	K 066	education of the Maintenance Director on 8/28/14 regarding the requirement to have a fire extinguisher available for use in the event of an emergency by the The education was completed by the Administrator.  4. The Maintenance Director will continue to monitor the outdoor employee smoke area 5 days/week, using the Outdoor Extinguisher Log Sheet to ensure a fire extinguisher is available for use in the event of an emergency and document the presence of the fire extinguisher. The QAPI Committee has approved the plan of correction and Outdoor Extinguisher Log Sheet. The Administrator will validate the Outdoor Extinguisher Log Sheet with findings reported to the QA Committee. The Administrator will continue to audit the Outdoor Extinguisher Log Sheet, weekly, for four weeks and monthly for six months.  5. Compliance Date: 9/13/14		



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K 066	<p>Continued From page 10</p> <p>Observation, on 08/12/14 at 10:24 AM, with the Director of Plant Operations revealed the designated outdoor smoking area for employees did not have a fire extinguisher available for use in the event of an emergency.</p> <p>Interview, on 08/12/14 at 10:26 AM, with the Director of Plant Operations revealed the designated employee smoking area had a fire extinguisher available for use in the event of an emergency and stated it was missing as a result of a recent theft. The smoking area was contained by a wrought iron fence and gate and opened to the surrounding neighborhood.</p> <p>The census of ninety-six (96) was verified by the Administrator on 08/12/14. The findings were acknowledged by the Administrator and verified by the Director of Plant Operations at the exit interview on 08/12/14.</p> <p>Reference: NFPA 101 Life Safety Code (2000 edition)</p> <p>19.7.4* Smoking. Smoking regulations shall be adopted and shall include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such areas shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking.</p>	K 066		



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K 066	Continued From page 11 Exception: In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (2) Smoking by patients classified as not responsible shall be prohibited. Exception: The requirement of 19.7.4(2) shall not apply where the patient is under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.  Reference: S & C Letter: 12-04-NH; Date: November 10, 2011 Smoking Safety in Long Term Care Facilities	K 066		

